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Carrier 01	**Administrative Cost Reduction**	WEA Select Medical Plans through Premera: A. Premera has been a leader in implementing "Lean" thinking since 2005. The goal is to be able to improve quality, improve the enrollee experience, and improve efficiency while eliminating wasted time and work effort and lowering expenses. Premera uses this method to continue to evaluate and improve internal/external processes. Other organizations participate in Premera's "Lean" workshops so they can incorporate them in their own business – including the State of Washington, various provider groups, etc. Through Lean Premera has reduced overall administrative costs from 8.8% in 2005 to 6.6% in 2014. The administrative costs specific to the WEA Plans are approximately 5% of premium and have been under 6% for over 12 years. B. BlueCard provides significant savings to WEA/Premera enrollees traveling or residing outside the Premera service area. C. The percentage of WEA claims paid through auto adjudication remain some of the highest within Premera, which reduces the need for manual intervention. This provides peace of mind for providers as well as for enrollees with quick turnaround on payments for services and lower administrative costs.
Carrier 01	**Cost Savings**	WEA Select Medical Plans through Premera: A. The high number of Premera members, currently over 2 million, helps Premera negotiate greater discounts locally and nationally. In addition to WEA's over 110,000 enrollees, Premera also provides coverage to enrollees on the state Exchange, Individual, small and large group accounts. Furthermore, Premera provides coverage for many large, national accounts, including: Microsoft, Amazon, Starbucks, Weyerhaeuser, Alaska Air Group, etc. a. Provider contracting - Premera has the highest number of providers "in network" in the state (resulting in 98% + of all paid claims are "in-network"). Substantial provider discounts result in lower claims cost for the plan and lower out-of-of pocket costs for enrollees on a WEA Plan. b. BlueCard – (Premera's national "Blue" network) has negotiated significant discounts which are passed on to WEA Premera enrollees who travel or reside outside the Premera service area. B. Evidence-based medical initiatives that allow Premera to provide efficient and cost-effective care as well as to identify appropriate alternative care based on the enrollees needs. C. Real-time access to consumer decision-support resources to help enrollees understand and direct their health care needs.

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		D. Provider advisory groups continually monitor Premera's medical and pharmacy policies and procedures, and make changes to formularies to ensure they are appropriate level/tier, and cost and care-efficient. E. Member 360 dashboard - Proprietary tool used by Premera Case Managers to identify enrollees with specific healthcare needs and ensure they are receiving the appropriate services. F. Plans that include copayments for Emergency Room service (waived if admitted), copayments for inpatient hospital admissions, and higher copayments for brand, non-preferred and specialty drugs. G. Programs that monitor controlled medication substances to ensure appropriate use for enrollees. H. An open 3-tiered drug formulary that provides choice for enrollees and their physicians while being prudent and ensuring the drugs are cost and care-effective. I. Child COBRA Rate – Overage dependents pay the lower child rate rather than a subscriber rate. J. The premium rate for dependent children is the same whether there is one or more enrolled K. Prior Authorization – Some services require an approval for coverage from Premera before a planned medical service or procedure occurs, which provides financial protection and prevents unnecessary services. L. Choice – 7 freestanding medical plans available statewide with a broad range of benefits and rate levels to meet the diverse needs of school district employees and their families. Lower cost plans are available such as the HDHP or the EasyChoice Plan. The EasyChoice Plan provides three options all at the same rate. It was developed so employees could pick the plan most appropriate for their needs, and take the cost decision off the table. This plan has copays for office visits and generic drugs are covered in full. M. Waiver – employees can waive medical coverage under WEA. Any left-over state allocation is put back into the insurance pool to reduce the cost for those with monthly co-premiums.
Carrier 01	**Customer Service**	Premera's WEA claims, customer service and field service teams are all dedicated to the WEA account and are based in Washington. These teams: A. Provide a website with access to information about the employee's benefits, including a cost estimator. This tool helps them

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		determine which providers require less out-of pocket costs. The website provides educational information about wellness programs, plan benefits, and houses forms commonly used by employers and enrollees. B. Conduct independent surveys to measure enrollee satisfaction and then put a focus on making changes to improve satisfaction. C. Use "Ulyssess Learning™" – leading to first call resolution and a higher level of satisfaction from enrollees. D. Conduct "Lean" workshops which improve policies and processes for all areas within the company that support WEA enrollees. Premera places a high value on continuing to enhance the enrollee experience. E. Through Field Service staff, provide year-round servicing and are available to work directly with enrollees or family members who may need additional assistance with their plans. Premera provides an array of services from providing education about the benefits and the plan choices to when a plan change can be made. Premera also works to resolve claim issues for enrollees. This provides additional support to the district as well as direct support to their employees. F. Create the newsletters for WEA enrollees, which are published twice a year and provide information on a variety of topics including how to maximize their benefits, wellness resources, provider updates, and benefit and rate changes. G. Work with enrollees or their provider to address escalated or complex issues. H. Accept input from enrollees or school districts which has led to making modifications to processes or benefit changes to the Plans.
Carrier 01	**District Management of Health Plans**	• Premera passed on lower increases to dependents than to employee only tiers for the past three years for all school district business. • Premera added lower cost options, such as the HDHP, that have lowered premiums for all school district plans. • Premera provides a website with access to information about the employee's benefits – this includes a cost estimator which helps enrollees determine which providers require less out of pocket costs. The website provides educational information about wellness programs and their plan benefits. • Premera does independent surveys to measure enrollee satisfaction and then puts a focus on making changes to improve

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		satisfaction. • Premera has "Ulysses Learning™" which leads to first call resolution and a higher level of overall satisfaction from enrollees. • Premera's "Lean" workshops include Customer Service, Claims and Billing and Sales and Marketing processes which we continue to focus on in order to improve the enrollee experience. • In addition, Premera has: • Patient-centered medical home program enabled enrollees to select a clinic at which they received their non-emergent health care without having a copayment. • BlueCard national network of providers and international network via BlueCard Worldwide • Integrated Utilization management that work with members and providers across the care continuum, focused disease management program for lung and breast cancer as well as high-risk pregnancy. • The ability to arrange biometric testing for employees. WEA Select Plans: • Year-round service for members and districts is available for enrollees or family members who may need additional assistance with their plans. Premera provides an array of services from providing education about the benefits, the plan choices, network status, special enrollment rights, etc. Premera works to resolve claim issues for the enrollees as well. This provides additional support to the district as well as direct support to the employees. • WEA Select Plans added a lower cost option (EasyChoice) that has a lower premium and many first dollar benefits. • WEA has their own separate claim review process that allows enrollees to go before a board of their peers and have the claim upheld, denied or have an administrative allowance made. The input from the enrollees has assisted the WEA in developing benefit revisions to their plans.

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		• Leave of Absence coverage for up to 18-months • Coverage during a Labor Dispute • Coverage for those affected by a Reduction in Force • Semi-annual newsletters are sent to enrollees to educate them on their plans and provide access to information to help support decision making and healthier lifestyle decisions. • Meetings to assist payroll and HR with plan information, updates, education, etc.
Carrier 01	**Part-Time Employee Coverage Protection**	WEA Select Medical Plans through Premera: A. Have provided access to coverage for part-time employees working 17.5 hours a week for over 30 years. Individual districts can choose to allow participation for employees working fewer hours, providing that the employer is contributing towards the cost of the medical plan. B. Offer lower cost options, such as the EasyChoice plan that has lower premiums and many first dollar benefits (such as generic drugs paid in full). Additionally, a High Deductible Health Plan (HDHP) is available.
Carrier 02	**Administrative Cost Reduction**	Health plan systems replacement - Group Health focused our 2014 systems efforts on our existing technology, making needed improvements to Premier and other legacy systems in order to meet federal, state, and industry guidelines and continue to provide the best service to our customers. In 2015, we are turning our attention to researching long-term technology solutions that will support current industry best practices and are flexible enough to adapt to the changing needs of the health care market. Streamline our management structure - This ongoing work involves setting standards for management roles and examining variation in our management structure.

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Carrier 02	**Cost Savings**	In 2014, Group Health made real progress on a majority of priorities: • Deployed cost-saving initiatives such as clinical pharmacy redesign and data center move • Continued securing new contracts with care partners to support quality and affordability, most notably our choice to move Seattle hospital services to Swedish effective January 2016 • Deployed Press-Ganey customer experience measures in medical centers We work closely with the client to find the right benefit designs and network options and integrate them with our own delivery system to ensure that the group can maximize cost controls. We offer patient-centered care that promotes collaboration between physicians, specialists, and other members of the health care team. We empower employees to improve health through cost effective care management, wellness solutions, and occupational health services. All of these can result in a more productive workforce and lower overall costs. In order to ensure claims timeliness and accuracy, we have online systems that catch inappropriate billing, review coding, identify duplicate billings and COB/subrogation opportunities. We perform pre-payment review of high dollar claims and post-payment audits. In an effort to improve health care quality and reduce clinical cost trend in high-cost areas such as: emergency department (ED) visits, hospital inpatient (HI) days, and skilled nursing facility stays, Group Health developed new standardized work processes to ensure the use of evidence-based strategies in emergency rooms, hospitals, post-hospital transitions, nursing homes, and palliative

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		care settings. As part of these standard processes, Group Health clinicians assess the full range of patients' needs as soon as they enter the hospital or emergency room. ER staff consult with Group Health's on-site hospitalists to evaluate patients' symptoms, review their electronic health records, and determine whether they need to be admitted to the hospital or whether their conditions can be treated safely and more effectively in other settings (e.g., in rehabilitation or long-term care facilities, or at home with home health care services). If hospitalists and ER clinicians believe patients can be treated more effectively outside the hospital, they contact a Group Health physician and a health plan staff member designated as the patient resource - both of whom are on call 24/7. The patient resource staffer confers with patients and their families to discuss the options, checks patients' benefits, and helps arrange safe placement in care facilities. As a result of our focus on prevention and coordinated care, and operating as a medical home, we've seen extraordinary reductions in hospitalizations and emergency department visits. Our HEDIS utilization measures show we're at or above the 95th percentile nationally – meaning we have the lowest utilization rates – in hospital admissions, hospital days, readmission rates, and emergency department visits.
Carrier 02	**Customer Service**	All new Customer Service Representatives receive six weeks of formal classroom training on how to handle member calls regarding claims, benefits, eligibility, referrals, and more. They learn how to access this information using our internal systems. Directly after the formalized training we begin a four-week mentoring program, which provides one-on-one assistance from content experts. Our knowledge-based training system is ongoing and includes scripting and procedures for handling member's inquiries and concerns. Members can conviently access customer service via our member website, MyGroupHealth, at www.ghc.org, or our mobile app, which is available for the iPhone and Android Smartphones. It includes many features available on our MyGroupHealth for Members Website, including access to Consulting Nurse, Symptom Checker, clinic locations and wait times, and more. From the website, members can use online forms to order a new ID card, file a claim, update their personal information, and provide feedback about Group Health.

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		Using MyGroupHealth, members receiving care in Group Health medical centers have online access to a shared medical record consisting of their entire electronic medical record (except chart notes). Patients are able to communicate directly with their primary care team – at their convenience – which improves service and builds a stronger provider-patient relationship. Members can view their online records any time. Features available to them include: • Access to lab/test/radiology results, after-visit summaries, allergy and immunization records, medication histories, blood pressure, weight, and current health conditions for health care services provided at owned and operated medical centers • Secure messaging with their primary care team if at an owned and operated medical center • View Coverage Agreements and Summary of Benefits • Access Explanation of Benefits statements with payment information on claims • Check benefits usage and remaining coverage • Order prescriptions and have them delivered to their homes
Carrier 02	**District Management of Health Plans**	Group Health's online employer portal, MyGroupHealth for Employers, offers secure, convenient access to the transactional tools employers need to effectively manage their health care benefit programs. You can login to enroll new subscribers and their dependents online, and make changes for your existing employees — adding or terminating dependents, or terminating the entire subscriber record. You can order ID cards with a few simple clicks. The site also features content that helps employers understand the value of Group Health's business solutions for health care.
Carrier 02	**Part-Time Employee Coverage**	We allow access for part-time employees working a minimum of 17.5 hours per week.

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Carrier 03	**Administrative Cost Reduction**	Regence is constantly looking at how to do more with less. We have invested heavily in technology and systems that can help us to operate more effectively with less people and general overhead costs. We have downsized as needed while keeping a keen eye on not slipping on customer satisfaction. As a result, Regence was rated number three in the country for all Blue Cross Blue Shield plans in the area of service and customer satisfaction. Unfortunately, many of the efficiencies developed have been offset by increased compliance and legislative requirements which are mandated. In addition, Deploying a strategy of smaller, more cost effective, higher quality networks with PCP based selection, will benefit the School Districts and its employees by keeping costs down through collaborative arrangements with key provider systems. In addition, we feel that we are best positioned to work with these key provider entities to enter into exclusive network and product arrangements geared specifically toward the School Districts and its employees. We will also look at different product optoins, including new High Deductible plans. We will continue to streamline our service delivery models to gain additional efficiences and cost saving through investments in technology and people. All customer services functions related to regence School Distict business, are run through one, centralized service center which helps keeps cost down while maintaining dedicated subject matter experts knowledgeable about the products and services delivered to the Districts in order to achieve administrative savings.
Carrier 03	**Cost Savings**	Most recently, Regence has rolled out with a new and innovative Accountable Health Network (Pay for Perfomance Model) with several doctor and hospital systems. This is a serious and dynamic game changer in WA setting the bar higher for the industry and driving to partner with providers to have skin in the game. This new product will drive lower costs and future trends while providing a better member experience that is more efficient and will deliver better quality outcomes. Providers will have the opportunity for bonus payments and the end result will be a lower overall cost of care. Outside of this, Regence has the highest number of providers “in network” in the state (98%+ of all claims are paid “in network”) and we have the deepest discount arrangements with the vast majority of providers to deliver lower costs which can be supported by claims file reproecessing a validated studies by Milliman. We deomstrate a consistent practice of using evidence-based medical protocols that allow Regence to provide efficient and cost-effective care as well as identifying appropriate alternative care based on the member’s needs. We provide members with real-time access to consumer decision-support resources (ie: myregence.com, and HealthSparq transparency solutions) to help enrollees understand the cost and quality of care by provider. This helps members to make wiser health care decisions. We provide districts with access to robust wellness solutions (360Me) desinged to meet each district where they are at offering a suite of products and services that fit their culture. This is geared to helping districts to change member behavior. Knowing that 70% of all claims are life style related, Regence is prepared to work with districts to educate, incent, and

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		empower members to live healthier lifestyles and to know their biometric screening numbers which are early indicators of health care needs before they become high cost cases. Not only are these programs reducing costs but also bending future trends. We are working with districts to be consultative in our approach to offer incentives to members to complete biometric screenings, participate in wellness programs that can be supported by gamification programs like our HubBub program, and to encourage participation in disease management programs and health coaching offered by Regence.
Carrier 03	**Customer Service**	Regence has a world class website called myregence.com with access to information about the employee benefits – this includes a cost estimator which helps them determine what provider may require less out-of-pocket costs for the enrollee or their family. The website provides educational information about wellness programs and their plan benefits. This website has been nationally recognized by the Blue Cross and Blue Shield Association as the template for transparency tools nationwide. All customer services functions related to regence School Distict business, are run through one, centralized service center which helps keeps cost down while maintaining dedicated subject matter experts knowledgeable about the products and services delivered to the Districts in order to achieve administrative savings. Most recently Regence received the distinction of being ranked as number 3 in the country for all BCBS plans.
Carrier 03	**District Management of Health Plans**	Regence offers an array of servives and tools to help Districts manage benefits. We start by assigning each District a Senior Account Executive. This person is the strategic liasion between the District, it's broker, and Regence. This individual is responsible to work with the District to help manage benefits, look at plan design options, discuss cost containment services, and to focus on member engagement while directing the appropriate resources from a service perspective. In addition, we offer Real-time access to consumer decision-support resources (ie: myregence.com- as described below) to help enrollees understand and direct their health care needs.
Carrier 03	**Part-Time Employee Coverage Protection**	When a full time employee's hours are decreased, we will work with the member to review other plan options that allow the individual to remain covered on a medical program. We also offer lower cost plan options to help part time employees.
Carrier 04	**Administrative Cost Reduction**	The principles of the Patient Centered Medical Home (PCMH) are fundamental to the way we've been practicing medicine and delivering care for over 65 years. The Patient Centered Medical Home (PCMH) at Kaiser Permanente Northwest (KPNW) is our model for proactively delivering patient-centered care and achieving dramatic improvements in quality, member satisfaction, clinician and staff morale, and affordability. Our PCMH is a primary care team-based practice centered on the patient as an active and informed participant in his or her own care. With a proactive approach to prevention and by eliminating delays in needed care, we believe we can make a big difference in the health of individuals and the entire population.
		Kaiser Permanente has developed advanced technology and processes to support the PCMH model:

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		• Personal physician – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care. Because they are uniformly recruited, paid, and trained to practice medicine in ways consistent with the PCMH model, Northwest Permanente, PC, physicians have extensive personal experience and the support of their colleagues in providing a patient-centered approach to care. • Physician-directed medical practice – the personal physician leads a team of care providers at the practice level who collectively take responsibility for the ongoing care of patients. Kaiser Permanente has the advantage of having one medical record that follows employees wherever they receive care within our system. This helps their care teams stay informed about their medical history, evaluations, tests, and overall treatment plan. • Whole-person orientation – the personal physician is responsible for coordinating care for all of the patient's health needs at all stages of life – preventive services, acute care, chronic care, and end-of-life care. Kaiser Permanente's electronic medical record tracks biometric data and other risk factors (such as lifetime exposure to radiation from medical scans) so that his or her care team can monitor and respond to incremental changes in health status. • Care is coordinated and integrated across all elements of the complex health care system and the patient's community. Thanks to electronic evidence-based treatment guidelines, Northwest Permanente physicians can order many of the tests a patient will need prior to his or her first visit with a specialist, consulting physician, or other caregiver. • Quality and safety are hallmarks of the medical home. In a comparison of all health plans in the markets we serve, Aon Hewitt Associates reported that we consistently outperform other plans in clinical quality. We report regularly to the Quality Corporation. Independent organizations like NCQA and Quality Corporation provide the most objective assessment of a care delivery system and health plan performance; and are often more reliable than self-reporting system improvements. • Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication. At Kaiser Permanente, patients not only communicate with their care team through secure email, but they can also see openings in their doctor's schedules and make appointments online, review lab results, refill prescriptions and review prior visit information and visit summaries. We have implemented a process in our membership services call center to ensure that patients who ask for a same-day appointment can reliably get such appointments scheduled with one phone call.

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		• Payment appropriately recognizes the added value provided to patients who have patient-centered medical home. Northwest Permanente physicians have a pay-for-performance payment model that is heavily weighted towards quality and service measures as compared to personal financial results that currently take place in other medical groups. The PCMH serves to either directly provide, or coordinate, all care needs (preventive, acute, chronic) for patients who are part of that medical home. The patient's primary care needs are provided directly by his or her PCMH team. Almost all care is provided within the KPNW Medical Neighborhood (including specialty care, hospital, and continuing care). The PCMH also coordinates and supervises all care provided to patients outside of KPNW. Patient Centered Medical Home Recognition The National Committee for Quality Assurance (NCQA) awarded all 17 of our primary care medical offices with Level III Patient Centered Medical Home (PCMH) Recognition - the highest level of recognition possible. Each medical office was reviewed and scored independently against 168 specific items across a set of 9 standard categories. All medical offices received 100% of points sought. Level III PCMH recognition is granted through July of 2015. As a nonprofit organization, we reinvest our revenues to support programs that benefit individuals and communities across our service areas. We: • increased access to healthy food and safe walkways • promoted healthy lifestyles in underserved communities • supported community clinics

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		• conducted research • trained health care workers • expanded access to health care • subsidized members and patients who needed help covering medically necessary care. Supporting Affordability through Investments at KPNW • Westside Medical Center — Opening new medical centers allows Kaiser Permanente to provide expanded services, meet regulatory requirements, and build with an eye to saving energy and resources. The Northwest Region's Westside Medical Center opened in August 2013, in Portland, Oregon. The facility became Kaiser Permanente's first hospital to earn Leadership in Energy and Environmental Design (LEED) gold certification. LEED's calls for such things as pedestrian friendliness, sustainable site development, efficient water and energy use, indoor environmental quality, and chemical avoidance make it one of the most influential forces in building design in the world. Kaiser Permanente used the occasion of Westside's opening to announce our commitment to pursuing the same environmentally rigorous standards on construction of all new hospitals and medical offices going forward. People didn't have to wait long to see that commitment in action. In December, the Northwest's Gateway Medical Offices opened in Portland in what was formerly a vacant Circuit City building. The foreclosed big-box store was completely redesigned to become a light-filled LEED gold certified medical office with a bright, colorful interior and outdoor patio. The conversion of the building is sparking additional neighborhood improvements in the urban East Portland community.

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		• Northwest Region Improves Quality, Saves Money — Medical and dental integration allows caregivers to prevent and address significant dental conditions before they become serious and costly medical conditions. Being an integrated care system is at the core of Kaiser Permanente's ability to deliver high-quality, affordable health care. In the Northwest Region, one team recognized how they could take the integrated approach to a whole new level. The Medical/Dental Integration Project is a collaborative effort between four entities: Northwest Permanente, Permanente Dental Associates, Kaiser Foundation Health Plan medical plan, and Kaiser Foundation Health Plan dental plan. The Medical/Dental Integration Project involved three phases: The first phase first internalized about 250 dental surgery cases for patients who have Kaiser Permanente medical benefits but not Kaiser Permanente dental benefits, and improved coordination of care for another 175 patients who have both Kaiser Permanente medical and dental benefits. In addition to improving quality and the care experience, the cost savings are significant: The Northwest Region no longer spends up to $10,000 per case in operating suite and anesthesia charges for patients who were previously treated in external settings. Phase Two provided physicians and patients with seamless access to dental services for acute conditions and dental clearances of all medically necessary dental work prior to certain medical treatments. This work will integrate care so that patients' oral health is satisfactory before they undergo major procedures provided by Kaiser Permanente physicians. Phase Three occurred when Permanente Dental Associates and Northwest Permanente partnered for the first time to recruit and hire an oral and maxillofacial surgeon for complex oral surgery, ensuring that patients with severe medical head and neck conditions receive the right care at the right time.

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Carrier 04	**Cost Savings**	With this integrated program in place, the Northwest Region will now have the ability to address significant dental conditions before they become acute systemic medical conditions. The primary ways Kaiser Permanente controls costs are by engaging members to participate in their own health, and by reducing waste—helping healthy members stay healthy and motivating those with unhealthy habits to make positive lifestyle changes, eliminating unnecessary procedures, decreasing unwarranted variation in care and reducing paper costs. Unlike traditional health care providers, we offer a fundamentally different approach to care. Our health plan, doctors, hospitals, medical offices, pharmacies, labs, and more are all part of one organization. Because our doctors are salaried and measured according to how well they raise the bar for member health, our model frees doctors to focus on patients—not the itemization of services or the collection of claims. Their personalized, dedicated approach to member health is supercharged with the incredible tools and information within Kaiser Permanente HealthConnect®. This award-winning system is at the fingertips of every caregiver in every one of our facilities. Our investment in our industry-leading electronic health record (EHR) system is not only our most effective member engagement tool; it also helps reduce overutilization and maximizes information sharing. All Kaiser Permanente providers can securely access this system and view a member's previous test results and other physician notations, which help reduce duplication of lab tests, unnecessary medical visits, redundant utilization of services, and pharmacy errors. Because we're set up differently, we're aligned to better deliver what matters to you: improved health, better clinical outcomes, more value, and consistent service. We're caregivers, hospitals, and health plans working in concert to set the benchmark for quality, affordability, and service. It allows us to deliver some powerful benefits: • consistent service and consistent value across the country • more stability and better cost management • better health for employees so your clients' businesses can thrive • the right care at the right time for healthier, more productive employees

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		Strategies we use to contain costs include: Cost effective disease management Members with chronic conditions drive 85 percent of health care costs, so it's essential that these individuals learn ways to manage their conditions. We have disease management programs, which can help members with chronic conditions. Some key features of the program are: • We intervene with members early, even before they have symptoms or have been diagnosed with a disease, using member health status, risk factors, and family history to assess their risk status for a chronic condition. This means conditions are well controlled or prevented before they reach an advanced stage that requires usage of more services. • We don't use dollar triggers to initiate case management. We use the more direct and effective method of automatically enrolling members in disease management registries based on health status and member information, rather than anecdotal information. • Our program is seamlessly integrated into our member-centered, "whole person" continuum of care — it's not a separate carve-out program through a vendor that costs employer groups extra money. Online health care management tools My Health Manager, available at kp.org, provides member-facing online tools that uniquely empower members to manage their family's health care through secure online access. It's easy and convenient for members to email their doctor's office, make routine appointments, order prescription refills, view lab results, and much more. Often times saving a phone call or an unnecessary trip to the doctor's office:

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		• Members who used the free secure email service were 7 to 10 percent less likely to schedule an office visit. • Members using Kaiser Permanente HealthConnect®, our industry-leading electronic health record system, called their physician 14 percent less than those not using Kaiser Permanente HealthConnect®. These online services aren't available through other health plans. Broad consumer engagement and preventive care To encourage members to take a more proactive role in their own health care, we provide a full range of health and wellness resources that include: • Health education classes and online self-care programs to help members learn how to make healthier lifestyle choices. • Online decision-support tools that empower consumers to make better health care decisions, resulting in better health outcomes and appropriate service utilization. • Preventive services and screenings at either reduced copayment or no cost to encourage members to stay healthy. Elimination of redundancies and improved member safety Our investment in Kaiser Permanente HealthConnect® is greatly enhancing efficiency by maximizing information sharing. All of our providers can securely access this system and view a member's previous test results and other physician notations among the

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		many features, which helps reduce, duplication of lab tests, unnecessary medical visits, redundant utilization of services, and pharmacy errors. Wider selection of affordable price points We've added several competitive plan designs to our core HMO offerings so that employer groups and members can select lower premium products with higher deductibles and more copayment options. This added flexibility allows groups the opportunity to select the plan that best fits their specific needs. Recognized for cost efficiency In the six regions where we operate, the Kaiser Permanente plan is ranked #1 for financial efficiency across all product and funding offerings, according to the Hewitt Health Value Initiative™ report. Further, the report shows that in all six regions we offer the most cost-efficient plans for: • HMO • PPO • Self-funding Also, Aon Hewitt and Associates rated Kaiser Permanente with the highest clinical quality in every region. Employer groups can receive the full Hewitt Health Value Initiative report by contacting their sales representative or account manager.
Carrier 04	**Customer Service**	Member, patient, and customer perceptions, experiences, feedback (comments and complaints) and requests drive Service Quality improvement initiatives for our Membership Services. One of the pillars of our Operating Plan is "People and Culture" with a vision to create a culture of high performance that epitomizes partnership and mutual support with a focus on care and service to members. With this vision come four goals and the aspiration of having a flexible, agile, empowered work force. Performance is

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		measured by the People Pulse work unit index defined by specific measures. To meet these goals we have implemented a number of service and care experience initiatives in the areas of service behavior standards, recognition, environmental improvements, performance management, satisfaction data literacy, leadership education and consultative team support. Ownership and accountability for work environment satisfaction reside in every individual but are emphasized in the accountabilities of leaders. Outcomes Measurements & Benchmarks: We are committed to measuring and tracking the satisfaction of our members so that we may continue to improve the quality of care and service we provide. We conduct various internal surveys as well as participate in the National Committee for Quality Assurance's (NCQA) Consumer Assessment of Health Plans Survey (CAHPS) to evaluate member satisfaction with health care and service. The results of both internal and external surveys are disseminated throughout the organization and are used to monitor performance and target areas of improvement. We participate in the annual Consumer Assessment of Health Plans (CAHPS) Study and consistently meet or exceed regional and national averages on a broad range of survey questions pertaining to member satisfaction with the Health Plan, Plan physicians, member services, and access to care.
Carrier 04	**District Management of Health Plans**	We engage with each district to provide personalized service and consultation that fits the district's preference. We provide extensive reporting that analyzes plan utilization and demonstrates the value and cost savings achieved through our integrated care. We provide consultation on industry trends, product innovations, workplace wellness strategies, and benefit plan design options. We are available for member education events regarding health plan benefits, as well as wellness events. Our goal is to make it easy for the district's employees to engage in their health at home, online and at our facilities. This is our all-inclusive approach that saves the district money, which supports the school's budget, as well as the health and well-being of their employees.

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		Other achievements include Kaiser Permanente sponsoring the Thriving Schools program which is a comprehensive, multi-year effort to support the health of students, staff and teachers in the communities that KP serves. Priority areas for Thriving Schools include promoting healthy eating, encouraging physical activity, supporting social and emotional health and creating a healthy school environment. In order to meet our goals, KP partners with several community organizations: The Alliance for a Healthier Generation has recruited 35 schools in the Longview and Evergreen school districts to their Healthy Schools program designed to create a healthy school environment. Kaiser Permanente is offering grant funding to those schools to implement individual health and wellness projects. Playworks has provided training for adults to lead active play in several schools in the Evergreen School District. As a result, Evergreen School District was the first NW school district to host Playworks' Team Up model of one full-time coach assigned to work directly with school staff and administration in four schools to implement Playworks' inclusive group management techniques and facilitate safe and active play during recess throughout the year. Schools in Clark and Cowlitz County have signed up to participate in the Fire Up Your Feet campaign, which encourages staff, students and their families to be physically active before, during and after school. Kaiser Permanente's Educational Theatre Production, The Pressure Point!, was hosted in schools in Clark and Cowlitz County engaging kids and adults in making healthy life decisions.

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		The School Based Health Alliance's Hallways to Health program expands the role of school based health centers in advancing obesity prevention and social and emotional health. Washington Middle School Based Health Center in Seattle is part of the learning collaborative supported by Kaiser Permanente.
Carrier 04	**Part-Time Employee Coverage Protection**	Benefit eligibility is determined by the group and we are happy to accommodate covering part-time employees.
Carrier 05	**Administrative Cost Reduction**	Operating cost management and productivity disciplines are embedded throughout UnitedHealth Group's businesses. Productivity is also generated by leveraging the increasing scale of our business. Strong growth in Medicaid enrollment and the insourcing of commercial pharmacy benefits management have contributed to productivity gains in those areas, and growth on the exchanges should drive additional leverage in 2015. Over the past several years, we have generated significant productivity gains through actions in five principal categories: ? Quality: Eliminating waste and improving core operating process performance; ? Automation: Reducing manual processing by leveraging technology; ? Integration and Modernization: Advancing a more integrated, simple and modern processing environment, including significant cost savings from decommissioning legacy acquired and redundant platforms; Overall we expect productivity efforts to improve our operating cost ratio on an equivalent business mix by an average of 20 to 40 basis points per year over the next several years. Our consolidated ratio, however, may not decrease by this amount in any given year as we expect an increasing mix of services business and business from Amil Participações S.A (Amil). In October 2012, UnitedHealth Group and Amil, Brazil's largest health care company, announced that the companies agreed to merge, bringing together two leading organizations with the broad scale, distinctive resources and advanced technology to help modernize the

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		performance of the health systems and serve the health care needs of consumers in their markets in the Americas. Both our services businesses and Amil carry higher operating cost ratios. The operating cost ratio is also significantly impacted by the insurer tax that took effect in 2014 and has scheduled increases through 2018. ? Procurement and Sourcing: Cost reductions related to optimizing procurement and sourcing; and ? Payment Integrity: Medical cost reductions from improving payment accuracy and from various program integrity offerings and other initiatives to reduce improper billing and payment.
Carrier 05	**Cost Savings**	We have provided overviews of our efforts and achievements toward controlling the cost of health care. CONTROLLING COST AND IMPROVING AFFORDABILITY We are improving health care quality and affordability by delivering new and innovative network product designs, empowering consumers and enhancing the performance of medical cost management. We offer advanced network product designs featuring quality, efficient and cost-effective care providers including gated products and tiered network products. We continually refine and evaluate our national network of care providers based on proven records of quality and patient satisfaction. To help ensure consumers receive the most effective care, we partner with care providers who are evaluated on objective health outcomes data, not solely on cost, health system affiliation or word-of-mouth. We are pioneering change in the structure of health care reimbursement through value-based contracts and accountable care organizations (ACOs). Value-based contracts reward providers for quality, efficiency and optimal medical outcomes. Value-based contracts are contributing to our overall reduction in hospital utilization. Our Healthplan Manager helps employers and government customers create a data-driven strategic roadmap to more effectively

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		improve health plan performance, and consumers now have access to our Personal Rewards program that encourages and rewards healthier behaviors. We constantly enhance the performance of medical cost management. We continue to design and implement comprehensive inpatient care management programs to reduce hospital utilization. Across UnitedHealth Group, we deploy nearly 2,000 clinicians, who apply evidence-based medical criteria and robust informatics in order to reduce unnecessary inpatient admissions, prevent readmissions, ensure appropriate average lengths of stay and engage contracted physicians to increase appropriate use of outpatient and ambulatory services. The success of these programs is illustrated by our consistent reduction in hospital utilization per insured member for over five years in all lines of business. This year-over-year reduction continued in 2014 and is expected to continue in 2015. We also apply our strong medical management strategies across outpatient services. CONTROLLING CLAIM DOLLAR PAYOUT Because you have entrusted us to process your claims in the most cost-effective manner, we designed our claim system specifically to control costs, prevent payment of non-covered services and protect from fraud and abuse. COST CONTROL FEATURES ? Secure, tested load of the benefit plan for online benefit calculation ? Online eligibility determination ? Online coordination of benefits detection and calculation ? Online duplicate detection ? Online deductible and out-of-pocket calculations

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		? Online application of negotiated rates ? Online utilization review and calculation FEATURES INTENDED TO PREVENT PAYMENT OF NON-COVERED SERVICES ? Secure tested load of the benefit plan to include non-covered services ? Online medical guidelines that can specifically indicate non-covered procedures ? Complete quality review to focus on non-covered services ? Complete training of specialists about coverage specifics PROTECTION FROM FRAUD AND ABUSE ? Online security module to prevent unauthorized access to the claim system or payment beyond authorized limits ? National physician and other health care professionals file unit to prevent loading a physician or other health care professional into the claim system until completion of detailed investigation ? Anti-Fraud and Recovery Solutions (AFRS) a comprehensive program designed to limit the impact of abuse and fraud for customers and for us ? A comprehensive training and fraud awareness program used to train transaction teams, underwriting and customer service representatives to identify potential fraud issues ? Designated transaction center and health plan staff throughout the country who works with AFRS to detect and prevent

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		inappropriate medical benefit payments resulting from abuse or fraud ? A clinical prospective review program that uses internal flags to review suspect claims prior to payment ? A recovery team that investigates possible overpayments related to abuse and fraud and recovers funds lost through those practices ? A compliance program that ensures adherence to local, state and federal laws related to potential fraud matters and how they are handled HOSPITAL BILL AUDITS Our hospital audit vendor receives a monthly claim payment extract for inpatient and outpatient claims that exceed $10,000 in billed charges. The vendor runs those claims against its database and selects those that are candidates for audit. Selection is based on diagnosis, type of services rendered and previous billing history with a facility. In an up-front review of the claim information against a copy of the hospital bill, the audit vendor may detect a hospital billing error. Other claims may be subjected to an in-depth review of all charges against the hospital's medical records. This is referred to as a line-by-line review of billed charges. Our vendor will schedule and complete the audit. The vendor collects the refund, deducts its fee for services and sends the net refund amount to us. The fee is contingent upon recovery. HIGH-DOLLAR CLAIM NOTIFICATION PROCESS

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		The high-dollar claim notification process notifies various business areas and the customer, as appropriate of high-dollar claims. It includes an additional operational review of claim payments of $250,000 or more before the payment is released, and payment notification at the $250,000 level. Designated representatives from the production (claim) department's Development and Standards, and Quality organizations ensure that benefits are paid according to existing policies and procedures, and audit the claim using established audit criteria. After this review, an Operations High-dollar Claim Review Committee reviews the proposed claim payment to confirm that claim payment is reasonable and accurate according to benefit plan guidelines, contracts with physicians and other health care professionals, industry guidelines and our reimbursement policy. Online claim payment information is always available through Employer eServices. OVERPAYMENT RECOVERY We have a comprehensive internal recovery program. In addition to our team of employees dedicated exclusively to recovering overpayments, we can recover overpayments from physicians and other health care professionals by offsetting future payments. To supplement our internal recovery efforts, we use a number of vendors to maximize recovery. Recovered dollars are returned to the customer's bank account. CREDIT BALANCE RECOVERY Credit balance recovery is a component of overpayment recovery performed by an external vendor.

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		Credit balance recovery is performed by AIM Healthcare, part of OptumInsight, a UnitedHealth Group company. AIM performs on-site reviews of positive balances or credits existing on customer accounts and is responsible for identifying, validating and recovering the overpayments on our behalf. AIM retains 10 percent of the recovered amount as reimbursement for the cost of this service. NETWORK SAVINGS We offer our customers and members three levels of reimbursement programs. While our traditional discounts save expenses on network services, we also have two non-network strategies that lower the costs of non-network and out-of-area claims. FIRST TIER - TRADITIONAL DISCOUNTS Our traditional networks are broad with easy access and benefit designs that encourage members to use our network services whenever possible, resulting in the highest possible claim savings. Our contracting process capitalizes on both our national strengths and our local market knowledge and expertise to achieve our national network goals. Our contracting efforts are designed to: Increase access by maintaining a large number of physician and other health care professionals in a variety of specialties ? Establish positive and supportive physician relationships that promote delivery of quality health care to all of our members ? Reimburse physicians only for those services actually rendered and only for services that are medically appropriate ? Achieve the most favorable price through fixed, negotiated rates SECOND TIER - PHYSICIAN SHARED SAVINGS PROGRAM

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		The Physician Shared Savings Program (SSP) makes up the second-tier level of discounts in our discount program by enhancing our traditional participating network. It includes both wrap network discounts and claim-specific negotiations. We have contracted with Multiplan, First Health Group, Viant and other non-logo networks, which have thousands physicians contracted nationally for vendor wrap. SSP discounts can apply regardless of the member's benefit level. This means that SSP may apply to non-participating claims, including radiology, anesthesiology, pathology and laboratory services (RAPL), regardless of benefit level. Through these programs, a discount may be applied when a member accesses a wrap network physician. ADVANTAGES TO EMPLOYERS ? The programs are easy to administer. Discounts are automatically applied when a claim is processed and are noted on the member's explanation of benefits (EOB), eliminating any need for employer intervention. ? Plan changes are not required. ADVANTAGES TO MEMBERS ? Members who receive services from these programs benefit from reduced coinsurance dollars for their discounted fees. ? Physicians and other health care professionals participating in the SSP vendor's network are prohibited from balance billing members when their contractual discount is taken (*). ? Members will not receive a separate SSP provider directory, but electronic access to the SSP vendor directory is available to the member through myuhc.com. Savings are applied post-service when an SSP physician or other health care professional has been used. ? Easy-to-read billing identifies when an SSP physician and other health care professional was accessed that resulted in cost savings. ? Special claim forms are not required when a member accesses the SSP physician or other health care professional.

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(*) There may be situations in which the SSP providers are not paid per the SSP, but are instead paid like other non-network providers. In such cases, the member's out-of-pocket cost will be the same as if discounts were not available through the SSP.

THIRD TIER – MAXIMUM NON-NETWORK REIMBURSEMENT PROGRAM

In addition to our SSP program, our Maximum Non-Network Reimbursement Program (MNRP) offers yet another alternative to help reduce the impact of rapidly rising, uncontrolled non-network expenses. Instead of basing non-network reimbursement on uncontrolled, charge-based prevailing fees, we reimburse plan expenses according to standards established by the federal government (such as Medicare). Members retain the freedom of choice to access either network or non-network health care services, but realize they may carry a more significant financial responsibility when using non-emergency, non-network services, thereby creating a member incentive to use our broad, discounted network.

Under this approach:

? Reimbursement for non-emergency, non-network physicians and other health care professionals including non-network facilities is based on a percentage of the published rates allowed by Medicare for the same or similar services. These standards are cost-based payment methodologies established by the Centers for Medicare and Medicaid Services (CMS). Medicare's payment methodologies are widely understood and accepted by physicians and other health care professionals.

? The program applies only to non-emergency services that are provided by non-network physicians and other health care professionals including non-network facilities; however, it does not apply when non-network services are coordinated and approved by UnitedHealthcare as covered network services, or to any other non-network services that are considered payable as a network benefit.

? If no Medicare rate exists for a particular service, then the eligible charges will default to 50 percent of billed charges.

? This program can be administered alongside our SSP, with the Medicare-based reimbursement levels applying only where savings are not obtained under that program.

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		We make information available in a variety of ways to assist employees in understanding how the program works. This includes written consumer materials, conversations with customer service representatives, consumer activation messaging on health statements and information on myuhc.com.
		We make information available in a variety of ways to assist employees in understanding how the program works. This includes written consumer materials, conversations with customer service representatives, consumer activation messaging on health statements and information on myuhc.com.
Carrier 05	**Customer Service**	RESULTS SHOW MNRP WORKS For employers with MNRP, the rate of total cost trend on average slowed 1 percent to 2 percent within the first year. We expect additional savings beyond the first year. These savings can be attributed to a combination of change in employee behavior from non-network physicians to network physicians, and to lower reimbursement to non-network physicians. For employers who experience high non-network utilization, savings can be significantly higher. At UnitedHealthcare, we like to keep things simple. So we offer members an array of easy ways to learn more when they have questions: mobile apps, educational websites, communications and digital newsletters.
		Available 24 hours a day, 7 days a week, mobile devices help us meet our members where they are, in location and in functionality. Members and their families can make their health care decisions faster, easier and more conveniently than ever before with several mobile capabilities. The mobile version of myuhc.com provides links to the most common features accessed on myuhc.com using a web optimized browser view. Our mobile application, Health4Me, provides instant member access to health care information, the nearest physician, the status of a claim, treatment costs or to speak directly with a nurse or have a representative call back. Our member tools and mobile applications are integrated and access our core systems – the same systems accessed by member services and clinical staff.

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		In 2013, members made 8.9 million transactions via Health4Me, accessing information and support whenever and wherever they needed it. Because we've dialed up our communication options to meet changing service patterns, we've been able to dial down our CSR to member ratios, yet still earn high satisfaction levels. It helps that we're also good at answering questions correctly the first time, provide EOBs that are easy to understand, and pay claims right the first time. A handy statistic – the number of calls per 1000 members – assures us that we're moving in the right direction. In 2010, we received 91 calls per 1,000 members. In 2013, we received only 61.7 calls per 1,000 members. And caller satisfaction levels with our customer service representatives (CSRs) – as measured by the post-call United Experience Survey – is currently at 95.4 percent. We are proud that UnitedHealthcare recently received three honors in the national "Best in Biz Awards" for online and mobile programs and services that engage consumers in their health and make it easier for them to navigate the health system. ? myClaims Manager earned gold in the Consumer Service of the Year category ? Health4Me mobile app received silver in the Consumer Product of the Year category ? UHC TVSM earned bronze in the Website of the Year category Health4Me also earned the 2013 eValue8 Innovation award, which recognizes innovative work of health plans to develop programs that address critical health care issues.

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		However, when members do choose to call us, our CSRs are at the ready to provide members with access to a range of information and services: medical benefits, claims, pharmacy, financial, behavioral, clinical, incentives, health education, provider research, appointment scheduling, treatment cost estimation, and more. Our Enhanced Service Model combines expert service with meaningful advising for a complete member service experience. Our CSRs are available from 8 a.m. to 8 p.m., Monday through Friday, for all covered members in their local time zone, based on the area code they are dialing from. To facilitate these hours of service availability, calls are forwarded to an alternate customer care center outside of the normal operating hours of the primary customer care center. SERVICE Managing a claim or benefits problem or resolving a billing dispute can be a huge stressor for members. These issues are often too complex for members to sort out on their own, or even discuss with their doctor. They want to call an expert who will work through these issues immediately. Equipped with powerful technology, resources and key contacts, our experienced customer service representatives can alleviate that stress by taking ownership of the problem and resolving nearly all issues during the first call. Depending on the situation, the CSR will: ? Call providers or billing agencies for members to resolve claims issues or obtain additional information to pay a claim. ? Work directly with our internal business partners to resolve inquiries not resolved on the phone. ? Follow-up with members to report on status or resolution of an inquiry. On another level, our Web-based suite of technology capabilities help our CSRs deliver a more personalized and effective customer care experience to your members. For example, the CSR is ready to: ? Offer personalized messages to educate members on ways to improve health or reduce costs. ? Give a snapshot view of all products members can use to their advantage.

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		? Use an advanced knowledge management system to better answer members' questions. CSRs have special navigational access to claim and benefit information, reducing the amount of time the member stays on the phone. However, we think it's important to note that we don't limit talk time, as we believe the member determines how long the call lasts based on their questions and concerns. Having a CSR who assumes full ownership of member issues, and takes responsibility for fast resolution of inquiries translates to satisfaction. Caller satisfaction scores with CSRs consistently exceed 94 percent. ADVISING With member behavior driving 50 percent of health care utilization, we must use every touch point possible to engage members in their health and well-being. In addition to providing expert service, we believe the customer service representative's role is to advise members on how to maximize their health care investment and improve their health care decision making abilities, which ultimately affects the health of your bottom line. To that end, CSRs work to: ? Educate members on various health- and financial-related topics, including network doctors, generic drug utilization, UnitedHealth Premium provider designations, and ways to optimize CDHPs. ? Promote educational campaigns to improve enrollment or utilization of value-added programs, such as online wellness services or certain procedures like mammography screening.

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		? Engage our medical directors or nurses to resolve clinical concerns; or even tap financial experts to resolve a member's questions or problem. They can even help make an appointment with a physician. We know that health benefits offerings are complex and the system is often difficult to navigate. Helping members understand their benefits and how best to use them results in better health, lower out-of-pocket expenses and savings for your employees. KNOWING THE CUSTOMER To deliver exceptional service performance, we feel it's imperative to talk directly, learn your company culture, know your service objectives, and discern the specific needs of your employees. Your account management team (AMT) will meet with you to review the specifics of your benefits plan, plan set-up, special processing provisions, and most importantly, your members' needs, your culture and your specific directives. To tailor a service strategy, we pay close attention to: ? Past experiences (likes, dislikes, service issues, expectations) ? Employee demographic factors (age, sex, race, marital status, income level, education) ? Geographic factors (locations, urban/suburban, rural) ? Behaviors (lifestyle choices, attitudes) ? Your industry dynamics (products, markets, competitors, work force) From there, we tailor a service strategy to your satisfaction, and execute a detailed training plan for our customer service representative team—one that focuses on how you like to do business

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		OUR CUSTOMER SERVICE REPRESENTATIVE TEAM To help members make better health care decisions and utilize benefits effectively, you need a team skilled in listening, responding and influencing. We have assembled a team of remarkable customer service representatives whose focus on building rapport and managing relationships is as important as their knowledge of benefits, policies and procedures. Team members assigned to OIC have withstood a rigorous selection process and a comprehensive 15-week training program that focuses on extensive soft-skill, product and process training. They will be thoroughly trained on your culture, your people and your goals, and we will tie their compensation to your satisfaction, with a quarterly bonus program that is weighted on member satisfaction and quality. All of their training and performance objectives will be aligned with your strategy and your expectations of us. ONE STOP POSSIBLE WITH INTEGRATED TECHNOLOGY We have a history of using innovative technology, alongside our people, to connect better with members and drive behavior change. Customer service representatives access an integrated systems platform, so they can instantly answer questions on a broad set of benefit programs and services. We are currently resolving 95.4 percent of calls while the member is on the telephone with us, by accessing a myriad of information online, including medical, pharmacy, as well as all other relevant benefit- and claims-related information. We can also support interfaces to many external programs and health care professionals. We also maintain a dedicated OIC section of our online resource tools, so we can easily reference the nuances of your culture, preferences, benefits, programs, special services and all training materials specific to your plan. To enable CSRs to communicate effectively with a diverse group of members, we use a tool called Behavioral Analytics. This innovative technology analyzes the caller's voice and predicts caller dissatisfaction or distress. The tool allows us to personalize our call handling, based on each unique member's needs and attitudes. We also use the results to provide ongoing training and coaching for our customer care staff. The results are higher levels of member satisfaction and greater first-call resolution.

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		By leveraging technology, people and time to connect on a personal level with each individual, we aim to fully engage members in their health. Engagement and behavior change will bring about better health for your employees and for your bottom line. CSRs will be assigned to your account based on anticipated call volume and final enrollment. In times of heavy call volume, other team members will be available to assist and ensure that high service standards are maintained. All CSRs have access to complete member information and desktop reference tools that put your specific benefits information at their fingertips to ensure informed service for all calls.
Carrier 05	**District Management of Health Plans**	When you're looking for better results, better discounts are only part of the formula. You need a health plan that provides better information to help your employees make better health decisions. Better information for you and your employees—arrived at through the right information, proven analysis methods and recommendations that are closely tailored to your population—is necessary to bend the cost curve and to deliver the results you want. The information derived from our affordability tools and the corresponding solutions achieve consistently strong results across a diverse customer base because we have the experience and discipline to: ? Identify exactly what drives costs today and what it will take to impact them tomorrow ? Understand how each individual consumes and manages health care benefits ? Thoughtfully select and calibrate programs to meet specific business and employee health benefits requirements We have developed two proprietary tools to assist customers in optimizing their health care investment. ? Modernized Health Plan Continuum - Focuses on your specific plan offerings and identifies opportunities to improve plan

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		financial return by combining plan components, such as clinical programs, rewards and technology, in a way that meets your specific population health needs and overall goals ? CAI - Focuses on how your employees make decisions and identifies opportunities to help them make better health choices If you have invested in affordability programs, we want to ensure they are working effectively for you and your employee population. Our Modernized Health Plan Continuum tiers each UnitedHealthcare customer based on their medical cost performance and the degree to which tailored affordability solutions have been adopted. Generally, the larger the number of key affordability programs comprising a customer's health care plan, the greater the ability to control medical costs. However, there is more to achieving better results than simply piling on new programs. We find the right programs based on a thorough analysis of your data. That may mean removing programs that no longer are producing results or no longer fit the make-up of an employee population. By scoring plan components on expected intensity for both cost reduction and increased individual activation, we can plot your benefit plan on the Modernization Continuum and compare your position to relevant benchmarks. This allows us to measure the performance of the components as well as the synergy produced by integration. We believe that it is the calibration of plan components, informed by an employer's specific health population needs and company culture that leads to the best results. The Results: Tailored strategies for optimal adoption of your affordability programs. Our account management teams (AMTs) extensively analyze each customer's health cost drivers and risks and identify the right solutions to address their financial challenges. By using the principles of the Modernized Health Plan, we can ensure that we are maximizing the value of the solutions we recommend to our customers. Our advice is backed by our experience with more than five million members in CDHPs, more than two million members in rewards-based plans and the insights gained from analyzing more than 30 million health care decisions each year.

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		Even if you have the right programs, how do you know that employees are using them to make good health decisions? The CAI gives us the capability to learn how individuals make choices and to help them make better ones. The CAI stratifies member populations by health risk, lifestyle risk, demographics and disease state and then analyzes consumer behavior on 51 decision points encompassing financial, care setting and the use of health care and wellness information, resources and services. By breaking down an aggregate population into smaller groups with similar demographic, socio-economic and health care engagement levels, we can better understand how health benefits are used, identify areas of the plan that may not be optimally utilized and develop strategies that can promote positive behavior change. The CAI gives us invaluable insights into past performance and helps us address the underlying decisions. For example, if your results show that your employees did not comply with mammography screenings; your AMT would work with you to develop a targeted communications program. Once consumers modify their behavior and learn to make the best decisions possible, their lives improve—and so does your balance sheet. The CAI gives us invaluable insights into past performance and helps us address the underlying decisions. Armed with these CAI insights, we help customers address problems by creating programs with greater member relevance—so our customers can focus their dollars where they will produce the greatest result. Our research shows that employees make suboptimal decisions about their health 40 percent of the time. We see that not as a problem, but as an opportunity. By using these tools, we will conduct a thorough and ongoing analysis of your plan's performance, assessing employee adoption of programs and utilization by population segment. Working with you and your employees, we will define specific behavioral goals for each population segment, outline desired results and develop engagement strategies based on

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		life stages and change readiness—strategies that work. Our fully integrated solutions will continually evolve with your changing business needs.
Carrier 05	**Part-Time Employee Coverage Protection**	Employee eligibility is determined by the employer. Individuals working 20 or more hours per week are considered eligible according to the terms of the Policy.
Carrier 06	**Administrative Cost Reduction**	Providence Health Plan has significantly reduced administrative costs over the last few years. We have targeted cost increases closer to CPI, rather than associating administrative cost with medical cost inflation. This has resulted in reduced percentage of premium administrative cost. As such, as much as 90%-91% of premium dollars go towards claims expense costs. PHP is also not required to refund any premiums due to not meeting the MLR (medical loss ratio) requirements of PPACA.
Carrier 06	**Cost Savings**	Providence Health Plan has invested in preventive care and chronic Case and Disease Management Programs to improve on heath care outcomes, implementation of inteventions to prevent inpatient hospital readmissions, early adoption of voluntary patient safety reporting, inititatives in place to reduce complaints and potential medical errors, the Health Plan includes a comprehensive array of health and wellness promotion and preventive services through our Fit Together program and a best-in-class pharmacy management program.
Carrier 06	**Customer Service**	Providence Health Plan Customer Service and Claims are located in Beaverton, Oregon, hours of operation 8:00 am to 5:00 pm PST, toll free 800 number for members. Customer Service Representatives are trained to answer all calls with 92% of calls answered at the point of service. Translation services available, automated voice response systement and call tracking software for real time an historical activty. The Health Plan has invested heavily in web based tools for members for outside of standard business hours which includes a variety of self service options and tools.
Carrier 06	**District Management of Health Plans**	Providence Health Plan has best-in-class medical and care management services designed to achieve the Triple Aim (better care, better patient satisfaction at a lower cost). Through our care management programs and provider contracting efforts, we have the best regional PPO medical trends per recent surveys conducted by various consulting firms. In addition, our pharmacy management program has been recognized nationally as having the highest generic adoption rate and realizing reduced pharmacy costs and trend through our pharmacy benefit management efforts. Our pharmacy trend has been, and continues to be, the lowest in our regional market for several years. PHP will work with the districts and their producers or consultants to identify benefit design strategies to help meet budget goals and mitigate future cost increases.
Carrier 06	**Part-Time Employee Coverage Protection**	Providence Healht Plan will allow districts to offer exend medical benefits to their part-time eligible employees should the district choose to do so.
Carrier 07	**Administrative Cost**	Continued integration of operational and administrative function into the GHC parent organization eliminates redundancy and controls admistrative costs.

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Carrier	Category	Efforts and Achievements
	Reduction	
Carrier 07	**Cost Savings**	Pre-authorization requirements and large-case management services
Carrier 07	**Customer Service**	KPS continues to maintain levels of customer service for all customers that consistently earn high ratings from OPM for the KPS FEHB program.
Carrier 07	**District Management of Health Plans**	Select negotiated accounts receive their rate-development projection and basic experience data
Carrier 07	**Part-Time Employee Coverage Protection**	Yes, on a negotiated case-specific basis
Carrier 08	**Administrative Cost Reduction**	Uniform Medical Plan: 1. Renegotiated our pharmacy network discounts to achieve significant savings for 2014-15 drug claims 2. We expanded the types of services requiring preauthorization to ensure quality, cost-effective care is provided by the UMP.
Carrier 08	**Cost Savings**	Uniform Medical Plan: 1. Renegotiated our pharmacy network discounts to achieve significant savings for 2014-15 drug claims 2. xpanded the types of services requiring preauthorization to ensure quality, cost-effective care is provided by the UMP.
Carrier 08	**Customer Service**	Uniform Medical Plan: The Health Care Authority has industry standard customer service requirements in place with our contracted Third Party Adminsitrator (TPA). The standards are measured and subject to financial penalties and a corrective action plan if the goals are not met.
Carrier 08	**District Management of Health Plans**	Uniform Medical Plan: All PEBB programs in effect are directed to the entire PEBB population within a community rated risk pool. There are no programs specifically targeted to K-12 district populations.

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Carrier 08	**Part-Time Employee Coverage Protection**	Uniform Medical Plan: Eligibility for PEBB benefits, as determined by the PEBB Program, includes part-time employees who work an average of at least 80 hours per month and at least eight hours in each month for more than six consecutive months.
Carrier 09	**Administrative Cost Reduction**	We are continually exploring innovative ways to help control costs while seeing that our members receive quality care. We have initiated several efforts to better manage our health care costs, as well as our selling, general and administrative (SG&A) expenses. For example, the Executive Management Information System (EMIS) is an automated single source of certain financial, medical cost management, operational reporting, sales and human resources data which fosters a "one-company" view and culture, allowing for greater profit and loss (P&L) accountability. Another key process in managing operating costs is a monthly review of our SG&A expenses by type of spend and business area with a goal of improving discipline, consistency and accountability. Additionally, we have developed a robust forecasting and planning tool to foster accountability, enhance predictability and ultimately reduce SG&A costs.
Carrier 09	**Cost Savings**	Aetna uses a rigorous, dual approach to evaluate medical costs and identify opportunities to manage medical cost and trend. This process allows for proactive development and timely implementation of action plans and initiatives that control medical costs and improve utilization patterns. Examples of initiatives that were implemented to address medical cost opportunities are: (1) Emergency room frequent utilizers, (2) Home health care steerage to efficient and effective providers, (3) Multiple strategies to promote the use of participating providers, (4) High-tech radiology steerage, and others.
Carrier 09	**Customer Service**	At Aetna, we make very deliberate decisions and investments to connect our customers and members with solutions that meet their changing needs. A smarter health plan helps members take charge of their health and health care and to think and act like informed consumers. We offer members a variety of ways to get customer service information through our use of : (1) friendly, knowledgeable and proactive customer service representatives (CSRs), (2) Secure member website, (3) Interactive voice response technology, and (4) Smartphone applications When members call, our CSRs not only answer their questions, they proactively educate callers about their plan of benefits, tell them about programs available to them and encourage them to use – and assist them with – our online resources to help them become more informed health care consumers. Our online services are continually monitored and improved to make self-service a pleasant, productive and hassle-free experience.

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Carrier 09	**District Management of Health Plans**	With the right tools and technology, school districts can streamline their interactions with us, manage employee benefits, and understand where health care dollars are being spent. We have the technology, tools and expertise to help achieve exactly that. Our Employer Secure Website adds a "single sign-on" site for districts to access Aetna online tools. Districts will see additional eligibility, enrollment, online billing and report capabilities, as well as forms and content as we continue to roll out and develop the Employer Secure Website. Internet-based eligibility transfer solutions enable districts to quickly and efficiently transmit information to us. Through systems such as SecureTransport?, EZLinkTM and EZenroll®, districts receive the advantages of e-commerce; eliminating the need to submit paper forms, tapes, cartridges or diskettes
Carrier 09	**Part-Time Employee Coverage Protection**	We typically follow the plan sponsor's definition of eligible employee as long as the customer's definition is otherwise consistent with applicable laws. Customers are responsible for confirming eligibility to enroll in coverage. We do not determine eligibility for individuals. We advise customers to seek their own legal counsel concerning the effect of applicable laws on their plans.
Carrier 10	**Administrative Cost Reduction**	We are continuously looking for ways to reduce administrative costs. We have a team which meets regularly to identify, prioritize and implement efficiencies. We maintain a "green" mentality to protect natural resources and reduce our carbon footprint. Primarily we focus on: - streamlining processes - leveraging electronic capabilities - eliminating duplicate work with our providers, groups and members Some of hte initiatives that already have been implemented to address administrative costs are the following: - electronic Explanation of Benefits (EOBs) - electronic claims submissions (837) and payments to providers (835)

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Carrier	Category	Efforts and Achievements
		- electronic eligibility verification (270/271) - IVR for member payments In addition, we currently are in the process of implementing the following initiatives: - automating group set up - auto authorization - streamlining provider data management - increasing claims auto adjudication rates
Carrier 10	**Cost Savings**	Moda Health (Moda) strives to manage costs while providing the highest quality service and care for our members. Our programs help members meet their health care needs through prevention, wellness and condition specific programs. We are continually looking for opportunities to help members maximize the effectiveness of their health care dollars. We prioritize member service as our number one strategic initiative because helping members be better is at the essence of our existence. Our priority is to assist members in getting the right care, at the right time, at the right place, at the right cost. To accomplish this, we examine every way and medium, (current and emerging) that members will access information from us. We are always working on new approaches to improve the member's experience, as well as new ways to be accountable to members. We strongly believe it is our duty to manage benefits within a global budget. Accomplishing this allows for healthcare costs to be more predictable and therefore compete less with member's wages and other benefits. We also work diligently to design benefit plans that promote quality, improve health outcomes and reward members, their families and providers for reaching sustaining health goals. The world of health insurance is changing and changing rapidly. To accommodate this change and continue to provide plans and

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		benefits that reach the Triple Aim in a comprehensive manner, we've focused much of our time on building new kinds of partnerships. These new partnerships focus on engaging providers and patients in new ways. Instead of focusing on the traditional provider/insurer/payor contracts and employer/payor relationship, we've chosen to focus our time, energy and talents on developing partnerships that are transformational to patient care and provider payments. We have a history of innovation in benefit design, predictive modeling, medical management, population health management and coordination of care. We were one of the early pioneers in th Patient Centered Medical Home Pilot program. In addition, we partnered with the Oregon Educators Benefits Board to define, design and implement evidence-based,value-based benefit designs and value tiers which reduce patient barriers to care. Our work also includes the development of unique approaches to address sleep studies and advanced imaging management. Our comprehensive data warehouse, which combines all medical, pharmacy, dental, vision and other data into a single data source, allows us to approach predictive modeling in a new and innovative way. To aide this initiative, we also combined the data warehouse with a new analytics department. The primary purpose of this new department is to analyze the date, and from the analysis, make suggestions and recommendations regarding benefit designs to achieve the Triple Aim. In addition, we have built a coordinated care organization from the ground up and in a geographical location that has previously not had managed care. And, on a continual basis, we work to grow and strengthen our innovative regional partnerships. Here are a few examples of ongoing cost containment and quality improvement efforts at Moda. - Medical Quality Improvement Committee (MQIC) - Comprised of representatives from multiple departments that oversees Moda quality improvement programs. This committee monitors and evaluates the health care services provided to Moda members to ensure that they meet current medical practice and service standards. The MQIC meets at least six times per year and facilitates communication among Moda departments, providers, employer groups and members to ensure the delivery of healthcare services in an efficient management of resources.

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		- Pharmacy and Therapeutics Committee - Chaired by a Moda medical director, this robust multidepartment committee oversees drug formulary decisions to ensure the availability of safe and effective drug choices by: promoting evidence-based standards in the formulary decision-making process to ensure clinical efficacy, patient safety, and cost-effective medication options; establishing policies and procedures to educate and inform health care providers, members and clients about drug products and appropriate use; as well as developing protocols and procedures for the ease of and access to non-formulary drugs. - Case Management and Care Coordination - Our programs use evidence-based medicine and best practice clinical care guidelines. The guidelines are used when prior authorizing inpatient and surgical admissions, durable medical equipment, outpatient therapies and chiropractic care, acupuncture and massage therapy. In addition, evidence based-guidelines are used to assign initial length of stay, continued stay, and to confirm the appropriate level of care for inpatient, acute rehabilitation and skilled nursing facility admissions. Care coordination nurses follow members through preauthorization of an inpatient admission, inaptient concurrent review, discharge planning, and the recovery phase of an acute condition, when coordination of additional services is needed. The care management programs use nationally recognized clinical care guidelines developed through evidence-based medicine and best practice. This approach supports our readmission prevention program. Moda has ongoing quality improvement projects for congestive heart failure (CHF), inpatient readmissions, depression screening, and hospice utilization. These efforts also include communication among case managers, health coaches, and behavioral healthcare coordinators to ensure the members receive the appropriate level of care with the appropriate provider. To ensure quality centers of excellence are available for transplant care, specialized cancer care that is nto available locally, kidney dialysis, and complex neonatal case management.
Carrier 10	**Customer Service**	Moda has consistently recognized that exceptional customer service is a core value that can be leveraged to build brand loyalty and retain membership. This is a key differentiator for Moda and our ability to better understand the value our members place on this is critical to our success. We have taken a "voice of the customer" approach (e.g., survey tools, focus groups) to better understand what is valued in the eye of our customers and demonstrably extend customer loyalty and brand advocacy. Our goal is to deliver a consistent and satisfying customer experience across the consumer lifecycle through all our channels of

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		communication. Moda experienced a surge in membership growth in 2014 related to the enactment of the ACA and the confusion around the federal and state marketplaces. We used multiple approaches to improve the experience for our members. - Increased customer staff throughout 2014. - Outsource vendor utilized to increase capacity. - Opened a call center in Bend, Oregon. - Extended call center hours and added evening and weekend shifts. - Implemented new Contact Center software with additional features. - Moda continues to evaluate root causes for phone calls for process improvement opportunities. - Moda continues to evaluate staffing needs and adjust accordingly.
Carrier 10	**District Management of Health Plans**	Moda has a long history of working with purchasers in administering their benefits and assisting them with benefit design recommendations. We have successfully demonstrated our ability to effectively evaluate performance metrics, anticipate utilization trends and bring opportunities for change and improvement forward to support evidence and value-based purchasing. We utilize the expertise of our data analyst and clinical experts to evaluate opportunities for plan enhancements and modifications. Moda applies a consultative approach to client services.

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Carrier	Category	Efforts and Achievements
Carrier 10	**Part-Time Employee Coverage Protection**	We have established an open forum with our clients, their consultants and often other health plans servicing the same population to discuss opportunities for improvement in care and the management of the health benefit. Collectively, we review utilization trends and evaluate modifications to the plan that will ensure appropriate and cost effective care. Moda actively shares claims and utilization experience for school districts with 100 or more employees. It is through this active collaboration that we are able to identify opportunities that meet the specific needs of the client. Employee eligibility is determined by the employer and must be compliant with PPACA regulations. We offer several plan designs at varying price points to help meet specific member needs. In addition, we offer individual medical plans at the bronze, silver and gold metallic levels.