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Carrier	Category	Efforts and Achievements
Carrier 1	**Administrative Cost Reduction**	• 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 6.3% in 2013 WEA's administrative costs have been under 6% for over 11years. • BlueCard provides significant savings to Premera enrollees traveling or residing outside the Premera service area. • WEA Specific – The WEA Plan's auto adjudication rates remain some of the highest within Premera, which reduces the need for manual intervention and provides peace of mind for providers as well as for members with quick turnaround on payments for services.
Carrier 1	**Cost Savings**	• Provider contracting – Premera has the highest number of providers "in network" in the state (98% + of all claims paid are "in-network") • With over 1.9 million members enrolled on a Premera plan, the volume of enrollment in Premera assists in negotiating higher discounts locally and nationally. (In addition to our Exchange, individual, small and large group accounts, Premera provides coverage for many large, national accounts, including: Microsoft, Amazon, Starbucks, Weyerhaeuser, Alaska Air Group, etc.) • BlueCard (Premera's national "Blue" network) has negotiated discounts that are at the highest level within the state and provides significant savings to Premera enrollees who travel or reside outside the Premera service area. • 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 enrollee's needs. • Real-time access to consumer decision-support resources to help enrollees understand and direct their health care needs. • Provider advisory groups for medical and pharmacy that continually monitor Premera's policies and procedures, and make changes to formularies to ensure they are appropriate, and cost and care-efficient. • Member 360 Dashboard – Proprietary tool that uses more than claims to identify members with specific healthcare needs. • Plans include copayments for Emergency Room services (waived if admitted), copayments for inpatient hospital admissions, and higher copayments for brand, nonpreferred, and specialty drugs.

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Carrier 1	**Customer Service**	• Programs that monitor controlled medication substances to provide protection for enrollees. • An open drug formulary that provides choice for enrollees and their physicians while being prudent and ensuring the drugs are cost and care-effective. • Premera provides a website with access to information about the employee's benefits which includes a cost estimator which helps them determine which providers requires 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 satisfaction. • "Ulysses Learning™" – leading to first call resolution and a higher level of satisfaction from enrollees. • Premera's "Lean" workshops include Customer Service, Claims and Billing processes – which we continue to focus on improving the enrollee experience. • The dedicated Premera sales team provides year-round servicing and is 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 the enrollees. This provides additional support to the district as well as direct support to their employees. • Semi-annual newsletters to enrollees to educate them on their plans and provide access to information to help support decision making and healthier lifestyle decisions.. • Dedicated staff in Customer Service and in Sales who work to address escalated or complex issues with the enrollee/designated representative and/or their provider.
Carrier 1	**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

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		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 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.

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		• 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. • 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 1	**Part-Time Employee Coverage Protection**	• Premera's WEA Select plans 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 with even fewer hours worked providing that the employer is contributing towards the cost of the medical plan • When a full time employee's hours are decreased, Premera works with the enrollee to review other plan options that allow the individual to remain covered on a medical program.
Carrier 2	**Administrative Cost Reduction**	• All Premera school district options include lower cost options to help mitigate overall renewal increases. Health plan systems replacement - Group Health focused our 2013 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 2014, 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. We recently implemented a new care management information and workflow system and customer relationship management tools.
Carrier 2	**Cost Savings**	Streamlining our management structure - This ongoing work involves setting standards for management roles and examining variation in our management structure. We work closely with the client to find the right benefit designs and network options and integrate them with our own

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		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 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.
Carrier 2	**Customer Service**	All new Customer Service Representatives receive six weeks of formal classroom training on how to handle member calls regarding claims, benefits, eligibility and referrals. They will 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 system includes scripting and procedures for handling member's inquiries and concerns. Group Health's Quality Assurance Program utilizes call monitoring to measure, manage, and improve the quality performance of individual representatives and the call center overall. Customer Service Representatives calls are randomly recorded and monitored to use them as a performance evaluation tool and determine if representatives are meeting quality standards. To ensure consistency in scoring, supervisors and leads who monitor the calls meet to calibrate on a weekly basis.

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		Monthly we review calls escalated to our leads and misquoted benefits to determine coaching opportunities for each representative. We use our documentation of the reason for the customer contact to identify trends so we can provide scripting, training, and coaching as needed. This is done formally on a monthly basis and informally in our team huddles on a daily basis.
Carrier 2	**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 2	**Part-Time Employee Coverage Protection**	We allow access for part-time employees working a minimum of 17.5 hours per week.
Carrier 3	**Administrative Cost Reduction**	As a member of the Blue Cross and Blue Shield Association, BlueCard provides significant savings to Regence employees traveling or residing outside the Regence service area. 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 3	**Cost Savings**	Regence has the highest number of providers “in network” in the state (98%+ of all claims are paid “in network”). We also use 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. Real-time access to consumer decision-support resources (ie: myregence.com- as described below) to help enrollees understand and direct their health care needs.- Also see Innovations Section (below) for additional ideas for cost savings.
Carrier 3	**Customer**	Regence has a world class website called myregence.com with access to information about the employee benefits – this

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	Service	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.
Carrier 3	**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 3	**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 4	**Administrative Cost Reduction**	Kaiser Permanente is committed to administrative simplification and responsible stewardship of our assets. In our care delivery model, doctors, nurses, and specialists work collaboratively to provide the right care at the right time, keeping care costs low. Our doctors, hospitals, medical offices, pharmacies, labs, and health plan are all part of one organization. This makes it easier for us to coordinate care for lower costs and better results. In 2014-15, Kaiser Permanente will continue focusing our resources on our care delivery system, internalization, quality and efficiency, while also driving care transformation strategies with a focus on managing complex patients. Our plan includes process improvement and eliminating waste and variation across our operations. We are driving for improvements in primary and specialty care cost per visit. We will place a strong focus on delivering a two hospital system in Portland that is market competitive on a unit cost basis, and improving our position in peripheral markets. Reducing out of network costs is also a key focus. As an integrated health care delivery system we know that we are a more efficient and effective health plan. Further, because our health care teams can share information easily, we are also collectively smarter and this built in collaboration among experts leads to better health care outcomes. Information is shared across the hall and across the state. One shared electronic medical record means every physician, nurse, pharmacist, and other member of the care team can pull up a member's entire medical history, lab test results, and list of prescriptions. The results of our collaborative efforts are clear: • Less likely to repeat tests—our physicians are 12 percent less likely to repeat tests or procedures than physicians at other large practices, lab utilization decreases of up to 7%, and overall decrease of up to 14% in radiology tests.

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Carrier 4	**Cost Savings**	• Paper medical record costs - reductions in by as much as 64% • Reducing costly hospital readmissions—one out of five hospitalizations among Medicare patients results in a readmission within 30 days of discharge. We developed a heart failure transitional care program across all our regions that reduced hospital readmission for members with heart failure by 30 percent—saving $12 million and an estimated 410 lives. • Complete information sharing—primary care physicians and specialists can view each other's treatment notes in real time via the member's electronic medical record. This allows for a thorough and accurate exchange of information, which can help keep members healthier. • Higher medical benefit ratio—our April 1, 2014 preliminary medical benefit ratio filing was above the thresholds established by the Affordable Care Act—a minimum of 85 percent of premium revenue for large groups and 80 for small group, individual, and Student Health in nearly every area of the country in which we provide health care coverage. Overall, we operated in 2012 above the threshold for more than 99% of our 9 million members nationwide Key initiatives enabling successful performance were drug utilization initiatives of $25M, Internalization of Kaiser Permanente Care expansion of $20M (i.e. the opening of our Kaiser Westside Medical Center and expanding our Radiation Oncology services), and Medical Management of $8M. Elimination of variability in drug utilization, focusing on appropriately converting patients from high cost brand drugs to generic alternatives. 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. In 2013, a comparison of health plans across the United States, AON

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		Hewitt reported that Kaiser Foundation Health Plan of the Northwest is the most cost-efficient plan across all markets we serve. Nationally, Kaiser Permanente is 10% more cost-efficient than the average HMO and 15% more cost-efficient than all plans in the markets it serves. We also outperformed other plans in clinical quality, scoring 58% better than the average HMO and 167% better than the all-plan average.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. In 2013, a comparison of health plans across the United States, AON Hewitt reported that Kaiser Foundation Health Plan of the Northwest is the most cost-efficient plan across all markets we serve. Nationally, Kaiser Permanente is 10% more cost-efficient than the average HMO and 15% more cost-efficient than all plans in the markets it serves. We also outperformed other plans in clinical quality, scoring 58% better than the average HMO and 167% better than the all-plan average. Member Engagement We emphasize keeping members engaged and healthy, with a strong focus on prevention. An important way we do this is by offering a broad range of programs to promote good health and encourage members to fully participate in their own health care. We offer comprehensive disease management programs, healthy lifestyles program, health education classes and self-care programs, and decision-support tools that empower consumers. The results of these programs include: • Among participants in HealthMedia Care® for Diabetes online program, productivity increased 5% after just 30 days in the program. Projected savings is several thousand dollars per year per participant. • Care for Diabetes users had A1c numbers that dropped from 7.3 to 6.8, and 90 percent said they are better able to manage their disease

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		• Approximately 58% of members participating in the HealthMedia Breathe® program report that they've quit smoking • Of the members surveyed who completed the HealthMedia Balance® weight management program, 56% lost weight after participating for six months• Our asthma management program has shown to dramatically reduce members' acute asthma episodes, Emergency Department visits, and hospitalizations. A National Hospital Discharge Survey found the national rate for asthma-related hospital admissions was 12.5 per 10,000 admissions; our rate was less than half of that, 5.4 per 10,000 Provider Engagement Our physicians and other care providers work as a team within a health care model that frees them to focus on patients versus the administrative demands of private practice including profitability. You get the most out of your health care dollars because doctors are focused on delivering better care. • Improving physician productivity and efficiency to increase capacity without increasing costs by: o Making the best use of registered nurses, nurse practitioners, physician assistants, medical assistants, case managers, and clerical staff in panel management, administrative tasks, and patient care o Providing evidence-based clinical practice guidelines, decision-support tools and prompts, electronic alerts, and electronic prescribing support at the point of care to eliminate redundancies, save time, and make it easier for our physicians to provide quality care • Reducing unnecessary office visits and follow-up appointments so that physicians have more time to see the members who really need to see them by: o Providing 24-hour nurse advice to help members determine if they need to see their physician o Developing clinical guidelines that enable the provision of standardized care by phone for select common conditions such as urinary tract infections o Alerting members and their physicians to any needed preventive services—such as Pap tests, mammograms, vaccinations, and laboratory tests—so that they can be taken care of in the same visit when possible

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Carrier 4	**Customer Service**	o Offering members extensive self-care educational resources 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 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 4	**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 demonstates 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 empoyees. Other achievements include Kaiser Permanente sponsoring the Thriving Schools program which is a comprehensive, multi-

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		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 is recruiting districts and schools to their Healthy Schools program designed to create a healthy school environment. Longview School District has signed up to participate. This year Playworks has provided training to 60 adults to lead active play in 7 schools in the Evergreen School District. In May, 17 schools in Clark and Cowlitz County have signed up to participate in the Spring Fire Up Your Feet campaign that encourages staff, students and their families to be physically active before, during and after school. For the Fall, 2013 challenge, 12 schools had signed up. Kaiser Permanente's Educational Theatre Production, The Pressure Point!, was hosted in 33 schools in Clark and Cowlitz County engaging 5,256 kids and 255 adults in making healthy life decisions. 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 School Based Health Center in Seattle is part of the learning collaborative supported by Kaiser Permanente.
Carrier 4	**Part-Time Employee Coverage Protection**	Benefit eligibility is determined by the group and we are happy to accommodate covering part-time employees.
Carrier 5	**Administrative Cost Reduction**	UnitedHealth Group has been executing on a plan to reduce run-rate operating costs by $1 billion and derivative medical costs by $2 billion through the application of improved payment integrity. The targeted savings come from 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.

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		* Procurement and Sourcing. Cost reductions related to optimizing procurement and sourcing. * Payment Integrity. Medical cost reductions from improving payment accuracy and from various program integrity offerings and other initiatives to reduce improper billing and payment. These initiatives, along with other ongoing productivity initiatives, are key to achieving our target of reducing our operating costs and medical costs associated with clinical billing practices over the long term. We have far exceeded our initial goals and have line of sight to substantial additional savings in 2014 and beyond with particular focus on advancing automation, achieving next stage integration, improving the effectiveness of our clinical operations and further advancing our payment integrity efforts. 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. We also believe that helping our members get the best care is the best way we can address cost. By utilizing a comprehensive range of tools and resources, our strategic account management team (AMT) will work with you to design customized solutions. Your priorities provide the framework to guide the process. Here are some examples of how UnitedHealthcare is leading the industry in addressing medical costs, while at the same time promoting the health of our members: ENHANCING QUALITY ACROSS THE ENTIRE SYSTEM By building on our provider relationships and centering our efforts on the best providers, we have achieved a broad national network that is the largest, individually owned network in the nation. But the data is clear that there are differences in the way individual physicians and hospitals deliver care, and these differences result in wide variations in both the quality and cost of care delivered to consumers. Building on this knowledge, we support health care professionals with the right tools, such as the best available scientific guidance and performance feedback. To enhance and incent high-quality, efficient health care in our networks, we offer the UnitedHealth Premium program to all of our customers and members at no additional charge. HELPING PEOPLE THROUGH TAILORED CLINICAL SOLUTIONS

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Carrier 5	**Cost Savings**	Our organizational mission is to help people live healthier lives—to identify opportunities to improve their health earlier rather than after a medical event. Our goal is to be able to identify members with health risks sooner, help them keep chronic conditions under control and have more information about that individual available to us when they need our help. Through our eSync technology platform, we are able to integrate data from numerous sources, such as medical and behavioral health claims, pharmacy data, lab results and health assessments. This means we can create a whole-person view of each member to get a clear picture of his or her health status. eSync then helps us identify opportunities for intervention before a major health event occurs. Intervening early can influence as much as half of overall costs. 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 * 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 inappropriate medical benefit payments resulting from abuse or fraud

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		* 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 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. 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,

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		validating and recovering the overpayments on our behalf. AIM retains a percentage of the recovered amount as reimbursement for the cost of this service. COORDINATION OF BENEFITS During enrollment, we ask for other coverage information for both employees and their dependents. We load this information into our claim system. Then, if during claim processing, an indicator states that other coverage is applicable to any dependent, our system denies that dependent's claim and requests a primary insurance statement for the dependent. We request an update to other coverage status every 12 months unless there is an indication of other insurance present. If complete coordination of benefits (COB) information is not provided on the enrollment application, we may send an inquiry letter or call to the member requesting the information we need. 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. 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 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.

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		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. (^) 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.

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		* This program can be administered alongside our SSP, with the Medicare-based reimbursement levels applying only where savings are not obtained under that program. 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. 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. This program is not only reducing the impact of escalating non-network cost trend, but is also encouraging physicians to join our network. It is just one more component of our commitment to providing practical, affordable products and services, along with extensive network access to quality care.
Carrier 5	**Customer Service**	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, seven 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. 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 1,000 members – assures us that we're moving in the right direction. In 2010, we received 91 calls per 1,000 members, but in 2011, only 59.3. In 2013, that number dropped even lower, to 57.2 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 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

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		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. 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 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. * 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.

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		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 consumer driven health plans (CDHPs). * Promote educational campaigns to improve enrollment or utilization of value-added programs, such as online wellness services or certain procedures like mammography screening. * 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 YOUR MEMBERS To deliver exceptional service performance, we feel it's imperative to talk to you directly, learn your company culture, know your service objectives, and discern the specific needs of your employees. Your 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 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 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

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		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 SERVICE 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 percent of calls while the member is on the telephone with us, by accessing a myriad of information online, including medical, pharmacy, Flexible Spending Account (FSA) and Health Reimbursement Account (HRA) data, 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 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. 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. STATISTICS Our 2013 national customer care statistics are: * Average speed to answer: 23 seconds * Abandonment rate: 1 percent * First-call resolution rate: 92.37 percent * Overall call quality: 98.3 percent * Ratio of CSRs to members: 1:12,000 * Number of CSRs: over 1,300
Carrier 5	**District Management of Health Plans**	Below are just of few the efforts we have in place to help the districts manage health benefits. UTILIZATION MANAGEMENT Our utilization management program focuses on helping members receive the right care in the right setting at the right time by evaluating the quality, continuity, timeliness and outcomes of health services. Our medical directors and nursing staff work closely with health care providers to ensure treatment plans are consistent with evidence-based guidelines, are

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		clinically appropriate, cost effective and optimize health care outcomes. PRIOR AUTHORIZATION We require prior authorization of certain services and procedures to identify gaps in care, confirm available benefits, assess for inpatient care management and discharge needs, identify readmissions, apply medical policy and coverage review of certain services and procedures, prevent delays in care and promote delivery of the physician's treatment plan. For services requiring advance notification, we authorize the service as well as the treatment setting. CLINICAL COVERAGE REVIEW Clinical coverage review (CCR) encompasses pre-service review and medical claims review (retrospective review). We provide pre-service review for services that require advance notification and prior authorization. Medical claim review provides post-service clinical review of claims using medical policies and benefit plan documents. We review claims for coding appropriateness, reimbursement and claim code edits. Our CCR team also reviews appeals related to adverse determinations. CCR sends the case to the appropriate medical director (not previously involved in the case, in the same specialty). Medical directors may determine the case requires external physician review. ADMISSION NOTIFICATION We require hospitals, skilled nursing facilities and acute rehabilitation facilities to notify us within 24 hours of all inpatient facility admissions or by next business day for weekend admits. For emergency admissions where a member/enrollee is unstable and not capable of providing coverage information at the time of admission, the facility should notify UnitedHealthcare as soon as the information is known and communicate the extenuating circumstances. CARDIOLOGY PRIOR AUTHORIZATION PROGRAM We require cardiac prior authorization for: * Diagnostic catheterization * Electrophysiology (EP) implants: defibrillators and pacemakers RADIOLOGY PRIOR AUTHORIZATION PROGRAM We require radiology prior authorization for: * Advanced outpatient imaging * Positron emission tomography (PET) Scans * Computerized tomography (CT) Scans * Nuclear medicine INPATIENT CARE MANAGEMENT Inpatient care management (ICM) nurses perform on-site or telephonic review. Nurses evaluate all cases assigned early on the same business day and determine the frequency of review at that time. Continuing a trend of consistent improvement in every year since 2008, our average commercial inpatient days per

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		thousand declined by 3.1% in 2012 compared to the previous year. The 2012 performance translates to an annual inpatient savings of $6.53 per employee per month (PEPM). CONCURRENT REVIEW Concurrent review is a component of inpatient care management to ensure a hospital stay is proceeding as planned. Nurses complete an initial assessment to determine the goal length of stay, which determines the frequency of review and/or referral to other care management programs. Nurses use Milliman Care guidelines, internal protocols, and our proprietary risk-scoring tool to prioritize reviews. DISCHARGE PLANNING Nurses work with the attending physician and hospital to coordinate the timely delivery of hospital services. The inpatient care management team assists with the arrangements for alternative services or programs, as appropriate, and facilitates discharge and/or transition to a lower level of care at the appropriate time during the course of care. Members may also be enrolled in transitional case management for ongoing care or to holistically address a particular condition as part of notification or during discharge planning. TRANSITIONAL CASE MANAGEMENT Our Transitional Case Management program serves as a bridge between the hospital and home for members at high risk of readmission. Designed to ensure that post-discharge plans and home health care needs are being met, Transitional Case Management supports members with the greatest needs in order to avoid preventable hospital readmissions. ESYNC TECHNOLOGY PLATFORM Our care management model is uniquely positioned by virtue of our eSync Platform. Simply put, eSync employs a technologically-advanced solution and logic set to promote a healthier culture and long-term health care value for all consumer populations, from the most healthy to those at the greatest risk. This robust platform allows us to synchronize wellness, behavioral and clinical programs across the spectrum of care. Rather than simply integrating multiple programs into a single view on a nurse's computer screen, eSync delivers an optimized and concerted set of features, synchronizing complex and vast data streams with value-based opportunities for proactive actions, and accounting for consumer science—intelligence about the specific member's stage of life, readiness to make changes and any other life and health-impacting situation. More specifically, eSync drives the following: * Total population monitoring and holistic member view. Constant monitoring and synchronization of population data to build a holistic view of each member using a combination of pre-adjudicated medical and behavioral claims, pharmacy data, lab results and leading clinical indicators as well as behavioral and worklife elements. * Proactive health management: * Identification of opportunities for intervention relating to more than 50 states, such as heart failure, breast cancer, epilepsy, osteoporosis and depression. Disease monitoring gaps, medical management considerations, medication

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		adherence and interaction alerts, provider and treatment choice options, lifestyle enhancement opportunities, and money saving tips are all used to help members make better informed decisions. * Because we are capturing incurred claim data, rather than adjudicated claim data, we have access to actionable information in as little as five days, where the industry average is 120 days. And, most importantly, because almost 65 percent of our value drivers are proactive, identifying opportunities before a major health event occurs, we can focus on prevention and not simply gaps in care. * Quantification and prioritization of opportunities for intervention using value drivers that evaluate the expected impact on utilization, spending and required effort to close gaps. We can prioritize and focus on those opportunities with the biggest potential clinical and cost impact. Value drivers focus on linking members with the right providers, the right treatments, the right medications and the right lifestyle choices. Members are guided to the optimal care providers and facilities for their unique care needs, including UnitedHealth Premium designated physicians and facilities as well as over 1,300 Centers of Excellence. * Member engagement—Increased member engagement by providing access to tools and information such as the personal health record, online Web-based behavior modification programs, health assessment results and health kiosks along with access to personalized HealtheNotes messaging via mail and our member and physician portals (myuhc.com, UnitedHealthcare Online). HEALTHENOTES HealtheNotes messaging is also delivered by nurses via telephone and secure email for high-risk members engaged in one of our acute or chronic condition management programs. Expanded capabilities being explored for the future include delivering personalized consumer messaging via mobile phone or IVR. HealtheNotes Reminders are the one of the vehicles that can communicate these opportunities to the member. These communications are proven interventions that incorporate distinct patient messaging to improve the quality of care and create a more engaged and compliant consumer. Through eSync, we are able to execute on the concerted delivery of care management, which is accomplished by synchronizing vast and complex data streams with evidence-based medicine rules and value-based opportunities, all focused on clear, concise and immediately actionable recommendations. The result is that all nurses, health coaches and providers across every one of our care management programs will be able to monitor any gaps in care that arise for their members. They are notified of care opportunities and can easily review and discuss any gaps in care or messaging that were identified and sent to the member, resulting in a fully integrated program and member experience. USING MOBILE TECHNOLOGY Mobile devices help us to 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.

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		The mobile version of myuhc.com provides links to the most common features accessed on myuhc.com using a web optimized browser view. Since the view is optimized for mobile devices, it is easier for members to quickly navigate to and read the information they need on the device's smaller screen. Our award-winning mobile application, Health4Me, provides instant member access to health care information, the nearest physician, check the status of a claim, look up treatment costs or 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. We also provide several direct-to-consumer mobile apps and web sites. For example, members can take charge of their health and fitness activity with OptumizeMe, a direct-to-consumer mobile health challenges application. Members can use the Smart Patient mobile application to help prepare for doctor visits using checklists and accessing those checklists during their appointment to help remember important details. HEALTH4ME MOBILE APPLICATION We put your employees' health care resources in their hands. Health4Me provides your employees with instant access to their health care information — anytime/anywhere. Whether they want to find the nearest physician, check the status of a claim, look up treatment costs or speak directly with a nurse or have a representative call back, Health4Me is their go-to resource for everything health related. Health4Me is one in a series of UnitedHealthcare technology advancements designed to simplify and enhance the member's total health care experience. Health4Me is available for iPhones and Android and can be downloaded free of charge using the mobile device. A myuhc.com username and password are required to use the application. Please access a demo at http://www.welcometomyuhc.com/health4Me/index.html MYUHC.COM MOBILE VERSION Members accessing the full myuhc.com website from their smartphone device are given the option to access the mobile version. The mobile version of myuhc.com provides a web-optimized browser experience. With an easy-to-use interface, members can quickly access the features that are most commonly used on our full website. After entering their username and password, members have easy access to the features they use most: * Find a provider or hospital at the touch of a button based on current location * View (and share) ID cards * View basic benefit information * Check account balances * View claims history Members seeking health care when they are traveling or in a new neighborhood can appreciate easy access to important health information no matter where they are. A myuhc.com username and password are required to the use the mobile version of myuhc.com. SMART PATIENT

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		We have been partnering with renowned heart surgeon and host of The Dr. Oz Show, Dr. Mehmet Oz, since 2006 to promote the UnitedHealth Premium program and health and wellness initiatives. We teamed up with this author of the New York Times bestselling book, YOU: The Smart Patient, to provide information about quality and cost-efficient health care. The UnitedHealthcare Smart Patient mobile application is part of a series of UnitedHealthcare technology advancements designed to simplify and enhance the health care experience for all consumers. Smart Patient is designed to help users manage their health care activity so they can make informed choices at every step, giving users a portable reference to bring along to medical appointments that can help them get the most from their health care visits. Smart Patient users enter key health information (blood pressure, body mass index (BMI), cholesterol and waist size) and update it as things change. The application makes it easy to enter appointments and stay on track by setting reminders. Smart Patient helps users go to their appointments prepared, using built-in checklists that guide users with questions to ask: * During a doctor's appointment * Before a medical test * After a diagnosis * When filling a prescription * Before surgery * When being released from the hospital * If it's time to go to the emergency room By checking a few boxes, users can bring a list of questions and simply refer to their device during an appointment and review the list. Smart Patient users can even record and save voice and text notes during appointments – a great way to remember doctor's orders. In addition, UnitedHealthcare and Dr. Oz offer powerful tools and resources to help consumers become a smart patient. Users can watch short, informative videos from The Dr. Oz Show to get practical information and helpful health and wellness tips. Smart Patient also provides nutrition information and the most recent blogs from Source4womencommunity.com. UnitedHealthcare Smart Patient is available at no charge in the iTunes Store for iPhone and Google Play for Android. The application is for consumers in general, not just UnitedHealthcare members. Anyone can download and use the UnitedHealthcare Smart Patient application without a login ID. OPTUMIZEME With OptumizeMe, consumers have a way to pursue their health goals through online social networks. The direct-to-consumer mobile health challenges application was selected by Microsoft as a Premier Launch App and can be downloaded free of charge. OptumizeMe doesn't just track activity. It is a collaborator that helps motivate users to engage in wellness by making healthy activity a social activity. Using OptumizeMe, individuals can:

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		* Create health and fitness challenges * Track their progress * Compete and/or collaborate with friends * Post results to their Facebook page via their mobile phones OptumizeMe is available for iPhone, Android and Windows Phone 7 OS mobile devices. The application is for all consumers, not just UnitedHealthcare members. Anyone can download and use OptumizeMe without a myuhc.com login and password.
Carrier 5	**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 6	**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 6	**Cost Savings**	Providence Health Plan has invested in preventive care and chronic care management 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 6	**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 6	**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 6	**Part-Time**	We allow coverage for part-time employees, if the employer requests it. We will also be compliant with PPACA regulations

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Carrier	Category	Efforts and Achievements
	Employee Coverage Protection	pertaining to coverage for part-time employees.
Carrier 7	**Administrative Cost Reduction**	Continued integration of operational and administrative function into the GHC parent organization eliminates redundancy and controls admistrative costs.
Carrier 7	**Cost Savings**	Pre-authorization requirements and large-case management services
Carrier 7	**Customer Service**	KPS continues to mainatin levels of customer service for all customers that earned consecutive 'highest-rated' awards from OPM for the FEHB program.
Carrier 7	**District Management of Health Plans**	Select negotiated accounts receive their rate-development projection and basic experience data
Carrier 7	**Part-Time Employee Coverage Protection**	Yes, on a negotiated case-specific basis
Carrier 8	**Administrative Cost Reduction**	Uniform Medical Plan: UMP's competitively awarded TPA contract with Regence BlueShield is in place for four years, which limits administrative costs. It also limits fee increases for additional renewal years.
Carrier 8	**Cost Savings**	Uniform Medical Plan: 1. For the PEBB self-insured population (UMP Classic and UMP Consumer-Directed Health Plan), these plans participate in a primary care multi-payer medical home project. This is the second year of two-year pilot. 2. UMP also offers Intensive Outpatient Care Program for patients in the top 5-15% of medical spending. This program directs additional payment to primary care providers to manage their care. 3. The plan does not pay for hospital readmissions for three conditions. 4. UMP is self-funded and contracts third-party administrator (TPA -Regence BlueShield) that manages the provider contracts within the network and enforces penalties if health-care cost trend exceeds specified limits set in the contract.
Carrier 8	**Customer Service**	Uniform Medical Plan:

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Carrier	Category	Efforts and Achievements
		The Health Care Authority has industry stamdard 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 8	**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.
Carrier 8	**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 9	**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 has been developed and implemented to foster accountability, enhance predictability and ultimately reduce SG&A costs.
Carrier 9	**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 9	**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)

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Carrier	Category	Efforts and Achievements
Carrier 9	**District Management of Health Plans**	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 are 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. 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 9	**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.