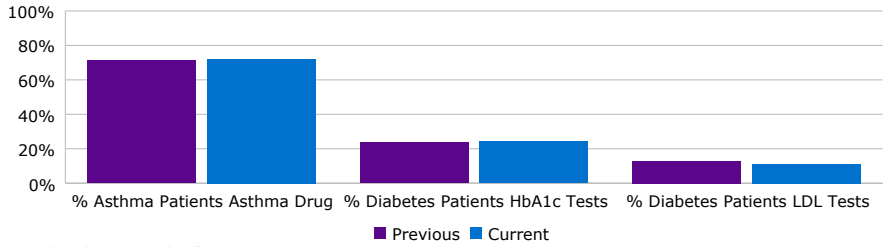
Medical and Prescription Drug Dashboard - Medicare Retirees

Previous Period: Jul 2016 - Jun 2017 (Paid)
Current Period: Jul 2017 - Jun 2018 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

2. High Cost Claimants*

*Members with >=$100,000 in Medical and Rx Net Payments

	Previous	Current	Trend
Patients	112	145	29%
Patients per 1,000	4.6	5.7	24%
Payments (in millions)	$12.3	$17.3	40%
Payment per Patient	$109,822	$119,060	8%

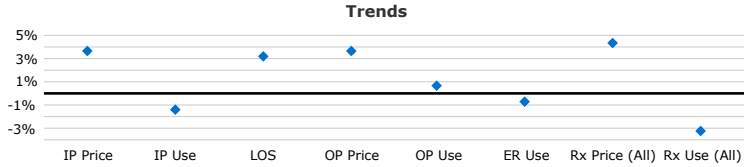
3. Well Care and Preventive Visits

	Previous	Current	Trend
Visits Per 1000 Prevent Adult	177.1	213.7	20.7%

4. Medical Plan Eligibility

	Previous	Current	Trend
Average Employees	23,088	24,023	4%
Average Members	23,103	24,124	4%
Family Size	1.0	1.0	0%
Member Age	73.3	73.2	0%
Members % Male	42%	42%	0% pts

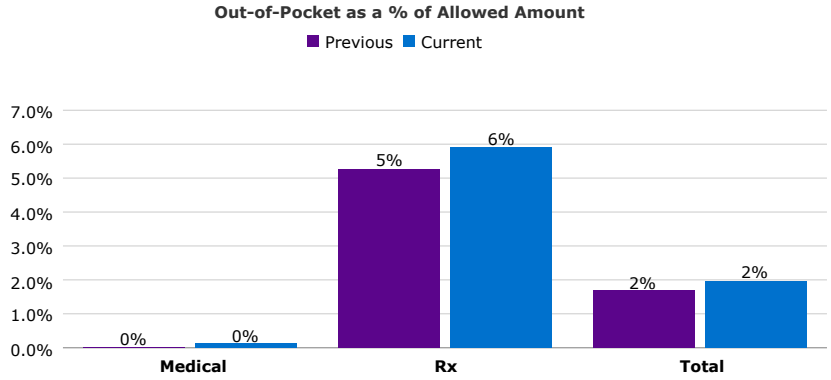
5. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$16,137	$30,656	●	4%
Admits per 1,000	178.3	57.2	■	-1%
Days LOS	5.6	4.6	■	3%
Outpatient				
Allowed per Service	$107	$121	●	4%
Services PMPY	72.1	31.1	■	1%
Emergency Room Visits per 1,000	539	228	■	-1%
Prescription Drugs				
Allowed/Days Supply	$2			-4%
Days Supply PMPY	1,436			-3%
Specialty Drugs				
Allowed/Days Supply	$71			19%
Days Supply PMPY	23			1%
All Prescription Drugs				
Allowed/Days Supply	$3	$3	●	4%
Days Supply PMPY	1,459	381	●	-3%

● Represents a lower than -3% comparison to the benchmark
◆ Represents a comparison to the benchmark within +/-3%
■ Represents a higher than 3% comparison to the benchmark

6. Cost Sharing



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Previous Period: Jul 2016 - Jun 2017 (Paid)
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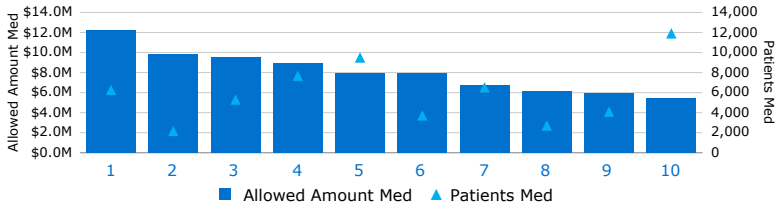
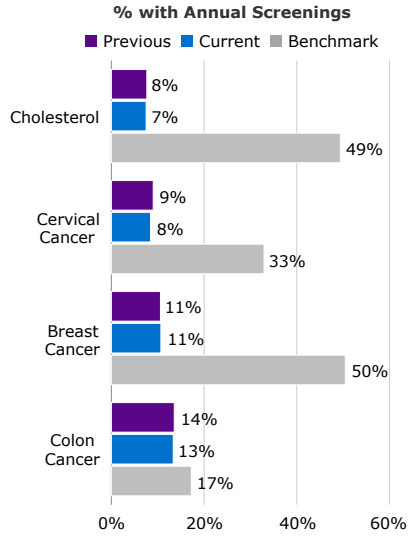
7. Top Medical Conditions (by cost)

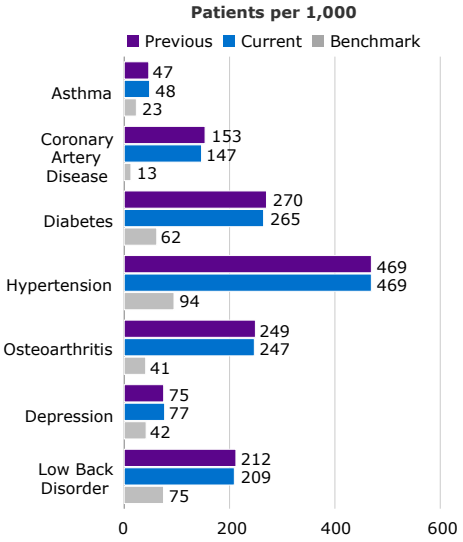


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Osteoarthritis	$12,223,187	6,275	$1,948
2	Renal Function Failure	$9,793,003	2,183	$4,486
3	Spinal/Back Disord, Low Back	$9,541,878	5,310	$1,797
4	Eye Disorders, Degenerative	$8,888,796	7,690	$1,156
5	Arthropathies/Joint Disord NEC	$7,953,835	9,510	$836
6	Coronary Artery Disease	$7,902,404	3,730	$2,119
7	Respiratory Disord, NEC	$6,753,691	6,523	$1,035
8	Cerebrovascular Disease	$6,126,513	2,722	$2,251
9	Cardiac Arrhythmias	$5,965,481	4,105	$1,453
10	Hypertension, Essential	$5,452,108	11,917	$458

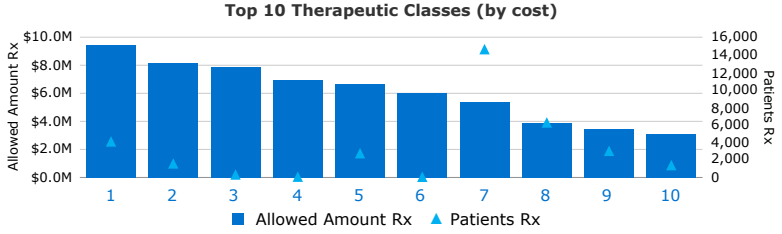
8. Screening Rates



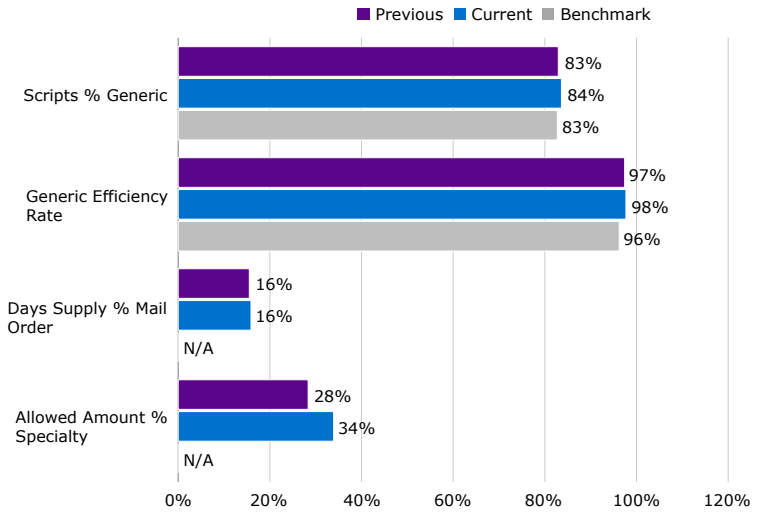
9. Chronic Condition Prevalence



10. Prescription Drug Metrics



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Antidiabetic Agents, Misc	$9,425,205	4,112	$2,292
2	Antidiabetic Agents, Insulins	$8,180,860	1,603	$5,103
3	Immunosuppressants, NEC	$7,874,456	340	$23,160
4	Molecular Targeted Therapy	$6,977,645	93	$75,028
5	Coag/Anticoag, Anticoagulants	$6,671,883	2,771	$2,408
6	Biological Response Modifiers	$6,049,086	78	$77,552
7	Antihyperlipidemic Drugs, NEC	$5,353,465	14,636	$366
8	Adrenals & Comb, NEC	$3,900,982	6,277	$621
9	Misc Therapeutic Agents, NEC	$3,465,914	3,039	$1,140
10	CNS Agents, Misc.	$3,113,671	1,414	$2,202



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Dashboard Glossary

General

- **Claims** are completed for claims incurred but not yet recorded (IBNR)
- **Benchmark** represents 2016 U.S. Total MarketScan norms that are age, gender, geographic, and/or severity adjusted as appropriate
- **PMPY** stands for Per Member Per Year and is weighted based on the number of months a member was enrolled in medical benefits
- **Allowed Amount (Allowed)** is the amount of submitted charges eligible for payment for medical and prescription drug claims; it is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts
- **Net Payment (Payment)** is the net amount paid by the company for medical and prescription drug claims; it represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted
- **Inpatient (IP)** represents claims for services provided under medical coverage in an acute inpatient setting; acute inpatient settings include inpatient hospitals, birthing centers, inpatient psychiatric facilities, and residential substance abuse treatment facilities
- **Outpatient (OP)** represents claims for medical services provided in any non-inpatient setting
- **Prescription Drug (Rx)** represents any claim paid under the pharmacy benefit
- **Patients** represents any member with a claim for the service (e.g., medical or prescription drug) being reported during the time period

1. Well Care and Preventive Visits

2. High Cost Claimants

- High Cost Claimants (HCCs) are members with $100,000 or more in medical and prescription drug net payments incurred during the year
- Non-High Cost Claimants (HCCs) are members with less than $100,000 in medical and prescription drug net payments incurred during the year

3. Quality Metrics

4. Medical Plan Eligibility

- **Average Employees** represents the number of employees with medical coverage; each employee is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Average Members** represents the number of members with medical coverage; each member is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Family Size** represents the average number of covered members per subscriber
- **Member Age** represents the average age of covered members during the year
- **Members % Male** represents the number of male members as a percent of total members

5. Risk Score

The Member Risk Score represents the DCG non-rescaled concurrent score

- The Member Risk Score is produced using the Verisk DCG® model
- This model measures the health risk of a population relative to the national average as of the time the model was developed (i.e., 100)

6. Price and Use

- **Current** represents your Price or Use rate in the Current year
- **Benchmark** represents the U.S. Total MarketScan norm for the Price or Use rate
- The **Symbol** next to the Benchmark represents your Current rate compared to the Norm
- The **Trend** represents your year-over-year trend for the Price or Use rate

7. Cost Sharing

The cost sharing percentage represents Out-of-Pocket divided by Allowed Amounts

- Out-of-Pocket represents the amount paid out-of-pocket by the member for facility, professional, and prescription drug services; this generally includes coinsurance, copayment, and deductible amounts

8. Top Medical Conditions (by cost)

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Clinical conditions include medical claims (i.e., prescription drug is not included)
- Note: The clinical condition of *Signs/Symptoms/Oth Cond, NEC* is excluded from this exhibit

9. Screening Rates

- **Cholesterol** identifies lipid screening tests for males aged 35+ years and females aged 45+ years; lipid screening tests include lipid panels, serum cholesterol tests, blood lipoprotein tests (e.g., HDL, LDL), and triglyceride tests *[source for age and gender criteria: US Preventive Services Task Force]*
- **Cervical Cancer** identifies the percentage of females aged 21 to 64 who received cervical cancer screening services *[source for age, gender, procedure, diagnosis, and revenue code criteria: NCQA HEDIS 2014]*
- **Breast Cancer** identifies the percentage of females aged 50 to 74 who received mammography services *[source for age, gender, diagnosis, procedure, and revenue code criteria: NCQA HEDIS 2014]*
- **Colon Cancer** identifies the percentage of adults aged 50 to 75 who received colon cancer screening services *[source for age, diagnosis and procedure criteria: NCQA HEDIS 2014]*

10. Chronic Condition Prevalence

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Chronic conditions identified based on medical claims

11. Prescription Drug Metrics

- **Therapeutic Class** represents the Redbook Therapeutic Class Intermediary
- **Scripts % Generic** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled
- **Generic Efficiency Rate** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled that could have been filled with a generic drug
- **Days Supply % Mail Order** is the percent of all prescription days supply filled via mail order
- **Allowed Amount % Specialty** is the percent of total prescription drug allowed amounts that were for medications considered to be specialty drugs (identified using Truven Health Service Categories)