SOQ NO. 22-037

for Group Medicare Advantage Plan

UnitedHealthcare

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Jo Ann Wetzel
Vice President, Client Development
UnitedHealthcare Retiree Solutions
Office: 612-395-7955
Email: jwetzel@uhc.com

August 12, 2022

RE: Jefferson Parish Government – SOQ 22-037

We appreciate the opportunity to propose a retiree health care program that will meet the needs of the Jefferson Parish Government and their Medicare-eligible retiree population. We recognize that Jefferson Parish Government seeks to design a program that will provide quality and affordable care to its retirees for 2023 and beyond.

WHY CHOOSE UNITEDHEALTHCARE?

The value we provide is our ability to deliver cost savings, financial stability, and experience. UnitedHealthcare is one of the nation's largest, most financially stable health care coverage providers. We offer one of the broadest portfolios of products and services for retirees.

- With more than 40 years of experience in the federal Medicare program, we provide the service and support your retirees deserve.
- Our experience results in the delivery of quality health plans and programs that serve 1 in 3 Medicare beneficiaries.
- Significant financial and manpower resources are dedicated solely to the group retiree marketplace.
- We offer fully insured solutions, reducing or eliminating administration.

As requested, we have prepared a proposal consisting of our Group Medicare Advantage PPO with integrated Part D Prescription Drug (MAPD PPO) plan. Through our national passive PPO plan Jefferson Parish Government's retirees will enjoy the same level of benefits both in- and out-of-network in all 50 states and the U.S. territories.

MEDICARE ADVANTAGE

- #1 provider of Group Medicare Advantage National PPO plans in the market
- Over 4.5 million Medicare Advantage members
- A continued commitment to the Medicare Advantage marketplace evidenced by our UnitedHealthcare Group Medicare Advantage PPO plan
- A provider network with more than 905,097 contracted providers
- A wide range of benefit plans, many available at a lower cost than traditional employer plans including HMO and PPO plan designs
- 98% client retention year over year

GROUP PART D

- UnitedHealthcare is the largest provider of Medicare Part D plans in the United States covering 4.9 million individual and group members, with plans available to residents of all 50 states, the District of Columbia and the five U.S. territories
- A satisfied membership, with over 96% of survey responses indicating "completely" or "very" satisfied
- Access to over 68,000 chain and independent pharmacies throughout the United States
- Flexible, standard plan designs with limited, generic or full coverage in the gap.
- Coverage offering a single national rate, plan design and group enrollment
- The size of our Medicare Part D programs promotes rate stability and gives us a unique ability to leverage our membership to provide the best health care possible to our members

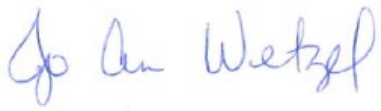
RETIREE-SPECIFIC EXPERTISE

As one of the world's largest businesses dedicated to retiree health and wellness, servicing the needs of this population is not only our specialty, but our primary focus. Our customer care professionals are dedicated to serving American seniors, including those who are non-English speaking and hearing or visually impaired, and are adept in the intricacies of all parts of Medicare. Our retiree focus is most clearly seen in the way we measure our customer care professionals, whose performance is tracked by the number of retiree issues they successfully resolve, not the number of calls they process.

In closing, we emphasize our commitment to help our clients control costs and reduce financial liability while providing health care coverage that contributes to their retirees' well-being. At UnitedHealthcare, we are dedicated to partnering with our clients for the health of their organization, their people, and their future.

We would be honored to serve Jefferson Parish Government and their retirees, and look forward to a long and mutually beneficial relationship.

Sincerely,



Jo Ann Wetzel
Vice President, Client Development
UnitedHealthcare Retiree Solutions

MINIMUM QUALIFICATIONS

The following are mandatory requirements for all proposers that cannot be delegated to another entity and must be met by the actual entity submitting the proposal. Failure to meet any of these requirements at the time of the submission deadline will result in the disqualification of a proposal:

1. **Proposer must be properly licensed in Louisiana. Please provide copies of all licensing credentials.**

   Confirmed. Louisiana state licensing credentials have been attached. Please reference document titled "Exhibit 1: LA Certificate of Authority."

2. **Proposer must have at least five (5) years of experience in providing the type of plans and services requested in this SOQ.**

   Confirmed.

3. **Proposer must offer the type of plans and services as described in this SOQ to at least two (2) similar employer groups or municipalities with similar total members as Jefferson Parish Government, and provide as references.**

   Confirmed. References have been provided as requested in Attachment D – Carrier Questionnaire.

EVALUATION CRITERIA

1. **Financial Proposals – 30 points maximum;**
2. **Demonstrated experience providing quality medical and pharmacy plan benefits for large groups (1,000+ members) – 20 points maximum;**
3. **Company's financial strength – 10 points maximum;**
4. **Demonstrated ability to provide excellent customer service to the Plan Administrator and Members – 20 points maximum;**
5. **Benefit Structure, Nationwide provider network, Dental Benefits, Vision Benefits, Other Value Added Benefits – 20 Points maximum**

   Noted.

The person or firm submitting a Statement of Qualification (General Professional Services Questionnaire) must identify all subcontractors who will assist in providing professional services for the project, in the professional services questionnaire. Each subcontractor shall be required to submit a General Professional Services Questionnaire and all documents and information included in the questionnaire. (Refer to Jefferson Parish Code Ordinance, Section 2-928).

Confirmed.

All persons or firms (including subcontractors) must submit a Statement of Qualifications (General Professional Services Questionnaire) by the deadline. The latest professional services questionnaire may be obtained by contacting the Purchasing Department at (504) 364-2678 or via the Jefferson Parish website at www.jeffparish.net . This questionnaire can be accessed by hovering over "Business and Development" on the website and clicking on the Professional Services Questionnaires option under "Doing Business in Jefferson Parish".

Confirmed.

Submissions will only be accepted electronically via Jefferson Parish's e-Procurement site, Central Bidding at www.centralauctionhouse.com or www.jeffparishbids.net. Registration is required and free for Jefferson Parish vendors by accessing the following link: www.centralauctionhouse.com/registration.php .

Noted.

No submittals will be accepted after the deadline.

Noted.

Affidavits are not required to be submitted with the Statement of Qualifications, but shall be submitted prior to contract approval.

Confirmed. The Affidavit shall be provided prior to contract approval.

Disputes/protests relating to the decisions by the evaluation committee or by the Jefferson Parish Council shall be brought before the 24th Judicial Court.

Noted.

SCOPE OF SERVICES

GENERAL SERVICES

- **Mail all plan related materials to all covered retirees to be received prior to commencement of open enrollment meetings on an annual basis. Materials will include plan summary, all inclusive network provider list/booklet, prescription drug coverage information, material describing ancillary coverage, such as dental, vision, etc.**

  We can mail our pre-enrollment Plan Guides to retirees prior to open enrollment meetings on an annual basis. The timing of this needs to be coordinated with JPG to ensure appropriate data and sufficient time is available to complete the mailing.

  The Plan Guides include the CMS-required materials such as the Summary of Benefits, which provides plan summary information. The Plan Guide also includes additional information describing prescription drug coverage and ancillary coverage, as appropriate for the plan. Retirees have access to the online provider and pharmacy search tools with all the available providers and pharmacies and can print a local listing on demand.

- **Will comply with all applicable Federal, State, and Local laws, rules and regulations. These laws, rules and regulations will be deemed to be included in the contract the same as though herein written in full.**

  UnitedHealthcare administers its Medicare Advantage plans in accordance with the requirements of Medicare and CMS regulations, as well as other applicable federal and state laws and regulations. UnitedHealthcare's Medicare Advantage products are governed by, and required to comply with, federal laws applicable to Medicare, including Health Insurance Portability and Accountability Act (HIPAA) and the regulations and guidance promulgated by CMS. It is always our intent to comply with all applicable laws and regulations, and we have made investments in compliance programs and corporate culture that are designed to support our goal to meet the expectations of our government payers.

- **The healthcare provider must mail subscriber and dependent ID cards annually prior to the first of each year after open enrollment.**

  Confirmed.

- **Provide annual open enrollment support by providing a speaker at each retiree meeting upon request. Provide representatives to meet with retirees individually upon request for possible enrollment when the retiree reaches age 65.**

  Confirmed. UnitedHealthcare will provide full support to JPG throughout the open enrollment period. We are recommending both in-person meetings and webinars or teleconferences. We can also identify and arrange a centrally located senior-friendly venue within Jefferson Parish, free of charge. We have our own Group Retiree open enrollment team who will develop and coordinate the on-site educational meeting strategy in partnership with JPG.

  Pre-enrollment advisors are also available throughout the entire process to answer retiree questions and guide them through the initial transition.

PROFESSIONAL SERVICES

- **Provide a network of physicians, hospitals and ancillary medical providers. Maintain a thorough, well documented credentialing procedure, and conduct an ongoing quality assurance program under the purview of a peer review committee.**

  Confirmed.

- **Provide utilization management services designed to authorize care with the fewest number of hospital days and/or elective surgeries such that quality of care and patient satisfaction are not reduced. Reviews to be conducted by staff consisting of registered nurses and a panel of physician advisors including specialists.**

  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 clinically appropriate, cost effective and optimize health care outcomes.

  Our utilization management program consists of the following components: medical necessity review for all services on our core prior authorization list, admission notification and inpatient care management that includes concurrent review.

PRIOR NOTIFICATION/PRECERTIFICATION

Because the notification process is designed to identify members with potentially unmet health care needs, the process is also applied to inpatient and outpatient services being received by members who are likely to benefit from care management programs and interventions. All inpatient admissions for network providers require prior notification. Participation in the precertification program is required of network providers but is not required of members. If a required precertification is not obtained by the network provider, the member is not penalized for failure to obtain the precertification.

Our prior authorization list is reviewed regularly and subject to change based on evidence-based medicine guidelines. We perform a thorough financial and non-financial analysis of services and procedures prior to adding them to our prior authorization list. We consider cost-effectiveness and quality of care when recommending prior authorization of services.

Our network providers are contractually obligated to notify us of all inpatient admissions and to obtain prior authorization for services and procedures on our prior authorization list, whether performed in an inpatient or outpatient setting. Providers can access the current prior authorization list on the provider portal, **uhcprovider.com**.

PRE-SERVICE REVIEW

Pre-service review, including prior authorization and precertification processes, involves our prior assessment that a requested service is both clinically appropriate and a covered benefit. Pre-service review includes eligibility verification, benefit interpretation and medical necessity review for approval of inpatient or outpatient services.

When adverse determinations are necessary for medical reasons, those determinations are made by medical directors or supporting physician specialists, supported by national clinical guidelines and/or internally developed clinical policies. Nurses may issue denials of coverage without physician input for explicit benefit coverage reasons only.

Whenever we make an adverse determination, the member and/or their physician or other care professional has the right to appeal the determination within 60 days from the date of the determination.

Pre-service review includes:

- Hospital precertification, which is required for any acute, emergent or elective procedure.
- Surgical procedures, which are authorized on both medical necessity and place of service.

Concurrent Review

Our comprehensive concurrent review program strives to ensure the member is receiving the right care at the right time and in the right setting. Clinicians assess the medical necessity or appropriateness of services as they are rendered in an acute, in-patient, skilled-nursing facility and transitional care settings and help facilitate access to care or alternate-care settings.

Concurrent review ensures a hospital stay is proceeding as planned. Nurses complete an initial assessment to determine the length of stay goal, which determines the frequency of review and/or referral to other care management programs. Nurses use evidence-based guidelines, internal protocols, and our proprietary risk-scoring tool to prioritize reviews. Generally, reviews of new admissions, certain surgical admissions, admissions that exceed the recommended length of stay and unplanned readmissions are prioritized for review and completed within one business day following admission.

Inpatient Care Management

Our inpatient care management activities focus on:

- Ensuring the physician's treatment plan is clinically appropriate, cost-effective and adheres to evidence-based medicine
- Identifying and preventing potential delays in care, tests and procedures
- Facilitating access to specialists if needed via consultation with the medical director
- Supporting discharge planning, including identifying members for post-discharge follow-up

Inpatient care management nurses perform telephonic review. We provide active, real-time management by applying evidence-based clinical criteria to determine appropriateness of services; anticipate future services; assess the quality of care, anticipate discharge planning needs and help implement the discharge plan to ensure a safe disposition.

The inpatient care manager receives new inpatient cases from intake and Clinical Coverage Review and identifies cases requiring management from the hospital census reports. The inpatient care manager evaluates all cases assigned early on the same business day. Cases assigned later in the day will be reviewed by the following day, and retrospective cases are reviewed within seven days on the initial admission date. The inpatient care manager will then determine the frequency of case review based on clinical criteria, summary of benefits or evidence of coverage and medical necessity status.

Cases not meeting criteria for admission are escalated for medical director review and/or peer-to-peer discussions. Our medical director reviews cases at least every seven days.

DISCHARGE PLANNING AND TRANSITION OF CARE

Members are identified for discharge planning during the initial inpatient review; discharge planning continues throughout the inpatient stay.

Our clinical staff collaborates with the attending physician and facility to coordinate the member's discharge needs, including services such as home health care, transition to a skilled nursing facility or another component of our care management program, based on member eligibility.

Our clinical staff identifies and refers members who may benefit from post-discharge support through our hospital transition program and/or complex condition management programs to avoid preventable hospital readmissions.

New members might be receiving treatment from non-contracted physicians. Policies for transition of care allow a member to continue his/her health care with the non-contracted physician, under certain circumstances and for a defined period of time. After that time, the member is assisted in finding a contracted physician who can provide the required care. The transition of care period applies only to current treatment for specific health issues as described in the "Qualifying Clinical Conditions" section of the Transition of Care Policy, or applicable policy. The Transition of Care Policy might also apply in special circumstances where there are substantial changes to the local network that affect a participant's current treatment plan

POST-SERVICE REVIEW

Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment of services.

Post- service reviews are based on established review guidelines and includes:

- Review of medical necessity.
- Appropriateness of level of care.
- Identifying claims issues.
- Eligibility determination.
- Initiation of appropriate follow-up actions for utilization and quality issues.
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission

- **Provide information on all programs that target treatment of chronic diseases, i.e., disease management. Discuss health assessment surveys, nurse interventions and health outcome data, different therapies used to treat different diseases and dissemination of data to network physicians.**

We have comprehensive, best-in-class care and disease management programs that are based on supporting members that are healthy and well, returning to health, living with chronic illness and end of life. We focus on managing illness and chronic conditions, encouraging preventive care, coordinating care, and promoting evidence-based medicine to achieve the best possible clinical outcomes.

Our goal is to provide your retirees access to health care and resources at the right time with the right provider at the right place. In 2021, UnitedHealthcare clinicians worked directly on care plans with approximately 48% of Group Medicare Advantage members through our clinical programs.

Quality of care is the primary focus of our clinical programs and services, with markers of success being measurable improvements in retirees' health statuses and clinical outcomes. Our high Star ratings reflect how we are improving retiree health outcomes, closing gaps in care and helping retirees take the right action at the right time. We offer the only 5 Star rated national PPO plan in the Group Medicare Advantage market.

Our clinical programs favorably impact quality of care and clinical outcomes. We have several programs that work directly with the retiree to ensure preventive screenings occur, chronic conditions are managed, and on-going support is offered when they need it. Over the past four years, we have closed over 8.2 million quality gaps in care for our Group Medicare Advantage members. This includes activities such as colon cancer screenings, breast cancer screenings, and controlling blood pressure. Another example of how we improve care is through our in-home HouseCalls program, which lowers the rate of hospitalization and emergency room visits and increases visits back to the primary care provider, based on published medical studies specifically on the UnitedHealthcare program.

The following is an overview of our programs and services that will be available to JPG members for 2023.

HouseCalls

HouseCalls is the industry standard for in-home health assessments and coordination of care. Our UnitedHealth Group-employed, licensed health care practitioners visit eligible members in their own homes to assess medical history, conduct a physical exam, review medications, discuss health concerns and provide education on health-related issues. The program provides an opportunity to identify members who have gaps in care and refers members to their primary care physician as well as into our case and condition management programs.

Summary of Results

A key outcome of the HouseCalls visit is to identify unmet health care needs the members may be experiencing and refer them to programs and resources such as UnitedHealthcare's care and condition management programs as well as local community resources such as area agencies on aging.

- In 2016, an Independent Commissioned RAND Study found that our HouseCalls program resulted in a 6% decrease in Emergency room visits, 6% decrease in Hospital Admissions and a 3% increase in Physician Office visits.
- An additional, RAND study conducted in 2017 found that there was a 22% increase in Diabetes detection rates and a 14% increase in COPD detection rates through our HouseCalls Program.
- In 2021, more than 330,000 Group Medicare Advantage members completed a Depression screening and Social risk assessment as part of their HouseCalls visit.
- In 2021, through our HouseCalls program over 100,000 members were offered screening for Prediabetes across our book of business, with 24% of the tested population being identified to be Prediabetic and an additional 3% identified as undiagnosed diabetics.

- With every HouseCalls visit, we close, on average, three gaps in care. Over the past decade, over 2 million HouseCalls have been completed for our Group Medicare Advantage retirees, generating a 99 percent member satisfaction rate.

HEALTH RISK ASSESSMENTS

Health Risk Assessments are used to assess the retiree's medical conditions, including chronic conditions, medications, general health, utilization, mental health, and the need for psychosocial services or help at home.

TELEPHONIC NURSE SUPPORT

UnitedHealthcare offers telephonic and digital resources with access to registered nurses, empowering members to make better health care decisions. Where appropriate, registered nurses use their medical and clinical expertise to provide members with care-seeking recommendations and a review of treatment options. The responding nurse guides members to the right level of support, identifying opportunities for additional clinical support referrals and connecting our members to available resources.

ADVOCATE 4ME

Advocate4Me is our customer service program that proactively identifies members with the most complex needs and connects them with the service professional best equipped to deliver on those needs, including complex health issues related to acute or chronic diseases. Ultimately, this service model will help ensure the most appropriate utilization of health care, improve quality performance, and Star ratings and make the overall customer service experience simpler, more satisfying and effective for the Agency members. Members can self-refer into our clinical programs through Advocate4Me.

NAVIGATE 4ME

Navigate4Me is our personalized concierge services program that supports and guides members with complex chronic health challenges or a sudden health event. The team consists of nurse navigators who can help members navigate the health care system—together, whether it is clinical, service, social, behavioral, pharmaceutical or financial. A personalized member navigation plan is developed using member data, taking into consideration the member’s clinical and service needs, proactively removing obstacles and ensuring it works with the member’s lifestyle.

CAREGIVER SUPPORT

We offer a comprehensive caregiver solution designed to support family caregivers in helping aging family members stay healthy, function as independently as possible, live with dignity, and remain in the community for as long as possible. Our caregiver solutions are designed to help support the needs of the growing caregiver population, while providing peace of mind, referrals and resources to save time and money. Caregiver resources are available to address an array of concerns to members or their caregivers who have long-term or advanced illness, are elderly or have disabilities.

Disease/Chronic Condition Management

Diabetes Management Program

UnitedHealthcare is a leader in diabetes management. We offer comprehensive programs that support and educate retirees with diabetes across the spectrum of their condition to help them understand and better manage their condition more effectively. The diabetes programs are designed to improve each member's ability to self-manage not only their diabetes, but the other diagnoses frequently encountered with diabetes. The primary goal is to change behaviors in order to prevent unnecessary hospitalizations and further progression of the disease.

UnitedHealthcare's Diabetes Support Program is designed to educate eligible members on the importance and relevance of achieving good diabetes control. Our Diabetes Management Program addresses each member's clinical needs, helping them achieve optimal care by working closely with the member's physician. In this program, we address the needs of members with comorbidities and a high risk for hospital admission. We use predictive modeling systems and a member's claims data to identify possible gaps in care such as missing lab tests, prescription medications and screenings.

We provide digital tools for improved management of their blood sugars. In addition to predictive modeling, members may also be identified through HRAs, our care management process, inpatient and outpatient notification, direct referral, and through Telephonic Nurse Support. Upon identification of an individual at risk, we deliver the program's components through a combination of mailings and telephonic outreach by specially trained program nurses and dietitians.

Pre- Diabetes

Through UnitedHealthcare's early disease identification initiatives in 2020 and 2021, we offered members who were at risk of pre-diabetes to be screened during a HouseCalls visit. 24% of the Group Medicare Advantage members tested were identified as prediabetic by our HouseCalls practitioners and 3% were identified as undiagnosed diabetics.

Hypertension Support Program

The hypertension support program is designed to educate eligible members on the importance and relevance of achieving good blood pressure control. Members who qualify have demonstrated difficulty managing hypertension and are identified as eligible for the controlling blood pressure measure. Members are engaged through outreach calls.

High-Risk Care Management

High-Risk Care Management is a national telephonic, chronic care management program of nurse care managers providing targeted interventions for retirees identified with chronic conditions and or frequent hospitalizations. Retirees are "high risk" based on utilization and a designated risk score. Care managers monitor general health status, current conditions, mobility, medications and risk for admission. The program supports retirees by helping them access care, coordinate services and learn to better manage their chronic conditions.

Remote Patient Monitoring

We are engaging members where they are in their health care journey with a goal to reach the vast majority of our members. Our remote patient monitoring program offers real-time, condition-specific clinical support and on-demand digital coaching through a phone-based application or tablet, and Bluetooth enabled medical equipment to support members in their own homes. The capability is a complete, retiree-centered and holistic connected care platform that leverages remote monitoring, clinical pathways and rules that automate alerts for care managers to proactively address escalations.

Kidney Disease Program

The Kidney Disease program identifies and attempts to case manage members with advancing kidney disease that are moving towards dialysis, currently on dialysis, or awaiting transplant. Based on the severity of disease and geography, members will either work with a Renal Nurse Care Manager and Health Advocate or a team of community-based providers who provide both in home and remote education and support services. Members will work with their care team to, delay or stop Chronic Kidney Disease (CKD) or End-Stage Renal Disease (ESRD) progression, overcome any treatment barriers, and find a high-quality nephrologist. Through collaboration with the member's providers, the Kidney Disease Program works to proactively obtain dialysis access, evaluation for in-home dialysis, and initiation of dialysis prior to emergent need.

Transplant Case Management

Our transplant management program drives positive clinical outcomes by addressing the complex needs of older adults who are facing transplants. We cover all phases of transplant coordination, from evaluation, pre-transplant, transplant, post-transplant and 12-month follow-up health care. Our unique clinical experience significantly reduces overall medical costs. Our Centers of Excellence network health care providers drive quality patient outcomes, with high patient one-year survival rates. In addition to cost containment, the goal and objective of our transplant management program is to provide the breadth of quality providers, facilities and care for those in need of transplants.

Our specialized nurse managers work with members to provide condition-specific education and care coordination services for those seeking high-cost and treatment-variable transplant procedures for solid organ and bone marrow/stem cell transplant services. Engaged transplant members receive, on average, one contact per month by their assigned transplant care manager, to assess and check their progress. By empowering members with information about our transplant Centers of Excellence, as well as preparing for, and recovering from, transplant surgery, we drive positive clinical outcomes. We validate members' decisions and maximize economic value through operational efficiencies and cost avoidance.

Advanced Illness and Palliative Care Program

The UnitedHealthcare Advanced Illness (AI) Program provides an extra layer of support for our most vulnerable seniors. Specially trained nurses and social workers call these members by phone regularly and more often when their condition worsens. They provide support and guidance and help the member connect with their other doctors as well as establish a contingency plan for when urgent issues arise to protect members from avoidable hospital admissions. AI nurses and social workers work with the member to make sure they follow up with their doctors and that they have a contingency plan for when symptoms occur. Family caregivers who provide care to our seriously ill members often suffer themselves from anxiety, stress and burnout and rarely have access to the support they need as unpaid caregivers.

In 2019, we began offering field-based palliative care resources to seriously ill members in the comfort of their home. This program is available in major metropolitan markets across 42 states. Our palliative care program provides 24-hour member support with a multidisciplinary team of palliative care experts, nurse practitioners, nurses, and social workers in partnership with local care providers. The focus of this home-based palliative care support is pain and symptom management and helping people meet their care goals.

In 2022, we have enhanced our delivery of in-home palliative & serious illness care by:

- Adopting new virtual capabilities for members who utilize our telephonic Advanced Illness program, allowing for improved access to care for members across all 50 states, the US Virgin Islands and Puerto Rico. Continued multidisciplinary support to identify social needs and promote care coordination

- Community focus includes collaboration with current providers and assessment of social and environmental factors (social determinants of health) to support members' goals of care.

Behavioral Health

Our behavioral health management program reflects an integrated approach with our medical team to identify, engage and manage retirees' behavioral health concerns. Our behavioral health care programs are led by experienced geriatric psychiatrists and licensed behavioral health clinicians with significant geriatric expertise. Our medical-behavioral integration specialist (care manager) is highly skilled and will coordinate behavioral health referrals from our HouseCalls program and other clinical programs.

Inpatient and Transitional Care

Transitional Programs

UnitedHealthcare understands that being discharged from an inpatient or skilled nursing facility often involves stress, confusion, compromised care and avoidable hospital readmissions. Our transitional programs are provided to members who were admitted to the hospital or to a skilled nursing facility for specific conditions.

Healthy at Home

For retirees experiencing an inpatient admission or a stay at a skilled nursing facility, the goal is to ultimately recover in the comfort of their own home. We know that members need support beyond traditional medical care to be healthy at home. To prevent new or worsening social determinants of health, we utilize our extensive admission and discharge data to identify the most vulnerable retirees for readmission. UnitedHealthcare's Healthy at Home program provides the support retirees need to successfully recover at home and is available to members at no charge.

The UnitedHealthcare Healthy at Home bundle combines our market-leading meal delivery, transportation and in-home non-medical care offerings into an easy to use, affordable program that delivers needed support, care and measurable results to the retirees we serve:

- Meal Delivery provides up to 28 meals following all inpatient or skilled nursing facility discharges when referred by an. UnitedHealthcare advocate.

- Transportation includes up to 12 rides to and from medically related appointments and to the pharmacy following all inpatient or skilled nursing facility discharges when referred by an UnitedHealthcare advocate.

- In-home Personal Care provides up to 6 hours of in-home personal care following all inpatient and skilled nursing facility discharges through our exclusive provider. Members receive assistance with Activities of Daily Living such as meal preparation, medication reminders, bathing, respite care, and more. No referral is required.

UnitedHealthcare Social Determinants of Health Interventions in 2021 included:

- Over 330,000 social needs assessments were completed through our HouseCalls programs.

- Over 604,661 post-discharge meals delivered to members across the country.
- Provided in-home personal care to over 15,000 members assisting them with activities of daily living, household tasks, fall prevention, medication adherence resulting in 92.5 caregiver tasks completed for every engaged member.

Inpatient Care Management

Our Inpatient Care Management (ICM) program promotes the timely delivery of needed services to hospitalized members, helping them to receive the most appropriate care based on their specific clinical status and health care needs. It is designed to achieve optimal clinical outcomes by applying nationally recognized evidence-based clinical guidelines and best practices to reduce unnecessary variation in clinical use of services. The program focuses on helping members move through the continuum of care, including transitions during and after hospitalization.

ICM nurses perform telephonic review. We provide active, real-time management by applying evidence based clinical criteria to determine appropriateness of services; anticipate future services; assess the quality of care, anticipate discharge planning needs and help implement the discharge plan to ensure a safe disposition.

One Hospital: One Nurse

Our One Hospital One Nurse model is a geographically based design that strategically assigns (ICM) nurses to our network hospital facilities in their regions across the United States. UnitedHealthcare ICM nurses work telephonically and may have access to facility electronic medical records if facility contracts allow.

Cases are directed to a designated ICM nurse, who serves as the primary resource for that facility. All ICM nurses and physicians have expertise in using evidence-based care guidelines. The ICM nurses have an intimate knowledge of the facility's culture and procedures. This knowledge helps them access patient information quickly and increases awareness of how members are progressing through their hospital stay. This allows them to promote an evidence-based approach in that facility. ICM nurses may have direct access to the member's current medical record through electronic medical record review which helps to decrease the number of missed opportunities that might impact the member's inpatient stay.

Hospital Care Transition Program

Hospital Care Transition Program is a patient-centric approach to seamless care transitions from hospitals to post-acute networks, enhancing the member experience and bringing value to our customers and care providers. Our program goals include:

- Improved clinical outcomes
- Increased member satisfaction
- Reduced readmissions
- Significant cost savings

Hospital Care Transition (HCT) Coordinators engage members at the bedside upon admission to medical/surgical floors and/or observation.

When the patient is ready for discharge, HCT Coordinators work with facility staff to implement the discharge plan and provide education about in-network care providers, programs they may be eligible for, community-based resources and more.

Post-Acute Transition Program

Through this in-person, hands-on approach to care, Post-Acute Transition program ensures members are medically and functionally ready to return home, while preventing unnecessary delays at skilled nursing facility discharge and avoiding readmissions. The program has reduced the length of stay in a skilled nursing facility by five days on average.

Our Post-Acute Transition Program uses an individualized, whole-person approach to remove barriers to discharge from post-acute care, such as skilled nursing facilities so the member can safely return to the least restrictive setting possible. Our nurse care managers collaborate with facilities, physicians, families and caregivers after their hospital stay and throughout the post-acute stay. The nurse care manager participates in care conferences, family meetings, and discharge planning as appropriate to communicate with members/families and discuss benefits, progress, goals of care, discharge plans, home health referrals, etc. Nurse care managers are telephonic and may be on-site to perform care management, coordination and concurrent review and engage the member and facility to effectively manage length of stay. Nurse care managers evaluate the entire scope of a member's needs, provide members and their caregivers with coaching and resources and coordinate referrals to community-based services.

Patient Connect

Patient Connect is a clinical program engaging Medicare Advantage members transitioning to a skilled nursing facility from an acute inpatient stay needing continuity of care for rehabilitation purposes and expedient recovery. Our nurse practitioners who are on-site at designated facilities focus on medication review and reconciliation, clear care paths, and proactive discharge planning for members in skilled nursing facilities. Results of this program are favorably impacting member experience, care coordination, and avoidable utilization.

Members in the Patient Connect program have a reduction in skilled nursing facility length of stay of 20% on average, 52% lower unnecessary readmission rates, improved Star gap closure, and higher advance care planning completion and hospice referral rates.

Provider Communications

Our nurses and social workers provide support and guidance and help the member connect with their doctors as well as establish a contingency plan for when urgent issues arise to protect from avoidable hospital admissions. We collaborate with the member's current care team and do not replace the primary care provider.

Our care managers help members maneuver through the health care system when they are experiencing unstable health or need support to work toward meeting their health care goals. In addition to identifying their needs, barriers and develop a plan of care, our care managers also coach members on discussing their condition with their primary provider and on ways to manage themselves. The care manager will engage the primary provider and specialists to discuss the member's plan of care and medication regime and often may coordinate a conference between the member and provider(s). Care managers follow HIPAA guidelines and adhere to our confidentiality guidelines in communicating with members and providers. Frequency of contact is dictated by the need according to the member's plan of care.

POINT OF CARE ASSIST (POCA)

UnitedHealthcare recently developed Point of Care Assist, adding real-time patient information — including clinical, pharmacy, labs, prior authorization, eligibility and cost transparency — to existing electronic medical records (EMRs) to make it easier for physicians to understand what patients need at the point of care. Point of Care Assist integrates patients' UnitedHealthcare health data within the EMR to provide real-time insights of their care needs, aligned to their specific member benefits and costs. This makes it easier for providers to see potential Star gaps in care and other quality gaps, select labs, estimate care costs and check prior pharmacy and medical authorization requirements — including benefit eligibility and coverage details. This helps them better serve their patients and achieve better results for their practice. Our year-end 2021 enterprise report shows that we currently have 661,000 active providers utilizing our Point of Care Assist system. These providers have processed 120 million transactions and addressed 1.5 million gaps in care.

GAPS IN CARE REPORTING

The Patient Care Opportunity Report (PCOR) provides comprehensive health data on our Medicare Advantage members based on claims and pharmacy records, as well as data on care received from our members' other health care providers.

The gaps in care are identified in the PCOR database, which the provider has access to, and are reported in summary form in our patient summary reports are available online as well. Providers can identify current gaps in care, engage the patient for a visit, and update the database by completing a claim submission.

ADMINISTRATIVE SERVICES

- **Establish, maintain, and update Master Record file(s). Prepare and print all plan documents:**
  - **Group Policy/ Plan Document**

    The Evidence of Coverage (EOC) will be available for retirees to access online prior to open enrollment annually in accordance with CMS requirements. Retirees may contact UnitedHealthcare Group Retiree member service center at any time and request to receive a hard copy EOC via mail.
  - **Summary Plan Description (SPD)**

    Not confirmed. Summary Plan Descriptions (SPDs) are not required under our Medicare Advantage plans. Instead, retirees receive the CMS-required Summary of Benefits and Statements of Understanding in their pre-enrollment Plan Guide. Once a retiree has been enrolled into our plan, they will receive a post-enrollment Welcome Kit that includes all the CMS-required materials.
  - **Other documents as may be required by federal state and local laws**

    Confirmed.
- **Furnish all standard forms to be used in connection with the administration of the plan:**
  - **Enrollment Forms**

Confirmed; however, many of our clients choose to automatically enroll eligible individuals into our plan via electronic files, making enrollment forms unnecessary.

- **Claim Forms**

  Not confirmed. Retirees rarely need to submit claims to UnitedHealthcare and in the instance a retiree needs to file a claim, there is no form required to request reimbursement from us. For the convenience of the retiree, they may pay the provider directly and submit an itemized receipt obtained from the provider to UnitedHealthcare for reimbursement.

- **ID cards**

  Confirmed.

- **EOBs**

  Confirmed.

- **Review, in a consultative capacity, summary plan descriptions and other similar material to be distributed to plan participants.**

  Confirmed.

- **Consult on plan provisions, plan design, impact of local, state, or federal legislation, new medical procedures/technology, emerging benefits trends, cost containment, and other ongoing services issues.**

  Confirmed.

PERFORMANCE STANDARDS

- **Proposer shall maintain the following performance levels, as applicable:**
  - **Eligibility Loading- Load all eligibility files into system within five (5) business days of receipt. Measurement Criteria- Elapsed time from date file received to the date upon which the file is loaded to the eligibility system.**
  - **ID Cards -mailed within ten (10) business days after final member eligibility is received, system loaded and passes a quality assurance check. Measurement Criteria - Date ID cards are mailed.**
  - **Electronic "Claim Ready Date"- Electronic Claim Ready by the effective date or within twenty (20) business days after account structure is entered into the system, final member eligibility is received, and benefit plan design is finalized. Measurement Criteria - Date plan benefits and employee and dependent eligibility data is system loaded.**
  - **Claim Operations: Measurement Criteria- by standard claim operations reports:**
  - **Time to Pay- 90% of "non-controversial' or "clean" claims paid in ten (10) business days**
  - **Financial Accuracy- 99% of submitted charges processed correctly**

- **Procedural Accuracy- 95% of claims processed without non-financial error**
- **Penalties: The annual penalty for failure to maintain the performance levels above shall be:**
- **Eligibility Loading** **$20,000**
- **ID Cards** **$50,000**
- **Electronic "Claims Ready Date"** **$50,000**
- **Time to pay** **$50,000 for failure to pay 90% of claims within 10 days; Increase $5,000 per extra day to meet 90% standard to a maximum of 15 days and maximum of $100,000.**
- **Financial Accuracy** **$100,000 for failure to process 99% of claims correctly; Increase $5,000 per 25% reduction in accuracy to 98% and maximum of $200,000**
- **Procedural Accuracy** **$20,000 for failure to process 95% of claims without a Non- financial error; increase $5,000 per .50% reduction in accuracy to 93% and maximum of $40,000.**

Partially confirmed. UnitedHealthcare is pleased to offer our standard suite of performance guarantees reflected in the document titled, “Exhibit 2: JPG – UHC 01.01.2023 Standard PGs.”

In addition to performance guarantees, UnitedHealthcare is providing an implementation credit of up to $10,000. The implementation credit may be used to offset various implementation-related expenses associated with the transition, such as mailing the announcement letters, custom communications, developing files, health fairs, etc. We will reimburse JPG upon receipt of an invoice, or we will pay a vendor’s invoice on behalf of the Parish.

Implementation credits will be processed upon the execution of a UnitedHealthcare Group Medicare Advantage contract, and upon receipt of the itemized invoices, receipts, and/or bills (e.g., a bill for consulting fees associated with the implementation) as proof of the implementation expenses that JPG has incurred.

CLAIMS PROCESSING SERVICES

- **Maintain and update eligibility file.**

Confirmed. Within 48 hours of the enrollment file being received, UnitedHealthcare will load the file into our Electronic Eligibility Management System (EEMS). EEMS is an automated file review and pre-processor program that systematically loads membership files sent by JPG via the file transfer connection to our eligibility and enrollment system, GPS. After the file has been processed via EEMS, the enrollment records are fed into GPS. The record is then compared to CMS's pre-enrollment eligibility query application to quickly validate the member meets basic Medicare eligibility requirements, prior to submitting the transaction file to CMS. After this initial successful validation, the member’s record is then passed to CMS for final eligibility processing.

If the initial validation is not successful, our operations team attempts to remove any errors. This often requires working with either the client or the member to clarify or supplement any of the required data elements. The process can take up to seven calendar days.

- **Administer the plans' Coordination of Benefits (COB) provision.**

  Confirmed. The Medicare Advantage plan pays in place of standard Medicare Parts A, B and optionally, D benefits. Accordingly, members are required to be enrolled in both Medicare Parts A and B to enroll in the plan. The coordination of benefits (COB) process with other insurance vendors involves first submitting claims to the primary plan. The secondary plan pays additional benefits, if appropriate, so total reimbursement equals what would be received under the secondary plan alone.

  UnitedHealthcare has a dedicated team responsible for COB investigation. Staff is trained on state and federal regulations for COB. Upon indication of other insurance through a claim, a COB indicator and timeline is entered on the member's record. Upon receipt of a claim for the member (during the designated COB period), the claim is pended for manual review. The claim system has multiple COB edits and system logic that identify instances in which other insurance may be involved. We utilize existing policies and procedures detailing COB requirements and necessary documentation for claims determination.

  We make one attempt to verify COB information. COB follow-up is done by phone and, if needed, via email. After initial verification of other coverage, we do not re-verify coverage unless further information is received.

  We exchange member COB eligibility data with CMS daily to reconcile primary status when our members have more than one health plan. We are required to verify and to report to CMS on all other insurance updates.

- **Review claims submitted for medical services that appear excessive and/or establish medical necessity for services rendered or expenses incurred.**

  Confirmed. UnitedHealthcare's operations teams have various processes and procedures to assist in controlling costs and identifying unnecessary expenses through fraud, waste, abuse and error (FWAE) identification, medical necessity requirements, and high claim reviews.

  Our claim and member service operations centers have established policies and procedures for detecting, preventing and reporting FWAE, in compliance with CMS. Our FWAE operations team conducts objective, thorough investigations of members, physicians and other health care professionals suspected of FWAE, therefore eliminating excessive or unnecessary billing.

  Additionally, to process claims correctly and assist in maintaining cost, we rigorously apply various coding systems and internal guidelines. Our guidelines and system logic help us determine whether medical services are "medically necessary" or "medically appropriate." The codes are maintained in our core system and updated on a quarterly basis. Inbound claims containing codes not part of these standard codes sets are denied.

  Furthermore, Physician claims with billed charges of $10,000 or greater and hospital claims with billed charges of $7,000 or greater go through an additional review by a processing team dedicated to high dollar claims. A payment integrity team confirms that payments are accurate.

- **Make available the services of field claim consultants and/or professional services resources for the evaluation of complex claims.**

Confirmed. Our UnitedHealthcare claim processors concentrate solely on processing Group Medicare Advantage claims. Claim processors are thoroughly trained in each group's covered benefits, policies and procedures for each product, and each product's inventory is monitored and maintained separately.

Our in-depth knowledge of the Medicare program, coordination of benefits (COB) and federal and state claim processing rules and regulations ensures our ability to process claims efficiently and effectively. We develop the competency of our claims examiners over a five-month training program. The program includes dedicated classroom training focused on adjudication accuracy and compliance with mandates from CMS. Following the classroom training, our quality-auditing team evaluates performance through monthly audits of a statistically-significant sample of claims.

UnitedHealthcare's commitment to our claim processors training helps ensure proper evaluation of complex claims and the processing thereafter when manual intervention is needed.

- **Maintain peer review relations.**

  Confirmed.

CUSTOMER FOCUSED QUALITY MODEL

UnitedHealthcare has an established quality program providing oversight and support to various operational areas through a Customer Focused Quality Model (CFQM) which strives in whole or in part to:

- Proactively detect and remediate defects to improve critical to quality metrics
- Utilize retroactive audits in compliance with legal, contractual and regulatory requirements
- Identify opportunities to create and measure quality at the source
- Provide a closed loop feedback system for continuous improvement

We are committed to continually improving the efficiency and effectiveness of the services we provide to our clients. Our quality programs assess new and existing products to improve the client experience and the value we deliver. Our goal is to deliver the right outcome to our clients the first time, every time.

- **Discuss disputed charges with providers when appropriate.**

  Confirmed.

- **Must notify JPG of any and all PPACA changes and updates that will impact JPG financially and administratively.**

  Confirmed. Your strategic account executive (SAE), Veronica Reynada, will update JPG about any significant change within the company that would impact JPG or your retirees directly.

- **Maintain and store claim detail data elements for statistical analysis.**

  Confirmed. Claims documents are maintained in our online system for a period of 10 years from the initial payment date. Our record retention periods are based on federal and state statutes, agency regulations and operational needs.

- **Provide online and mobile claim viewing access to participants.**

Confirmed. Members are able to view claim status and history on our member portal, **retiree.uhc.com** as well as the UnitedHealthcare Mobile App.

New Business Installation Services

- **Consult on new products, alternate health care delivery system, and healthcare cost management techniques.**

  Confirmed.

- **Participate in and/or conduct retiree meetings as requested.**

  Confirmed.

- **Act as a liaison with administrative, technical services, and claims departments.**

  Confirmed.

- **If you are awarded the contract, you will be responsible for developing, printing and distribution of the required ID cards, claim forms, provider directories and employee booklets. Any cost for these services must be absorbed by the proposer.**

  Confirmed. We will distribute all required and any applicable materials to retirees at no additional cost.

  We direct retirees online for the provider and pharmacy search, as well as plan documents for formulary, certificate and Evidence of Coverage (EOC); however, all these items are available to be mailed to a retiree upon request.

Other Services

- **Provide a network of physicians, hospitals and other health care professionals and providers offering discounts or special fee arrangements to their normal service fee schedules.**

  The UnitedHealthcare Group Medicare Advantage PPO plan is a national Medicare Advantage plan with a comprehensive network of contracted providers across the United States. Retirees have access to our industry leading national network of 905,097 contracted healthcare providers and 3,806 hospitals. Our plan delivers access to all willing Medicare providers, regardless of network status, and members pay the same cost-share whether they see one of our network providers or any other willing non-network Medicare provider. Should they need or wish to go outside our contracted network, they are covered when seeing any willing health care provider who participates in Medicare.

- **A dedicated nationwide toll free customer service line specifically for retirees of the Parish is required.**

  Confirmed.

- **JPG reserves the right to return to the top candidates to request a final proposal based on one or more components of the initial proposal. JPG reserves the right to negotiate certain terms and conditions relative to the contract.**

  Confirmed.

SCHEDULE OF EVENTS

Action	Target Date
Released to Insurance Carriers	**7/20/2022**
Proposal Submitted to JPG	**8/18/2022**
Successful Carrier Selected	**TBD**
Successful Carrier Contract Ratified	**TBD**
Effective Date	**01/01/2023**

- **Note: Jefferson Parish reserves the right to deviate from these dates.**

Noted.

LIST OF ATTACHMENTS

The following attachments are made a part of this SOQ. Please respond completely to all as indicated.

Attachment A General Professional Services Questionnaire

Completed.

Attachment B Insurance Requirements and Indemnification

Completed.

Attachment C Proposed Rate Form

Completed.

In addition to the proposed rate form, which provides pricing information for two separate plan options, a document titled “Attachment C-1: Two Year Rate Guarantee” has also been included. UnitedHealthcare is pleased to offer a two-year rate guarantee for the proposed plan options effective 01/1/2023 – 12/31/2024.

Attachment D Carrier Questionnaire

Completed.

Attachment E SOQ Affidavit

Noted. An executed SOQ Affidavit shall be submitted as required prior to contract approval per instruction.

General Professional Services Questionnaire

A. Project Name and Advertisement Resolution Number:

SOQ 22-037 - Group Medicare Advantage Plan with a Nationwide Provider Network for all Medicare Eligible Retirees and Dependents
Jefferson Parish Government

B. Firm Name & Address:

Firm Name: Sierra Health and Life Insurance Company, Inc.
Address: 2720 N. Tenaya Way, Las Vegas, Nevada 89128

Sierra Health and Life Insurance Company, Inc. is the underwriting entity and wholly-owned subsidiary of UnitedHealth Group which will perform services under this agreement for the Group Medicare Advantage PPO.

C. Name, title, & contact information of Firm Representative, as defined in Section 2-926 of the Jefferson Parish Code of Ordinances, with at least five (5) years of experience in the applicable field required for this Project:

Proprietary and Confidential

Name: Ryan Kuehn
Title: Director, Underwriting
Phone: 952-931-5466
E-mail: ryan.kuehn@uhc.com

D. Address of principal office where Project work will be performed:

9800 Health Care Lane
Minnetonka MN 55343
USA

E. Is this submittal by a JOINT-VENTURE? Please check:

YES _____ **NO** ___X___

If marked "No" skip to Section H. If marked "Yes" complete Sections F-G.

F. If submittal is by JOINT-VENTURE, list the firms participating and outline specific areas of responsibility (including administrative, technical, and financial) for each firm. Please attach additional pages if necessary.

N/A

1. N/A

General Professional Services Questionnaire

2. N/A

G. Has this JOINT-VENTURE previously worked together? Please check: YES _____ NO _____

N/A

H. List all subcontractors anticipated for this Project. Please note that all subcontractors must submit a fully completed copy of this questionnaire, applicable licenses, and any other information required by the advertisement. See Jefferson Parish Code of Ordinances, Sec. 2-928(a)(3). Please attach additional pages if necessary.

Name & Address:	Specialty:	Worked with Firm Before (Yes or No):
1. Our organization will continue to leverage external third-party subcontractors to augment our operations and service offerings, when/where appropriate. We have programs in place to ensure these subcontractors meet relevant performance, operational, contractual/compliance and regulatory standards. In general, subcontractors are selected based on the strategic needs of our entire organization and dependent on the subcontractors' abilities to comply with our requirements. Because of the broad spectrum of UnitedHealth Group businesses and subcontractor relationships, we are unable to provide a complete list of proposed subcontractors at this time.	Because of the broad spectrum of UnitedHealth Group businesses and subcontractor relationships, we are unable to provide a complete list of proposed subcontractors at this time.	Because of the broad spectrum of UnitedHealth Group businesses and subcontractor relationships, we are unable to provide a complete list of proposed subcontractors at this time.
2. N/A	N/A	N/A

3. N/A	N/A	N/A
4. N/A	N/A	N/A
5. N/A	N/A	N/A

General Professional Services Questionnaire

I. Please specify the total number of support personnel that may assist in the completion of this Project:
5

J. List any professionals that may assist in the completion of this Project. If necessary, please attach additional documentation that demonstrates the employment history and experience of the Firm's professionals that may assist in the completion of this Project (i.e. resume). Please attach additional pages if necessary.
Proprietary and Confidential

PROFESSIONAL NO. 1

Name & Title:

Jo Ann Wetzel
Vice President, Client Development

Name of Firm with which associated:

UnitedHealthcare

Description of job responsibilities:

Leads sale of retiree products and sets strategy to deliver the best retiree solutions available in the market. Develops the initial sales strategy and recommends appropriate solutions. Communicates details of sold plans/benefits, including employer expectations identified during the sales process, to UnitedHealthcare's implementation and operations team members to ensure a seamless transition and ongoing business relationship.

Years' experience with this Firm:

6+ years

Education: Degree(s)/Year/Specialization:

B.S./2000/Business Management and Organizational Development

Other experience and qualifications relevant to the proposed Project:

30+ years of experience in the health care industry serving in leadership and sales roles for major carriers throughout the country. Experience with account management, sales, strategy, network development and public presentations as a subject matter expert at various conferences and events.

General Professional Services Questionnaire

PROFESSIONAL NO. 2
Name & Title:
Ryan Kuehn Director, Underwriting
Name of Firm with which associated:
UnitedHealthcare
Description of job responsibilities:
Uses underwriting principles, financial and statistical modeling and trend projections to lead and support the development of UnitedHealthcare's pricing and rate setting process. Provides leadership to and is accountable for the performance and success of senior level underwriters.
Years' experience with this Firm:
11 years
Education: Degree(s)/Year/Specialization:
B.A./2006/Economics and Political Science
Other experience and qualifications relevant to the proposed Project:
Significant experience in the setting of annual plans, goals and growth strategy in support of UnitedHealthcare's new and renewing group retiree business.

General Professional Services Questionnaire

PROFESSIONAL NO. 3
Name & Title:
Veronica Reynada Strategic Account Executive (SAE)
Name of Firm with which associated:
UnitedHealthcare
Description of job responsibilities:
Leads the partnership, manages resources to deliver on service and financial expectations and is accountable for the overall business relationship. Primary goals include formulating a strategic plan that delivers over the short and long term, enabling them to provide health care policy and plan design recommendations; thus, ensuring that our service delivery team is exceeding the client's expectations. Facilitates the development of a communication and enrollment strategy to ensure that, ultimately, the client achieves complete and successful onboarding.
Years' experience with this Firm:
12 years
Education: Degree(s)/Year/Specialization:
Certificate/1991/Phlebotomy Relevant Coursework: ▪ Communications (1996 to 2010) ▪ General education and communications (1986 to 1988)
Other experience and qualifications relevant to the proposed Project:
24+ years of experience in the health care industry. Holds licenses for both Life and Health insurance. Specializes in ensuring customer satisfaction and has developed strong and lasting relationships with her clients and broker network. Extensive experience with public sector clientele. Has maintained a 99% persistency rate within book of business.

General Professional Services Questionnaire

PROFESSIONAL NO. 4
Name & Title:
Lani Pacheco Client Service Manager (CSM)
Name of Firm with which associated:
UnitedHealthcare
Description of job responsibilities:
Manages the day-to-day overall service experience and works with experts within each of the functional areas to deliver on all service expectations. Proactive and empowered with the tools and team to resolve any service issues quickly and effectively. Works on identifying trends and solutions, ensuring timely and accurate delivery of communications, providing relevant reporting and partnering with the SAE (Veronica) to explain plan options and new products, as well as policy, procedural and legislative changes.
Years' experience with this Firm:
7 years
Education: Degree(s)/Year/Specialization:
Certificate/1985/Medical Billing and Front Office Assistance Relevant Coursework: ▪ General education and administration/1982 to 1983 ▪ General education/1991 to 1992
Other experience and qualifications relevant to the proposed Project:
18+ years of experience in insurance and managed care. Holds licenses for both Life and Health insurance. Previously served as Field Service Account Manager at Arizona State Retirement System—a large, complex group of retirees. Experience with benefits education and counseling, enrollment, billing and resolving all services including escalated issues timely and accurately.

General Professional Services Questionnaire

PROFESSIONAL NO. 5
Name & Title:
Maureen Schaltegger Implementation Manager (IM)
Name of Firm with which associated:
UnitedHealthcare
Description of job responsibilities:
Works with all parties to provide implementation support, including development, tracking and facilitation of a detailed implementation project plan. Coordinates development of a timeline, provide roster file layouts and manage the production and distribution of member communications.
Years' experience with this Firm:
1 year with UnitedHealthcare/8 years with UnitedHealth Group
Education: Degree(s)/Year/Specialization:
B.A./1990/Communications
Other experience and qualifications relevant to the proposed Project:
20+ years of experience in the healthcare industry. Specializes in serving the retiree health care needs of client groups. Provides essential expertise and oversight in driving the successful implementation of new client group retiree offerings. Has worked with clients of all backgrounds, sizes and complexities and brings a wealth of knowledge and best practices to her implementations. Focused on building collaborative client relationships and achieving superior customer satisfaction.

General Professional Services Questionnaire

K. List all prior projects that best illustrate the Firm's qualifications relevant to this Project. Please include any and all work performed for Jefferson Parish. Please attach additional pages if necessary.	
PROJECT NO. 1	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
N/A	UnitedHealthcare is a leader in the retiree health care field with over 40 years of leadership and sustainability. Our experience helps us provide the service and support your retirees deserve. What makes us unique is our innovative ability to combine and customize our products and services to create a solution tailored to your needs. Our business is built around making the health care system work better through the application of technology, information, and compassion. Our products, service model and know-how enable us to quickly adapt to changes in the Medicare landscape. We have extensive experience in supporting clients like Jefferson Parish Jefferson Parish Government. As of January 2022, we provide coverage for 2.2 million Group Medicare members nationwide. Government entities represent 53% of this total membership and 21% of our total groups served are government clients. Currently, 100% of our Group Medicare Advantage PPO members are enrolled in a 5 Star plan. As the nation's leading Medicare Advantage provider, UnitedHealthcare is the only carrier in the market who has consistently achieved this level of quality and care for our members. As an organization dedicated solely to serving the Group Retiree marketplace, we are able to capitalize on our experience to create programs, services and experiences that result in better health outcomes for members while saving money and administrative expense for our clients.
Length of Services Provided:	**Cost of Services Provided:**
N/A	N/A

PROJECT NO. 2	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**

General Professional Services Questionnaire

N/A	N/A
Length of Services Provided:	**Cost of Services Provided:**
N/A	N/A

General Professional Services Questionnaire

PROJECT NO. 3	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
N/A	N/A
Length of Services Provided:	**Cost of Services Provided:**
N/A	N/A

PROJECT NO. 4	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
N/A	N/A
Length of Services Provided:	**Cost of Services Provided:**
N/A	N/A

General Professional Services Questionnaire

PROJECT NO. 5	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
N/A is not providing any goods.	N/A
Length of Services Provided:	**Cost of Services Provided:**
N/A	N/A

PROJECT NO. 6	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
N/A	N/A
Length of Services Provided:	**Cost of Services Provided:**
N/A	N/A

General Professional Services Questionnaire

PROJECT NO. 7	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
N/A	N/A
Length of Services Provided:	**Cost of Services Provided:**
N/A	N/A

PROJECT NO. 8	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
N/A	N/A
Length of Services Provided:	**Cost of Services Provided:**
N/A	N/A

General Professional Services Questionnaire

PROJECT NO. 9	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
N/A	N/A
Length of Services Provided:	**Cost of Services Provided:**
N/A	N/A

PROJECT NO. 10	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
N/A	N/A
Length of Services Provided:	**Cost of Services Provided:**
N/A	N/A

General Professional Services Questionnaire

L. List all prior and/or on-going litigation between Firm and Jefferson Parish. Please attach additional pages if necessary.		
Parties:		**Status/Result of Case:**
Plaintiff:	**Defendant:**	
1. Because of the nature of UnitedHealthcare's business, we are routinely subject to lawsuits alleging various causes of action. Although the results of pending litigation are always uncertain, we do not believe the results of any such actions, currently threatened or pending, individually or in the aggregate, will have a material adverse effect on our consolidated financial position or the results of our operations. Any material litigation or legal actions are disclosed in our financial statements available on the UnitedHealth Group Incorporated (UnitedHealth Group) website: **www.unitedhealthgroup.com.** UnitedHealth Group is our parent company.	N/A (please see explanation provided in the Plaintiff field)	N/A (please see explanation provided in the Plaintiff field)
2. N/A	N/A	N/A
3. N/A	N/A	N/A
4. N/A	N/A	N/A
M. Use this space to provide any additional information or description of resources supporting Firm's qualifications for the proposed project.		

General Professional Services Questionnaire

We believe in the dedication to Group Medicare Advantage, so in addition to the five team members that will directly support the proposed JPG project, we have 2,000 employees dedicated to group members. All employees are onshore. We also have a significant Medicare footprint dedicated to all retiree lives, and our total staff for Individual and Group is 5,100.

JPG retirees will be served by approximately 110 nurses that are dedicated to our Group Medicare Advantage business. In addition, UnitedHealthcare HouseCalls nurses provide direct clinical support to members and their physicians to coordinate and facilitate personalized service. UnitedHealthcare directly employs approximately 2,600 advanced practice clinicians (APCs) nationally to administer the HouseCalls program.

N. To the best of my knowledge, the foregoing is an accurate statement of facts.

Signature: _____ **Print Name:** Ryan Kuehn

Title: Director, Underwriting **Date:** August 17, 2022

INDEMNITY

To the fullest extent permitted by law, Proposer, agrees to protect, defend, indemnify and save the Parish, its agents, officials, employees, volunteers or any firm, company, organization, or individual, or their Proposers, or subcontractors with whom the Parish may be contracted harmless from and against any and all claims, demands, actions, and causes of action of every kind and character including but not limited to claims based on negligence, strict liability, and absolute liability which may arise in favor of any person or persons on account of illness, disease, loss of property, services, wages, death or personal injuries resulting from acts or omissions of Proposer, its agents, employees, assigns, or subcontractors, during the operations contemplated by the contract.

This indemnity does not extend to the sole negligence of the Parish and the Proposer shall not be liable to the Parish for its lost profits or revenue or consequential damages except claims advanced in tort and/or claims advanced in contract due to the bad faith of Proposer. Bad faith shall mean a breach of some motive or interest of ill will on the part of the Proposer.

Further, Proposer hereby agrees to indemnify the Parish for all reasonable expenses including but not limited to all fees and charges of attorneys and other professionals and all court or other dispute resolution costs incurred by or imposed upon the Parish in connection therewith for any such loss, damage, injury or other casualty. Proposer further agrees to pay all reasonable expenses and attorneys' fees incurred by the Parish in establishing the right to indemnity pursuant to the provisions in this agreement."

UnitedHealthcare will indemnify the employer for claims that may arise out of gross negligence or willful misconduct in the performance of our obligations as described in the agreement between the parties, as determined by a court or other tribunal having jurisdiction over the matter. Further, we would expect to be similarly indemnified by the employer. Network providers/health care professionals are not our agents; therefore, we will not indemnify the employer group for any acts or omissions of network providers/health care professionals.

The insurance requirements shall be as follows:

All insurance requirements shall conform to Jefferson Parish Resolution No. 113646 dated 12/09/2009.

The proposer shall not commence work under this contract until it has obtained all insurance and complied with the insurance requirements of the specifications and Resolution No. 113646.

WORKER'S COMPENSATION INSURANCE

As required by Louisiana State Statute, except Employer's Liability, Section B shall be

$1,000,000 per occurrence when Work is to be over water and involves maritime exposures to cover all employees not covered under the State Worker's Compensation Act; otherwise, this limit shall be no less than $500,000 per occurrence.

COMMERCIAL GENERAL LIABILITY

Shall provide limits not less than the following: $1,000,000.00 Combined Single Limit per Occurrence for bodily injury and property damage.

COMPREHENSIVE AUTOMOBILE LIABILITY

Bodily injury liability $1,000,000.00 each person; $1,000,000.00 each occurrence. Property Damage Liability $1,000,000.00 each occurrence.

DEDUCTIBLES

No insurance required shall include a deductible greater than $10,000.00. The cost of the deductible is borne by the Proposer.

PROFESSIONAL LIABILITY

Shall provide Combined Single Limit of $1,000,000.00 per Occurrence.

UMBRELLA LIABILITY COVERAGE

An umbrella policy or excess may be used to meet minimum requirements.

SUBCONTRACTOR INSURANCE

The Proposer shall include all subcontractors as insured's under its policies or shall insure that all subcontractors satisfy the same insurance requirements stated herein for the Proposer.

The types of insurance coverages we carry for our business operations include, but are not limited to, those described within the following high-level summary.

Automobile Liability

We maintain automobile liability insurance in the amount of $5 million combined single limit, per accident. This coverage is with Old Republic Insurance Company.

Surety or Performance Bond

We are prepared to provide a surety bond, if required. A copy of the contract must be reviewed by our bond broker. We have a preferred bond form.

Fidelity / Crime Insurance

We carry a fidelity/crime bond through Beazley Insurance Company, Inc. The bond amount is at least $5 million per occurrence. This bond covers the actions of all of our employees, regardless of job description.

Commercial General Liability

We carry commercial general liability coverage through Old Republic Insurance Company in the amount of $2 million per occurrence and $4 million in the aggregate.

Professional Liability, Including Errors and Omissions

We maintain professional liability insurance, which includes errors and omissions coverage, of at least $10 million each claim and $10 million in the aggregate. This coverage is with Old Republic Insurance Company.

Cyber Liability

We maintain cyber liability insurance in the amount of $10 million each claim and $10 million in the aggregate. This coverage is with Old Republic Insurance Company.

PROPERTY

We carry property and business interruption insurance through Zurich American Insurance Company. Limits of liability are at least $100 million per occurrence.

WORKERS' COMPENSATION INCLUDING EMPLOYER'S LIABILITY (TO COVER OUR EMPLOYEES)

We maintain workers' compensation coverage, with the statutory limits. We maintain Employer's Liability with a limit of $2 million each accident/disease.

UnitedHealthcare Group Medicare Advantage (PPO)
Jefferson Parish County Government

Rates for: 1/1/2023 - 12/31/2023 **Plan Year: 2023**

Total Premium*	Quote Name	Product Combination	Quoted Membership	UHC Rate ID	Quoted Service Area
$44	MAPD Plan 1 - Matches Humana plan design	MAPD	892	RP-19982	National
$61	MAPD Plan 2 - Matches People's Health plan design	MAPD	892	RP-19983	National

Stipulations

- This is a Preliminary quote effective 1/1/2023 - 12/31/2023. The situs state is Louisiana.
- To ensure proper claim adjudication effective 1/1/2023, it is imperative that we have final 1/1/2023 plan design decisions from employers as soon as possible. Final decisions received after 11/1/2022 could be problematic in terms of claim adjudication on 1/1/2023.
- If the enrollment were to change by more than +/- 10% from the submitted census, we reserve the right to adjust the rates.
- The premium rate quoted herein assumes that premiums are due in full on a monthly basis on or before the last business day of the month.
- 15 Pre-65 Medicare eligible retirees are included.
- Quote assumes $11.00 PMPM commission level.
- United reserves the right to modify its 2023 rates in the event of changes to existing laws, regulations, or any new legislation, assessments, taxes, and/or marketplace changes to the Medicare Advantage and Part D programs that will have an impact to the program costs or revenue, including but not limited to: (i) any proposed changes to the Part D program; (ii) changes in the methodology used to calculate CMS payments including any changes due to EGWP bid waiver; (iii) any plan design changes required by the applicable regulatory authority (i.e. mandated benefits); (iv) any Force Majeure event, including but not limited to national pandemic, act of God, acts of terrorism, or anything beyond United's reasonable control; or (v) as otherwise permitted in our contract. This quote assumes that the Point-of Sale (POS) Rebate Rule will not be effective as of January 1, 2023. If the POS Rebate Rule becomes effective as of January 1, 2023, United will modify the 2023 rates accordingly.
- If members who have previously opted out are to be allowed back into the plan, then this fact must be disclosed at the time of quote.
- Please note the following with regard to the drug coverage on these MAPD products: (i) We reserve the right to change our Part D formulary for calendar year 2023 . We also reserve the right to change our pharmacy benefit manager and/or our pharmacy network for calendar year 2023. (ii) There is a specific, Part D drug formulary that applies to all of our MAPD plan offerings. (iii) All Part D prescription drug coverage is considered to be creditable, therefore Creditable Coverage Notices are not required.
- This quote assumes that the employer pays 50% of the premium.
- While we make every effort to honor the rates quoted (notwithstanding the other quote stipulations below), we reserve the right to change these preliminary rates and/or the plan designs quoted based on the final call letter from CMS and the actual National average Part D bid for 2023
- These rates are quoted on a full replacement basis.

*** Premium Rates are Per Member Per Month (PMPM)**

Medical Coverage

Benefit Name	In Network Services	Out of Network Services
Annual Medical Deductible	None	None
Annual Medical Out-of-Pocket Maximum	$2,500	$2,500
Is Annual Medical Out-of-Pocket Maximum combined for IN and OUT of network?	Yes	
Physician Services		
Primary Care Physician Office Visit (includes Non-MD office visits)	$5	$5
Specialist Office Visit	$20	$20
Virtual Office Visit	$0	$0
- with Providers: **AmWell, Doctor on Demand,** or **Teladoc**	$0	
Telemedicine	$0	$0
Annual Routine Physical Exam	$0	$0
Inpatient Services		
Inpatient Hospital Stay	$150 Per Day	$150 Per Day
Day Range 1	Days 1 - 5	Days 1 - 5
	$0 Per Day	$0 Per Day
Day Range 2	Days 6+	Days 6+
Skilled Nursing Facility Care - Prior hospital stay requirement waived	Yes	Yes
Skilled Nursing Facility Care - Benefit Period	100 Days	
Skilled Nursing Facility Care	$0 Per Day	$0 Per Day
Day Range 1	Days 1 - 20	Days 1 - 20
	$25 Per Day	$25 Per Day
Day Range 2	Days 21 - 100	Days 21 - 100
Inpatient Mental Health Lifetime Maximum	190 Days	
Inpatient Mental Health/ Substance Abuse in a Psychiatric Hospital	$150 Per Day	$150 Per Day
	$0 Per Day	$0 Per Day
Day Range 2	Days 6 - 190	Days 6 - 190
Outpatient Services		
Outpatient Surgery	$0	$0
Outpatient Hospital Services	$0	$0
Outpatient Mental Health/Substance Abuse - Individual Visit	$20	$20
Outpatient Mental Health/Substance Abuse - Group Visit	$5	$5
Partial Hospitalization (Mental Health Day Treatment) per day	$55	$55
Comprehensive Outpatient Rehabilitation Facility (CORF)	$20	$20
Occupational Therapy	$20	$20
Physical Therapy and Speech/Language Therapy	$20	$20
Cardiac/Intensive Cardiac/Pulmonary Rehabilitation/SET	$20	$20
Intensive Cardiac Rehabilitation	$20	$20
Pulmonary Rehabilitation	$20	$20
Supervised Exercise Therapy (SET) for Symptomatic peripheral artery disease (PAD)	$20	$20
Kidney Dialysis	$0	$0
Medicare Covered Services		
Chiropractic Visit	$20	$20
Podiatry Visit	$20	$20
Eye Exam	$0	$0
Eyewear (Frames and Lenses after cataract surgery)	$0	$0
Hearing Exam	$20	$20
Dental Services	$20	$20
Ambulance/Emergency Room/Urgent Care		
Ambulance Services	$50	$50
Ambulance Copay Waived if Admitted	No	No
Emergency Room (includes Worldwide coverage)	$65	$65
Emergency Room Copay Waived if Admitted within 24 hours	Yes	Yes
Urgent Care (Includes Worldwide Coverage)	$5	$5
Urgent Care Copay Waived if Admitted within 24 hours	Yes	Yes

Part B Drugs And Blood		
Part B Drugs	20%	20%
Part B Chemotherapy Drugs	20%	20%
Blood (3 pint deductible waived)	$0	$0
Durable Medical Equipment (DME) And Supplies		
Durable Medical Equipment	10%	10%
Prosthetics	10%	10%
Orthotics	10%	10%
Diabetic Shoes and Inserts	10%	10%
Medical Supplies	10%	10%
Diabetic Monitoring Supplies	$0	$0
Insulin Pumps and Supplies	10%	10%
Home Healthcare Agency & Hospice		
Home Health Services	$0	$0
Hospice (Medicare-covered)	$0	$0
Procedures		
Clinical Laboratory Services	$0	$0
Outpatient X-ray Services	$0	$0
Diagnostic Procedure/Test (includes non-radiological diagnostic services)	$0	$0
Diagnostic Radiology Service	$0	$0
Therapeutic Radiology Service	$0	$0
Preventive Services (Medicare-Covered)		
Cardiovascular Screenings	$0	$0
Immunizations (Flu, Pneumococcal, Hepatitis B)	$0	$0
Pap Smears and Pelvic Exams	$0	$0
Prostate Cancer Screening	$0	$0
Colorectal Cancer Screenings	$0	$0
Bone Mass Measurement (Bone Density)	$0	$0
Mammography	$0	$0
Diabetes - Self-Management Training	$0	$0
Medical Nutrition Therapy and Counseling	$0	$0
Annual Wellness Exam and One-time Welcome-to-Medicare Exam	$0	$0
Smoking Cessation Visit	$0	$0
Abdominal Aortic Aneurysm (AAA) Screenings	$0	$0
Diabetes Screening	$0	$0
HIV Screening	$0	$0
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	$0	$0
Screening for Depression in Adults	$0	$0
Screening for Sexually Transmitted Infections (STIs) and high intensity Behavioral Counseling to prevent STIs	$0	$0
Intensive Behavioral Therapy to reduce Cardiovascular Disease Risk	$0	$0
Screening and Counseling for Obesity	$0	$0
Glaucoma Screening	$0	$0
Kidney Disease Education	$0	$0
Dialysis Training	$0	$0
Hepatitis C Screening	$0	$0
Lung Cancer Screening	$0	$0

Additional Benefits/Non-Medicare Covered Services		
Routine Podiatry		
Routine Podiatry	$20	$20
Routine Podiatry - Number of visits per year	6 Visits	
Routine Vision		
Routine Eye Exam Refraction - Every 12 months	$0	$0
Vision Hardware - Allowance for Eyeglasses	$400	
- OR - Contact Lenses (in lieu of Eyeglasses)	$400	
Vision Hardware - Benefit Period	Every 12 Months	
Routine Hearing		
Routine Hearing Exam for Hearing Aids	$0	$0
Routine Hearing Exam - Number of Visits	1 Visit	
Routine Hearing Exam - Benefit Period	1 Year	
Routine Hearing Aid - Allowance Per Ear or Combined	Combined	N/A
Routine Hearing Aid - Number of Devices	Unlimited	N/A
Routine Hearing Aid - Benefit Period	1 Year	N/A
Routine Hearing Aid - Device Allowance	$1,000	N/A
Routine Dental		
Dental Plan Type	Plan 3 - Comprehensive Plan	
Dental Reimbursement Schedule	MAC	MAC
Dental Deductible (P&D not Included)	$50	$50
Dental Calendar Maximum	$1,000	$1,000
Dental Class 1 (Preventive & Diagnostic) Plan Coverage	100%	100%
Dental Class 2 (Minor Services) Plan Coverage	80%	80%
Dental Class 3 (Major Services) Plan Coverage	50%	50%
Dental Class 4 (Ortho Services) Plan Coverage	Not Covered	Not Covered
Wellness/Clinical Programs		
UHC Healthy At Home - Post-Discharge Program, following each discharge: - 12 non-emergency medical rides - 28 home delivered meals - 6 hours in-home personal care	Included	
Rally Coach • **Wellness Coaching**: blended model of personal coaching, self-paced online learning and digital support across a variety of wellbeing topics such as healthy eating, sleep management, and more. • **Quit For Life** tobacco cessation program using an evidence-based combination of physical, psychological and behavioral strategies to help members overcome their addiction to tobacco. • **Real Appeal**: Real Appeal Diabetes Prevention.	Included	
Personal Emergency Response System - Benefit includes a lightweight device (worn on the wrist or as a pendant) that provides 24/7 access to emergency care.	Included	
Over-the-Counter Care - Benefit includes a $50 quarterly allowance to purchase over-the-counter health related products from the FirstLine Essentials website or catalog. - Note: Allowance expires quarterly.	Included	
Fitness Program	Included	
Case and Disease Management, including: - High Risk Members - Heart Failure - Respiratory Illness - Kidney Disease - Diabetes - Behavioral Health - Nurse Support - 24/7	Included	
Preferred Diabetic Supply Program	Included	
UHC Hearing Aid Discount Program - Note: Available services and offerings may be limited in the U.S. Territories	Included	
HouseCalls Program	Included	
Member Rewards Program - Reward cards for completing certain health care activities	Included	

Additional Benefit Details

Code	Description
F395	Behavioral health virtual visit $0 copay
Temp	Allergy shots and Antigen serum, MC, INN/OON, MOOP applies, $0 cost share for Serum and administration regardless of place of service.

Outpatient Prescription Drug Coverage

Prescription Drug Plan	Custom
Formulary	Standard Formulary H (Group Select Formulary)
Bonus Drug List	List U
Formulary Edits (step therapy, quantity limits, prior authorization)	Standard: Edits On

Benefit Name	In Network Services
Part D Gap Coverage	
Part D Gap Coverage	Full Coverage
Custom OOP, ICL, Catastrophic	
Initial Coverage Limit	$4,660
True Out of Pocket Threshold (TrOOP)	$7,400
Catastrophic Coverage over TrOOP	CMS Standard Member pays greater of:
Copay for generics	$4.15
Copay for all other drugs	$10.35
- OR - Coinsurance	5%
Day Supply Information **Note: 90 day retail supply is available for 3x copay amount**	
Retail Day Supply	30
Retail Day Supply Specialty Tier Limit	30
Mail Order Day Supply	90
Mail Order Day Supply Specialty Tier Limit	30
Part D Retail Copay	
Tier 1: Preferred Generic (All covered generic drugs)	$10
Tier 2: Preferred Brand (Many common brand name drugs, called preferred brands)	$20
Tier 3: Non-Preferred Drug (Non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in Tier 3.)	$40
Tier 4: Specialty Tier (Unique and/or very high-cost brand and generic drugs)	25%
Part D Mail Order Copay	
Tier 1: Preferred Generic (All covered generic drugs)	$0
Tier 2: Preferred Brand (Many common brand name drugs, called preferred brands)	$40
Tier 3: Non-Preferred Drug (Non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in Tier 3.)	$80
Tier 4: Specialty Tier (Unique and/or very high-cost brand and generic drugs)	25%

Additional Rx Benefit Details

Code	Description
Rx139	For Tier 1 Drugs, Group has requested a lower cost share in mail then retail. For DS 1-30 (1 month) group needs to have parity (equal) with retail pricing. Days 31-90 at mail for the same tier will have the mail order cost share.
Rx148	Tier 4 Specialty Drugs are Limited to 30 Day Supply for both Retail and Mail Order. 1x Retail T4 Cost Share will Apply to Both Retail and Mail Order.

Medical Coverage

Benefit Name	In Network Services	Out of Network Services
Annual Medical Deductible	None	None
Annual Medical Out-of-Pocket Maximum	$2,500	$2,500
Is Annual Medical Out-of-Pocket Maximum combined for IN and OUT of network?	Yes	
Physician Services		
Primary Care Physician Office Visit (includes Non-MD office visits)	$5	$5
Specialist Office Visit	$10	$10
Virtual Office Visit	$0	$0
- with Providers: **AmWell, Doctor on Demand,** or **Teladoc**	$0	
Telemedicine	$0	$0
Annual Routine Physical Exam	$0	$0
Inpatient Services		
Inpatient Hospital Stay	$50 Per Day	$50 Per Day
Day Range 1	Days 1 - 10	Days 1 - 10
	$0 Per Day	$0 Per Day
Day Range 2	Days 11+	Days 11+
Skilled Nursing Facility Care - Prior hospital stay requirement waived	Yes	Yes
Skilled Nursing Facility Care	$0 Per Day	$0 Per Day
Day Range 1	Days 1 - 20	Days 1 - 20
	$25 Per Day	$25 Per Day
Day Range 2	Days 21+	Days 21+
Inpatient Mental Health Lifetime Maximum	190 Days	
Inpatient Mental Health/ Substance Abuse in a Psychiatric Hospital	$50 Per Day	$50 Per Day
	$0 Per Day	$0 Per Day
Day Range 2	Days 11 - 190	Days 11 - 190
Outpatient Services		
Outpatient Surgery	$0	$0
Outpatient Hospital Services	$0	$0
Outpatient Mental Health/Substance Abuse - Individual Visit	$10	$10
Outpatient Mental Health/Substance Abuse - Group Visit	$10	$10
Partial Hospitalization (Mental Health Day Treatment) per day	$10	$10
Comprehensive Outpatient Rehabilitation Facility (CORF)	$0	$0
Occupational Therapy	$0	$0
Physical Therapy and Speech/Language Therapy	$0	$0
Cardiac/Intensive Cardiac/Pulmonary Rehabilitation/SET	$0	$0
Intensive Cardiac Rehabilitation	$0	$0
Pulmonary Rehabilitation	$0	$0
Supervised Exercise Therapy (SET) for Symptomatic peripheral artery disease (PAD)	$0	$0
Kidney Dialysis	$0	$0
Medicare Covered Services		
Chiropractic Visit	$10	$10
Podiatry Visit	$10	$10
Eye Exam	$15	$15
Eyewear (Frames and Lenses after cataract surgery)	$0	$0
Hearing Exam	$10	$10
Dental Services	$10	$10
Ambulance/Emergency Room/Urgent Care		
Ambulance Services	$50	$50
Ambulance Copay Waived if Admitted	No	No
Emergency Room (includes Worldwide coverage)	$50	$50
Emergency Room Copay Waived if Admitted within 24 hours	Yes	Yes
Urgent Care (Includes Worldwide Coverage)	$10	$10
Urgent Care Copay Waived if Admitted within 24 hours	Yes	Yes

Part B Drugs And Blood		
Part B Drugs	5%	5%
Part B Chemotherapy Drugs	5%	5%
Blood (3 pint deductible waived)	$0	$0
Durable Medical Equipment (DME) And Supplies		
Durable Medical Equipment	5%	5%
Prosthetics	5%	5%
Orthotics	5%	5%
Diabetic Shoes and Inserts	$0	$0
Medical Supplies	5%	5%
Diabetic Monitoring Supplies	$0	$0
Insulin Pumps and Supplies	5%	5%
Home Healthcare Agency & Hospice		
Home Health Services	$0	$0
Hospice (Medicare-covered)	$0	$0
Procedures		
Clinical Laboratory Services	$0	$0
Outpatient X-ray Services	$0	$0
Diagnostic Procedure/Test (includes non-radiological diagnostic services)	$0	$0
Diagnostic Radiology Service	$0	$0
Therapeutic Radiology Service	$0	$0
Preventive Services (Medicare-Covered)		
Cardiovascular Screenings	$0	$0
Immunizations (Flu, Pneumococcal, Hepatitis B)	$0	$0
Pap Smears and Pelvic Exams	$0	$0
Prostate Cancer Screening	$0	$0
Colorectal Cancer Screenings	$0	$0
Bone Mass Measurement (Bone Density)	$0	$0
Mammography	$0	$0
Diabetes - Self-Management Training	$0	$0
Medical Nutrition Therapy and Counseling	$0	$0
Annual Wellness Exam and One-time Welcome-to-Medicare Exam	$0	$0
Smoking Cessation Visit	$0	$0
Abdominal Aortic Aneurysm (AAA) Screenings	$0	$0
Diabetes Screening	$0	$0
HIV Screening	$0	$0
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	$0	$0
Screening for Depression in Adults	$0	$0
Screening for Sexually Transmitted Infections (STIs) and high intensity Behavioral Counseling to prevent STIs	$0	$0
Intensive Behavioral Therapy to reduce Cardiovascular Disease Risk	$0	$0
Screening and Counseling for Obesity	$0	$0
Glaucoma Screening	$0	$0
Kidney Disease Education	$0	$0
Dialysis Training	$0	$0
Hepatitis C Screening	$0	$0
Lung Cancer Screening	$0	$0

Additional Benefits/Non-Medicare Covered Services		
Routine Podiatry		
Routine Podiatry	$10	$10
Routine Podiatry - Number of visits per year	6 Visits	
Routine Vision		
Routine Eye Exam Refraction - Every 12 months	$0	$0
Vision Hardware - Allowance for Eyeglasses	$400	
- OR - Contact Lenses (in lieu of Eyeglasses)	$400	
Vision Hardware - Benefit Period	Every 12 Months	
Routine Hearing		
Routine Hearing Exam for Hearing Aids	$0	$0
Routine Hearing Exam - Number of Visits	1 Visit	
Routine Hearing Exam - Benefit Period	1 Year	
Routine Hearing Aid - Allowance Per Ear or Combined	Combined	N/A
Routine Hearing Aid - Number of Devices	Unlimited	N/A
Routine Hearing Aid - Benefit Period	3 Years	N/A
Routine Hearing Aid - Device Allowance	$500	N/A
Routine Dental		
Dental Plan Type	Plan 5 - Comprehensive Plan	
Dental Reimbursement Schedule	MAC	UCR
Dental Deductible (P&D not Included)	$50	$50
Dental Calendar Maximum	$1,500	$1,500
Dental Class 1 (Preventive & Diagnostic) Plan Coverage	100%	100%
Dental Class 2 (Minor Services) Plan Coverage	80%	80%
Dental Class 3 (Major Services) Plan Coverage	50%	50%
Dental Class 4 (Ortho Services) Plan Coverage	Not Covered	Not Covered
Wellness/Clinical Programs		
UHC Healthy At Home - Post-Discharge Program, following each discharge: - 12 non-emergency medical rides - 28 home delivered meals - 6 hours in-home personal care	Included	
Rally Coach • **Wellness Coaching**: blended model of personal coaching, self-paced online learning and digital support across a variety of wellbeing topics such as healthy eating, sleep management, and more. • **Quit For Life** tobacco cessation program using an evidence-based combination of physical, psychological and behavioral strategies to help members overcome their addiction to tobacco. • **Real Appeal**: Real Appeal Diabetes Prevention.	Included	
Personal Emergency Response System - Benefit includes a lightweight device (worn on the wrist or as a pendant) that provides 24/7 access to emergency care.	Included	
Over-the-Counter Care - Benefit includes a $40 quarterly allowance to purchase over-the-counter health related products from the FirstLine Essentials website or catalog. - Note: Allowance expires quarterly.	Included	
Fitness Program	Included	
Case and Disease Management, including: - High Risk Members - Heart Failure - Respiratory Illness - Kidney Disease - Diabetes - Behavioral Health - Nurse Support - 24/7	Included	
Preferred Diabetic Supply Program	Included	
UHC Hearing Aid Discount Program - Note: Available services and offerings may be limited in the U.S. Territories	Included	
HouseCalls Program	Included	
Member Rewards Program - Reward cards for completing certain health care activities	Included	

Additional Benefit Details

Code	Description
F532	Includes 8 hours per month of non-skilled care services (respite and homemaker/personal care) through vendor Carelinx. Hours do not roll over. No claims impact.

Outpatient Prescription Drug Coverage

Prescription Drug Plan	Custom
Formulary	Standard Formulary Group Performance
Bonus Drug List	BDL U 5 Tier
Formulary Edits (step therapy, quantity limits, prior authorization)	Standard: Edits On

Benefit Name	In Network Services
Part D Gap Coverage	
Part D Gap Coverage	Full Coverage
Custom OOP, ICL, Catastrophic	
Initial Coverage Limit	$4,660
True Out of Pocket Threshold (TrOOP)	$7,400
Catastrophic Coverage over TrOOP	CMS Standard Member pays greater of:
Copay for generics	$4.15
Copay for all other drugs	$10.35
- OR - Coinsurance	5%
Day Supply Information **Note: 90 day retail supply is available for same copays as Mail Service**	
Retail Day Supply	30
Retail Day Supply Specialty Tier Limit	30
Mail Order Day Supply	90
Mail Order Day Supply Specialty Tier Limit	30
Part D Retail Copay	
Tier 1: Preferred Generic (Lower-cost, commonly used generic drugs)	$3
Tier 2: Generic (Many generic drugs)	$10
Tier 3: Preferred Brand (Many common brand name drugs, called preferred brands and some higher-cost generic drugs)	$25
Tier 4: Non-Preferred Drug (Non-preferred generic and non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in Tier 4.)	$50
Tier 5: Specialty Tier (Unique and/or very high-cost brand and generic drugs)	20%
Part D Mail Order Copay	
Tier 1: Preferred Generic (Lower-cost, commonly used generic drugs)	$0
Tier 2: Generic (Many generic drugs)	$0
Tier 3: Preferred Brand (Many common brand name drugs, called preferred brands and some higher-cost generic drugs)	$50
Tier 4: Non-Preferred Drug (Non-preferred generic and non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in Tier 4.)	$100
Tier 5: Specialty Tier (Unique and/or very high-cost brand and generic drugs)	20%

Additional Rx Benefit Details

Code	Description
Rx319	Specialty Tier Drugs are Limited to 30 Day Supply for both Retail and Mail Order. 1x Retail T5 Cost Share will Apply to Both Retail and Mail Order.
Rx139	For Tier 1 Drugs, Group has requested a lower cost share in mail then retail. For DS 1-30 (1 month) group needs to have parity (equal) with retail pricing. Days 31-90 at mail for the same tier will have the mail order cost share.
Rx140	For Tier 2 Drugs, Group has requested a lower cost share in mail then retail. For DS 1-30 (1 month) group needs to have parity (equal) with retail pricing. Days 31-90 at mail for the same tier will have the mail order cost share.

ATTACHMENT C-1: Two-Year Rate Guarantee

Proprietary and Confidential

UnitedHealthcare MEDICARE & RETIREMENT

Jefferson Parish Gov
Medicare Advantage and Part D

This schedule applies to the Jefferson Parish Gov population if more than 800 members are enrolled with UnitedHealthcare for a Medicare Advantage and Part D plan population as of 01/01/2023 for the 2024 rate guarantee.

	2023 Rate	2024 Rate
Option 1	$44.00	$44.00
Option 2	$61.00	$61.00

Stipulations

(1) This is a quote effective 01/01/2023 - 12/31/2024
(2) These rates are quoted on a Full Replacement basis.
(3) This quote assumes that the employer pays 50% of the premium.
(4) Please note the following with regard to the drug coverage on these Medicare Advantage and Part D (MAPD) products:
  (a) We reserve the right to change our Part D formulary for calendar years 2023 and 2024. We also reserve the right to change our pharmacy benefit manager and/or our pharmacy network for calendar year 2023 and 2024.
  (b) There is a specific Part D drug formulary that applies to all of our MA-PD plan offerings.
  (c) All Part D prescription drug coverage is considered to be creditable, therefore Creditable Coverage Notices are not required.
(5) UnitedHealthcare (United) reserves the right to make adjustments at a later date if highly utilized specialty/high cost drugs are introduced that have not been considered in the pricing.
(6) The premium rate quoted herein assumes that premiums are due in full on a monthly basis on or before the last business day of the month prior to the month for which the premium applies.
(7) United reserves the right to modify its 2024 rates in the event of changes to existing laws, regulations, or any new legislation, assessments, taxes, and/or marketplace changes to the Medicare Advantage and Part D programs that will have an impact to the program costs or revenue, including but not limited to:
  (a) any changes to the Part D program including, but not limited to, any current proposals or legislation that have not yet been finalized. (Please note that this proposal does account for the recent rule regarding "Pharmacy Price Concessions to Drug Prices at the Point of Sale" that was finalized in the Medicare Advantage and Part D Final Rule for Contract Year 2023, effective January 1, 2024. However, this proposal does not account for any impacts arising from other potential and/or current proposals, legislation or rulemaking related to the Part D program (for example the Point of Sale Rebate legislation that is currently slated to become effective as of 1/1/2026));
  (b) changes in the methodology used to calculate CMS payments including any changes due to EGWP bid waiver;
  (c) any plan design changes required by the applicable regulatory authority (i.e., mandated benefits);
  (d) any Force Majeure event in 2023 or beyond, including but not limited to national pandemic, acts of God, acts of terrorism, or anything beyond United's reasonable control; or
  (e) as otherwise permitted in our contract.
(8) Not withstanding 7 above, United assumes the risk and will hold the rates above if United fails to qualify for Medicare Advantage Quality Bonus Payments provided the Bonus Payments program remains in effect. (i.e., United takes the risk of failure to qualify for the Bonus Payments program).

Updated as of: August 17, 2022

CARRIER QUESTIONNAIRE

1. Name and address of parent company and local office.

UnitedHealthcare's parent company, UnitedHealth Group Incorporated (UnitedHealth Group), is located at the UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343.

2. Is your company a wholly-owned subsidiary or a division of another company? If so, please identify the company name and address.

Yes. Sierra Health and Life Insurance Company Inc. is the underwriting entity and wholly-owned subsidiary of UnitedHealth Group which will perform services under this agreement for the Group Medicare Advantage PPO. UnitedHealthcare is the brand name used for products and services provided by Sierra Health and Life Insurance Company, Inc.; Sierra holds it's principle executive offices at 2720 N. Tenaya Way, Las Vegas, Nevada 89128.

3. How many members are currently being served nationally and in Louisiana? How many employers with over 1000 retirees are currently being served?

UnitedHealthcare currently serves 14,630,000 Medicare members nationally and 165,000 Medicare members in Louisiana. Currently, UnitedHealthcare is serving 226 employers with over 1000 members.

4. Provide three references that have similar dynamics to Jefferson Parish Government. At least one reference group should have gone through the respective enrollment process within the last two years. Include contact names, phone numbers and email addresses.

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Current Client - Reference 1	
Organization name:	Chatham County, GA
Contact and title:	Carolyn Smalls, HR Director
Address:	Savannah, GA
Phone number:	(912) 652-7925
E-mail address:	csmalls@chathamcounty.org

Current Client - Reference 2	
Organization name:	St. John the Baptist Parish School Board
Contact and title:	Wayne Francigues, Sr. Area Vice President
Address:	Reserve, LA
Phone number:	(504) 416-7679
E-mail address:	wayne_francingues_sr@ajg.com

Current Client - Reference 3	
Organization name:	Terrebonne Parish School Board
Contact and title:	Curtis Constrantiche, Risk Manager
Address:	Houma, LA
Phone number:	(985) 876-7400
E-mail address:	curtisconstrantiche@tpsd.org

5. How long has your company been in business?

UnitedHealth Group has been in business since 1977.

6. What is your AM Best Rating? If applicable.

A+.

7. What is the size of your local staff?

UnitedHealthcare currently employs 1,941 individuals in the state of Louisiana.

8. Provide a resume for each key employee in your organization who will be handling our account.

UnitedHealthcare has provided biographies for the members of the experienced account management team (AMT) that will be assigned to JPG's account. Please see the attached document titled "Exhibit 3: JPG – UHC Account Management Team Biographies."

9. List three references of over 1,000 retirees' who you administer the health plan. Please provide employer, contact, address and phone number of references.

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Current Client - Reference 1	
Organization name:	Louisiana State University
Contact and title:	Katti Galatas, Asst Plan Administrator
Address:	Baton Rouge, LA
Phone number:	(225) 578-1324
E-mail address:	kgalatas@lsu.edu

Current Client - Reference 2	
Organization name:	State of Alabama - LGHIB - Local Government Health Insurance Board
Contact and title:	David Hilyer, Chief Operating Officer
Address:	Montgomery, AL
Phone number:	(334) 263-8402
E-mail address:	dhilyer@lghip.org

Current Client - Reference 3	
Organization name:	Ascension Parish School Board
Contact and title:	Brooke Brunet, Account Manager
Address:	Donaldsonville, LA
Phone number:	(985) 876-3983
E-mail address:	brooke.brunet@hubinternational.com

10. Describe the account management services and the team that would be responsible for handling the Parish account.

An experienced account management team (AMT) will be assigned to ensure that all JPG's expectations and contractual requirements are satisfactorily met. This team includes the vice president, client development (VP); strategic account executive (SAE); client service manager (CSM) and implementation manager (IM).

We offer a dedicated Group Retiree organization, and we align SAEs and CSMs that only manage clients within their specific line of business. Having an AMT that focuses on public sector accounts strengthens their awareness and ability to provide consultative and strategic direction that addresses JPG's business needs. The AMT is available to provide support before and after the coverage effective date.

The proposed team has been outlined below.

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JO ANN WETZEL, VICE PRESIDENT, CLIENT DEVELOPMENT (VP)

The VP develops the initial sales strategy and recommends appropriate solutions. Once JPG chooses a solution, the VP communicates details of the sold plans/benefits—including expectations for JPG identified during the sales process—to our implementation and ongoing operations team members.

VERONICA REYNADA, STRATEGIC ACCOUNT EXECUTIVE (SAE)

The SAE leads the partnership, manages resources to deliver on service and financial expectations and is accountable for the overall business relationship. Their primary goals include formulating a strategic plan that delivers over the short and long term, enabling them to provide health care policy and plan design recommendations, thus ensuring that our service delivery team is exceeding JPG's expectations. Additionally, the SAE will facilitate the development of a communication and enrollment strategy to ensure that, ultimately, JPG achieves complete and successful onboarding.

LANI PACHECO, CLIENT SERVICE MANAGER (CSM)

The CSM manages the day-to-day overall service experience and works with experts within each of the functional areas to deliver on all service expectations. The CSM is proactive and empowered with the tools and team to resolve any service issues quickly and effectively. The CSM will also work on identifying trends and solutions, ensuring timely and accurate delivery of communications, providing relevant reporting and partnering with the SAE to explain plan options and new products, as well as policy, procedural and legislative changes.

MAUREEN SCHALTEGGER, IMPLEMENTATION MANAGER (IM)

An experienced IM is designated and works with all parties to provide implementation support, including development, tracking and facilitation of a detailed implementation project plan. The unique skills provided by the IM include the ability to coordinate development of a timeline, provide roster file layouts and manage the production and distribution of member communications.

11. Describe the support you would provide as part of a change in vendors. Provide an implementation and communication schedule showing tasks, allocation of responsibilities and personnel.

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UnitedHealthcare's priority in the implementation process is to start JPG on the right track for a seamless experience with both implementation and a new health plan. To that end, our entire implementation process is built on a foundation of best practices we've learned during our time in the retiree space. This experience has provided us with methods that will reduce disruption, minimize stress and frustration and allow us to put our best foot forward, together, in our new partnership.

JPG's assigned implementation manager (IM), Maureen Schaltegger, will serve as the primary point of contact throughout the implementation experience. Maureen will serve as JPG's consultant, helping walk through the process, preparing JPG for each new step and navigating any tricky spots along the way. She will tackle a variety of logistical tasks, including project plan and timeline development, supply of roster file layouts, member communication development and distribution, and key milestone tracking.

To ensure continuity in the process, the assigned account management team (AMT) members are present from day one of implementation. Our approach achieves responsive, consistent support both before and after JPG's coverage effective date. JPG will always have a team member available to address day-to-day operational issues, as well as larger implementation strategies.

We are confident that our implementation process delivers on its promise—a sentiment based on the quantitative feedback we receive. As a result of our market-leading expertise and best practices, our implementation experience has led to a Net Promoter Score (NPS) of 85. In other words, the organizations we've worked with have consistently ranked their implementation experience as a very positive one. We look forward to our opportunity to collaborate with JPG to continue in that tradition.

The requested implementation and communication schedule has been provided as an attachment. Please reference the document titled "Exhibit 4: JPG – UHC 01.01.2023 Implementation Project Plan."

12. Do you agree to comply with all of the proposal assumptions and requirements as outlined in this SOQ? If not, specifically explain how your proposal deviates from this.

Yes, we agree.

13. Do you agree to administer the requested benefits plan as described? If not, specifically identify any variations in plan designs.

We have made a good-faith effort to match or improve upon the requested benefits plan. Any variations in the requested benefits plan are outlined on the attached document titled "Exhibit 5: JPG – UHC 01.01.2023 MAPD Enhancements and Deviations".

14. Describe your enrollment process.

UnitedHealthcare has unparalleled experience coordinating eligibility and enrollment processes in conjunction with CMS, vendors, our customers and their retirees. We will work with JPG to define the requirements and processes to smoothly enroll and transition your retirees to our Medicare Advantage plan while being fully compliant with CMS guidelines.

UnitedHealthcare accepts electronic enrollment files in one of the standard file formats (834-5010 HIPAA or our proprietary flat file) that include the required data elements in accordance with CMS guidance for Medicare applications. JPG can auto-enroll eligible members into our plan through electronic files - applications are not necessary for this process. We will work with JPG to establish a mutually agreed upon file transfer schedule.

Within 48 hours of the file being received, UnitedHealthcare loads the file into our Electronic Eligibility Management System (EEMS). EEMS is an automated file review and pre-processor program that systematically loads membership files sent by the client via Secure File Transfer Protocol to our eligibility and enrollment system. The record is then transmitted to CMS's pre-eligibility vendor. This validation quickly ensures the member meets basic Medicare eligibility requirements prior to submitting the transaction file to CMS. Once the record returns from this initial successful validation, the member's record is then passed to CMS for final eligibility processing. If the initial validation is not successful, our operations team attempts to remove any errors. This often requires working with either the client or the member to clarify or supplement any of the required data elements.

Electronic eligibility files are transmitted to CMS that add, delete and modify membership records and subsequently drive capitation from CMS. CMS reply transactions are received electronically and uploaded into our system. All membership activity is logged on a timeline and retained electronically to support CMS and internal audits, provide historical transaction records and verify receipt of CMS records. Retiree notification letters, ID cards and fulfillment materials are requested within seven calendar days of receipt of information (application, enrollment files, transactions from CMS, etc.).

To help ensure a successful implementation, we ask that JPG provide a list of members who are eligible for Medicare Advantage coverage on the effective date of implementation. Upon receipt of the initial member enrollment file from JPG, your assigned account management team works closely with you to establish a normal file transfer schedule and discrepancy resolution process.

We will continue to partner with JPG on the established requirements and processes to smoothly enroll and transition your members to our Group Medicare Advantage PPO plan while being fully compliant with CMS guidelines.

UnitedHealthcare also provides the following enrollment support resources and processes to JPG, at no additional cost:

TELEPHONIC SUPPORT

The goal of our pre-enrollment advisors is to help members understand their new Group Medicare Advantage PPO plan. Our advisors are highly skilled in discussing our Medicare plans as they complete a specialized training program focused on assisting members with questions about how the plan will work for them during the transition to the plan.

COMMUNICATION MATERIALS

Eligible members will receive a pre-enrollment plan guide, mailed by UnitedHealthcare, which includes information about the plan, how the plan works if using non-network providers and how to contact UnitedHealthcare if there are any questions.

ENROLLMENT MEETINGS

UnitedHealthcare will provide full support to JPG for virtual and/or on-site open enrollment meetings, educational events and health fairs, at no additional cost. To supplement these educational meetings, we provide marketing materials and giveaways to help engage members and encourage participation.

WEB RESOURCES

Designed with older adults in mind, **UHCRetiree.com** provides easy-to-read access, including larger font and logical categories of topics to make researching options simple.

15. What is your administration charge as a percentage of premiums for JPG?

Approximately 10% of the total revenue applies to administration, risk and profit.

16. What is the JPG pooling level and estimated pooling charge for 2021?

Risk pools do not apply to Group Medicare Advantage plans.

17. What unique services or support does your organization provide that you believe sets you apart from your competition?

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UnitedHealthcare is a leader in the retiree health care field with 40 years of leadership and sustainability. Our experience helps us provide the service and support your members deserve. What makes us unique is our innovative ability to combine and customize our products and services to create a solution tailored to your needs.

Our Group Medicare Advantage solution offers the unique opportunity to provide a better experience and better health for overall material cost savings. UnitedHealthcare is distinctively positioned as we:

- Offer the most experience as the first to market and now serve more than 1.7 million retirees
- Operate a mature business at scale with 2,000 fully dedicated employees and 5,500 additional designated employees; 80% of our clients and more than 1 million of our members having been with our plan for 4+ years
- Offer a unique holistic approach to improving wellness, closing gaps in care and accurately coding our population
- Exhibit unmatched expertise in delivering 4.5 stars or better for 5 straight years on an annually growing population, and now currently offer the only 5 Star rated national PPO plan
- Demonstrate a track record of proven financial stability with a cumulative medical book of business premium decrease of over $38 per member per month (PMPM) over the last 5 years, as well as premium decreases in our Medicare Advantage Part D plans over the last 3 years.
- Benefit from being part of the UnitedHealth Group enterprise and an annual $5 billion investment on Innovation

Our first to market approach with a focus on dedicated resources for the Group Retiree marketplace, allowed us to earn the right to serve the market's largest Medicare Advantage membership, and ensures an improved retiree experience with minimal disruption and overall substantial improvements to the health and wellness of the retiree population.

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The following is an overview of our programs and services that will be available to the Jefferson Parish Government members for 2023:

- **HouseCalls** is the industry standard for in-home health assessments and coordination of care. Our UnitedHealth Group-employed, licensed health care practitioners visit eligible members in their own homes to assess medical history, conduct a physical exam, review medications, discuss health concerns and provide education on health-related issues. The program provides an opportunity to identify members who have gaps in care and refers members to their primary care physician as well as into our case and condition management programs.

- **Health Risk Assessments** are used to assess the retiree's medical conditions, including chronic conditions, medications, general health, utilization, mental health, and the need for psychosocial services or help at home.

- **Fitness Benefit:** United Healthcare's fitness program is enjoyed by more than one million participants nationwide. As part of the benefit, members are eligible for a free fitness membership to national participating locations. For those members who are unable to go to a fitness location, they can simply request a home workout kit and meet their fitness goals in the comfort of their own home. The fitness benefit is included at no additional cost. In 2021, our Group Medicare Advantage members completed more than 5.5 million gym visits.

- **UnitedHealthcare Healthy At Home:** For retirees experiencing an inpatient admission or a stay at a skilled nursing facility, the goal is to ultimately recover in the comfort of their own homes. We know that members need support beyond traditional medical care to be healthy at home. To prevent new or worsening social determinants of health, we utilize our extensive admission and discharge data to identify the most vulnerable retirees for readmission. UnitedHealthcare's Healthy at Home program provides the support retirees need to successfully recover at home and is available to members at no charge.

  The UnitedHealthcare Healthy at Home bundle combines our market-leading meal delivery, transportation and in-home non-medical care offerings into an easy to use, affordable program that delivers needed support, care and measurable results to the retirees we serve:

  - Meal Delivery provides up to 28 meals following all inpatient or skilled nursing facility discharges when referred by a UnitedHealthcare advocate.

  - Transportation includes up to 12 rides to and from medically related appointments and to the pharmacy following all inpatient or skilled nursing facility discharges when referred by an UnitedHealthcare advocate.

  - In-home Personal Care provides up to 6 hours of in-home personal care following all inpatient and skilled nursing facility discharges through our exclusive provider. Members receive assistance with Activities of Daily Living such as meal preparation, medication reminders, bathing, respite care, and more. No referral is required.

- **Rally Coach**: Offers three unique programs that provide varying levels of online coaching and digital engagement designed to promote health and wellness: Real Appeal Weight Loss/Real Appeal Diabetes Prevention, Wellness Coaching and Quit for Life.

  - **Wellness Coaching** - Digital coaching tool that includes personal coaching, online learning, and support for a variety of different topics that promote whole person health. Wellness Coaching offers a comprehensive solution to address the member's physical, mental, social and emotional needs.

- **Quit For Life** - Members have access to over-the-phone coaching for all types of tobacco use. The program includes, but is not limited to:
  - Up to 5 scheduled one-to-one (outbound) coaching calls with a certified tobacco quitting specialist and unlimited (inbound) calls to the specialist
  - Delivery of nicotine replacement products to help members succeed
- **Real Appeal** - RA Weight Loss Support is a 52-week digital weight loss support program that offers tools that may help members lose weight, reduce the risk of developing serious health conditions and lead healthier lifestyles. RA Diabetes Prevention Program (not available with stand-alone Real Appeal) is also a digital weight loss support program with the same features of RA Weight Loss but includes longer coaching sessions and CDC-developed content.

- **Personal Emergency Response System**: Whether our members are recovering from an illness, have a debilitating condition, or are simply looking to provide a peace of mind about their wellbeing to family members, caregivers and circle of friends, UnitedHealthcare offers an affordable and reliable solution – PERS (Personal Emergency Response System). The PERS is a monitoring device that can give members peace of mind, knowing in any situation they are able get quickly helped -365 days of the year, 24/7. The wearable device is a lightweight, waterproof button that can be worn on the wrist or as a pendant and provides quick access to a response center 24 hours a day.

  Devices are available with AutoAlert fall detection which can automatically provide access to help when a fall is detected. Members can also choose the Go Safe Mobile GPS pendant which allows for monitoring in and out of the home. This device uses Assisted GPS, an advance location tracking technology that integrates nearby Wi-Fi signals and intelligent breadcrumbing to accurately pinpoint the general location of the member. In 2023 Lifeline will also be offering new advanced technology that allows families and caregivers the ability to proactively monitor the location of their loved ones, set-up Geo-Fencing and receive real time alerts with the member's exact location.

- **Member Rewards Program:** Our rewards program motivates members to take action. The program rewards the achievement of certain milestone activities. The program contains characteristics shown by research to be effective at providing encouragement to promote member engagement and help people make healthy lifestyle choices that reduce the likelihood of adverse health outcomes. Our programs are specifically tailored and dedicated to serve Medicare beneficiaries in particular.

- **UnitedHealthcare Hearing Aid Program**: Through UnitedHealthcare Hearing, members have access to premium name brand and private-labeled hearing aids from major manufacturers at discounted costs ranging from $699- $2,499, saving them thousands of dollars. With locations nationwide, and the option to purchase hearing aids in-person, through a hearing provider or have the hearing aids delivered directly to their home, members have more choices than ever before, making it easier to improve their hearing health.

- **Web-Based Health Resources**: Retirees can navigate **UHCRetiree.com** for health and wellness information including topic-related articles, quizzes and videos. Our extensive online resources help our retirees achieve healthier lifestyles while gaining the peace of mind that comes from being better informed on health care topics such as aging, nutrition, exercise, treatment options, weight and stress management and dealing with life's mental and physical challenges.

- **Routine Podiatry**: Routine Podiatry is offered as a way to help reduce avoidable foot conditions and help improve the quality of life for our retirees. The benefit addresses the need for ongoing foot care allowing members to stay mobile and independent. As part of the plan, we cover up to six routine podiatry visits per year, which includes preventive care.

- **Preventive Care Reminders**: The Preventive Care Reminders program targets retirees who have missed specific, high-priority preventive services recommended by sources such as the United States Prevention Services Task Force, the American Diabetes Association and the Centers for Disease Control and Prevention. We identify retirees based on claims and other administrative data. We contact targeted retirees through a combination of mailings and/or telephonic interactive voice response (IVR) technologies to encourage them to seek appropriate services.

- **Screening Exams And Immunizations**: We send health and wellness reminders to encourage all of our retirees to have an annual wellness visit with their physician and other important preventive screenings. By receiving screenings and preventive care during their annual visit and engaging in our programs, retirees have the tools for better self-management and improved outcomes.

- **Telephonic Nurse Support**: UnitedHealthcare offers telephonic and digital resources with access to registered nurses, empowering members to make better health care decisions. Where appropriate, registered nurses use their medical and clinical expertise to provide members with care-seeking recommendations and a review of treatment options. The responding nurse guides members to the right level of support, identifying opportunities for additional clinical support referrals and connecting our members to available resources.

- **Advocate4Me**: Advocate4Me is our customer service program that proactively identifies members with the most complex needs and connects them with the service professional best equipped to deliver on those needs, including complex health issues related to acute or chronic diseases. Ultimately, this service model will help ensure the most appropriate utilization of health care, improve quality performance, and Star ratings and make the overall customer service experience simpler, more satisfying and effective for the Agency members. Members can self-refer into our clinical programs through Advocate4Me.

- **Navigate4Me**: Navigate4Me is our personalized concierge services program that supports and guides members with complex chronic health challenges or a sudden health event. The team consists of nurse navigators who can help members navigate the health care system—together, whether it is clinical, service, social, behavioral, pharmaceutical or financial. A personalized member navigation plan is developed using member data, taking into consideration the member’s clinical and service needs, proactively removing obstacles and ensuring it works with the member’s lifestyle.

- **Caregiver Support**: We offer a comprehensive caregiver solution designed to support family caregivers in helping aging family members stay healthy, function as independently as possible, live with dignity, and remain in the community for as long as possible. Our caregiver solutions are designed to help support the needs of the growing caregiver population, while providing peace of mind, referrals and resources to save time and money. Caregiver resources are available to address an array of concerns to members or their caregivers who have long-term or advanced illness, are elderly or have disabilities.

- **Diabetes Support And Management Program**: We offer comprehensive programs that support and educate members with diabetes to help them understand and better manage their condition more effectively. Our diabetes programs are designed to improve each member's ability to self-manage not only their diabetes, but the other diagnoses frequently encountered with diabetes. The primary goal is to change behaviors in order to prevent unnecessary hospitalizations and further progression of the disease.

  Our diabetes support program is designed to educate eligible members on the importance and relevance of achieving good diabetes control. Our diabetes management program addresses each member's clinical needs, helping them achieve optimal care by working closely with the member's physician. We use predictive modeling systems and a member's claims data to identify possible gaps in care such as missing lab tests, prescription medications and screenings.

  One of our key initiatives is our diabetes outreach program. This program is designed to educate eligible low and moderate risk diabetic members on the importance and relevance of achieving good diabetes control. Engaged members receive diabetes education and strong encouragement to see their primary care physician; if needed, see an endocrinologist; and become engaged with a local diabetes educator for personalized care and diabetes self-management education. In addition, we provide one-on-one coaching that stresses the importance of medication management and/or reaching out to their doctor or pharmacist regarding specific concerns/instructions.

- **Hypertension Support Program**: The hypertension support program is designed to educate eligible members on the importance and relevance of achieving good blood pressure control. Members who qualify have demonstrated difficulty managing hypertension and are identified as eligible for the controlling blood pressure measure. Members are engaged through outreach calls.

- **High-Risk Care Management**: High-Risk Care Management is a national telephonic, chronic care management program of nurse care managers providing targeted interventions for retirees identified with chronic conditions and or frequent hospitalizations. Retirees are "high risk" based on utilization and a designated risk score. Care managers monitor general health status, current conditions, mobility, medications and risk for admission. The program supports retirees by helping them access care, coordinate services and learn to better manage their chronic conditions.

- **Remote Patient Monitoring**: We are engaging members where they are in their health care journey with a goal to reach the vast majority of our members. Our remote patient monitoring program offers real-time, condition-specific clinical support and on-demand digital coaching through a phone-based application or tablet, and Bluetooth-enabled medical equipment to support members in their own homes. The capability is a complete, retiree-centered and holistic connected care platform that leverages remote monitoring, clinical pathways and rules that automate alerts for care managers to proactively address escalations.

- **Kidney Disease Program**: The Kidney Disease program identifies and attempts to case manage members with advancing kidney disease that are moving towards dialysis, currently on dialysis, or awaiting transplant. Based on the severity of disease and geography, members will either work with a Renal Nurse Care Manager and Health Advocate or a team of community-based providers who provide both in home and remote education and support services. Members will work with their care team to, delay or stop Chronic Kidney Disease (CKD) or End-Stage Renal Disease (ESRD) progression, overcome any treatment barriers, and find a high-quality nephrologist. Through collaboration with the member's providers, the Kidney Disease Program works to proactively obtain dialysis access, evaluation for in-home dialysis, and initiation of dialysis prior to emergent need.

- **Transplant Case Management**: Our transplant management program drives positive clinical outcomes by addressing the complex needs of older adults who are facing transplants. We cover all phases of transplant coordination, from evaluation, pre-transplant, transplant, post-transplant and 12-month follow-up health care. Our unique clinical experience significantly reduces overall medical costs. Our Centers of Excellence network health care providers drive quality patient outcomes, with high patient one-year survival rates. In addition to cost containment, the goal and objective of our transplant management program is to provide the breadth of quality providers, facilities and care for those in need of transplants.

  Our specialized nurse managers work with members to provide condition-specific education and care coordination services for those seeking high-cost and treatment-variable transplant procedures for solid organ and bone marrow/stem cell transplant services. Engaged transplant members receive, on average, one contact per month by their assigned transplant care manager, to assess and check their progress. By empowering members with information about our transplant Centers of Excellence, as well as preparing for, and recovering from, transplant surgery, we drive positive clinical outcomes. We validate members' decisions and maximize economic value through operational efficiencies and cost avoidance.

- **Advanced Illness And Palliative Care Program**: The UnitedHealthcare Advanced Illness (AI) Program provides an extra layer of support for our most vulnerable seniors. Specially trained nurses and social workers call these members by phone regularly and more often when their condition worsens. They provide support and guidance and help the member connect with their other doctors as well as establish a contingency plan for when urgent issues arise to protect members from avoidable hospital admissions. AI nurses and social workers work with the member to make sure they follow up with their doctors and that they have a contingency plan for when symptoms occur. Family caregivers who provide care to our seriously ill members often suffer themselves from anxiety, stress and burnout and rarely have access to the support they need as unpaid caregivers.

  In 2019, we began offering field-based palliative care resources to seriously ill members in the comfort of their homes. This program is available in major metropolitan markets across 42 states. Our palliative care program provides 24-hour member support with a multidisciplinary team of palliative care experts, nurse practitioners, nurses, and social workers in partnership with local care providers. The focus of this home-based palliative care support is pain and symptom management and helping people meet their care goals.

- **Behavioral Health**: Our behavioral health management program reflects an integrated approach with our medical team to identify, engage and manage retirees' behavioral health concerns. Our behavioral health care programs are led by experienced geriatric psychiatrists and licensed behavioral health clinicians with significant geriatric expertise. Our medical-behavioral integration specialist (care manager) is highly skilled and will coordinate behavioral health referrals from our HouseCalls program and other clinical programs.

- **Transitional Programs**: UnitedHealthcare understands that being discharged from an inpatient or skilled nursing facility often involves stress, confusion, compromised care and avoidable hospital readmissions. Our transitional programs are provided to members who were admitted to the hospital or to a skilled nursing facility for specific conditions.

- **Inpatient Care Management**: Our Inpatient Care Management (ICM) program promotes the timely delivery of needed services to hospitalized members, helping them to receive the most appropriate care based on their specific clinical status and health care needs. It is designed to achieve optimal clinical outcomes by applying nationally recognized evidence-based clinical guidelines and best practices to reduce unnecessary variation in clinical use of services. The program focuses on helping members move through the continuum of care, including transitions during and after hospitalization.

  ICM nurses perform telephonic review. We provide active, real-time management by applying evidence-based clinical criteria to determine appropriateness of services; anticipate future services; assess the quality of care, anticipate discharge planning needs and help implement the discharge plan to ensure a safe disposition.

- **One Hospital**: One Nurse: Our One Hospital One Nurse model is a geographically based design that strategically assigns (ICM) nurses to our network hospital facilities in their regions across the United States. UnitedHealthcare ICM nurses work telephonically and may have access to facility electronic medical records if facility contracts allow. Cases are directed to a designated ICM nurse, who serves as the primary resource for that facility. All ICM nurses and physicians have expertise in using evidence-based care guidelines. The ICM nurses have an intimate knowledge of the facility’s culture and procedures. This knowledge helps them access patient information quickly and increases awareness of how members are progressing through their hospital stay. This allows them to promote an evidence-based approach in that facility. ICM nurses may have direct access to the member’s current medical record through electronic medical record review which helps to decrease the number of missed opportunities that might impact the member’s inpatient stay.

- **Hospital Care Transition Program**: Hospital Care Transition Program is a patient-centric approach to seamless care transitions from hospitals to post-acute networks, enhancing the member experience and bringing value to our customers and care providers. Our program goals include improved clinical outcomes, increased member satisfaction, reduced readmissions and significant cost savings.

  Hospital Care Transition (HCT) Coordinators engage members at the bedside upon admission to medical/surgical floors and/or observation. When the patient is ready for discharge, HCT Coordinators work with facility staff to implement the discharge plan and provide education about in-network care providers, programs they may be eligible for, community-based resources and more.

- **Post-Acute Transition Program**: Through this in-person, hands-on approach to care, Post-Acute Transition program ensures members are medically and functionally ready to return home, while preventing unnecessary delays at skilled nursing facility discharge and avoiding readmissions. The program has reduced the length of stay in a skilled nursing facility by five days on average.

  Our Post-Acute Transition Program uses an individualized, whole-person approach to remove barriers to discharge from post-acute care, such as skilled nursing facilities so the member can safely return to the least restrictive setting possible. Our nurse care managers collaborate with facilities, physicians, families and caregivers after their hospital stay and throughout the post-acute stay. The nurse care manager participates in care conferences, family meetings, and discharge planning as appropriate to communicate with members/families and discuss benefits, progress, goals of care, discharge plans, home health referrals, etc. Nurse care managers are telephonic and may be on-site to perform care management, coordination and concurrent review and engage the member and facility to effectively manage length of stay. Nurse care managers evaluate the entire scope of a member's needs, provide members and their caregivers with coaching and resources and coordinate referrals to community-based services.

- **Patient Connect**: Patient Connect is a clinical program engaging Medicare Advantage members transitioning to a skilled nursing facility from an acute inpatient stay needing continuity of care for rehabilitation purposes and expedient recovery. Our nurse practitioners who are on-site at designated facilities focus on medication review and reconciliation, clear care paths, and proactive discharge planning for members in skilled nursing facilities. Results of this program are favorably impacting member experience, care coordination, and avoidable utilization.

  Members in the Patient Connect program have a reduction in skilled nursing facility length of stay of 20% on average, 52% lower unnecessary readmission rates, improved Star gap closure, and higher advance care planning completion and hospice referral rates.

18. Please provide results from the following surveys for 2020 or 2021:

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- **Member Satisfaction**

  The 2021 results of our United Experience Survey for our Group Medicare line of business were 94.13% satisfied.

- **Provider Satisfaction**

  One of our primary feedback mechanisms, the Physician and Practice Manager Survey, measures provider perceptions of UnitedHealthcare on key measures such as Net Promoter Score (NPS), overall satisfaction, ease of doing business, and a host of other operational dimensions such as prior authorization and reimbursement. We gather nearly 3,000 responses per year from across the United States. A third-party vendor, Escalent administers the survey on our behalf to providers who are contracted within the UnitedHealthcare network.

  In addition to the Physician and Practice Manager Survey, which we distribute quarterly, we also gather provider feedback at the point of interaction with UnitedHealthcare. We survey providers after they contact our call center, on our main provider website, **uhcprovider.com**, and after our providers interact with our field staff. As part of this survey process, we "close the loop" and follow up with providers who indicate dissatisfaction with their interaction.

Additional, primary studies are also frequently conducted to evaluate market opportunities.

- **Benefits Manager Satisfaction**

  Our 2021 Retiree Solutions Customer Survey, which provides an opportunity for clients to provide feedback on the assigned account management team (AMT), showed 93% satisfaction.

19. For which services, and whom, do you outsource the following:

- **Mental Health**

  UnitedHealthcare offers an industry-leading behavioral health network built on quality and aggregate availability of clinicians that promotes precise clinician matching and problem resolution. Characteristics of our network include a large, specialized network of licensed behavioral health professionals, agencies and facilities that represent an array of clinical and cultural specialties for the treatment of mental health and substance use conditions at all levels of care. The network is made up of approximately 90,020 providers and 1,800 facilities.

- **Laboratory**

  Beginning in 2007, Laboratory Corporation of America (LabCorp) was the exclusive national clinical laboratory for UnitedHealthcare. As of January 1, 2019, both LabCorp and Quest Diagnostics are network laboratory care providers for UnitedHealthcare.

- **Vision**

  We do not outsource any aspects of our vision programs; they are administered internally.

- **Prescription drug**

  We do not outsource any aspects of our pharmacy program. Our pharmacy plans are administered internally by our wholly owned pharmacy benefits manager (PBM), OptumRx.

- **Network management**

  We own the vast majority of the networks we use for providing health care coverage (i.e., a 99% national network ownership versus less than 1% leased arrangements). We are committed to a directly contracted national network, which provides broad access and financial value through competitive market rates.

  Our national network enables a member to receive network benefits when using a physician or provider in a network area other than the one to which the member lives. Thus, a member visiting or traveling in another area served by our national network can access the network in that second site and receive the network-level benefits.

  We use leased or vendor networks where it is not feasible to develop our own networks. Vendor networks must comply with the same quality standards we use for our own networks. Vendor network compensation varies based on market demands and the customary practices of the local marketplace. We retain responsibility for claim processing. In addition, we oversee all quality issues, including quality control of the physicians and other health care professionals in the network.

  We use a leased network in the following sites:

Location	Vendor	Product
U.S. Virgin Islands	VI Equicare	UnitedHealthcare Group Medicare Advantage PPO
Western Kentucky	Center Care	UnitedHealthcare Group Medicare Advantage PPO

- **Utilization management**

  Our utilization management programs are developed and administered by UnitedHealth Group employees.

20. What are your weekday and weekend hours of telephone member services availability?

Advocates are available 8 a.m. to 8 p.m. in all U.S. time zones, Monday through Friday. Members who call our member service center after hours will hear a recorded announcement providing hours of operation and directing them to call their primary care physician or the nearest emergency room if they are experiencing an emergent health issue.

Our Telephonic Nurse Support provides access 24 hours per day, seven days per week to registered nurses for symptom and condition support, general health information, decision support, provider referral and an audio health information library with over 1,100 topics. Our members also have 24-hour emergency access to a registered pharmacist for specialty pharmacy support and assistance with questions. Information is also available on our website, **UHCRetiree.com**, 24 hours per day, seven days per week.

21. For member services, what was the 2020 or 2021 telephone average speed of answer?

- **Member Line**
  - **2020**: 43 seconds
  - **2021**: 24 seconds
- **Provider Line**
  - **2020**: 36.62 seconds
  - **2021**: 36.75 seconds
- **Combined Medical/Utilization Review Line**
  - **2020:** 36.62 seconds
  - **2021:** 36.75 seconds

  Please note, the combined medical/utilization review line and provider line are one line.

22. What is your Website address and what member information can be accessed from the Website?

The URL for our member portal is **UHCRetiree.com**. Members will be able to view claims status and history, access provider directories, print temporary ID cards, order replacement ID cards, review deductibles and copayment amounts, review claims history and status, review explanation of benefits as well as take a medical risk assessment on our member portal.

23. What is your 2021 target Per Member per Month (PMPM) medical cost for your network?

We are unable to provide yearly per member per month (PMPM) costs for our network. PMPM costs vary significantly based on plan design, demographics, employer contribution, etc.

24. For what procedures do you offer a Centers of Excellence program? Please provide a listing of locations utilized by procedure.

Standard Centers of Excellence contracting methodology varies by product, and focuses on all-inclusive, fixed pricing through case rates, per diems, fee schedules or fixed DRG payments. In limited cases, we have negotiated aggressive discounts.

Transplant-related services are bundled into the transplant contractual rate. Our transplant contracts cover transplant services rendered across all phases of transplant care, including the evaluation, pre-transplant period, transplant procedure and one-year post-transplant period.

We use a case rate for services rendered during the transplant procedure and 90 days post-transplant. The case rate typically includes donor acquisition and procurement costs, physician and hospital charges, inpatient and outpatient charges, a bank of inpatient days, etc.

Transplant Resource Services (TRS) covers all phases of member health care from evaluation, pre-transplant, transplant, post-transplant and 12-month follow-up health care. TRS contracts for the following solid organ and bone marrow/stem cell transplant services:

- Allogeneic related bone marrow/stem cell
- Allogeneic unrelated bone marrow/stem cell
- Autologous bone marrow/stem cell
- Heart
- Heart/Lung
- Intestinal
- Intestinal/liver
- Kidney/pancreas
- Kidney (living and cadaveric)
- Liver (living and cadaveric)
- Liver/kidney
- Lung (single and double)
- Multi-organ transplants
- Pancreas
- Tandem stem cell transplants

Below is the list of Centers of Excellence (COE) providers that we provide in Louisiana. Additional providers are available in our Transplant Access Network (TAP).

- Ochsner Medical Center - Jefferson [Blood/Marrow, Heart, Kidney, Kidney/Liver, Kidney/Pancreas, Liver, Pancreas]
- Tulane University Hospital and Clinic - New Orleans [Blood/Marrow, Kidney, Kidney/Liver, Liver]
- Louisiana TAP Network - Medicare Adult Transplant Access Program Network
- Tulane University Hospital and Clinic - New Orleans [Kidney/Pancreas, Pancreas]
- Willis-Knighton Health System - Shreveport [Kidney, Kidney/Pancreas, Pancreas]

25. A provider network is a critical part of the medical plan; therefore, include provider directory with your proposal. Also, provide a GEO Access report using a standard of two (2) providers within ten (10) miles.

UnitedHealthcare's provider directories can be accessed via web, tablet or mobile device at **UHCRetiree.com**. Upon enrolling, members can also call UnitedHealthcare Group Retiree member service center to request a directory be mailed. Hard-copy directories are generated based on the member's zip code.

The requested GEO Access report has been provided as an attachment. Please reference the document titled "Exhibit 6: JPG - PPO GEO Access Report."

26. Is MD Anderson in Houston a network provider?

While MD Anderson in Houston is not a network provider, MD Anderson is willing to see and treat UnitedHealthcare's Group MA PPO members out-of-network.

UnitedHealthcare's Group Medicare Advantage PPO provides a non-differential plan design with the same benefits in and out of network, which eliminates provider issues. With the UnitedHealthcare Group Medicare Advantage PPO plan, members can see doctors and other health care providers that are in and out of our network at the same cost share as long as they participate in Medicare and accept the plan. Because UnitedHealthcare also believes in unrestrained access to care, the Group Medicare Advantage PPO also holds both members and providers "harmless" for out-of-network utilization. When a member goes out of the network for care, the UnitedHealthcare Group Medicare Advantage PPO plan pays providers just as much as Original Medicare would have, and members pay the same amount out of pocket as if they had stayed in the network with no balance billing.

For the Group Medicare Advantage PPO, UnitedHealthcare reimburses non-contracted providers according to terms and conditions under CMS requirements for Medicare Advantage organizations. Reimbursement is set at prevailing CMS rates for traditional Medicare fee-for-services. Physicians are reimbursed using CMS's Resource Based Relative Value System.

Members covered by our non-differential national Group Medicare Advantage PPO Plans may access our broad national network of health care providers who have experience working with the retiree population and who focus on affordability, quality care and superior clinical outcomes. Should members need or wish to go outside UnitedHealthcare's contracted network, they are covered when seeing any willing health care provider who participates in Medicare and accepts the plan.

27. What disease management programs do you currently have in place?

We have comprehensive, best-in-class care and disease management programs that are based on supporting members that are healthy and well, returning to health, living with chronic illness and end of life. We focus on managing illness and chronic conditions, encouraging preventive care, coordinating care, and promoting evidence-based medicine to achieve the best possible clinical outcomes.

The following is an overview of our programs and services that will be available to Jefferson Parish Government in 2023. These programs are included at no additional cost.

DIABETES MANAGEMENT PROGRAM

UnitedHealthcare is a leader in diabetes management. We offer comprehensive programs that support and educate retirees with diabetes across the spectrum of their condition to help them understand and better manage their condition more effectively. The diabetes programs are designed to improve each member's ability to self-manage not only their diabetes, but the other diagnoses frequently encountered with diabetes. The primary goal is to change behaviors in order to prevent unnecessary hospitalizations and further progression of the disease.

UnitedHealthcare's Diabetes Support Program is designed to educate eligible members on the importance and relevance of achieving good diabetes control. Our Diabetes Management Program addresses each member's clinical needs, helping them achieve optimal care by working closely with the member's physician. In this program, we address the needs of members with comorbidities and a high risk for hospital admission. We use predictive modeling systems and a member's claims data to identify possible gaps in care such as missing lab tests, prescription medications and screenings.

We provide digital tools for improved management of their blood sugars. In addition to predictive modeling, members may also be identified through HRAs, our care management process, inpatient and outpatient notification, direct referral, and through Telephonic Nurse Support. Upon identification of an individual at risk, we deliver the program's components through a combination of mailings and telephonic outreach by specially trained program nurses and dietitians.

PRE-DIABETES

Through UnitedHealthcare's early disease identification initiatives in 2020 and 2021, we offered members who were at risk of pre-diabetes to be screened during a HouseCalls visit. 24% of the Group Medicare Advantage members tested were identified as prediabetic by our HouseCalls practitioners and 3% were identified as undiagnosed diabetics.

HYPERTENSION SUPPORT PROGRAM

The hypertension support program is designed to educate eligible members on the importance and relevance of achieving good blood pressure control. Members who qualify have demonstrated difficulty managing hypertension and are identified as eligible for the controlling blood pressure measure. Members are engaged through outreach calls.

HIGH-RISK CARE MANAGEMENT

High-Risk Care Management is a national telephonic, chronic care management program of nurse care managers providing targeted interventions for retirees identified with chronic conditions and or frequent hospitalizations. Retirees are "high risk" based on utilization and a designated risk score. Care managers monitor general health status, current conditions, mobility, medications and risk for admission. The program supports retirees by helping them access care, coordinate services and learn to better manage their chronic conditions.

Remote Patient Monitoring

Remote patient monitoring is a digital care management program that features comprehensive clinical support achieved with daily at-home biometric monitoring, care coordination and patient education. Examples of chronic conditions are diabetes, heart failure, chronic obstructive pulmonary disease (COPD), cardiac conditions, and polychronic condition management.

Kidney Disease Program

The Kidney Disease program identifies and attempts to case manage members with advancing kidney disease that are moving towards dialysis, currently on dialysis, or awaiting transplant. Based on the severity of disease and geography, members will either work with a renal nurse care manager and Health Advocate or a team of community-based providers who provide both in home and remote education and support services. Members will work with their care team to, delay or stop Chronic Kidney Disease (CKD) or End-Stage Renal Disease (ESRD) progression, overcome any treatment barriers, and find a high-quality nephrologist. Through collaboration with the member's providers, the Kidney Disease Program works to proactively obtain dialysis access, evaluation for in-home dialysis, and initiation of dialysis prior to emergent need.

Transplant Case Management

Our transplant management program drives positive clinical outcomes by addressing the complex needs of older adults who are facing transplants. We cover all phases of transplant coordination, from evaluation, pre-transplant, transplant, post-transplant and 12-month follow-up health care. Our unique clinical experience significantly reduces overall medical costs. Our Centers of Excellence network health care providers drive quality patient outcomes, with high patient one-year survival rates. In addition to cost containment, the goal and objective of our transplant management program is to provide the breadth of quality providers, facilities and care for those in need of transplants.

Our specialized nurse managers work with members to provide condition-specific education and care coordination services for those seeking high-cost and treatment-variable transplant procedures for solid organ and bone marrow/stem cell transplant services. Engaged transplant members receive, on average, one contact per month by their assigned transplant care manager, to assess and check their progress. By empowering members with information about our transplant Centers of Excellence, as well as preparing for, and recovering from, transplant surgery, we drive positive clinical outcomes. We validate members' decisions and maximize economic value through operational efficiencies and cost avoidance.

Advanced Illness and Palliative Care Program

The UnitedHealthcare Advanced Illness (AI) Program provides an extra layer of support for our most vulnerable seniors. Specially trained nurses and social workers call these members by phone regularly and more often when their condition worsens. They provide support and guidance and help the member connect with their other doctors as well as establish a contingency plan for when urgent issues arise to protect members from avoidable hospital admissions. AI nurses and social workers work with the member to make sure they follow up with their doctors and that they have a contingency plan for when symptoms occur. Family caregivers who provide care to our seriously ill members often suffer themselves from anxiety, stress and burnout and rarely have access to the support they need as unpaid caregivers.

In 2019, we began offering field-based palliative care resources to seriously ill members in the comfort of their home. This program is available in major metropolitan markets across 42 states. Our palliative care program provides 24-hour member support with a multidisciplinary team of palliative care experts, nurse practitioners, nurses, and social workers in partnership with local care providers. The focus of this home-based palliative care support is pain and symptom management and helping people meet their care goals.

In 2022, we have enhanced our delivery of in-home palliative & serious illness care by:

- Adopting new virtual capabilities for members who utilize our telephonic Advanced Illness program, allowing for improved access to care for members across all 50 states, the US Virgin Islands and Puerto Rico. Continued multidisciplinary support to identify social needs and promote care coordination
- Community focus includes collaboration with current providers and assessment of social and environmental factors (social determinants of health) to support members' goals of care.

BEHAVIORAL HEALTH

Our behavioral health management program reflects an integrated approach with our medical team to identify, engage and manage retirees' behavioral health concerns. Our behavioral health care programs are led by experienced geriatric psychiatrists and licensed behavioral health clinicians with significant geriatric expertise. Our medical-behavioral integration specialist (care manager) is highly skilled and will coordinate behavioral health referrals from our HouseCalls program and other clinical programs.

28. Describe your current Wellness Program options and results, including what programs are provided to assist in healthy living.

Proprietary and Confidential

We have comprehensive, best-in-class care wellness programs that support members that are healthy and well, along with members who have chronic medical conditions.

The following is an overview of our programs and services that will be available to Jefferson Parish Government members in 2023.

FITNESS BENEFIT

United Healthcare's fitness program is enjoyed by more than one million participants nationwide. As part of the benefit, members are eligible for a free fitness membership to national participating locations. For those members who are unable to go to a fitness location, they can simply request a home workout kit and meet their fitness goals in the comfort of their own home. The fitness benefit is included at no additional cost. In 2021, our Group Medicare Advantage members completed more than 5.5 million gym visits.

RALLY COACH

Offers three unique programs that provide varying levels of online coaching and digital engagement designed to promote health and wellness: Real Appeal Weight Loss/Real Appeal Diabetes Prevention, Wellness Coaching and Quit for Life.

- **Wellness Coaching** - Digital coaching tool that includes personal coaching, online learning, and support for a variety of different topics that promote whole person health. Wellness Coaching offers a comprehensive solution to address the member's physical, mental, social, and emotional needs.

- **Quit For Life** - Members have access to over-the-phone coaching for all types of tobacco use. The program includes, but is not limited to:

  - Up to 5 scheduled one-to-one (outbound) coaching calls with a certified tobacco quitting specialist and unlimited (inbound) calls to the specialist

  - Delivery of nicotine replacement products to help members succeed

- **Real Appeal** - RA Weight Loss Support is a 52-week digital weight loss support program that offers tools that may help members lose weight, reduce the risk of developing serious health conditions, and lead healthier lifestyles. RA Diabetes Prevention Program (not available with standalone Real Appeal) is also a digital weight loss support program with the same features of RA Weight Loss but includes longer coaching sessions & CDC- developed content.

MEMBER REWARDS PROGRAM

Our rewards program motivates members to take action. The program rewards the achievement of certain milestone activities. The program contains characteristics shown by research to be effective at providing encouragement to promote member engagement and help people make healthy lifestyle choices that reduce the likelihood of adverse health outcomes. Our programs are specifically tailored and dedicated to serve Medicare beneficiaries in particular.

TELEPHONIC NURSE SUPPORT

UnitedHealthcare offers telephonic and digital resources with access to registered nurses, empowering members to make better health care decisions. Where appropriate, registered nurses use their medical and clinical expertise to provide members with care-seeking recommendations and a review of treatment options. The responding nurse guides members to the right level of support, identifying opportunities for additional clinical support referrals and connecting our members to available resources. In 2021, 48% of pre-intent ER calls were triaged to a lower level of care.

ADVOCATE4ME

Advocate4Me is our customer service program that proactively identifies members with the most complex needs and connects them with the service professional best equipped to deliver on those needs, including complex health issues related to acute or chronic diseases. Ultimately, this service model will help ensure the most appropriate utilization of health care, improve quality performance, and Star ratings and make the overall customer service experience simpler, more satisfying and effective for the Agency members. Members can self-refer into our clinical programs through Advocate4Me.

NAVIGATE4ME

Navigate4Me is our personalized concierge services program that supports and guides members with complex chronic health challenges or a sudden health event. The team consists of nurse navigators who can help members navigate the health care system—together, whether it is clinical, service, social, behavioral, pharmaceutical or financial. A personalized member navigation plan is developed using member data, taking into consideration the member's clinical and service needs, proactively removing obstacles and ensuring it works with the member's lifestyle.

UnitedHealthcare Hearing Aid Program

Through UnitedHealthcare Hearing, members have access to premium name brand and private-labeled hearing aids from major manufacturers at discounted costs ranging from $699- $2,499, saving them thousands of dollars. With locations nationwide, and the option to purchase hearing aids in-person, through a hearing provider or have the hearing aids delivered directly to their home, members have more choices than ever before, making it easier to improve their hearing health.

Web-Based Health Resources

Retirees can navigate **UHCRetiree.com** for health and wellness information including topic related articles, quizzes and videos. Our extensive online resources help our retirees achieve healthier lifestyles while gaining the peace of mind that comes from being better informed on health care topics such as aging, nutrition, exercise, treatment options, weight and stress management and dealing with life's mental and physical challenges.

Routine Podiatry

Routine Podiatry is offered as a way to help reduce avoidable foot conditions and help improve the quality of life for our retirees. The benefit addresses the need for ongoing foot care allowing members to stay mobile and independent. As part of the plan, we cover up to six routine podiatry visits per year, which includes preventive care.

Health Risk Assessments

Health Risk Assessments are used to assess the retiree's medical conditions, including chronic conditions, medications, general health, utilization, mental health, and the need for psychosocial services or help at home.

Preventive Care Reminders

The Preventive Care Reminders program targets retirees who have missed specific, high-priority preventive services recommended by sources such as the United States Prevention Services Task Force, the American Diabetes Association and the Centers for Disease Control and Prevention. We identify retirees based on claims and other administrative data. We contact targeted retirees through a combination of mailings and/or telephonic interactive voice response (IVR) technologies to encourage them to seek appropriate services.

Screening Exams and Immunizations

We send health and wellness reminders to encourage all of our retirees to have an annual wellness visit with their physician and other important preventive screenings. By receiving screenings and preventive care during their annual visit and engaging in our programs, retirees have the tools for better self-management and improved outcomes.

29. Describe your pharmacy network.

Our CMS-compliant Medicare Part D network provides unrestricted, nationwide coverage in all 34 Medicare Part D regions (50 states) plus the five U.S. territories. Members have access to 67,000 retail pharmacies nationally (including nearly 5,000 long-term care pharmacies) and convenient home delivery options. Our retail pharmacy network features over 90% of America’s drug stores, independent stores and major chains, including the following retail pharmacies:

Walgreens	Kroger	ShopRite	Kmart
CVS	Shopko	Costco	Hy-Vee

Walmart	Omnicare	Publix	Winn-Dixie
Safeway	Longs	Rite Aid	Medicine Shoppe

All major chains are included in our Medicare Part D pharmacy network. CMS requires that Medicare Part D plans allow any willing providers to participate in the network.

Our individual and group (EGWP) Part D plans use the same Medicare Part D network. There are no anticipated major changes to our pharmacy network for 2021.

30. How many Prescription Drug Lists (PDL's) does your company administer?

We administer a total of 4 formularies. UnitedHealthcare is pleased to provide quotes for two different formularies in this RFP. One is provided as a custom-match the People's Health 5-tier structure and the second is provided to match the current Humana 4-tier structure. Additionally, we have included a Bonus Drug List for each of the two custom plan designs.

31. If more than one PDL, what is the pricing differentials for each PDL and what is the impact on premiums and co-pays?

Not applicable. While we are providing quotes for two different formularies in this RFP to custom-match the existing People's Health 5-Tier and Humana 4-Tier structures, there is no pricing differential or impact to premiums or copays.

32. Based on the top 100 drugs based on prescriptions filled, please identify which tier each drug falls under in your company's PDL.

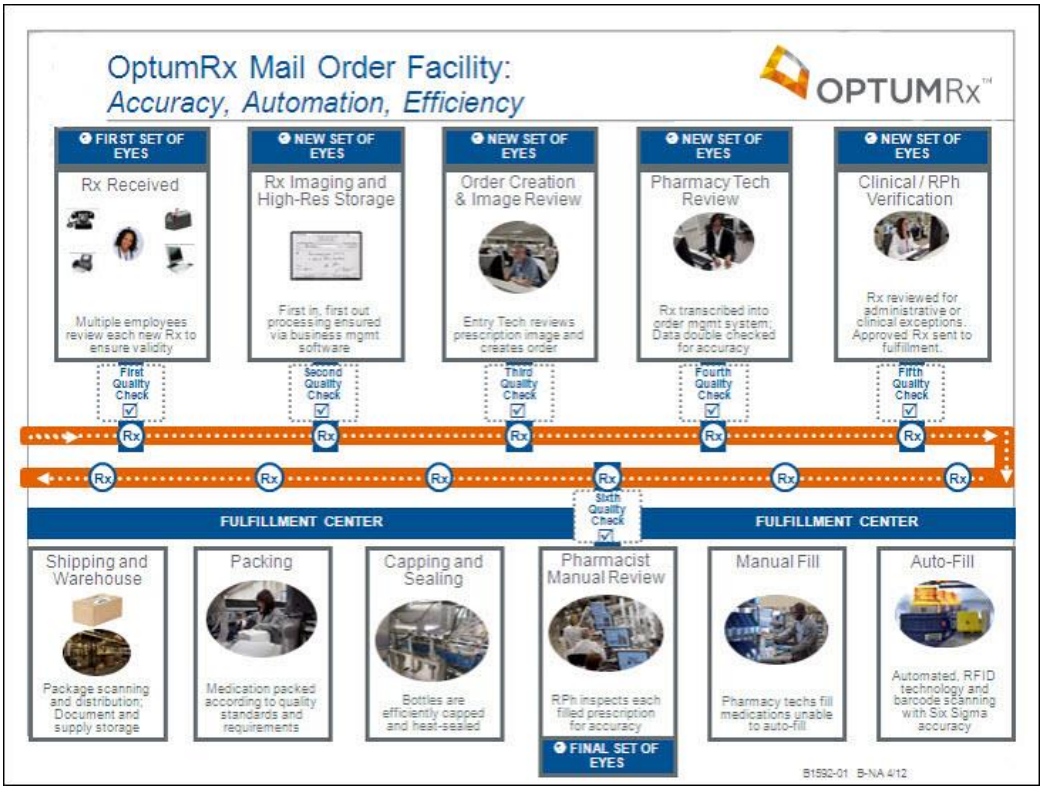
An analysis of UnitedHealthcare's Top 100 drugs, based on prescriptions filled has been completed and provided as an attachment. We are providing quotes for two different formularies to custom-match the People's Health 5-Tier and Humana 4-Tier structures and the UnitedHealthcare's Top 100 Drug Analysis includes results for both formularies. Please reference the document titled "Exhibit 7: JPG – UHC Top 100 Drug Tier Analysis."

33. Describe your mail order capabilities.

Our **OptumRx Home Delivery Pharmacy** provides high-quality, technologically advanced prescription fulfillment capabilities that offer safety, savings, convenience, improved adherence and better member experiences. Our Home Delivery Pharmacy approach is unique in the marketplace and offers multiple key differentiators to the Parish. With OptumRx Home Delivery, customers save an average of 9 percent off total pharmacy spend and members will typically save 17 percent over filling their prescriptions at a retail pharmacy.

Our home delivery operations are noted for accuracy, automation and efficiency. We maintain efficient, technologically advanced procedures for dispensing Home Delivery Pharmacy prescriptions and safeguard the security and integrity of all medications shipped from our facilities. Our carefully detailed process, consistent throughout all our facilities, includes the rigorous quality assurance and eyes-on measures OptumRx is noted for, resulting in an accuracy rate of 99.99 percent and an NPS of 87.

These numbers represent the median savings for those members using pricing tool, who ultimately fill at HDP vs. retail after doing a price check. Data for all lines of business, Jan 2020-Oct 2020 based on internal analysis of over 115,000 claims. Plan sponsor savings is the median savings per member per prescription switched to home delivery.



We have a multi-step process to confirm each fill is dispensed safely, accurately and on time. Each submission received at an OptumRx facility undergoes the same quality process steps adding to the convenience, efficiency and cost savings our customers, members and prescribers expect.

ORDER SUBMISSION

We offer several options for members and prescribers to order new prescriptions from our Home Delivery Pharmacy. Members may submit prescriptions by mail and prescribers may initiate new orders by phone, mail, fax, or e-prescribing. Members or prescribers may submit refill orders by telephone through a customer service agent or our interactive voice response (IVR) system, our website, or mail. We encourage members to expedite refill orders either by ordering online or calling our automated IVR system. New members receive a welcome kit that includes a description of our Home Delivery Pharmacy process and a convenient order form.

ORDER CAPTURE AND ENTRY

Following submission of the prescription order, of a new or refill prescription order, we review the order for authenticity, clarity and alterations. If a prescription is unclear or appears altered, we contact the member or prescriber for clarification. After an order is verified, we scan the information into our system using imaging software. This image capture initiates our electronic documentation process. The prescription is assigned a barcode to further maintain accurate tracking throughout the order dispensing process. Once the order is logged into our system for tracking, a licensed pharmacy technician reviews the prescription for completeness. If the prescription is not complete or is not legible, the technician contacts the member or prescriber to obtain the necessary information.

Eligibility and Coverage Screening

Once we verify the prescription information is complete, our mail service system screens and adjudicates the prescription according to member eligibility and coverage status of the prescription. If the member is not eligible or the drug is not covered by the member's plan, the system denies the claim. We then contact the member by phone within 48 hours to notify them of the denial and provide the reason for the denial. In addition, we send written notification of the denial to the member.

Pharmacist Intervention and Drug Review

A licensed pharmacist reviews each prescription for accuracy and screens for clinical appropriateness and safety issues. In addition, our system automatically scans the prescription against our drug utilization review (DUR) and prior authorization edits and alerts the pharmacist if there is potential for adverse interaction or if the prescription is subject to prior authorization or clinical edits, such as step therapy. If any limits apply, the pharmacist flags the prescription for coverage determination. If a safety issue exists, the pharmacist contacts the prescriber to discuss the issue and obtain a revised prescription if necessary.

If a DUR or prior authorization is required, a pharmacist contacts the prescriber to obtain the necessary clinical information. If the information submitted by the prescriber does not meet the criteria established by the plan sponsor (for example, the member does not meet medical necessity criteria for the prescription), the claim is denied and we send written notification to the member. If the information submitted meets the required criteria, we approve the claim and route the prescription for fulfillment.

Fulfillment

After a prescription is approved, the claim system electronically records the approval, processes the member's check, money order, or credit card payment and initiates the fulfillment phase. This phase includes a series of automated tasks through which the system identifies the type of medication, determines whether the medication is prepackaged or countable (for example, ointment versus tablets), flags the appropriate bottle size, if appropriate, and auto-dispenses the medication.

Our facilities employ an advanced pharmacy system (APS) for high volume fulfillment purposes. After an order is successfully imported, it is placed into the APS database to begin the filling process. All automated tasks are monitored and supported by a team of pharmacists and pharmacy technicians.

Pharmacist Verification

Following the fulfillment phase, a pharmacist performs a final verification of the prescription to confirm that the correct medication and quantity has been dispensed. This verification includes direct visual inspection of the medication dispensed. This verification phase is tracked through an electronic audit trail that time stamps the verification and notes the pharmacist performing the review. If an error is noted, the reviewing pharmacist flags the order for correction and re-dispensing. If the order is correct, it is flagged for shipping.

Shipping

Our Home Delivery Pharmacy staff packages approved and verified orders.

Most prescription orders are shipped by USPS First Class mail. As required, we ship urgently needed medications and injectable drugs through overnight carrier or expedited delivery. We also require a signature for delivery of orders, as appropriate, for controlled substances or high-cost medications. We accommodate delivery to either a member's home or a physician's office.

After an order has been packaged and manifested in our system, a file is exported to the host system. The file contains complete tracking of the order's fulfilment. Based on the member's communication preferences, we notify the member with an IVR call, a text notification and/or an email confirming the order is shipped.

TEMPERATURE CONTROL

Many medications have both an upper and lower range temperature that must be maintained. Our packaging is designed to protect medications in the event of a shipping delay or seasonal temperature variations. Our packaging includes:

- White packaging that maintains member privacy and facilitates faster processing
- A streamlined packaging process that includes larger gel packs and thicker package insulation
- Environmentally friendly Enviro-Ice packs:
  - The contents can be poured down the drain or used as plant food, as noted on the gel packaging
  - The insulation can be taken to select retail stores to be exchanged for store credit. The retailers wash and reuse the materials
  - Longer duration temperature maintenance
  - Medication protection that maintains temperatures for a greater duration [rated for 60 hours total and 36 hours during extreme heat (97-120 degrees F)]
- Uniform shipping protocols – our Summer Standard, Extreme Summer and 2-Day shipping are now identical to meet patient expectations and reduce packing errors

SECURITY AND ANTI-TAMPERING STRATEGIES

We operate a vigorous quality control system that includes multiple human and digital checkpoints to thoroughly monitor and inspect every prescription submitted to our Home Delivery Pharmacy facilities. Our comprehensive review includes checks for legibility, evidence of tampering, medication name, directions and quantity. Orders that indicate potential fraud or forgery are electronically sent to a pharmacist for review. The reviewing pharmacist may contact the prescriber or the member to address the issue. An electronic color image of all prescriptions is maintained in the system for historical reference.

We verify the integrity of every item shipped from our facilities by mailing medications in a tamper-evident plastic mailer that requires the destruction of the bag to gain entry. We seal bottles hermetically with aluminum, tamper-proof seals and dual-use caps that allow members to select twist-off or childproof functionality. As an additional layer of security for opioid products, warning labels and special caps are provided to highlight the risks of addiction and abuse.

34. What is your market share in your local market based on membership for 2019, 2020 and 2021?

Proprietary and Confidential

Our local market share, based on membership for 2019, 2020 and 2021, is as follows:

- **2019**: 80,890 members

- **2020**: 92,215 members
- **2021**: 93,487 members

35. What was your Louisiana profit/loss in 2020 and 2021? Please provide your 2020 or 2021 financial report.

Please see the attached file “Exhibit 8: Sierra Audited Financial Statements-2021”

LIST OF EXHIBITS

- Exhibit 1: LA Certificate of Authority
- Exhibit 2: JPG – UHC 01.01.2023 Standard PGs
- Exhibit 3: JPG – UHC Account Management Team Biographies
- Exhibit 4: JPG – UHC 01.01.2023 Implementation Project Plan
- Exhibit 5: JPG – UHC 01.01.2023 MAPD Enhancements and Deviations
- Exhibit 6: JPG – UHC PPO GEO Access Report
- Exhibit 7: JPG – UHC Top 100 Drug Tier Analysis
- Exhibit 8: Sierra Audited Financial Statements-2021

State of Louisiana

UNION JUSTICE AND CONFIDENCE

James J. Donelon

COMMISSIONER OF INSURANCE

CETIFICATE OF AUTHORITY

Whereas, the SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC. located at Nevada has applied for a certificate of authority and made the filings required of such Insurer. Therefore, I, James Donelon, the undersigned Commissioner of Insurance, do hereby certify that the said SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC. is authorized to transact its appropriate business of Health and accident; Life Insurance in this state, in accordance with the laws thereof. This certificate shall remain in effect until cancelled, suspended, revoked or the renewal thereof refused.

In Testimony Whereof, I hereunto subscribe my name, and affix the seal of my office at Baton Rouge this 14th day of February A.D. 2013

James J. Donelon
Commissioner of Insurance

Jefferson Parish County Government

Performance Guarantees

The below performance guarantees (these "Performance Guarantees") are effective for the term of this Agreement provided, however, United may specify to Group new Performance Guarantees upon a subsequent anniversary of the Effective Date . Any new Performance Guarantees must be in writing between the parties and shall supersede and replace these Performance Guarantees. With respect to the aspects of United's performance addressed in this exhibit, these fee adjustments are Group's exclusive financial remedies.

These Performance Guarantees will become effective upon the later of (1) the Effective Date of this Agreement; or (2) the date this Agreement is signed by both parties. In the event these Performance Guarantees become effective later than the Effective Date of this Agreement: (1) quarterly guarantees will become effective beginning with the next calendar quarter following signature of this Agreement by both parties and (2) annual guarantees will become effective commencing with the next anniversary of the Effective Date following the date this Agreement is signed by both parties.

These Performance Guarantees can be modified to the degree necessary to carry out the intent of the parties. United shall not be required to meet any of these Performance Guarantees or amendments thereto to the extent United's failure to meet these Performance Guarantees is due to fire, embargo, strike, war, accident, act of God, acts of terrorism; or United's required compliance with any law, regulation, or governmental agency mandate; or anything beyond United's reasonable control.

Total Fees at Risk for all Medicare Advantage Medical Performance Guarantees		**PREMIUM PLAN: 2% of total employer paid premium annually**
Product		**PPO plan**
Member Phone Service		
Phone service guarantees and standards apply to Member calls made to the customer care center that primarily services Group members.		
Abandonment Rate		
Definition	The percentage of calls queued that abandon (hang up) will be no greater than the percentage set forth.	
Measurement	The percentage of calls queued that abandon (hang up) before being answered by a representative.	3%
▪ Criteria	Standard system tracking reports.	
▪ Level	Group Retiree Medicare Advantage book of business.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Service Level		
Definition	The percentage of answered member calls that are answered within the parameters set forth.	
Measurement	Percentage of calls answered.	80%
	Time answered in seconds, on average.	seconds 30
▪ Criteria	Standard system tracking reports.	
▪ Level	Group Retiree Medicare Advantage book of business.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Claims Operations		
Dollar Accuracy		
Definition	Claims dollars paid accurately will not be less than the designated percent.	
Measurement	Percentage of claims dollars paid accurately.	99%
▪ Criteria	Standard Claims Operations Report. Statistically significant random sample of claims processed is reviewed to determine the percentage of claim processed without payment errors. Measurement: (Sample Claim Dollars Paid - Mispaid) / Sample Claim Dollars Paid.	
▪ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Procedural Accuracy		
Definition	Procedural accuracy rate of not less than the designated percent.	
Measurement	Percentage of claims processed without procedural (i.e. non-financial) errors.	97%
▪ Criteria	Standard Claims Operations Report. Statistically significant random sample of claims processed is reviewed to determine the percentage of claim processed without payment errors.	
▪ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures

Payment Accuracy		
Definition	Claims Payment Accuracy Percentage will not be less than the designated percent.	
Measurement	Percentage of sampled claims paid without errors.	97%
▪ Criteria	Standard Claims Operations Report.	
	(Number of Sampled Claims - Number of Sampled Claims with Financial Defects) / Number of Sampled Claims.	
▪ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Claims Time to Process in 30 calendar days		
Definition	The percentage of all claims United receives will be processed within the designated number of calendar days of receipt.	
Measurement	Percentage of clean claims processed (Par and Non Par Providers, including paid and un paid claims).	95%
	Calendar days after receipt.	30
▪ Criteria	Standard Claims Operations Report.	
▪ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Eligibility File		
Eligibility File Load		
Definition	Member Applications processed within the designated number of calendar days of receipt of properly completed applications.	
Measurement	Percentage of member applications or enrollment files processed within seven (7) calendar days of receipt (must be received by ***12:00 noon EST*** otherwise they are considered received on the following calendar day)	95%
▪ Criteria	Standard system tracking reports; the guarantee is waived for member applications that cannot be processed because they have been not properly completed.	
▪ Level	Customer specific.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Fulfillment - ID Cards		
New Member ID Card Distribution		
Definition	New Member ID Cards will be postmarked within the parameters set forth.	
Measurement	Percentage of new member ID cards mailed within seven (7) calendar days of receiving CMS approval.	99%
▪ Criteria	Calculated on the actual number of new member ID cards mailed within seven (7) calendar days divided by the total number of member applications.	
▪ Level	Customer specific.	
▪ Period	Annual enrollment period.	
Payment Period	Annually.	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Claim Operations - Pharmacy		
Electronic Claim Turnaround Time		
Definition	The number of seconds taken to process all clean electronic pharmacy claims received.	
Measurement	Percentage of claims processed : As measured by the total elapsed time from the point a transaction is received by United's pharmacy system from the dispensing pharmacy until the submitted transaction is adjudicated and appropriate claim payment information is issued.	99%
▪ Criteria	Time to process, not to exceed.	3 seconds
▪ Level	Book of Business (UHCMR).	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Retail Paper Claims Paid in 14 Days (PROMPT PAY DMR CLAIMS)		
Definition	The percentage of all clean pharmacy claims United receives will be processed within the designated number of calendar days of receipt.	
Measurement	Percentage of clean pharmacy claims processed.	99%
▪ Criteria	Time to process, in calendar days or less after receipt of clean claim.	14
▪ Level	Book of Business (UHCMR).	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures

Retail and Mail Order Claim Processing Accuracy		
Definition	Accuracy rate of not less than the designated percent.	
Measurement	Percentage of paper and electronic clean pharmacy drug claims processed accurately and with no errors.	99%
▪ Criteria	Statistically significant random sample of clean pharmacy claims processed is reviewed to determine the percentage of claims processed without errors.	
▪ Level	Book of Business (UHCMR).	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Mail Order Average Dispensing Time - Intervention Required		
Definition	Average dispensing time, for all mail order prescriptions that require administrative or clinical intervention, no greater than as set forth.	
Measurement		100%
	Average dispensing time in business days.	5
▪ Criteria	Average dispensing time is derived by dividing the total whole days to dispense all prescriptions by the total number of prescriptions dispensed, based on the date a prescription order is received and the date the order is shipped. Orders where the prescriber or Participants fails to respond will be excluded.	
▪ Level	Book of Business (UHCMR).	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Mail Order Average Dispensing Time - No Intervention		
Definition	Average dispensing time for all mail order prescriptions that require no administrative or clinical intervention, no greater than as set forth.	
Measurement		100%
	Average dispensing time in business days.	2
▪ Criteria	Average dispensing time is derived by dividing the total whole days to dispense all prescriptions by the total number of prescriptions dispensed, based on the date a prescription order is received and the date the order is shipped.	
▪ Level	Book of Business (UHCMR).	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Mail Order Dispensing Accuracy		
Definition	Mail order dispensing accuracy rating of the guaranteed percentage.	
Measurement	Percentage of prescriptions dispensed accurately.	99.99%
▪ Criteria	External feedback will be collected and tracked from individuals receiving prescriptions for home delivery. This guarantee is conditional upon utilization of United's standard pharmacy management claim processing protocols.	
▪ Level	Book of Business (UHCMR).	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
POS System Availability		
Definition	United guarantees that the pharmacy point of service system will be available a minimum of the displayed percentage of the time, not including scheduled downtime for maintenance, system updates, and telecommunication failures.	
Measurement	Percentage of time the system is available.	99.80%
▪ Criteria	United's internal systems measures.	
▪ Level	Book of Business (UHCMR).	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures

Jo Ann Wetzel

Vice President, Client Development

Jo Ann Wetzel is the Vice President of Client Development at UnitedHealthcare. She works in the Retiree Solutions division specializing in the public sector arena. Working as part of a team of dedicated retiree health care experts, Jo Ann is responsible for preparing financial analyses and setting strategy to deliver the best retiree solutions available in the market.

Jo Ann has over 30 years of experience in the insurance industry and previously held the role of Divisional VP of Municipal Accounts with BCBS of IL. Jo Ann has worked with key, large and national accounts partnering with brokers, consultants and other distribution channels. She brings extensive experience in both new sales and account management. Jo Ann has worked with other large insurance organizations in the commercial group area with companies like Cigna and Kaiser Permanente. She holds a B.S. in Business Administration from Mt. Olive University of NC.

Maureen Schaltegger

Implementation Manager, New Business Implementation

Maureen Schaltegger is an Implementation Manager with UnitedHealthcare Retiree Solutions who specializes in serving the retiree health care needs of employer groups. Working closely with other account management team members, Maureen provides essential expertise and oversight in driving the successful implementation of new employer-group retiree offerings.

Maureen has over 20 years of experience within the healthcare industry, more than 8 years with United Health Group. She has worked with clients of all backgrounds, sizes, and complexities and brings a wealth of knowledge and best practices to her implementations.

Her focus is on building collaborative client relationships, superior customer satisfaction, and delivering successful implementations. Maureen began her career with the UnitedHealthcare Retiree Solutions Implementation team in 2022 and resides in Mount Pleasant, South Carolina.

Key strengths:

- Relationship Building
- Customer-focused
- Solutions Oriented
- Project Management

Contact Information:

- Maureen Schaltegger, Implementation Manager
- Email: Maureen_Schaltegger@UHC.com
- Phone: 815-483-9108

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UnitedHealthcare®

Veronica Reynada

Strategic Account Executive

About Veronica:

Veronica Reynada is a Strategic Account Executive who specializes in ensuring customer satisfaction, and thereby has developed strong and lasting relationships with her clients and broker network.

Veronica joined UnitedHealthcare in in 2010 and has more than24 years experience in the health care industry.

Veronica's book of business is comprised of Public Sector clientele, including a State account. She has maintained a 99% persistency rate.

Veronica resides in Long Beach, CA. Veronica holds licenses for both Life and Health, and is also a certified phlebotomist.

Veronica's Fast Facts:

Key strengths and talents:

- Service-oriented, Possesses strong relationship building skills, Organized, Competitive, Empathetic, Proactive

Previous clients and broker examples:

- Cacique
- CalPERS
- Broker and client territory include range from Los Angeles into Northern California.

Key accomplishments:

- Earned award for key ancillary business sales on over 50% of her small group accounts
- Successfully executed plan to grow membership through conversion of multi-carrier accounts to sole carrier
- Built and sustained customer and broker relationships that span years
- In her spare time, she enjoys kickboxing and interval workouts

Contact Veronica:

P.O. Box 9472
Minneapolis, MN 55440 – 9472
(o) 916.403.0470 (c) 562.607.6169
veronica.reynada@uhc.com

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Lani Pacheco

Client Service Manager

As Client Service Manager, Lani is responsible for managing the overall service experience for group retiree clients. Lani primary focus is supporting the day-to-day relationship with the client to ensure customer satisfaction and is also the liaison between the client and all internal business channels/partners. This includes scheduling and facilitating client meetings and conference calls, ordering member materials, and resolving escalated issues.

Lani joined UnitedHealthcare Retiree Solutions in 2015 as Client Service Manager following her position as Field Service Account Manager at Arizona State Retirement System, a large complex group retiree since 2008, responsibilities includes benefits education and counseling, enrollment, billing and resolved all services including escalated issues within timely and accurately.

Lani brings with her 18 years of experience in insurance and managed care.

Lani resides in Long Beach, Southern CA.

Key strengths:

- Organize
- Learner
- Adaptable
- Timely
- Responsive

Contact Information

- Lani Pacheco, Client Service Manager
- Lani.pacheco@uhc.com
- Office: (952) 406-5300
- Cell: (623) 866-3115

EXHIBIT 4: JPG – UHC 01.01.2023 Implementation Project Plan

Client Name	Product	Expected Lives	Effective Date
Jefferson Parish Government	MAPD	892	1/1/2023

Task	Task Owner	Planned Date	Actual Date	Implementation Comments
New Case Discovery		**9/6/2022**		
Pull/Review Exception Management Tool Executive Summary report	UHC IM	9/6/2022		
Facilitates new case discovery call	UHC IM	9/6/2022		
Implementation Kick-Off		**9/6/2022**		
Schedule internal Kick-Off Meeting	UHC IM	9/8/2022		
Deliver agenda and implementation documents for external kick-off meeting	UHC IM	9/8/2022		
Conduct external kick-off meeting	UHC IM	9/9/2022		
Confirm detailed benefits with the group	UHC Sales	9/9/2022		
Review proposed timeline with group	UHC IM	9/9/2022		
Review Provider Outreach Program	UHC Sales	9/9/2022		
Determine Plan eligibility rules (surviving spouse, pre 65 etc.)	Jefferson Parish	9/9/2022		
Determine subsidy arrangement (100% of premium billed to group, split bill, and/or RRA)	Jefferson Parish	9/9/2022		
Discuss enrollment strategy (electronic enrollment, Telephonic, Paper)	Jefferson Parish	9/9/2022		
Confirm that opt out will be managed by the Jefferson Parish/TPA	Jefferson Parish	9/9/2022		
Discuss group structure requirements (i.e. Subsidy levels, distinctions among the retirees, LIPS, etc.)	Jefferson Parish	9/9/2022		
Advise group of MBI requirements	UHC IM	9/9/2022		
Advise group of permanent address requirements	UHC IM	9/9/2022		
Advise group of Part A & B requirements, if applicable	UHC IM	9/9/2022		
Discuss enrollment fallout strategy (i.e. members not able to be enrolled go back into current plan)	Jefferson Parish	9/9/2022		
High-level overview of Late Enrollment Penalty (LEP)	UHC IM	9/9/2022		
High-level overview of Low Income Premium Subsidy Process (LIPS)	UHC IM	9/9/2022		
High-level overview of Income Related Monthly Adjustment Amounts (IRMAA)	UHC IM	9/9/2022		
Review ESRD rules	UHC IM	9/9/2022		
High-level overview of Historical Claims	UHC IM	9/9/2022		
Offer Open Refill Transfer File / Prior Authorization (ORTF/PA), if applicable	UHC IM	9/9/2022		
Determine Implementation contacts	Jefferson Parish	9/9/2022		
Determine date and time for ongoing weekly implementation meetings	Jefferson Parish	9/9/2022		
Review Data Collection Document with Jefferson Parish	UHC IM	9/9/2022		
Claims and Benefit Set-Up		**9/12/2022**		
Jefferson Parish approves & signs off Data Collection Document	Jefferson Parish	9/14/2022		
Request Group Number(s)	UHC IM	9/15/2022		
Create & Share Group Reference document	UHC IM	9/23/2022		
Conduct Walkthrough & Custom Contact Data, if applicable	UHC IM	9/19/2022		
Confirm Group Set-Up in GPS	UHC IM	9/30/2022		
Communication Strategy		**9/6/2022**		
Confirm Open Enrollment Period	Jefferson Parish	9/9/2022		
Discuss communication needs & Determine if Jefferson Parishwill be sending additional enrollment materials	Jefferson Parish	9/9/2022		
Discuss termination letter that will be sent by the previous carrier and potential options to appropriately mitigate	UHC IM	9/9/2022		

Depending on agreement and outcome of above, either Add previous plan termination language into the Announcement letter OR Add previous carrier's termination letter mail date and a brief explanation of the letter into the Announcement letter	UHC IM	9/9/2022		
Present Group Pre-Enrollment Website	UHC IM	9/16/2022		
Prepare Custom Contact Data for Taft Hartley TFN	UHC IM	9/14/2022		
Announcement Letter		**9/14/2022**		
Review sample announcement letter with Jefferson Parish	UHC IM	9/9/2022		
Group provides revised announcement letter to UHC	Jefferson Parish	9/15/2022		
Submit announcement letter to Regulatory/Legal, if applicable	UHC Marketing	9/15/2022		
Receive and provide group with updated announcement letter feedback including legal feedback	UHC Legal and Regulatory	9/23/2022		
Group approves announcement letter	Jefferson Parish	9/28/2022		
Group mails announcement letter	Jefferson Parish	10/10/2022		
Confirm announcement letter was mailed & provide copy of final letter to UHC	Jefferson Parish	10/11/2022		
Plan Guides (Pre-Enrollment)		**9/9/2022**		
Provide sample of Plan Guides to group	UHC IM	9/9/2022		
Provide Plan Guide Roster File Template to Jefferson Parish	UHC IM	9/9/2022		
Jefferson Parish provides Roster File to UHC	Jefferson Parish	9/14/2022		
Determine in-hand date for Plan Guides	UHC/Jefferson Parish	9/9/2022		
Place order in fulfillment portal	UHC IM	9/23/2022		
Audit plan guide	UHC IM	10/10/2022		
Plan Guides arrive in home	UHC IM	10/24/2022		
Virtual Education Center				
High-level overview of the VEC	UHC SAE	9/9/2022		
Pre-Enrollment Call Center		**9/14/2022**		
Create Call Center Tool Kit	UHC IM	9/15/2022		
Submit final new sales Toolkit, final announcement letter, current benefit summary, roster and more to Pre-Enrollment intake team	UHC IM	10/3/2022		
Load document to call center tool SharePoint	UHC Pre Call Center	10/3/2022		
Launch Call Center	UHC Pre Call Center	10/10/2022		
Confirm change from Pre to Post Call Center	Center/UHC Post Call Center	11/16/2022		
Post-Enrollment Call Center		**10/24/2022**		
Confirm how the following are handled: Permanent Address changes, temporary address changes, mailing address changes, telephone number changes, email changes, disenrollments, reinstatements and termination changes.	UHC Post Call Center	10/24/2022		
Identify if the Employer Group, Union, or Third Party Admin is in or out of scope for ADP Calls (Outbound calls for pending apps due to missing information)	UHC Post Call Center	10/24/2022		
Ensure all Customer Service Exception Management Tool Requests http://emt.uhg.com requests are captured and included within post enrollment resources and training.	UHC Post Call Center	10/24/2022		
Open Enrollment Meetings		**9/7/2022**		
Determine Open Enrollment strategy (in-person and/or virtual)	UHC SAE/Jefferson Parish	9/9/2022		
Determine date and time(s) of Open Enrollment meeting, if applicable	UHC SAE/Jefferson Parish	9/14/2022		
Determine location(s) of Open Enrollment meetings	UHC SAE/Jefferson Parish	9/14/2022		
Jefferson Parish approves OE Meeting(s) locations, date and times	Jefferson Parish	9/23/2022		
Provide locations and/or telephonic information to include in announcement letter	UHC CSM	9/23/2022		
Enter meetings in Salesforce	UHC CSM	9/23/2022		
Determine staffing needs	UHC CSM	9/23/2022		

Train open enrollment staff, if applicable	UHC CSM	10/12/2022		
Order materials/give-a-ways for Open Enrollment meeting, if applicable	UHC CSM	9/23/2022		
Engage marketing team for Brainshark, if applicable	UHC SAE	9/9/2022		
Submit retiree presentation/Brainshark to group for approval, if applicable	UHC SAE	10/12/2022		
Group reviews and provides feedback on presentation	Jefferson Parish	10/14/2022		
Updated presentation submitted to group for final approval	UHC SAE	10/18/2022		
Jefferson Parish approves final presentation	Jefferson Parish	10/24/2022		
Record Brainshark, if applicable	UHC SAE	10/24/2022		
Conduct Retiree Education / Information Meetings	UHC CSM	10/26/2022		
Review feedback from meetings	UHC SAE	11/5/2022		
Age-In Process		**11/14/2022**		
Determine and document age-in process	UHC SAE	11/17/2022		
Meet with Jefferson Parish to discuss process	UHC IM	11/17/2022		
Determine if Jefferson Parish is attesting for LEP post-effective date	UHC CSM	11/22/2022		
Determine age-in materials	UHC SAE	11/22/2022		
Determine file transmission method for on-going age-ins	UHC SAE	11/22/2022		
Late Enrollment Penalty (LEP)				
Identify LEP payment responsibility (Employer or Member)	UHC IM	9/9/2022		
Determine if Employer Group is attesting pre-effective date with letter suppression	UHC IM	9/14/2022		
Determine if Employer Group is attesting post-effective date with no letter suppression	UHC IM	9/14/2022		
Review employer creditable coverage attestation, file layout, and xTool steps to group	UHC IM	9/14/2022		
Group provides completed LEP xTool file and signed attestation	Jefferson Parish	11/1/2022		
Submit completed LEP xTool File to Operations	UHC IM	11/1/2022		
Confirm LEP letter suppression completed	UHC IM	11/8/2022		
Remind group of LEP letter that will be going out and what the members will experience	UHC IM	11/1/2022		
Low-Income Premium Subsidy (LIPS)				
Advise group on LIPS refund recipient options based on subsidy levels.	UHC IM	9/9/2022		
Review LIPS Attestation Form with group, if applicable	UHC IM	9/9/2022		
Group provides completed LIPS Attestation Form, if applicable	Jefferson Parish	11/1/2022		
Submit completed / signed LIPS Attestation Form to Operations, if applicable	UHC IM	11/1/2022		
Request for LIPS report submitted to Operations for groups electing to receive monthly report, if requested	UHC CSM	11/1/2022		
Income Related Monthly Adjustment Amount (IRMAA)				
Review/Confirm understanding of IRMAA	UHC IM	9/9/2022		
ESRD - End Stage Renal Disease				
Advise on the 30-month coordination period for members diagnosed with ESRD	UHC IM/DA	9/9/2022		
Eligibility EEMS Setup		**9/14/2022**		
Complete initial high-level Electronic Eligibility Management System (EEMS) review with Jefferson Parish	UHC DA	9/14/2022		
Advise and share letter on phone number and email importance	UHC CSM	9/14/2022		
CMS Overview Presentation w/ Employer/TPA (EEA will present to Jefferson Parish) - CMS 101 or CMS 201 (CMS 201 to be used as a refreshed for groups that are familiar with Medicare Advantage)	UHC EEA	9/21/2022		
Determine targeted production file load date	UHC IM	9/14/2022		
Complete detailed EEMS review, eligibility file layout and Deployment "Eligibility Guide" with Jefferson Parish	UHC DA	9/14/2022		
Review File companion guide	UHC DA	9/14/2022		
Electronic Eligibility Questionnaire and Electronic Communication Gateway Questionnaire (ECG) presented to group and sent out	UHC DA	9/14/2022		
Group Structure document provided to Jefferson Parish "Help Sheet"	UHC DA	9/21/2022		

Electronic Communication Gateway (ECG) completed and returned to UHC	Jefferson Parish	9/21/2022		
Electronic Eligibility Questionnaire completed and returned to UHC	Jefferson Parish	9/21/2022		
(FTP) File connection setup completed	UHC DA	10/5/2022		
Send FTP File for connection and file format testing	Jefferson Parish	10/5/2022		
Confirm receipt of FTP connections and file format testing (dummy data)	UHC DA	10/6/2022		
Start end-to-end test scenarios	UHC/Jefferson Parish	10/5/2022		
Complete end-to-end test scenarios	UHC/Jefferson Parish	10/12/2022		
Groups sends Medicare comparison file with live production data (SMS/BEQ)	UHC/Jefferson Parish	10/12/2022		
Review Medicare comparison file results with Jefferson Parish (Rx COB, missing MBI, PO addresses, missing Part B)	UHC DA	10/14/2022		
Determine missing information campaign	UHC/Jefferson Parish	10/19/2022		
Review of standard production reporting with Jefferson Parish	UHC DA	10/26/2022		
Confirm reporting setup	UHC DA	11/2/2022		
Review eService reporting with Jefferson Parish's live data	UHC DA	11/16/2022		
Review plan for enrollment reconciliation file	UHC DA/EEA	11/22/2022		
Determine day for the reconciliation file and report to be delivered to Jefferson Parish	UHC DA/EEA	11/22/2022		
Discuss reasons for fall out and options to manage retirees that do not get enrolled	UHC SAE/Jefferson Parish	10/12/2022		
Jefferson Parish determines how the fallout process will be managed	Jefferson Parish	10/19/2022		
Enrollment / Eligibility File		**10/26/2022**		
Track Opt-outs, if applicable	Jefferson Parish	10/26/2022		
Remove Opt-outs from final enrollment file, if applicable	Jefferson Parish	11/4/2022		
Send final enrollment production file to UHC	Jefferson Parish	11/7/2022		
Review file for accurate information and file format and load file	UHC DA	11/8/2022		
Advise group of applications rejected/pending due to missing information	UHC EEA	11/9/2022		
Jefferson Parish reaches out to members to resolve missing information/report back to UHC	Jefferson Parish	11/10/2022		
Receive updated production file if needed from group	UHC DA	11/10/2022		
Perform additional Medicare bump if necessary	UHC DA	11/10/2022		
Members enrolled	UHC EEA	11/14/2022		
Monitor enrollments until all expected retirees are enrolled	UHC IM/EEA	Ongoing		
Transition Jefferson Parish from DA to EEA	UHC DA/EEA	11/30/2022		
Review Jefferson Parish specific Medicare and retiree file Policies & Procedures document	UHC DA	11/30/2022		
Refresher review of the standard production reporting with group once reports are produced	UHC EEA	11/14/2022		
Contract		**9/16/2022**		
Send Data Collection document to contracting team	UHC IM	9/16/2022		
Submit draft contract/billing agreement to group	UHC SAE	9/21/2022		
Submit group requested changes to legal team, if applicable	UHC SAE	10/5/2022		
Group signs original copy and send contract to UHC	Jefferson Parish	11/1/2022		
Confirm UHC signed contract and send contract to Jefferson Parish	UHC SAE	11/17/2022		
File Transfers		**9/12/2022**		
Enter file transfer tracker information into Teams	UHC IM	9/12/2022		
Hold alignment meeting with Jefferson Parish and prior carrier(s) to review all data requests and secure commitment to provide, including file layout, look back period, contact, NDA, timing and method of delivery	UHC/Jefferson Parish	9/21/2022		
Add case information to the URS File Transfer Tracker via TEAMS , attach new case discovery form	UHC IM	9/22/2022		
Provider Outreach Program		**9/19/2022**		
SAE requests provider data from prior carrier	UHC SAE	9/19/2022		

Group provides provider data for outreach program	Jefferson Parish	9/26/2022		
Provider outreach complete	UHC SAE	11/1/2022		
Communicate provider outreach results provided to Jefferson Parish	UHC SAE	11/1/2022		
Open Refill Transfer File / Prior Authorizations (ORTF/PA) / Member Crosswalk Files		**9/21/2022**		
Confirm agreement from Jefferson Parish that they would like to move forward with ORTF/PA process	Jefferson Parish	9/21/2022		
Complete ORTF/PA Channels in URS File Transfer Tracker via TEAMS	UHC IM	9/22/2022		
Provide previous carriers PBM contact information to UHC	Jefferson Parish	9/26/2022		
PBM provides ORTF Grid to UHC IM to attach to the ORTF Channel	PBM/Jefferson Parish	10/10/2022		
Incumbent PBM provides Member Crosswalk to map files together	Current PBM	11/1/2022		
ORTF test file is sent to UHC	PBM/Jefferson Parish	11/15/2022		
ORTF production file provided to UHC	PBM/Jefferson Parish	1/2/2023		
Confirm ORTF Files were loaded	UHC IM	1/9/2023		
ORTF Lag member list provided to UHC	PBM/Jefferson Parish	1/16/2023		
Welcome letters sent to retirees (ORTF)	UHC	1/27/2023		
PA production file sent to UHC	PBM/Jefferson Parish	11/1/2022		
Confirm PA Files were loaded	UHC IM	11/7/2022		
PA Lag file provided to UHC	PBM/Jefferson Parish	1/16/2023		
Historical Claims / Sending or receiving Rx Data		**9/15/2022**		
Schedule meeting with Optum Clinical, Housecalls, OptumRx teams to discuss current carrier call(s)	UHC IM	9/15/2022		
Optum to assign a Business Analyst to case	Optum Sr Client Mgr	9/19/2022		
Historical Claims Data presentation for Jefferson Parish (MA Only: Ongoing monthly PDP files required; PDP Only: Send ongoing monthly PDP files required)	UHC IM	9/21/2022		
Jefferson Parish confirms approval of historical claims data from prior carrier	Jefferson Parish	9/26/2022		
Jefferson Parish provides current carrier contact information	Jefferson Parish	9/26/2022		
Jefferson Parish contacts current carrier to inform them of the data request	Jefferson Parish	9/26/2022		
Complete Med CHF & Rx CHF Channels in URS File Transfer Tracker via TEAMS	UHC IM	9/22/2022		
Complete file connection setup - QuickConnect or FTP	UHC IM	9/22/2022		
Send test file: Historical Claims	Jefferson Parish	10/3/2022		
Review test file results: Historical Claims	UHC IM	10/3/2022		
Send production file to UHC: Historical Claims	Jefferson Parish	11/9/2022		
Send lag production file to UHC: Historical Claims	Jefferson Parish	1/31/2023		
ID Card and Quick Start Guide		**10/24/2022**		
Present ID Card and Quick Start Guide to Jefferson Parish for review	UCM IM	12/1/2022		
ID Card Audit	UHC IM/CSM	9/21/2022		
ID Card and Quick Start Guide generated as retirees enroll and CMS approval	UHC Fulfillment Materials Team	12/2/2022		
Confirm ID Card and Quick Start Guide mailed	UHC IM	12/5/2022		
Member Communication Bundles		**11/1/2022**		
Educate Jefferson Parish on ongoing member communication bundles	UHC CSM	11/1/2022		
Billing		**11/2/2022**		
Conduct billing meeting to review process with the group and introduce Billing Analyst (BA)	UHC Billing Analyst	11/2/2022		
Review sample billing invoice	UHC Billing Analyst	11/2/2022		
For ACH groups have Analyst provide routing info	UHC Billing Analyst	11/2/2022		
Advise group when to expect 1st invoice	UHC Billing Analyst	11/2/2022		
Group returns completed Excel billing set up document	UHC Billing Analyst	11/7/2022		
If Group would like to review bills in eServices, set up group in eServices	UHC Billing Analyst	11/2/2022		

Confirm Group has received eServices access - test access and demonstrate tutorial	UHC Billing Analyst	11/7/2022		
Phone Number and Email Member Acquisition		**11/28/2022**		
Remind Jefferson Parish that letters will be mailed for this in first quarter and review of results will occur shortly after	UHC CSM	11/28/2022		
Closure / Transition to AMT				
Provide one-pager contact information to Jefferson Parish	UHC AMT	12/7/2022		
Provide case transition checklist to AMT	UHC IM	1/16/2023		
Enter Business Rules into Phoenix	UHC CSM	2/1/2023		
Schedule external transition meeting with group and AMT	UHC IM	2/1/2023		
Transition meeting with group	UHC and Jefferson Parish	2/8/2023		

UnitedHealthcare Group Medicare Advantage (PPO)

Plan Variance/Enhancement Report

Jefferson Parish County Government

MAPD Plan 1

1/ 1/2023 - 12/31/2023

Plan Deviations

Current/Requested Benefit	Proposed Benefit	Assumption/Deviation
Deviation 1		
Humana COVID-19 benefits $0 copay for testing and treatment services for COVID-19. MOOP does not apply.	Federal Guidelines Apply. $0 copay for testing. Treatment cost share varies by place of service. MOOP applies.	Covered per CMS (Medicare) guidelines.

Medical Coverage

Benefit Name			In Network Services	Out of Network Services
Current/Requested Benefit	**Proposed Benefit**	**Proposed Variance or Enhancement**		
Physician Services				
Telemedicine			$0	$0
Telehealth services: PCP $0 copay, Specialist $20 copay, Urgent Care $0, Substance Abuse/Behavioral Health $0 copay.	All telehealth services cost share $0 regardless of place of service.	Benefit administration different from requested		
Outpatient Services				
Outpatient Surgery			$0	$0
Outpatient hospitals visit copay is $0 to $100 or 20% copay. Ambulatory surgical center is $75 copay.	Outpatient surgery $0 cost share. This would be the same for the Ambulatory surgical center cost share amount.	Benefit administration different from requested		
Outpatient Hospital Services			$0	$0
Outpatient hospitals visit copay is $0 to $100 or 20% copay. Ambulatory surgical center is $75 copay.	Outpatient hospital service cost share is $0.	Benefit administration different from requested		
Outpatient Mental Health/Substance Abuse - Individual Visit			$20	$20
Outpatient group and individual mental health and substance abuse treatment visits are $5 to $40 copay.	Individual Outpatient mental health/substance abuse treatment visits are $20 copay to follow specialist copay.	Benefit administration different from requested		
Outpatient Mental Health/Substance Abuse - Group Visit			$5	$5
Outpatient group and individual mental health and substance abuse treatment visits are $5 to $40 copay.	Group Outpatient mental health/substance abuse treatment visits are $5 copay to follow PCP copay.	Benefit administration different from requested		
Partial Hospitalization (Mental Health Day Treatment) per day			$55	$55
Benefit cost share not provided.	Partial hospitalization (mental health day treatment) per day cost share $55.	CMS/UHC cost share applied based on benefit plan structure.		
Comprehensive Outpatient Rehabilitation Facility (CORF)			$20	$20
Benefit cost share not provided.	Comprehensive OP Rehab Facility cost share $0.	CMS/UHC cost share applied based on benefit plan structure.		

Benefit Name	Current/Requested Benefit	Proposed Benefit	Proposed Variance or Enhancement	In Network Services	Out of Network Services
Occupational Therapy				$20	$20
	OT and ST copay is $20 to $40.	OT cost share $20.	Benefit administration different from requested		
Physical Therapy and Speech/Language Therapy				$20	$20
	PT and ST copay is $20 to $40.	PT and ST cost share is $20.	Benefit administration different from requested		
Cardiac/Intensive Cardiac/Pulmonary Rehabilitation/SET				$20	$20
	Cardiac Rehabilitation is a $20 to $40 copay. Pulmonary Rehabilitation is a $20 to $30 copay.	Cardiac Rehabilitation Cost Share $20. This copay amount would also apply to Intensive Cardiac Rehab, Pulmonary Rehab, and SET services.	Benefit administration different from requested		
Kidney Dialysis				$0	$0
	Renal dialysis is a $0 copay or 20% coinsurance.	Kidney dialysis cost share $0.	Benefit administration different from requested		
Medicare Covered Services					
Eye Exam				$0	$0
	Medicare-covered vision services $20 copay and Medicare-covered diabetic eye exam is $0.	Medicare-covered eye exam cost share $0.	Benefit administration different from requested		
Ambulance/Emergency Room/Urgent Care					
Urgent Care (Includes Worldwide Coverage)				$5	$5
	Urgently needed services copay is $5 to $20.	Urgently needed care cost share $5.	Benefit administration different from requested		
Part B Drugs And Blood					
Part B Chemotherapy Drugs				20%	20%
	Chemotherapy drug cost share not provided.	Chemotherapy drug cost share 20% coinsurance.	CMS/UHC cost share applied based on benefit plan structure.		
Blood (3 pint deductible waived)				$0	$0
	Blood cost share not provided.	Blood cost share $0.	CMS/UHC cost share applied based on benefit plan structure.		
Procedures					
Outpatient X-ray Services				$0	$0
	OP X-rays $0 to $20 copay	OP X-ray services cost share $0.	Benefit administration different from requested		
Diagnostic Procedure/Test (includes non-radiological diagnostic services)				$0	$0
	Diagnostic Tests and Procedures $0 to $20 copay.	Diagnostic Procedure/Test cost share $0.	Benefit administration different from requested		
Diagnostic Radiology Service				$0	$0
	Diagnostic Radiology $0 to $50 copay.	Diagnostic Radiology cost share $0.	Benefit administration different from requested		
Therapeutic Radiology Service				$0	$0
	Radiation Therapy is $0 to $20 copay.	Radiation Therapy cost share $0.	Benefit administration different from requested		

Additional Benefits/Non-Medicare Covered Services			In Network Services	Out of Network Services
Current/Requested Benefit	**Proposed Benefit**	**Proposed Variance or Enhancement**		
Routine Podiatry				
Routine Podiatry - Number of visits per year			6 Visits	
Routine podiatry not covered.	Routine podiatry rider included.	Standard Rider Applied - 6 visits per year, Specialist cost share applies		
Routine Vision				
Routine Eye Exam Refraction - Every 12 months			$0	$0
$15 copay for annual exam, $200 for eyeglasses 1 per year, $120 for premium progressive lenses 1 per year, $0 copay for eyeglasses-lenses 1 per year, $0 copay for contact lenses 1 per year.	$0 annual eye exam; $400 annual allowance for eyeglass frames and lens or contact lenses.	Benefit administration different from requested		
Routine Hearing				
Routine Hearing Aid - Allowance Per Ear or Combined			Combined	N/A
$699 copay for each Advanced level hearing aid up to 1 per ear per year; $999 copay for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty.	Combined $1000 annual allowance. UHC Hearing does include a 1 year supply with each new device sale.	Benefit administration different from requested		
Routine Dental				
Dental Plan Type			Standard Plan 3	Standard Plan 3
0% for preventative services; 50% of the cost for amalgam and/or composite filling 2 per year; $1000 maximum benefit coverage amount per year for preventive and comprehensive benefits.	100%/80%/50%; $50 deductible exclude preventative; $1000 max allowance	Routine Dental: Standard UHC plan included.		
Wellness/Clinical Programs				
Fitness Program			Included	
SilverSneakers Fitness vendor used.	Renew Active is the embedded Fitness Vendor.	Benefit administration different from requested		

UnitedHealthcare Group Medicare Advantage (PPO)

Plan Variance/Enhancement Report

Jefferson Parish County Government

MAPD Plan 2 1/ 1/2023 - 12/31/2023

Plan Deviations

Current/Requested Benefit	Proposed Benefit	Assumption/Deviation
Deviation 1		
Current plan design is an HMO-POS with higher cost shares for out-of-network benefits.	Proposed plan design is a non-differential PPO; matched in-network benefits.	Plan design is our National PPO with Non-Differential benefits In Network and Out-of-Network. Plan covers Medicare eligible members only.
Deviation 2		
Current benefits cover 12 sessions of respite care each year up to 4 hours per session for members diagnosed with dementia.	Proposed benefits to cover 8 hours per month of non-skilled care services (respite and homemaker/personal care) for all plan members. Hours do not roll over.	Benefit administration different from requested

Medical Coverage

Benefit Name			In Network Services	Out of Network Services
Current/Requested Benefit	**Proposed Benefit**	**Proposed Variance or Enhancement**		
Medicare Covered Services				
Chiropractic Visit			$10	$10
Current benefits state the Medicare-covered acupuncture cost shares vary depending on the provider.	Proposed benefits have a $10 copay for Medicare-covered acupuncture services.	Benefit administration different from requested		
Ambulance/Emergency Room/Urgent Care				
Emergency Room (includes Worldwide coverage)			$50	$50
Current benefits do not apply the MOOP to ER services provided outside the United States.	Proposed benefits apply the MOOP to all ER services regardless of where the service takes place.	Benefit administration different from requested		
Current benefits do not apply the MOOP to Urgent Care services provided outside the United States.	Proposed benefits apply the MOOP to all Urgent Care services regardless of where the service takes place.	Benefit administration different from requested		

Additional Benefits/Non-Medicare Covered Services			In Network Services	Out of Network Services
Current/Requested Benefit	**Proposed Benefit**	**Proposed Variance or Enhancement**		
Routine Podiatry				
Routine Podiatry - Number of visits per year				6 Visits
Routine podiatry benefit not provided.	Routine Eye Exam benefit applied; annual visit at specialist cost share.	Standard Rider Applied - 6 visits per year, Specialist cost share applies		
Routine Vision				
Vision Hardware - Benefit Period				Every 12 Months
Routine eye exam $15 copay.	Routine eye exam every 12 months; $0 copay. $400 allowance for eyeglasses instead of contacts or $400 allowance for contacts instead of eyeglasses every year.	Benefit administration different from requested		

Additional Benefits/Non-Medicare Covered Services			In Network Services	Out of Network Services
Current/Requested Benefit	**Proposed Benefit**	**Proposed Variance or Enhancement**		
Routine Hearing				
Routine Hearing Exam - Benefit Period				1 Year
Routine hearing exam benefit not provided.	Routine hearing exam benefit applied; $0 annual visit.	Standard Rider Applied - $0 annual visit.		
Routine Hearing Aid - Device Allowance			$500	N/A
Routine hearing aid benefit not provided.	Routine hearing aid benefit applied; $500 allowance for unlimited hearing aids.	Standard Rider Applied - $500 allowance for unlimited hearing aids, both ears combined, every 36 months.		
Routine Dental				
Dental Plan Type			Standard Plan 5	Standard Plan 5
Current benefits include: $2,500 annual maximum, $50 deductible, $0 for preventive, and varying copays for minor and major services.	Proposed benefits include: $1500 annual maximum, $50 deductible, 100% for preventive, 80% for minor and 50% for major services.	Routine Dental: Standard UHC plan included.		

UnitedHealthcare®

Network Analysis

Medicare & Retirement PPO Network

Jefferson Parish Government

August 8, 2022

Access Group Summary By Employee Group

August 8, 2022

Access Analysis
Standard

Employee / Provider Groups
All Employees
All PCPs
Specialist
Acute Care Hospitals

Employees With and Without Access								
Employee		Provider		Counts	With Access		Without Access	
Group	#	Group	Standard	#	#	%	#	%
All Employees	892	All PCPs	2 in 10 miles	1,150,985	886	99.3	6	0.7
		Specialist	2 in 10 miles	2,131,812	888	99.6	4	0.4
		Acute Care Hospitals	1 in 10 miles	4,327	807	90.5	85	9.5

Access Summary By City

August 8, 2022

Access Analysis
Standard

Employee Group
All Employees

Provider Group
All PCPs

[1] Provider counts represent:
#: Provider access points
P: Unique providers
L: Unique provider locations

Employees With and Without Access

Employee		Provider		With Access		Without Access		Counts[1]			Average Distance	
Group	#	Group	Standard	#	%	#	%	#	P	L	1	2
All Employees	892	All PCPs	2 in 10 miles	886	99.3	6	0.7	1,150,985	300,791	127,165	0.9	1.0

Key Geographic Areas

State Abbr	City	Employee	Provider		With Access		Without Access		Counts[1]	Average Distance	
		#	Group	Standard	#	%	#	%	#	1	2
LA	Metairie	181	All PCPs	2 in 10 miles	181	100.0	0	0.0	547	0.4	0.4
	Marrero	152	All PCPs	2 in 10 miles	152	100.0	0	0.0	200	0.7	0.7
	New Orleans	108	All PCPs	2 in 10 miles	108	100.0	0	0.0	1,491	0.5	0.6
	Kenner	69	All PCPs	2 in 10 miles	69	100.0	0	0.0	152	0.4	0.4
	Gretna	60	All PCPs	2 in 10 miles	60	100.0	0	0.0	103	0.3	0.4
	Westwego	54	All PCPs	2 in 10 miles	54	100.0	0	0.0	24	0.6	0.6
	Harvey	41	All PCPs	2 in 10 miles	41	100.0	0	0.0	22	0.9	0.9
	Covington	39	All PCPs	2 in 10 miles	39	100.0	0	0.0	257	1.7	2.0
	Mandeville	21	All PCPs	2 in 10 miles	21	100.0	0	0.0	38	1.0	1.0
	Ponchatoula	13	All PCPs	2 in 10 miles	13	100.0	0	0.0	14	2.5	2.8
	Bush	12	All PCPs	2 in 10 miles	9	75.0	3	25.0	0	8.6	9.1
	LA Place	10	All PCPs	2 in 10 miles	10	100.0	0	0.0	33	1.1	1.1
	Franklinton	7	All PCPs	2 in 10 miles	6	85.7	1	14.3	20	2.0	2.6
	Madisonville	6	All PCPs	2 in 10 miles	6	100.0	0	0.0	6	1.6	1.6
	Slidell	6	All PCPs	2 in 10 miles	6	100.0	0	0.0	184	0.4	0.4
	Kentwood	5	All PCPs	2 in 10 miles	5	100.0	0	0.0	3	4.4	4.5
	Lafitte	5	All PCPs	2 in 10 miles	5	100.0	0	0.0	5	1.5	1.5
MS	Bay Saint Louis	5	All PCPs	2 in 10 miles	5	100.0	0	0.0	79	0.7	0.8
LA	Belle Chasse	4	All PCPs	2 in 10 miles	4	100.0	0	0.0	16	2.5	2.9
	Folsom	4	All PCPs	2 in 10 miles	4	100.0	0	0.0	3	3.3	3.3
	Gonzales	4	All PCPs	2 in 10 miles	4	100.0	0	0.0	124	0.8	1.0
	Thibodaux	4	All PCPs	2 in 10 miles	4	100.0	0	0.0	84	1.4	1.4
	Baton Rouge	3	All PCPs	2 in 10 miles	3	100.0	0	0.0	1,335	0.7	0.8
	Destrehan	3	All PCPs	2 in 10 miles	3	100.0	0	0.0	8	0.8	0.8
	Gramercy	3	All PCPs	2 in 10 miles	3	100.0	0	0.0	9	0.3	0.3
	Hammond	3	All PCPs	2 in 10 miles	3	100.0	0	0.0	166	1.1	1.3
	Independence	3	All PCPs	2 in 10 miles	3	100.0	0	0.0	7	3.7	3.7
	Loranger	3	All PCPs	2 in 10 miles	3	100.0	0	0.0	4	3.5	3.5
	Luling	3	All PCPs	2 in 10 miles	3	100.0	0	0.0	35	0.9	0.9
	Saint Rose	3	All PCPs	2 in 10 miles	3	100.0	0	0.0	13	0.9	0.9
MS	Picayune	3	All PCPs	2 in 10 miles	3	100.0	0	0.0	53	2.4	2.4
AZ	Phoenix	2	All PCPs	2 in 10 miles	2	100.0	0	0.0	7,319	0.7	0.7
LA	Abita Springs	2	All PCPs	2 in 10 miles	2	100.0	0	0.0	1	1.2	3.4
	Bogalusa	2	All PCPs	2 in 10 miles	2	100.0	0	0.0	113	0.4	0.4
	Husser	2	All PCPs	2 in 10 miles	2	100.0	0	0.0	0	5.1	5.1

Access Detail By Zip Code

August 8, 2022

Access Analysis
Standard

Employee / Provider Groups
All Employees
All PCPs

Employees With Access										
State Abbr	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
			#	Group	Standard	#	#	%	1	2
AL	Brownsboro	35741	1	All PCPs	2 in 10 miles	3	1	100.0	1.5	1.6
	Mobile	36619	1	All PCPs	2 in 10 miles	38	1	100.0	0.4	1.3
AZ	Phoenix	85028	2	All PCPs	2 in 10 miles	67	2	100.0	0.7	0.7
CA	Alpine	91901	1	All PCPs	2 in 10 miles	17	1	100.0	0.1	0.1
	Long Beach	90802	1	All PCPs	2 in 10 miles	7	1	100.0	0.2	0.2
CO	Parker	80138	1	All PCPs	2 in 10 miles	345	1	100.0	2.3	2.3
FL	Cantonment	32533	1	All PCPs	2 in 10 miles	29	1	100.0	0.7	0.7
	Miami	33185	1	All PCPs	2 in 10 miles	3	1	100.0	1.0	1.0
	Panama City	32404	1	All PCPs	2 in 10 miles	9	1	100.0	1.4	1.4
LA	Abita Springs	70420	2	All PCPs	2 in 10 miles	1	2	100.0	1.2	3.4
	Addis	70710	1	All PCPs	2 in 10 miles	0	1	100.0	2.9	2.9
	Barataria	70036	1	All PCPs	2 in 10 miles	0	1	100.0	2.2	2.2
	Baton Rouge	70810	2	All PCPs	2 in 10 miles	60	2	100.0	0.6	0.7
		70817	1	All PCPs	2 in 10 miles	99	1	100.0	1.0	1.0
	Belle Chasse	70037	4	All PCPs	2 in 10 miles	16	4	100.0	2.5	2.9
	Bogalusa	70427	2	All PCPs	2 in 10 miles	113	2	100.0	0.4	0.4
	Bush	70431	12	All PCPs	2 in 10 miles	0	9	75.0	8.2	8.6
	Covington	70433	26	All PCPs	2 in 10 miles	256	26	100.0	0.5	0.6
		70435	13	All PCPs	2 in 10 miles	1	13	100.0	4.1	4.8
	Cut Off	70345	1	All PCPs	2 in 10 miles	4	1	100.0	1.0	1.4
	Denham Springs	70726	1	All PCPs	2 in 10 miles	56	1	100.0	1.7	1.7
	Destrehan	70047	3	All PCPs	2 in 10 miles	8	3	100.0	0.8	0.8
	Folsom	70437	4	All PCPs	2 in 10 miles	3	4	100.0	3.3	3.3
	Franklinton	70438	7	All PCPs	2 in 10 miles	20	6	85.7	1.2	1.3
	Gonzales	70737	4	All PCPs	2 in 10 miles	124	4	100.0	0.8	1.0
	Gramercy	70052	3	All PCPs	2 in 10 miles	9	3	100.0	0.3	0.3
	Gretna	70053	24	All PCPs	2 in 10 miles	25	24	100.0	0.4	0.4
		70054	2	All PCPs	2 in 10 miles	0	2	100.0	0.2	0.3
		70056	34	All PCPs	2 in 10 miles	78	34	100.0	0.3	0.4
	Hammond	70403	3	All PCPs	2 in 10 miles	160	3	100.0	1.1	1.3
	Harvey	70058	41	All PCPs	2 in 10 miles	22	41	100.0	0.9	0.9
	Houma	70364	1	All PCPs	2 in 10 miles	1	1	100.0	2.3	2.7
	Husser	70442	2	All PCPs	2 in 10 miles	0	2	100.0	5.1	5.1
	Independence	70443	3	All PCPs	2 in 10 miles	7	3	100.0	3.7	3.7
	Kenner	70062	15	All PCPs	2 in 10 miles	15	15	100.0	0.7	0.7
		70065	54	All PCPs	2 in 10 miles	137	54	100.0	0.3	0.3
	Kentwood	70444	5	All PCPs	2 in 10 miles	3	5	100.0	4.4	4.5
	LA Place	70068	10	All PCPs	2 in 10 miles	33	10	100.0	1.1	1.1
	Lafayette	70508	1	All PCPs	2 in 10 miles	222	1	100.0	0.4	0.4
	Lafitte	70067	5	All PCPs	2 in 10 miles	5	5	100.0	1.5	1.5

Continued on next page...

Access Detail By Zip Code

August 8, 2022

Access Analysis
Standard

Employee / Provider Groups
All Employees
All PCPs

Employees With Access										
State Abbr	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
			#	Group	Standard	#	#	%	1	2
LA	Lockport	70374	1	All PCPs	2 in 10 miles	2	1	100.0	0.8	0.9
	Loranger	70446	3	All PCPs	2 in 10 miles	4	3	100.0	3.5	3.5
	Luling	70070	3	All PCPs	2 in 10 miles	35	3	100.0	0.9	0.9
	Madisonville	70447	6	All PCPs	2 in 10 miles	6	6	100.0	1.6	1.6
	Mandeville	70448	7	All PCPs	2 in 10 miles	9	7	100.0	0.8	0.9
		70471	14	All PCPs	2 in 10 miles	29	14	100.0	1.0	1.1
	Marrero	70072	145	All PCPs	2 in 10 miles	200	145	100.0	0.7	0.8
		70073	7	All PCPs	2 in 10 miles	0	7	100.0	0.1	0.2
	Metairie	70001	47	All PCPs	2 in 10 miles	219	47	100.0	0.4	0.5
		70002	18	All PCPs	2 in 10 miles	54	18	100.0	0.2	0.2
		70003	58	All PCPs	2 in 10 miles	18	58	100.0	0.5	0.5
		70004	1	All PCPs	2 in 10 miles	0	1	100.0	0.2	0.4
		70005	42	All PCPs	2 in 10 miles	15	42	100.0	0.4	0.5
		70006	12	All PCPs	2 in 10 miles	241	12	100.0	0.1	0.2
		70011	2	All PCPs	2 in 10 miles	0	2	100.0	0.1	0.2
		70033	1	All PCPs	2 in 10 miles	0	1	100.0	0.5	0.5
	Morgan City	70380	1	All PCPs	2 in 10 miles	22	1	100.0	0.5	0.5
	Napoleonville	70390	2	All PCPs	2 in 10 miles	5	2	100.0	0.9	1.9
	Natchitoches	71457	1	All PCPs	2 in 10 miles	58	1	100.0	0.6	0.6
	New Orleans	70114	7	All PCPs	2 in 10 miles	49	7	100.0	0.4	0.5
		70117	1	All PCPs	2 in 10 miles	49	1	100.0	0.5	0.5
		70118	4	All PCPs	2 in 10 miles	210	4	100.0	0.6	0.6
		70119	2	All PCPs	2 in 10 miles	82	2	100.0	0.5	0.5
		70121	23	All PCPs	2 in 10 miles	10	23	100.0	0.3	0.4
		70122	5	All PCPs	2 in 10 miles	44	5	100.0	0.8	0.8
		70123	55	All PCPs	2 in 10 miles	12	55	100.0	0.6	0.7
		70124	3	All PCPs	2 in 10 miles	22	3	100.0	0.5	0.6
		70127	2	All PCPs	2 in 10 miles	75	2	100.0	0.3	0.3
		70129	2	All PCPs	2 in 10 miles	9	2	100.0	1.1	1.1
		70131	3	All PCPs	2 in 10 miles	15	3	100.0	0.6	0.7
		70174	1	All PCPs	2 in 10 miles	0	1	100.0	0.1	0.2
	Norco	70079	1	All PCPs	2 in 10 miles	15	1	100.0	0.9	0.9
	Pearl River	70452	2	All PCPs	2 in 10 miles	4	2	100.0	2.1	2.1
	Ponchatoula	70454	13	All PCPs	2 in 10 miles	14	13	100.0	2.5	2.8
	Prairieville	70769	1	All PCPs	2 in 10 miles	36	1	100.0	2.0	2.1
	Raceland	70394	1	All PCPs	2 in 10 miles	16	1	100.0	1.2	1.3
	Robert	70455	2	All PCPs	2 in 10 miles	0	2	100.0	5.0	5.0
	Saint Amant	70774	1	All PCPs	2 in 10 miles	2	1	100.0	1.9	1.9
	Saint Rose	70087	3	All PCPs	2 in 10 miles	13	3	100.0	0.9	0.9
	Slidell	70458	4	All PCPs	2 in 10 miles	132	4	100.0	0.2	0.2

Continued on next page...

Access Detail By Zip Code

August 8, 2022

Access Analysis
Standard

Employee / Provider Groups
All Employees
All PCPs

Employees With Access										
State Abbr	City	Zip Code	Employee #	Provider Group	Provider Standard	Counts #	With Access #	With Access %	Average Distance 1	Average Distance 2
LA	Slidell	70460	1	All PCPs	2 in 10 miles	9	1	100.0	0.5	0.5
		70461	1	All PCPs	2 in 10 miles	43	1	100.0	1.1	1.1
	Springfield	70462	1	All PCPs	2 in 10 miles	2	1	100.0	3.7	3.7
	Thibodaux	70301	4	All PCPs	2 in 10 miles	83	4	100.0	1.4	1.4
	Tickfaw	70466	1	All PCPs	2 in 10 miles	0	1	100.0	4.4	4.4
	Westwego	70094	52	All PCPs	2 in 10 miles	24	52	100.0	0.6	0.7
		70096	2	All PCPs	2 in 10 miles	0	2	100.0	0.4	0.5
MS	Bay Saint Louis	39520	5	All PCPs	2 in 10 miles	79	5	100.0	0.7	0.8
	Kiln	39556	1	All PCPs	2 in 10 miles	0	1	100.0	4.2	4.2
	Kokomo	39643	1	All PCPs	2 in 10 miles	0	1	100.0	8.2	9.7
	Picayune	39466	3	All PCPs	2 in 10 miles	53	3	100.0	2.4	2.4
NC	Bostic	28018	1	All PCPs	2 in 10 miles	0	1	100.0	8.4	8.4
	Etowah	28729	1	All PCPs	2 in 10 miles	13	1	100.0	0.5	0.5
	Franklin	28734	1	All PCPs	2 in 10 miles	150	1	100.0	0.3	0.5
	Weaverville	28787	1	All PCPs	2 in 10 miles	21	1	100.0	0.3	0.3
NY	Syosset	11791	1	All PCPs	2 in 10 miles	301	1	100.0	0.3	0.4
TN	Arlington	38002	2	All PCPs	2 in 10 miles	15	2	100.0	1.7	1.9
	Oak Ridge	37830	2	All PCPs	2 in 10 miles	73	2	100.0	0.4	0.6
TX	Austin	78727	2	All PCPs	2 in 10 miles	5	2	100.0	0.8	0.8
	Brownsville	78526	1	All PCPs	2 in 10 miles	138	1	100.0	0.6	0.6
	Galveston	77551	1	All PCPs	2 in 10 miles	61	1	100.0	0.2	0.5
VA	Stafford	22554	1	All PCPs	2 in 10 miles	159	1	100.0	0.2	0.2
Grand Totals			890	All PCPs	2 in 10 miles	4,951	886	99.6	0.9	0.9

Access Detail By Zip Code

August 8, 2022

Access Analysis
Standard

Employee / Provider Groups
All Employees
All PCPs

Employees Without Access										
State Abbr	City	Zip Code	Employee	Provider		Counts	Without Access		Average Distance	
			#	Group	Standard	#	#	%	1	2
LA	Bush	70431	12	All PCPs	2 in 10 miles	0	3	25.0	9.9	10.6
	Franklinton	70438	7	All PCPs	2 in 10 miles	20	1	14.3	7.1	10.3
MS	Meadville	39653	1	All PCPs	2 in 10 miles	0	1	100.0	2.2	19.5
	Poplarville	39470	1	All PCPs	2 in 10 miles	1	1	100.0	3.0	13.7
Grand Totals			21	All PCPs	2 in 10 miles	21	6	28.6	7.0	12.5

Access Summary By City

August 8, 2022

Access Analysis
Standard

Employee Group
All Employees

Provider Group
Specialist

[1] Provider counts represent:
#: Provider access points
P: Unique providers
L: Unique provider locations

Employees With and Without Access

Employee		Provider		With Access		Without Access		Counts[1]			Average Distance	
Group	#	Group	Standard	#	%	#	%	#	P	L	1	2
All Employees	892	Specialist	2 in 10 miles	888	99.6	4	0.4	2,131,812	590,268	177,514	0.9	1.0

Key Geographic Areas

State Abbr	City	Employee	Provider		With Access		Without Access		Counts[1]	Average Distance	
		#	Group	Standard	#	%	#	%	#	1	2
LA	Metairie	181	Specialist	2 in 10 miles	181	100.0	0	0.0	1,141	0.3	0.4
	Marrero	152	Specialist	2 in 10 miles	152	100.0	0	0.0	334	0.9	1.1
	New Orleans	108	Specialist	2 in 10 miles	108	100.0	0	0.0	2,409	0.4	0.5
	Kenner	69	Specialist	2 in 10 miles	69	100.0	0	0.0	251	0.4	0.4
	Gretna	60	Specialist	2 in 10 miles	60	100.0	0	0.0	159	0.3	0.3
	Westwego	54	Specialist	2 in 10 miles	54	100.0	0	0.0	42	0.6	0.6
	Harvey	41	Specialist	2 in 10 miles	41	100.0	0	0.0	59	0.8	0.9
	Covington	39	Specialist	2 in 10 miles	39	100.0	0	0.0	655	1.8	1.9
	Mandeville	21	Specialist	2 in 10 miles	21	100.0	0	0.0	135	0.5	0.5
	Ponchatoula	13	Specialist	2 in 10 miles	13	100.0	0	0.0	64	2.3	2.4
	Bush	12	Specialist	2 in 10 miles	9	75.0	3	25.0	0	9.1	9.1
	LA Place	10	Specialist	2 in 10 miles	10	100.0	0	0.0	94	0.5	0.8
	Franklinton	7	Specialist	2 in 10 miles	6	85.7	1	14.3	109	2.5	2.5
	Madisonville	6	Specialist	2 in 10 miles	6	100.0	0	0.0	5	1.1	1.1
	Slidell	6	Specialist	2 in 10 miles	6	100.0	0	0.0	397	0.4	0.4
	Kentwood	5	Specialist	2 in 10 miles	5	100.0	0	0.0	24	4.3	4.4
	Lafitte	5	Specialist	2 in 10 miles	5	100.0	0	0.0	8	1.5	1.5
MS	Bay Saint Louis	5	Specialist	2 in 10 miles	5	100.0	0	0.0	143	0.9	1.0
LA	Belle Chasse	4	Specialist	2 in 10 miles	4	100.0	0	0.0	34	0.9	1.2
	Folsom	4	Specialist	2 in 10 miles	4	100.0	0	0.0	2	3.3	3.3
	Gonzales	4	Specialist	2 in 10 miles	4	100.0	0	0.0	273	0.8	0.9
	Thibodaux	4	Specialist	2 in 10 miles	4	100.0	0	0.0	242	1.2	1.2
	Baton Rouge	3	Specialist	2 in 10 miles	3	100.0	0	0.0	2,871	0.7	0.7
	Destrehan	3	Specialist	2 in 10 miles	3	100.0	0	0.0	9	0.7	0.8
	Gramercy	3	Specialist	2 in 10 miles	3	100.0	0	0.0	4	0.4	0.5
	Hammond	3	Specialist	2 in 10 miles	3	100.0	0	0.0	461	1.1	1.1
	Independence	3	Specialist	2 in 10 miles	3	100.0	0	0.0	27	3.4	3.7
	Loranger	3	Specialist	2 in 10 miles	3	100.0	0	0.0	54	3.5	3.5
	Luling	3	Specialist	2 in 10 miles	3	100.0	0	0.0	76	0.7	0.8
	Saint Rose	3	Specialist	2 in 10 miles	3	100.0	0	0.0	22	0.9	0.9
MS	Picayune	3	Specialist	2 in 10 miles	3	100.0	0	0.0	73	2.4	2.4
AZ	Phoenix	2	Specialist	2 in 10 miles	2	100.0	0	0.0	12,270	0.6	0.6
LA	Abita Springs	2	Specialist	2 in 10 miles	2	100.0	0	0.0	0	2.7	2.9
	Bogalusa	2	Specialist	2 in 10 miles	2	100.0	0	0.0	237	0.4	0.4
	Husser	2	Specialist	2 in 10 miles	2	100.0	0	0.0	0	5.1	5.1

Access Detail By Zip Code

August 8, 2022

Access Analysis
Standard

Employee / Provider Groups
All Employees
Specialist

Employees With Access										
State Abbr	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
			#	Group	Standard	#	#	%	1	2
AL	Brownsboro	35741	1	Specialist	2 in 10 miles	0	1	100.0	2.7	2.7
	Mobile	36619	1	Specialist	2 in 10 miles	57	1	100.0	0.8	1.4
AZ	Phoenix	85028	2	Specialist	2 in 10 miles	199	2	100.0	0.6	0.6
CA	Alpine	91901	1	Specialist	2 in 10 miles	22	1	100.0	0.1	0.1
	Long Beach	90802	1	Specialist	2 in 10 miles	13	1	100.0	0.1	0.3
CO	Parker	80138	1	Specialist	2 in 10 miles	280	1	100.0	2.1	2.3
FL	Cantonment	32533	1	Specialist	2 in 10 miles	40	1	100.0	0.7	0.7
	Miami	33185	1	Specialist	2 in 10 miles	0	1	100.0	1.2	1.2
	Panama City	32404	1	Specialist	2 in 10 miles	7	1	100.0	1.4	1.6
LA	Abita Springs	70420	2	Specialist	2 in 10 miles	0	2	100.0	2.7	2.9
	Addis	70710	1	Specialist	2 in 10 miles	0	1	100.0	2.6	2.9
	Barataria	70036	1	Specialist	2 in 10 miles	0	1	100.0	2.2	2.2
	Baton Rouge	70810	2	Specialist	2 in 10 miles	258	2	100.0	0.6	0.6
		70817	1	Specialist	2 in 10 miles	152	1	100.0	1.0	1.0
	Belle Chasse	70037	4	Specialist	2 in 10 miles	34	4	100.0	0.9	1.2
	Bogalusa	70427	2	Specialist	2 in 10 miles	237	2	100.0	0.4	0.4
	Bush	70431	12	Specialist	2 in 10 miles	0	9	75.0	8.6	8.6
	Covington	70433	26	Specialist	2 in 10 miles	655	26	100.0	0.4	0.5
		70435	13	Specialist	2 in 10 miles	0	13	100.0	4.6	4.6
	Cut Off	70345	1	Specialist	2 in 10 miles	30	1	100.0	1.0	1.0
	Denham Springs	70726	1	Specialist	2 in 10 miles	149	1	100.0	1.1	1.6
	Destrehan	70047	3	Specialist	2 in 10 miles	9	3	100.0	0.7	0.8
	Folsom	70437	4	Specialist	2 in 10 miles	2	4	100.0	3.3	3.3
	Franklinton	70438	7	Specialist	2 in 10 miles	109	6	85.7	1.2	1.2
	Gonzales	70737	4	Specialist	2 in 10 miles	273	4	100.0	0.8	0.9
	Gramercy	70052	3	Specialist	2 in 10 miles	4	3	100.0	0.4	0.5
	Gretna	70053	24	Specialist	2 in 10 miles	14	24	100.0	0.3	0.4
		70054	2	Specialist	2 in 10 miles	0	2	100.0	0.1	0.1
		70056	34	Specialist	2 in 10 miles	145	34	100.0	0.3	0.3
	Hammond	70403	3	Specialist	2 in 10 miles	434	3	100.0	1.1	1.1
	Harvey	70058	41	Specialist	2 in 10 miles	59	41	100.0	0.8	0.9
	Houma	70364	1	Specialist	2 in 10 miles	10	1	100.0	2.3	2.3
	Husser	70442	2	Specialist	2 in 10 miles	0	2	100.0	5.1	5.1
	Independence	70443	3	Specialist	2 in 10 miles	27	3	100.0	3.4	3.7
	Kenner	70062	15	Specialist	2 in 10 miles	40	15	100.0	0.6	0.6
		70065	54	Specialist	2 in 10 miles	211	54	100.0	0.3	0.3
	Kentwood	70444	5	Specialist	2 in 10 miles	24	5	100.0	4.3	4.4
	LA Place	70068	10	Specialist	2 in 10 miles	94	10	100.0	0.5	0.8
	Lafayette	70508	1	Specialist	2 in 10 miles	545	1	100.0	0.4	0.4
	Lafitte	70067	5	Specialist	2 in 10 miles	8	5	100.0	1.5	1.5

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Access Detail By Zip Code

August 8, 2022

Access Analysis
Standard

Employee / Provider Groups
All Employees
Specialist

Employees With Access										
State Abbr	City	Zip Code	Employee #	Provider Group	Provider Standard	Counts #	With Access #	With Access %	Average Distance 1	Average Distance 2
LA	Lockport	70374	1	Specialist	2 in 10 miles	3	1	100.0	1.8	1.8
	Loranger	70446	3	Specialist	2 in 10 miles	54	3	100.0	3.5	3.5
	Luling	70070	3	Specialist	2 in 10 miles	76	3	100.0	0.7	0.8
	Madisonville	70447	6	Specialist	2 in 10 miles	5	6	100.0	1.1	1.1
	Mandeville	70448	7	Specialist	2 in 10 miles	31	7	100.0	0.6	0.6
		70471	14	Specialist	2 in 10 miles	103	14	100.0	0.5	0.5
	Marrero	70072	145	Specialist	2 in 10 miles	334	145	100.0	0.9	1.1
		70073	7	Specialist	2 in 10 miles	0	7	100.0	0.5	0.5
	Metairie	70001	47	Specialist	2 in 10 miles	289	47	100.0	0.3	0.4
		70002	18	Specialist	2 in 10 miles	192	18	100.0	0.1	0.2
		70003	58	Specialist	2 in 10 miles	39	58	100.0	0.5	0.6
		70004	1	Specialist	2 in 10 miles	0	1	100.0	0.4	0.4
		70005	42	Specialist	2 in 10 miles	63	42	100.0	0.3	0.4
		70006	12	Specialist	2 in 10 miles	558	12	100.0	0.1	0.1
		70011	2	Specialist	2 in 10 miles	0	2	100.0	0.1	0.1
		70033	1	Specialist	2 in 10 miles	0	1	100.0	0.2	0.3
	Morgan City	70380	1	Specialist	2 in 10 miles	55	1	100.0	0.4	0.4
	Napoleonville	70390	2	Specialist	2 in 10 miles	15	2	100.0	0.9	0.9
	Natchitoches	71457	1	Specialist	2 in 10 miles	176	1	100.0	0.6	0.6
	New Orleans	70114	7	Specialist	2 in 10 miles	92	7	100.0	0.3	0.4
		70117	1	Specialist	2 in 10 miles	35	1	100.0	0.5	0.5
		70118	4	Specialist	2 in 10 miles	319	4	100.0	0.4	0.4
		70119	2	Specialist	2 in 10 miles	96	2	100.0	0.5	0.5
		70121	23	Specialist	2 in 10 miles	36	23	100.0	0.3	0.3
		70122	5	Specialist	2 in 10 miles	57	5	100.0	0.6	0.7
		70123	55	Specialist	2 in 10 miles	20	55	100.0	0.5	0.5
		70124	3	Specialist	2 in 10 miles	48	3	100.0	0.4	0.5
		70127	2	Specialist	2 in 10 miles	147	2	100.0	0.2	0.3
		70129	2	Specialist	2 in 10 miles	5	2	100.0	1.1	1.1
		70131	3	Specialist	2 in 10 miles	18	3	100.0	0.7	0.8
		70174	1	Specialist	2 in 10 miles	0	1	100.0	0.2	0.2
	Norco	70079	1	Specialist	2 in 10 miles	31	1	100.0	0.9	0.9
	Pearl River	70452	2	Specialist	2 in 10 miles	16	2	100.0	2.1	2.1
	Ponchatoula	70454	13	Specialist	2 in 10 miles	64	13	100.0	2.3	2.4
	Prairieville	70769	1	Specialist	2 in 10 miles	94	1	100.0	1.1	1.7
	Raceland	70394	1	Specialist	2 in 10 miles	44	1	100.0	0.7	1.2
	Robert	70455	2	Specialist	2 in 10 miles	0	2	100.0	4.6	5.0
	Saint Amant	70774	1	Specialist	2 in 10 miles	2	1	100.0	1.9	1.9
	Saint Rose	70087	3	Specialist	2 in 10 miles	22	3	100.0	0.9	0.9
	Slidell	70458	4	Specialist	2 in 10 miles	266	4	100.0	0.2	0.2

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Access Detail By Zip Code

August 8, 2022

Access Analysis
Standard

Employee / Provider Groups
All Employees
Specialist

Employees With Access										
State Abbr	City	Zip Code	Employee #	Provider Group	Provider Standard	Counts #	With Access #	With Access %	Average Distance 1	Average Distance 2
LA	Slidell	70460	1	Specialist	2 in 10 miles	10	1	100.0	0.5	0.5
		70461	1	Specialist	2 in 10 miles	121	1	100.0	1.1	1.1
	Springfield	70462	1	Specialist	2 in 10 miles	30	1	100.0	3.7	3.7
	Thibodaux	70301	4	Specialist	2 in 10 miles	242	4	100.0	1.2	1.2
	Tickfaw	70466	1	Specialist	2 in 10 miles	0	1	100.0	3.6	3.9
	Westwego	70094	52	Specialist	2 in 10 miles	42	52	100.0	0.6	0.7
		70096	2	Specialist	2 in 10 miles	0	2	100.0	0.3	0.5
MS	Bay Saint Louis	39520	5	Specialist	2 in 10 miles	143	5	100.0	0.9	1.0
	Kiln	39556	1	Specialist	2 in 10 miles	2	1	100.0	3.8	4.0
	Kokomo	39643	1	Specialist	2 in 10 miles	0	1	100.0	8.2	10.0
	Meadville	39653	1	Specialist	2 in 10 miles	3	1	100.0	1.2	1.2
	Picayune	39466	3	Specialist	2 in 10 miles	73	3	100.0	2.4	2.4
	Poplarville	39470	1	Specialist	2 in 10 miles	3	1	100.0	1.2	2.2
NC	Bostic	28018	1	Specialist	2 in 10 miles	0	1	100.0	8.4	8.4
	Etowah	28729	1	Specialist	2 in 10 miles	5	1	100.0	0.5	0.5
	Franklin	28734	1	Specialist	2 in 10 miles	349	1	100.0	0.2	0.2
	Weaverville	28787	1	Specialist	2 in 10 miles	56	1	100.0	0.3	0.3
NY	Syosset	11791	1	Specialist	2 in 10 miles	1,580	1	100.0	0.2	0.3
TN	Arlington	38002	2	Specialist	2 in 10 miles	41	2	100.0	1.7	1.7
	Oak Ridge	37830	2	Specialist	2 in 10 miles	355	2	100.0	0.5	0.6
TX	Austin	78727	2	Specialist	2 in 10 miles	45	2	100.0	0.5	0.5
	Brownsville	78526	1	Specialist	2 in 10 miles	304	1	100.0	0.6	0.8
	Galveston	77551	1	Specialist	2 in 10 miles	68	1	100.0	0.2	0.5
VA	Stafford	22554	1	Specialist	2 in 10 miles	182	1	100.0	0.2	0.2
Grand Totals			892	Specialist	2 in 10 miles	11,200	888	99.6	0.9	0.9

Access Detail By Zip Code

August 8, 2022

Access Analysis
Standard

Employee / Provider Groups
All Employees
Specialist

Employees Without Access

State Abbr	City	Zip Code	Employee #	Provider		Counts	Without Access		Average Distance	
				Group	Standard	#	#	%	1	2
LA	Bush	70431	12	Specialist	2 in 10 miles	0	3	25.0	10.6	10.6
	Franklinton	70438	7	Specialist	2 in 10 miles	109	1	14.3	10.3	10.3
Grand Totals			19	Specialist	2 in 10 miles	109	4	21.1	10.5	10.5

Access Summary By City

August 8, 2022

Access Analysis
Standard

Employee Group
All Employees

Provider Group
Acute Care Hospitals

[1] Provider counts represent:
#: Provider access points
P: Unique providers
L: Unique provider locations

Employees With and Without Access

Employee		Provider		With Access		Without Access		Counts[1]			Average Distance	
Group	#	Group	Standard	#	%	#	%	#	P	L	1	2
All Employees	892	Acute Care Hospitals	1 in 10 miles	807	90.5	85	9.5	4,327	3,711	4,125	4.2	8.5

Key Geographic Areas

State Abbr	City	Employee	Provider		With Access		Without Access		Counts[1]	Average Distance	
		#	Group	Standard	#	%	#	%	#	1	2
LA	Metairie	181	Acute Care Hospitals	1 in 10 miles	181	100.0	0	0.0	1	2.4	6.7
	Marrero	152	Acute Care Hospitals	1 in 10 miles	152	100.0	0	0.0	1	2.2	4.0
	New Orleans	108	Acute Care Hospitals	1 in 10 miles	108	100.0	0	0.0	3	3.9	5.7
	Kenner	69	Acute Care Hospitals	1 in 10 miles	69	100.0	0	0.0	0	4.2	9.7
	Gretna	60	Acute Care Hospitals	1 in 10 miles	60	100.0	0	0.0	1	1.3	3.4
	Westwego	54	Acute Care Hospitals	1 in 10 miles	54	100.0	0	0.0	0	4.2	5.0
	Harvey	41	Acute Care Hospitals	1 in 10 miles	41	100.0	0	0.0	0	2.1	2.8
	Covington	39	Acute Care Hospitals	1 in 10 miles	33	84.6	6	15.4	1	6.0	22.0
	Mandeville	21	Acute Care Hospitals	1 in 10 miles	21	100.0	0	0.0	0	2.5	19.3
	Ponchatoula	13	Acute Care Hospitals	1 in 10 miles	0	0.0	13	100.0	0	20.0	29.4
	Bush	12	Acute Care Hospitals	1 in 10 miles	0	0.0	12	100.0	0	12.9	16.0
	LA Place	10	Acute Care Hospitals	1 in 10 miles	1	10.0	9	90.0	0	11.8	13.5
	Franklinton	7	Acute Care Hospitals	1 in 10 miles	5	71.4	2	28.6	1	4.4	16.1
	Madisonville	6	Acute Care Hospitals	1 in 10 miles	6	100.0	0	0.0	0	7.1	26.5
	Slidell	6	Acute Care Hospitals	1 in 10 miles	6	100.0	0	0.0	2	1.3	2.1
	Kentwood	5	Acute Care Hospitals	1 in 10 miles	2	40.0	3	60.0	0	10.1	21.7
	Lafitte	5	Acute Care Hospitals	1 in 10 miles	2	40.0	3	60.0	0	10.5	11.3
MS	Bay Saint Louis	5	Acute Care Hospitals	1 in 10 miles	5	100.0	0	0.0	0	4.7	14.8
LA	Belle Chasse	4	Acute Care Hospitals	1 in 10 miles	3	75.0	1	25.0	0	5.3	7.8
	Folsom	4	Acute Care Hospitals	1 in 10 miles	0	0.0	4	100.0	0	15.0	15.8
	Gonzales	4	Acute Care Hospitals	1 in 10 miles	4	100.0	0	0.0	2	2.7	2.7
	Thibodaux	4	Acute Care Hospitals	1 in 10 miles	4	100.0	0	0.0	1	2.1	13.1
	Baton Rouge	3	Acute Care Hospitals	1 in 10 miles	3	100.0	0	0.0	7	1.4	3.1
	Destrehan	3	Acute Care Hospitals	1 in 10 miles	3	100.0	0	0.0	0	3.0	12.4
	Gramercy	3	Acute Care Hospitals	1 in 10 miles	3	100.0	0	0.0	0	0.8	17.8
	Hammond	3	Acute Care Hospitals	1 in 10 miles	0	0.0	3	100.0	0	25.0	26.8
	Independence	3	Acute Care Hospitals	1 in 10 miles	0	0.0	3	100.0	0	17.6	26.8
	Loranger	3	Acute Care Hospitals	1 in 10 miles	0	0.0	3	100.0	0	18.9	20.7
	Luling	3	Acute Care Hospitals	1 in 10 miles	3	100.0	0	0.0	1	1.8	13.2
	Saint Rose	3	Acute Care Hospitals	1 in 10 miles	3	100.0	0	0.0	0	5.1	7.9
MS	Picayune	3	Acute Care Hospitals	1 in 10 miles	0	0.0	3	100.0	0	16.3	19.3
AZ	Phoenix	2	Acute Care Hospitals	1 in 10 miles	2	100.0	0	0.0	12	3.6	4.1
LA	Abita Springs	2	Acute Care Hospitals	1 in 10 miles	2	100.0	0	0.0	0	5.6	20.0
	Bogalusa	2	Acute Care Hospitals	1 in 10 miles	2	100.0	0	0.0	1	1.1	16.8
	Husser	2	Acute Care Hospitals	1 in 10 miles	0	0.0	2	100.0	0	15.2	21.3

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Employees With Access										
State Abbr	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
			#	Group	Standard	#	#	%	1	2
AL	Brownsboro	35741	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	4.9	5.1
	Mobile	36619	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	6.1	7.5
AZ	Phoenix	85028	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	3.6	4.1
CA	Long Beach	90802	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	0.7	2.6
CO	Parker	80138	1	Acute Care Hospitals	1 in 10 miles	1	1	100.0	4.2	8.4
FL	Cantonment	32533	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	8.6	11.0
	Miami	33185	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	3.8	8.1
	Panama City	32404	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	4.7	6.2
LA	Abita Springs	70420	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	5.6	20.0
	Addis	70710	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	9.3	9.9
	Baton Rouge	70810	2	Acute Care Hospitals	1 in 10 miles	1	2	100.0	1.1	1.9
		70817	1	Acute Care Hospitals	1 in 10 miles	1	1	100.0	2.1	5.5
	Belle Chasse	70037	4	Acute Care Hospitals	1 in 10 miles	0	3	75.0	3.4	6.3
	Bogalusa	70427	2	Acute Care Hospitals	1 in 10 miles	1	2	100.0	1.1	16.8
	Covington	70433	26	Acute Care Hospitals	1 in 10 miles	1	26	100.0	4.0	23.1
		70435	13	Acute Care Hospitals	1 in 10 miles	0	7	53.8	8.5	20.8
	Denham Springs	70726	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	8.2	10.8
	Destrehan	70047	3	Acute Care Hospitals	1 in 10 miles	0	3	100.0	3.0	12.4
	Franklinton	70438	7	Acute Care Hospitals	1 in 10 miles	1	5	71.4	1.7	17.4
	Gonzales	70737	4	Acute Care Hospitals	1 in 10 miles	2	4	100.0	2.7	2.7
	Gramercy	70052	3	Acute Care Hospitals	1 in 10 miles	0	3	100.0	0.8	17.8
	Gretna	70053	24	Acute Care Hospitals	1 in 10 miles	0	24	100.0	1.8	2.7
		70054	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	0.9	3.1
		70056	34	Acute Care Hospitals	1 in 10 miles	1	34	100.0	1.0	3.9
	Harvey	70058	41	Acute Care Hospitals	1 in 10 miles	0	41	100.0	2.1	2.8
	Houma	70364	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	2.7	3.6
	Kenner	70062	15	Acute Care Hospitals	1 in 10 miles	0	15	100.0	4.3	8.8
		70065	54	Acute Care Hospitals	1 in 10 miles	0	54	100.0	4.2	10.0
	Kentwood	70444	5	Acute Care Hospitals	1 in 10 miles	0	2	40.0	5.4	26.6
	LA Place	70068	10	Acute Care Hospitals	1 in 10 miles	0	1	10.0	10.0	14.7
	Lafayette	70508	1	Acute Care Hospitals	1 in 10 miles	6	1	100.0	0.8	0.9
	Lafitte	70067	5	Acute Care Hospitals	1 in 10 miles	0	2	40.0	9.0	9.6
	Luling	70070	3	Acute Care Hospitals	1 in 10 miles	1	3	100.0	1.8	13.2
	Madisonville	70447	6	Acute Care Hospitals	1 in 10 miles	0	6	100.0	7.1	26.5
	Mandeville	70448	7	Acute Care Hospitals	1 in 10 miles	0	7	100.0	3.2	18.1
		70471	14	Acute Care Hospitals	1 in 10 miles	0	14	100.0	2.2	19.9
	Marrero	70072	145	Acute Care Hospitals	1 in 10 miles	1	145	100.0	2.2	4.0
		70073	7	Acute Care Hospitals	1 in 10 miles	0	7	100.0	1.3	3.5
	Metairie	70001	47	Acute Care Hospitals	1 in 10 miles	0	47	100.0	2.3	5.9
		70002	18	Acute Care Hospitals	1 in 10 miles	0	18	100.0	1.3	6.4

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Employees With Access										
State Abbr	City	Zip Code	Employee	Provider		Counts	With Access		Average Distance	
			#	Group	Standard	#	#	%	1	2
LA	Metairie	70003	58	Acute Care Hospitals	1 in 10 miles	0	58	100.0	2.5	8.7
		70004	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	2.9	5.3
		70005	42	Acute Care Hospitals	1 in 10 miles	0	42	100.0	3.2	4.7
		70006	12	Acute Care Hospitals	1 in 10 miles	1	12	100.0	0.7	7.8
		70011	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	1.4	6.2
		70033	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	2.3	9.2
	Natchitoches	71457	1	Acute Care Hospitals	1 in 10 miles	1	1	100.0	0.7	23.6
	New Orleans	70114	7	Acute Care Hospitals	1 in 10 miles	0	7	100.0	2.4	3.2
		70117	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	2.7	3.0
		70118	4	Acute Care Hospitals	1 in 10 miles	0	4	100.0	2.5	3.2
		70119	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	1.9	3.7
		70121	23	Acute Care Hospitals	1 in 10 miles	0	23	100.0	3.7	4.7
		70122	5	Acute Care Hospitals	1 in 10 miles	0	5	100.0	3.5	5.5
		70123	55	Acute Care Hospitals	1 in 10 miles	0	55	100.0	4.7	7.0
		70124	3	Acute Care Hospitals	1 in 10 miles	0	3	100.0	3.7	4.7
		70127	2	Acute Care Hospitals	1 in 10 miles	1	2	100.0	0.5	5.0
		70129	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	4.0	7.7
		70131	3	Acute Care Hospitals	1 in 10 miles	0	3	100.0	2.9	4.1
		70174	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	2.6	2.8
	Norco	70079	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	6.1	13.8
	Pearl River	70452	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	6.9	8.1
	Prairieville	70769	1	Acute Care Hospitals	1 in 10 miles	1	1	100.0	3.5	7.0
	Saint Amant	70774	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	5.9	5.9
	Saint Rose	70087	3	Acute Care Hospitals	1 in 10 miles	0	3	100.0	5.1	7.9
	Slidell	70458	4	Acute Care Hospitals	1 in 10 miles	2	4	100.0	0.9	1.4
		70460	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	2.6	3.8
		70461	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	1.7	2.9
	Thibodaux	70301	4	Acute Care Hospitals	1 in 10 miles	1	4	100.0	2.1	13.1
	Westwego	70094	52	Acute Care Hospitals	1 in 10 miles	0	52	100.0	4.2	5.0
		70096	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	2.6	3.3
MS	Bay Saint Louis	39520	5	Acute Care Hospitals	1 in 10 miles	0	5	100.0	4.7	14.8
	Kiln	39556	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	5.1	17.9
NC	Etowah	28729	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	7.4	7.8
	Franklin	28734	1	Acute Care Hospitals	1 in 10 miles	1	1	100.0	0.5	13.1
	Weaverville	28787	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	9.7	9.9
NY	Syosset	11791	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	3.0	6.2
TN	Arlington	38002	2	Acute Care Hospitals	1 in 10 miles	0	1	50.0	6.6	13.2
	Oak Ridge	37830	2	Acute Care Hospitals	1 in 10 miles	1	2	100.0	0.9	9.6
TX	Austin	78727	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	1.3	2.1
	Brownsville	78526	1	Acute Care Hospitals	1 in 10 miles	1	1	100.0	2.5	4.3

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Employees With Access										
State Abbr	City	Zip Code	Employee #	Provider Group	Provider Standard	Counts #	With Access #	With Access %	Average Distance 1	Average Distance 2
TX	Galveston	77551	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	3.9	12.4
Grand Totals			832	Acute Care Hospitals	1 in 10 miles	27	807	97.0	3.0	7.2

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Employees Without Access

State Abbr	City	Zip Code	Employee	Provider		Counts	Without Access		Average Distance	
			#	Group	Standard	#	#	%	1	2
CA	Alpine	91901	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	15.3	18.1
LA	Barataria	70036	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	12.7	13.4
	Belle Chasse	70037	4	Acute Care Hospitals	1 in 10 miles	0	1	25.0	11.0	12.2
	Bush	70431	12	Acute Care Hospitals	1 in 10 miles	0	12	100.0	12.9	16.0
	Covington	70435	13	Acute Care Hospitals	1 in 10 miles	0	6	46.2	11.7	18.6
	Cut Off	70345	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	24.4	26.5
	Folsom	70437	4	Acute Care Hospitals	1 in 10 miles	0	4	100.0	15.0	15.8
	Franklinton	70438	7	Acute Care Hospitals	1 in 10 miles	1	2	28.6	11.1	12.8
	Hammond	70403	3	Acute Care Hospitals	1 in 10 miles	0	3	100.0	25.0	26.8
	Husser	70442	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	15.2	21.3
	Independence	70443	3	Acute Care Hospitals	1 in 10 miles	0	3	100.0	17.6	26.8
	Kentwood	70444	5	Acute Care Hospitals	1 in 10 miles	0	3	60.0	13.2	18.5
	LA Place	70068	10	Acute Care Hospitals	1 in 10 miles	0	9	90.0	12.0	13.3
	Lafitte	70067	5	Acute Care Hospitals	1 in 10 miles	0	3	60.0	11.5	12.4
	Lockport	70374	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	11.8	13.9
	Loranger	70446	3	Acute Care Hospitals	1 in 10 miles	0	3	100.0	18.9	20.7
	Morgan City	70380	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	21.5	23.6
	Napoleonville	70390	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	16.5	19.8
	Ponchatoula	70454	13	Acute Care Hospitals	1 in 10 miles	0	13	100.0	20.0	29.4
	Raceland	70394	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	11.0	12.5
	Robert	70455	2	Acute Care Hospitals	1 in 10 miles	0	2	100.0	16.9	24.9
	Springfield	70462	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	24.1	24.1
	Tickfaw	70466	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	20.9	27.7
MS	Kokomo	39643	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	27.0	30.4
	Meadville	39653	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	38.8	39.8
	Picayune	39466	3	Acute Care Hospitals	1 in 10 miles	0	3	100.0	16.3	19.3
	Poplarville	39470	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	18.6	26.5
NC	Bostic	28018	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	12.0	18.4
TN	Arlington	38002	2	Acute Care Hospitals	1 in 10 miles	0	1	50.0	10.3	16.5
VA	Stafford	22554	1	Acute Care Hospitals	1 in 10 miles	0	1	100.0	16.3	22.9
Grand Totals			106	Acute Care Hospitals	1 in 10 miles	1	85	80.2	16.0	20.3

EXHIBIT 7: JPG – UHC Top 100 Drug Tier Analysis

	GPI 12	NDC DRUG NAME	GENERIC INDICATOR	MAPD H Tier	High Performance Tier
1	394000101003	ATORVASTATIN CALCIUM	Y	1	1
2	340000031003	AMLODIPINE BESYLATE	Y	1	1
3	281000101003	LEVOTHYROXINE SODIUM	Y	1	1
4	361000300003	LISINOPRIL	Y	1	1
5	361500402003	LOSARTAN POTASSIUM	Y	1	1
6	332000300575	METOPROLOL SUCCINATE ER	Y	1	2
7	492700600065	OMEPRAZOLE	Y	1	2
8	372000300003	FUROSEMIDE	Y	1	1
9	272500500003	METFORMIN HYDROCHLORIDE	Y	1	1
10	492700701006	PANTOPRAZOLE SODIUM	Y	1	2
11	394000750003	SIMVASTATIN	Y	1	1
12	659917021003	HYDROCODONE BITARTRATE/ACETAMINOPHEN	Y	1	3
13	833700100003	ELIQUIS	N	2	3
14	394000601003	ROSUVASTATIN CALCIUM	Y	1	2
15	332000301003	METOPROLOL TARTRATE	Y	1	1
16	568520701001	TAMSULOSIN HYDROCHLORIDE	Y	1	2
17	333000070003	CARVEDILOL	Y	1	1
18	581200801003	TRAZODONE HYDROCHLORIDE	Y	1	1
19	651000951003	TRAMADOL HCL	Y	1	2
20	571000100003	ALPRAZOLAM	Y	1	2
21	851580201003	CLOPIDOGREL	Y	1	2
22	221000450003	PREDNISONE	Y	1	2
23	394000651003	PRAVASTATIN SODIUM	Y	1	1
24	445050501003	MONTELUKAST SODIUM	Y	1	2
25	581600341003	ESCITALOPRAM OXALATE	Y	1	2
26	442010101034	ALBUTEROL SULFATE HFA	Y	1	3
27	661000520003	MELOXICAM	Y	1	1
28	422000323018	FLUTICASONE PROPIONATE	Y	1	2
29	680000100003	ALLOPURINOL	Y	1	1
30	863300500020	LATANOPROST	Y	1	1
31	581800251067	DULOXETINE HYDROCHLORIDE	Y	1	2
32	659900022003	OXYCODONE/ACETAMINOPHEN	Y	1	3
33	602040801003	ZOLPIDEM TARTRATE	Y	1	4
34	571000600003	LORAZEPAM	Y	1	2

	GPI 12	NDC DRUG NAME	GENERIC INDICATOR	MAPD H Tier	High Performance Tier
35	492000300003	FAMOTIDINE	Y	1	3
36	721000100003	CLONAZEPAM	Y	1	2
37	651000751003	OXYCODONE HYDROCHLORIDE	Y	1	2
38	581600701003	SERTRALINE HCL	Y	1	1
39	591530701003	QUETIAPINE FUMARATE	Y	1	2
40	833700600003	XARELTO	N	2	3
41	272500500075	METFORMIN HYDROCHLORIDE ER	Y	1	1
42	832000302003	WARFARIN SODIUM	Y	1	1
43	332000200003	ATENOLOL	Y	1	1
44	581600201003	CITALOPRAM HYDROBROMIDE	Y	1	1
45	751000501003	CYCLOBENZAPRINE HYDROCHLORIDE	Y	1	4
46	300420101003	ALENDRONATE SODIUM	Y	1	1
47	580300500003	MIRTAZAPINE	Y	1	2
48	568510300003	FINASTERIDE	Y	1	2
49	375000200003	SPIRONOLACTONE	Y	1	2
50	726000300003	GABAPENTIN	Y	1	2
51	2710400300D2	LANTUS SOLOSTAR	N	2	3
52	021000200001	CEPHALEXIN	Y	1	2
53	369918025503	LISINOPRIL/HYDROCHLOROTHIAZIDE	Y	1	1
54	726000570001	PREGABALIN	Y	1	3
55	583000401075	BUPROPION HYDROCHLORIDE ER (XL)	Y	1	2
56	661000200003	IBUPROFEN	Y	1	2
57	393000300003	EZETIMIBE	Y	1	2
58	797000300004	POTASSIUM CHLORIDE ER	Y	1	2
59	272000270003	GLIMEPIRIDE	Y	Non-Formulary	Non-Formulary
60	034000100003	AZITHROMYCIN	Y	1	2
61	902100303040	DICLOFENAC SODIUM	Y	1	3
62	620510251003	DONEPEZIL HCL	Y	1	2
63	364000101003	HYDRALAZINE HYDROCHLORIDE	Y	1	2
64	442099024132	SYMBICORT	M	2	3
65	321000250075	ISOSORBIDE MONONITRATE ER	Y	1	2
66	050000201003	CIPROFLOXACIN HYDROCHLORIDE	Y	1	2
67	272000300003	GLIPIZIDE	Y	1	1

	GPI 12	NDC DRUG NAME	GENERIC INDICATOR	MAPD H Tier	High Performance Tier
68	751000901003	TIZANIDINE HYDROCHLORIDE	Y	1	2
69	620535501003	MEMANTINE HYDROCHLORIDE	Y	1	2
70	019900022003	AMOXICILLIN/CLAVULANATE POTASSIUM	Y	1	2
71	751000100003	BACLOFEN	Y	1	2
72	369940024503	LOSARTAN POTASSIUM/HYDROCHLOROTHIAZIDE	Y	1	1
73	905500851037	TRIAMCINOLONE ACETONIDE	Y	1	2
74	572000051003	BUSPIRONE HYDROCHLORIDE	Y	1	2
75	169900023003	SULFAMETHOXAZOLE/TRIMETHOPRIM DS	Y	1	2
76	542000500075	MYRBETRIQ	N	2	3
77	277000500003	JARDIANCE	N	2	3
78	275500701003	JANUVIA	N	2	3
79	392000250003	FENOFIBRATE	Y	1	2
80	340000101270	DILTIAZEM HYDROCHLORIDE ER	Y	1	2
81	2717001500D2	TRULICITY	N	2	3
82	171000954019	SHINGRIX	N	2	3
83	2210003000B7	METHYLPREDNISOLONE DOSE PACK	Y	1	2
84	362010101003	CLONIDINE HYDROCHLORIDE	Y	1	2
85	281000101003	SYNTHROID	O	2	3
86	394000500003	LOVASTATIN	Y	1	1
87	442099027580	BREO ELLIPTA	N	2	3
88	571000400003	DIAZEPAM	Y	1	2
89	502500650503	ONDANSETRON HYDROCHLORIDE	Y	1	2
90	726000430003	LEVETIRACETAM	Y	1	2
91	726000400003	LAMOTRIGINE	Y	1	2
92	661005250001	CELECOXIB	Y	1	3
93	581600400001	FLUOXETINE HYDROCHLORIDE	Y	1	2
94	541000452075	OXYBUTYNIN CHLORIDE ER	Y	1	2
95	376000400001	HYDROCHLOROTHIAZIDE	Y	1	1
96	272000300075	GLIPIZIDE ER	Y	1	1
97	863000501018	PREDNISOLONE ACETATE	Y	1	3
98	340000200075	NIFEDIPINE ER	Y	1	2
99	590700700003	RISPERIDONE	Y	1	2
100	592500150003	ARIPIPRAZOLE	Y	1	2

Sierra Health and Life Insurance Company, Inc.

Statutory Basis Financial Statements as of and for the Years Ended December 31, 2021 and 2020, Supplemental Schedules as of and for the Year Ended December 31, 2021, Independent Auditor's Report, and Qualification Letter

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.

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Deloitte.

Deloitte & Touche LLP
50 South 6th Street
Suite 2800
Minneapolis, MN 55402-1538
USA

Tel:+1 612 397 4000
Fax:+1 612 397 4450
www.deloitte.com

INDEPENDENT AUDITOR'S REPORT

To the Audit Committee of
Sierra Health and Life Insurance Company, Inc.
2720 N. Tenaya Way
Las Vegas, NV 89128

Opinion

We have audited the statutory basis financial statements of Sierra Health and Life Insurance Company, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2021 and 2020, and the related statutory basis statements of operations, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory basis financial statements (collectively referred to as the "statutory basis financial statements").

In our opinion, the accompanying statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of the Company as of December 31, 2021 and 2020, and the results of its operations and its cash flows for the years then ended in accordance with the accounting practices prescribed or permitted by the Nevada Division of Insurance described in Note 1.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Statutory Basis Financial Statements section of our report. We are required to be independent of the Company, and to meet our ethical responsibilities, in accordance with the relevant ethical requirements related to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Statutory Basis of Accounting

We draw attention to Note 1 of the statutory basis financial statements, which describes the basis of accounting. As described in Note 1 to the statutory basis financial statements, the statutory basis financial statements are prepared by the Company using accounting practices prescribed or permitted by the Nevada Division of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Nevada Division of Insurance. As a result, the statutory basis financial statements may not be suitable for another purpose. Our opinion is not modified with respect to this matter.

Responsibilities of Management for the Statutory Basis Financial Statements

Management is responsible for the preparation and fair presentation of these statutory basis financial statements in accordance with the accounting practices prescribed or permitted by the Nevada Division of Insurance. Management is also responsible for the design, implementation, and maintenance of

internal control relevant to the preparation and fair presentation of the statutory basis financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the statutory basis financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the statutory basis financial statements are issued.

Auditor's Responsibilities for the Audit of the Statutory Basis Financial Statements

Our objectives are to obtain reasonable assurance about whether the statutory basis financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the statutory financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the statutory basis financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the statutory basis financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the statutory basis financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Report on Supplemental Schedules

Our 2021 audit was conducted for the purpose of forming an opinion on the 2021 statutory basis financial statements as a whole. The supplemental investment risks interrogatories and the summary investment schedule as of and for the year ended December 31, 2021 are presented for purposes of

additional analysis and are not a required part of the 2021 statutory basis financial statements. These schedules are the responsibility of the Company's management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory basis financial statements. Such schedules have been subjected to the auditing procedures applied in our audit of the 2021 statutory basis financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the statutory basis financial statements or to the statutory basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the 2021 statutory basis financial statements as a whole.

Restriction on Use

Our report is intended solely for the information and use of the Audit Committee and the management of the Company and for filing with state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte + Touche LLP

April 22, 2022

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2021 AND 2020

	2021	2020
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 2,190,026,409	$ 2,762,280,078
Preferred stocks	3,270,000	-
Mortgage loans on real estate	18,932,656	-
Properties occupied by the company	50,985,245	2,215,518
Cash of $1,507,912 and $(2,228,055), cash equivalents of $350,924,874 and $680,103,643, and short-term investments of $0 and $105,254,078 in 2021 and 2020, respectively	352,432,786	783,129,666
Receivables for securities	3,001,069	-
Subtotal cash and invested assets	2,618,648,165	3,547,625,262
OTHER ASSETS:		
Investment income due and accrued	13,229,360	17,381,159
Premiums and considerations	1,337,779,824	1,177,537,439
Amounts receivable relating to uninsured plans	938,752,958	592,711,389
Current federal income tax recoverable	58,751,210	54,904,497
Net deferred tax asset	12,425,656	12,079,877
Guaranty funds receivable or on deposit	169,924	169,923
Receivables from parent, subsidiaries, and affiliates	136,370,908	153,928,077
Health care and other amounts receivable	424,077,514	388,651,624
Affiliate note receivable	-	159,000,000
Other assets	1,349,664	13,212,655
Subtotal other assets	2,922,907,018	2,569,576,640
TOTAL ADMITTED ASSETS	$ 5,541,555,183	$ 6,117,201,902
LIABILITIES, CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$ 1,950,738,470	$ 1,883,646,718
Accrued medical incentive pool and bonus amounts	86,993,875	145,341,948
Unpaid claims adjustment expenses	16,501,338	16,564,375
Aggregate health policy reserves, including $151,200,781 and $31,473,284 for medical loss ratio rebate per the Public Health Service Act for 2021 and 2020, respectively	351,240,667	435,620,210
Aggregate health claim reserves	2,697,549	2,433,735
Premiums received in advance	23,366,559	21,294,530
General expenses due or accrued	16,430,885	10,419,840
Remittances and items not allocated	3,626,398	2,089,352
Payable for securities	-	1,953,000
Liability for amounts held under uninsured plans	45,912,753	45,019,380
Premium deposit funds	184,756,987	220,390,021
Other liabilities	35,609	40,617
Total liabilities	2,682,301,090	2,784,813,726
CAPITAL AND SURPLUS:		
Common capital stock, $14.40 par value — 250,000 shares authorized, issued and outstanding	3,600,000	3,600,000
Gross paid-in and contributed surplus	632,349,031	632,341,371
Unassigned surplus	2,223,305,062	2,696,446,805
Total capital and surplus	2,859,254,093	3,332,388,176
TOTAL LIABILITIES, CAPITAL AND SURPLUS	$ 5,541,555,183	$ 6,117,201,902

See notes to statutory basis financial statements.

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2021 AND 2020

	2021	2020
REVENUES:		
Net premium income	$ 21,401,250,183	$ 19,350,388,395
Change in unearned premium reserves and reserve for rate credits	61,272,544	(270,653,296)
Total revenues	21,462,522,727	19,079,735,099
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	16,836,425,974	13,588,100,367
Other professional services	11,176,020	6,508,533
Emergency room and out-of-area	768,151,125	599,365,529
Prescription drugs	451,064,825	468,453,332
Incentive pool, withhold adjustments, and bonus amounts	120,135,391	218,032,201
Net reinsurance incurred	262,728	634,799
Total hospital and medical	18,187,216,063	14,881,094,761
Claims adjustment expenses	624,638,171	587,875,291
General administrative expenses	1,019,973,076	1,268,485,267
Total underwriting deductions	19,831,827,310	16,737,455,319
NET UNDERWRITING GAIN	1,630,695,417	2,342,279,780
NET INVESTMENT GAINS:		
Net investment income earned	64,862,703	63,434,029
Net realized capital gains less capital gains tax of $3,269,301 and $3,230,841 in 2021 and 2020, respectively	12,298,774	12,154,118
Total net investment gains	77,161,477	75,588,147
NET LOSS FROM PREMIUM BALANCES CHARGED OFF	(735,972)	(373,951)
OTHER INCOME	113,569	2,039,870
NET INCOME BEFORE FEDERAL INCOME TAXES	1,707,234,491	2,419,533,846
FEDERAL INCOME TAXES INCURRED	354,666,489	580,475,662
NET INCOME	$ 1,352,568,002	$ 1,839,058,184

See notes to statutory basis financial statements.

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2021 AND 2020

	Section 9010 Affordable Care Act ("ACA") Subsequent Fee Year Assessment	Common Capital Stock Shares	Amount	Gross Paid-In and Contributed Surplus	Unassigned Surplus	Total Capital and Surplus
BALANCE — January 1, 2020	$ 361,730,663	250,000	$ 3,600,000	$ 632,333,259	$ 1,959,173,314	$ 2,956,837,236
Net income	-	-	-	-	1,839,058,184	1,839,058,184
Change in net unrealized capital losses less capital gains benefit of ($41,004)	-	-	-	-	(154,249)	(154,249)
Change in net deferred income taxes	-	-	-	-	(9,654,699)	(9,654,699)
Change in nonadmitted assets	-	-	-	-	46,293,592	46,293,592
Paid-in surplus	-	-	-	8,112	-	8,112
Cash dividends to parent	-	-	-	-	(1,500,000,000)	(1,500,000,000)
Section 9010 ACA subsequent fee year assessment	(361,730,663)	-	-	-	361,730,663	-
BALANCE — December 31, 2020	-	250,000	3,600,000	632,341,371	2,696,446,805	3,332,388,176
Net income	-	-	-	-	1,352,568,002	1,352,568,002
Change in net unrealized capital losses less capital gains benefit of ($12,070)	-	-	-	-	(45,407)	(45,407)
Change in net deferred income taxes	-	-	-	-	333,709	333,709
Change in nonadmitted assets	-	-	-	-	(998,047)	(998,047)
Paid-in surplus	-	-	-	7,660	-	7,660
Cash dividends to parent	-	-	-	-	(1,825,000,000)	(1,825,000,000)
BALANCE — December 31, 2021	$ -	250,000	$ 3,600,000	$ 632,349,031	$ 2,223,305,062	$ 2,859,254,093

See notes to statutory basis financial statements.

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2021 AND 2020

	2021	2020
CASH FLOWS FROM OPERATIONS:		
Premiums collected, net of reinsurance	$ 21,183,985,719	$ 19,553,109,882
Net investment income	91,069,064	74,415,533
Benefit and loss related payments	(18,216,494,539)	(14,876,031,804)
Commissions and other expenses paid	(1,970,729,290)	(1,884,328,908)
Federal income taxes paid, net	(361,782,503)	(599,500,342)
Net cash provided by operations	726,048,451	2,267,664,361
CASH FLOWS FROM INVESTMENTS:		
Proceeds from investments sold, matured or repaid:		
Bonds	1,862,313,582	1,018,377,189
Mortgage loans	74,167	-
Net losses on cash equivalents and short-term investments	(12,001)	(46,937)
Miscellaneous proceeds	-	1,953,000
Total investment proceeds	1,862,375,748	1,020,283,252
Cost of investments acquired:		
Bonds	(1,295,696,282)	(1,919,598,934)
Stocks	(3,270,000)	-
Mortgage loans	(19,006,823)	-
Real estate	(49,320,000)	-
Miscellaneous applications	(4,954,069)	-
Total investments acquired	(1,372,247,174)	(1,919,598,934)
Net cash provided by (used in) investments	490,128,574	(899,315,682)
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Cash provided by (used in) net transfers from (to) affiliates	176,715,073	(80,283,407)
Paid-in surplus	7,660	8,112
Dividends paid	(1,825,000,000)	(1,500,000,000)
Other cash provided (applied)	1,403,362	(1,302,413)
Net cash used in financing and miscellaneous activities	(1,646,873,905)	(1,581,577,708)
RECONCILIATION OF CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS:		
NET CHANGE IN CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS	(430,696,880)	(213,229,029)
CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS — Beginning of year	783,129,666	996,358,695
CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS — End of year	$ 352,432,786	$ 783,129,666

See notes to statutory basis financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GOING CONCERN

Organization and Operation

Sierra Health and Life Insurance Company, Inc. (the "Company"), licensed as a life, accident, and health insurer, offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The Company is a wholly owned subsidiary of Sierra Health Services, Inc. ("Sierra"). Sierra is a wholly owned subsidiary of UnitedHealth Group Incorporated ("UnitedHealth Group"). UnitedHealth Group is a publicly held company trading on the New York Stock Exchange.

The Company was incorporated on August 16, 1906, as a life, accident, and health insurer and operations commenced in August 1906. The Company is certified as a life, accident, and health insurer by the Nevada Division of Insurance (the "Division") and is licensed in 50 states, the District of Columbia, and the U.S. Virgin Islands. The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees.

The Company offers comprehensive commercial, dental, vision, and Medicare supplement products to individual and employer groups. Each contract outlines the coverage provided and renewal provisions.

The Company serves as a plan sponsor offering Medicare Parts A & B, along with Medicare Part D prescription drug insurance coverage, as well as Medicare specialized programs including an Institutional Special Needs Plan (collectively "Medicare Plans") under contracts with the Centers for Medicare and Medicaid Services ("CMS").

A. Accounting Practices

The statutory basis financial statements (herein referred to as "financial statements") are presented on the basis of accounting practices prescribed or permitted by the Division.

The Division recognizes only statutory accounting practices, prescribed or permitted by the State of Nevada (the "State"), for determining and reporting the financial condition and results of operations of a life, accident, and health insurer for determining its solvency under Nevada Insurance Law. The State prescribes the use of the National Association of Insurance Commissioners' ("NAIC") Accounting Practices and Procedures manual ("NAIC SAP") in effect for the accounting periods covered in the financial statements.

No significant differences exist between the practices prescribed or permitted by the State and the NAIC SAP which materially affect the statutory basis net income and capital and surplus, as illustrated in the table below:

	SSAP #	AFS Line Desc	December 31, 2021	December 31, 2020
Net (Loss) Income				
(1) Company state basis	XXX	XXX	$ 1,352,568,002	$ 1,839,058,184
(2) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not Applicable			-	-
(3) State permitted practices that are an increase/(decrease) from NAIC SAP: Not Applicable			-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	$ 1,352,568,002	$ 1,839,058,184
Capital and Surplus				
(5) Company state basis	XXX	XXX	$ 2,859,254,093	$ 3,332,388,176
(6) State prescribed practices that are an increase/(decrease) from NAIC SAP:			-	-
(7) State permitted practices that are an increase/(decrease) from NAIC SAP: Not Applicable			-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	$ 2,859,254,093	$ 3,332,388,176

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of these financial statements in conformity with the NAIC Annual Statement Instructions and the NAIC SAP include certain amounts that are based on the Company's estimates and judgments. These estimates require the Company to apply complex assumptions and judgments, often because the Company must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to hospital and medical benefits, claims unpaid, aggregate health policy reserves (including medical loss ratio rebates), aggregate health claim reserves, and risk adjustment estimates. The Company adjusts these estimates each period as more current information becomes available. The impact of any changes in estimates is included in the determination of net income in the period in which the estimate is adjusted.

C. Accounting Policy

Basis of Presentation — The Company prepares its financial statements on the basis of accounting practices prescribed or permitted by the Division. These statutory practices differ from accounting principles generally accepted in the United States of America ("GAAP").

The Company has deemed the following to be significant differences between statutory practices and GAAP:

- Certain debt investments categorized as available-for-sale or held-to-maturity under GAAP are presented at the lower of book/adjusted carrying value or fair value in accordance with the NAIC designations in the financial statements, whereas under GAAP, these investments are shown at fair value or book/adjusted carrying value, respectively.

- Cash, cash equivalents, and short-term investments in the financial statements represent cash balances and investments with original maturities of one year or less from the time of acquisition, whereas under GAAP, the corresponding caption of cash, cash equivalents, and short-term investments includes cash balances and investments that will mature in one year or less from the balance sheet date.

- The statutory basis statements of cash flows reconcile the corresponding captions of cash, cash equivalents, and short-term investments, which can include restricted cash reserves, with original maturities of one year or less from the time of acquisition, whereas under GAAP, the statements of cash flows reconcile the corresponding captions of cash, cash equivalents and restricted cash with maturities of three months or less. Short-term investments with a final maturity of one year or less from the balance sheet date are not included in the reconciliation of GAAP cash flows. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and NAIC SAP. The statutory basis statements of cash flows are prepared in accordance with the NAIC Annual Statement Instructions.

- Certain assets, including certain aged premium receivables, certain health care and other amounts receivable, prepaid expenses, and certain amounts receivable relating to uninsured plans, are considered nonadmitted assets under the NAIC SAP and are excluded from the financial statements and charged directly to unassigned surplus (deficit).

- Comprehensive income and its components are not separately presented in the financial statements, whereas under GAAP, it is a requirement to present comprehensive income and its components in the financial statements.

Accounting policy disclosures that are required by the NAIC Annual Statement instructions are as follows:

(1–2) Bonds and short-term investments are stated at book/adjusted carrying value if they meet NAIC designation of one or two and stated at the lower of book/adjusted carrying value or fair value if they meet an NAIC designation of three or higher. The Company does not have any mandatory convertible securities or Investment Analysis Office of the NAIC (“IAO”) identified funds (i.e.: exchange traded funds or bond mutual funds) in its bond portfolio. Amortization of bond premium or accretion of discount is calculated using the constant-yield interest method. Bonds and short-term investments are valued and reported using market prices published by the IAO in accordance with the NAIC Valuation of Securities manual prepared by the IAO or an external pricing service;

(3–4) The Company holds no common stock. Preferred stocks are nonaffiliated and have a carrying value that is calculated in accordance with the guidance set forth in the Statement of Statutory Accounting Principles (“SSAP”) No. 32, Preferred Stock;

(5) Mortgage loans on real estate are stated at aggregate carrying value calculated in accordance with the guidance set forth in SSAP No. 37, Mortgage Loans;

(6) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors. The Company’s investment policy limits investments in nonagency residential mortgage-backed securities, including home equity and sub-prime mortgages, to 10% of total cash and invested assets. Total combined investments in mortgage-backed securities and asset-backed securities cannot exceed more than 30% of total cash and invested assets;

(7) The Company holds no investments in subsidiaries, controlled, or affiliated entities;

(8) The Company has no investment interests with respect to joint ventures, partnerships, or limited liability companies;

(9) The Company holds no derivatives;

(10) Premium deficiency reserves ("PDR") (inclusive of conversion reserves) and the related expenses are recognized when it is probable that expected future health care expenses, claims adjustment expenses ("CAE"), direct administration costs, and an allocation of indirect administration costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries considered over the remaining lives of the contracts, and are recorded as aggregate health policy reserves in the financial statements. Indirect administration costs arise from activities that are not specifically identifiable to a specific group of existing contracts, and therefore, those costs are fully allocated among the various contract groupings. The allocation of indirect administration costs to each contract grouping is made proportionately to the expected margins remaining in the premiums after future health care expenses, CAE and direct administration costs are considered. The data and assumptions underlying such estimates and the resulting reserves are periodically updated, and any adjustments are reflected in the financial statements in the period in which the change in estimate is identified. The Company does anticipate investment income as a factor in the PDR calculation (see Note 30);

(11) CAE are those costs expected to be incurred in connection with the adjustment and recording of accident and health claims. Pursuant to the terms of the management agreement ("Agreement") (see Note 10), the Company pays a management fee to its affiliate, United HealthCare Services, Inc. ("UHS"), in exchange for administrative and management services. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and general administrative expenses ("GAE") to be reported in the financial statements. It is the responsibility of UHS to pay CAE in the event the Company ceases operations. The Company has recorded an estimate of unpaid CAE associated with incurred but unpaid claims, which is included in unpaid CAE in the financial statements. Management believes the amount of the liability for unpaid CAE as of December 31, 2021 is adequate to cover the Company's cost for the adjustment and recording of unpaid claims; however, actual expenses may differ from those established estimates. Adjustments to the estimates for unpaid CAE are reflected in operating results in the period in which the change in estimate is identified;

(12) Maintenance and repairs that do not improve or extend the life of the respective assets are expensed in the period incurred and included in GAE in the financial statements. The Company has not modified its capitalization policy from the prior period.

Property Occupied by the Company — The Company owns two properties (collectively referred to as "real estate"). The first property includes land and a building which is occupied by the Company. The second property, purchased in 2021, includes land and a building which is leased by affiliates.

Real estate is carried at depreciated cost less encumbrances unless events or circumstances indicate the carrying amount of the asset may not be recoverable. The Company calculates depreciation using the straight-line method over the estimated useful lives of the property, excluding land, which is 35 to 40 years for buildings and 5 to 35 years for improvements. An impairment loss is recognized when the individual carrying amounts exceed the fair value. The new cost basis shall not be changed for subsequent recoveries in fair value. The Company did not recognize any impairment losses on properties occupied by the Company in 2021 and 2020. Depreciation expense of $550,273 and $166,301 in 2021 and 2020, respectively, is netted against net investment income earned in the financial statements.

The Company has recorded rental income (excluding imputed rent) and expenses (excluding depreciation) for real estate in the amount of $892,145 and $78,817 in 2021 and $26,100 and $434,192 in 2020, respectively, which is included in net investment income earned in the financial statements. The Company's imputed rental income and expense of $1,582,724 in 2021 and 2020 is calculated in accordance with NAIC SAP principles and is included in net investment income earned and GAE in the financial statements.

The components of real estate, at December 31, 2021 and 2020, are as follows:

	2021	2020
Real Estate		
Land, buildings, and improvements	$ 56,846,485	$ 7,526,485
Less: accumulated depreciation	(5,861,240)	(5,310,967)
Net admitted Real Estate	$ 50,985,245	$ 2,215,518

(13) Health care and other amounts receivable consist of pharmacy rebates receivable estimated based on the most currently available data from the Company's claims processing systems and from data provided by the Company's affiliated pharmaceutical benefit manager ("PBM"), OptumRx, Inc. ("OptumRx"). Health care and other amounts receivable also include receivables for amounts due to the Company for provider advances and claim overpayments to providers, hospitals and other health care organizations. Health care and other amounts receivable are considered nonadmitted assets under the NAIC SAP if they do not meet admissibility requirements. Accordingly, the Company has excluded receivables that do not meet the admissibility criteria from the financial statements (see Note 28).

The Company has also deemed the following to be significant accounting policies:

ASSETS

Cash and Invested Assets

- Bonds include securities with a maturity of greater than one year at the time of purchase;

- Cash equivalents include securities that have original maturity dates of three months or less from the date of acquisition. Cash equivalents also consist of the Company's share of a qualified cash pool sponsored and administered by UHS. The investment pool is recorded at cost or book/adjusted carrying value depending on the composition of the underlying securities. Interest income from the pool accrues daily to participating members based upon ownership percentage. Cash equivalents, excluding money-market funds, are reported at cost or book/adjusted carrying value depending on the nature of the underlying security, which approximates fair value. Money-market funds are reported at fair value or net asset value ("NAV") as a practical expedient;

- Realized capital gains and losses on sales of investments are calculated based upon specific identification of the investments sold. These gains and losses are reported as net realized capital gains less capital gains tax ("net realized capital gains (losses) less taxes") in the financial statements.

- The Company continually monitors the difference between amortized cost and estimated fair value of its investments. If any of the Company's investments experience a decline in value that the Company has determined is other-than-temporary, or if the Company has determined it will sell a security that is in an impaired status, the Company will record a

realized loss in net realized capital gains (losses) less taxes in the financial statements. The new cost basis is not changed for subsequent recoveries in fair value. The prospective adjustment method is utilized for loan-backed securities for periods subsequent to the loss recognition (see Note 5).

Other Assets

- **Premiums and Considerations** — The Company reports uncollected premium balances from its insured members, groups, and CMS as premiums and considerations in the financial statements. Uncollected premium balances that are over 90 days past due, with the exception of amounts due from government insured plans, are considered nonadmitted assets. In addition to those balances, current balances are also considered nonadmitted if the corresponding balance greater than 90 days past due is deemed more than inconsequential. Premiums and considerations also include amounts for CMS risk adjustment receivables for the Medicare Plans.

  Premium adjustments for the CMS risk adjustment programs are accounted for as premium adjustments subject to redetermination (see Note 24).

- **Amounts Receivable Relating to Uninsured Plans** — The Company reports amounts due to the Company from CMS and groups for the administrative activities it performs for which it has no insurance risk as amounts receivable relating to uninsured plans (see Note 18). Amounts receivable relating to uninsured plans include costs incurred by the Company that are in excess of the cost reimbursement under the Medicare Plans for the catastrophic reinsurance subsidy and the low-income member cost sharing subsidy and amounts due from the pharmaceutical manufacturers for reimbursement of the discounts under the Patient Protection and Affordable Care Act and its related legislation (“ACA”) which mandates consumer discounts on brand name prescription drugs for Part D plan participants in the coverage gap.

LIABILITIES

- **Claims Unpaid and Aggregate Health Claim Reserves —** Claims unpaid and aggregate health claim reserves include claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  The estimates for incurred but not yet reported claims are developed using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates such liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. These estimates may change as actuarial methods change or as underlying facts upon which estimates are based change. The Company did not change actuarial methods during 2021 and 2020. Management believes the amount of claims unpaid and aggregate health claim reserves is a best estimate of the Company’s liability for unpaid claims and aggregate health claim reserves as of December 31, 2021; however, actual payments may differ from those established estimates.

  The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital per diem to provide medical care services to enrollees. Some of these contracts are with related

parties (see Note 10). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

- **Aggregate Health Policy Reserves** — The Company establishes a liability for estimated accrued retrospective and redetermination premiums due from the Company based on the actuarial method and assumptions for each respective contract. Aggregate health policy reserves includes estimated medical loss ratio ("MLR") rebates payable on the comprehensive commercial and Medicare plans and experience rated refund payables for employer groups that have contracts with retrospective rating features based on the underlying contractual terms of the agreements.

  Premium adjustments for the estimated MLR rebates and experienced rated refund payables are accounted for as premium adjustments subject to retrospectively rated features (see Note 24).

CAPITAL AND SURPLUS AND MINIMUM STATUTORY REQUIREMENTS

- **Restricted Cash Reserves** — The Company is in compliance with various states regulatory deposit requirements as of December 31, 2021 and 2020, respectively, for qualification purposes as a domestic and foreign insurer. These restricted cash reserves are stated at book/adjusted carrying value, which approximates fair value. These restricted deposits are included in bonds in the financial statements. Interest earned on these deposits accrues to the Company (see Note 5).

- **Minimum Capital and Surplus** — Under the laws of the State of Nevada, the Company's domiciliary state, the Division requires the Company to maintain a minimum capital and surplus equal to $1,500,000.

  Risk-based capital ("RBC") is a regulatory tool for measuring the minimum amount of capital appropriate for a life, accident and health organization to support its overall business operations in consideration of its size and risk profile. The Division requires the Company to maintain minimum capital and surplus equal to the greater of the state statute as outlined above, or the company action level as calculated by the RBC formula, or the level needed to avoid action pursuant to the trend test in the RBC formula.

  The Company is also subject to minimum capital and surplus requirements in other states where it is licensed to do business.

  The Company is in compliance with the minimum required capital and surplus amounts where it is licensed to do business, as of December 31, 2021 and 2020.

STATEMENTS OF OPERATIONS

- **Net Premium Income and Change in Unearned Premium Reserves and Reserve for Rate Credits** — Revenues consist of net premium income that is recognized in the period in which enrollees are entitled to receive health care services. Net premium income is shown net of reinsurance premiums received and reinsurance premiums earned but not received in the financial statements. The corresponding change in unearned premium from year to year is reflected as a change in unearned premium reserves and reserve for rate credits in the financial statements.

  Comprehensive commercial health plans with MLRs on fully insured products, as calculated under the definitions in the ACA and implementing regulations, that fall below

certain targets are required to rebate ratable portions of premiums annually. The Company classifies changes to the estimated rebates and retrospective premium adjustments as change in unearned premium reserves and reserve for rate credits in the financial statements (see Note 24). In addition, pursuant to Section 1343 of the ACA, the Company records premium adjustments for changes to the commercial risk adjustment balances which are reflected in net premium income in the financial statements (see Note 24).

Medicare Plans with MLRs on fully insured products, as calculated under the definitions in the ACA and implementing regulations, that fall below certain targets are required to rebate ratable portions of premiums annually. In addition, the Company records premium adjustments for changes to the CMS Medicare Plans risk corridor program. Changes to these estimates are reflected in change in unearned premium reserves and reserve for rate credits in the financial statements (see Note 24). Net premium income also includes premium under the Medicare Plans which includes CMS premiums, including amounts pursuant to the CMS risk adjustment program (see Note 24), member premiums, and the CMS low-income premium subsidy for the Company's insurance risk coverage.

Net premium income also includes dental, vison, and Medicare supplement revenue. Dental, vision, and Medicare supplement revenue is recognized in the period in which enrollees are entitled to receive services.

- **Total Hospital and Medical Expenses** — Total hospital and medical expenses include claims paid, claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  Total hospital and medical expenses also include amounts incurred for incentive pool, withhold adjustments, and bonus amounts that are based on the underlying contractual provisions with the respective providers. In addition, adjustments to claims unpaid estimates and aggregate health claim reserves are reflected in the period once the change in estimate is identified and included in total hospital and medical expenses in the financial statements.

- **General Administrative Expenses** — General expenses that have been paid as of the reporting date in addition to general expenses that have been incurred but are not due until a subsequent period are reported as general administrative expenses. Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to UHS in exchange for administrative and management services. Costs for items not included within the scope of the Agreement are directly expensed as incurred. State income taxes and premium taxes are also a component of GAE. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and GAE to be reported in the financial statements.

  Administrative fee revenues consist primarily of fees derived from services performed for customers that self-insure the pharmaceutical benefits of their employees and retirees. Under these contracts, the Company recognizes revenue in the period in which the related services are performed. The customers retain the risk of financing pharmaceutical benefits for their employees and retirees, and the Company administers the payment of customer funds to pharmaceutical providers. As the Company has neither the obligation for funding the pharmaceutical benefits, nor the primary responsibility for providing the pharmaceutical benefits, the Company does not recognize net premium income and prescription benefits for these contracts. Administrative fee revenue and related expenses are netted against GAE in the financial statements (see Note 18).

- **Federal Income Taxes Incurred** — The provision for federal income taxes incurred is calculated based on applying the statutory federal income tax rate of 21% to net income before federal income taxes and net realized capital gains subject to certain adjustments (see Note 9).

OTHER

- **Vulnerability Due to Certain Concentrations** — The Company is subject to substantial federal and state government regulation, including licensing and other requirements relating to the offering of the Company's existing products in new markets and offerings of new products, both of which may restrict the Company's ability to expand its business.

  The Company has no commercial customers that individually exceed 10% of total direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, for the years ended December 31, 2021 and 2020.

  Direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, from members and CMS related to the Medicare Plans as a percentage of total direct premiums written and total uncollected premiums, including receivables for contracts subject to redetermination, are 98% and 99% as of December 31, 2021 and 98% and 99% as of December 31, 2020, respectively.

Recently Issued Accounting Standards — In July 2020, the NAIC revised SSAP No. 106, *Affordable Care Act Section 9010 Assessment* for the repeal of the ACA Section 9010 Assessment, effective January 1, 2021. The Company adopted the revision on the effective date.

The Company reviewed all other recently issued guidance in 2021 and 2020 that has been adopted for 2021 or subsequent years' implementation and has determined that none of the items would have a significant impact to the financial statements.

D. Going Concern

The Company has the ability and will continue to operate for a period of time sufficient to carry out its commitments, obligations and business objectives.

2. ACCOUNTING CHANGES AND CORRECTIONS OF ERRORS

No changes in accounting principles or corrections of errors have been recorded during the years ended December 31, 2021 and 2020.

3. BUSINESS COMBINATIONS AND GOODWILL

A–E. The Company was not party to a business combination during the years ended December 31, 2021 and 2020, and does not carry goodwill in its financial statements.

4. DISCONTINUED OPERATIONS

A. Discontinued Operation Disposed of or Classified as Held for Sale

(1–4) The Company did not have any discontinued operations disposed of or classified as held for sale during 2021 and 2020.

B. Change in Plan of Sale of Discontinued Operation — Not applicable.

C. Nature of any Significant Continuing Involvement with Discontinued Operations after Disposal — Not applicable.

D. Equity Interest Retained in the Discontinued Operation after Disposal — Not applicable.

5. INVESTMENTS

For purposes of calculating gross realized gains and losses on sales of investments, the amortized cost of each investment sold is used. The gross realized gains and losses on sales of long-term investments were $23,447,462 and $7,697,079, respectively, for 2021 and $20,258,691 and $2,805,865, respectively, for 2020. The gross realized gains and losses on sales of short-term investments were $1,850 and $14,004, respectively, for 2021 and $0 and $23,898, respectively, for 2020. The net realized gain is included in net realized capital gains (losses) less taxes in the financial statements. Total proceeds on the sale of long-term investments were $1,322,224,841 and $702,640,412 and for short-term investments were $39,207,391 and $139,433,387 in 2021 and 2020, respectively.

As of December 31, 2021 and 2020, the book/adjusted carrying value, fair value, and gross unrecognized unrealized gains and losses of the Company's investments, excluding cash and cash equivalents of $352,432,786 and $667,875,588 respectively, are disclosed in the table below:

	2021				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 442,370,220	$ 4,028,073	$ 7,040,364	$ 191,949	$ 439,165,980
State and agency municipal securities	185,193,652	9,983,711	404,158	73,363	194,699,842
City and county municipal securities	230,704,238	8,642,858	461,402	93,857	238,791,837
Corporate debt securities	1,331,758,299	25,309,543	4,629,201	406,741	1,352,031,900
Preferred stocks	3,270,000	143,880	-	-	3,413,880
Total bonds and preferred stocks	$ 2,193,296,409	$ 48,108,065	$ 12,535,125	$ 765,910	$ 2,228,103,439

	2021				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
Less than one year	$ 16,514,931	$ 19,660	$ 25,938	$ -	$ 16,508,653
One to five years	527,301,371	10,094,684	3,222,049	1,772	534,172,234
Five to ten years	820,452,528	22,064,204	2,759,476	240,604	839,516,652
Over ten years	829,027,579	15,929,517	6,527,662	523,534	837,905,900
Total bonds and preferred stocks	$ 2,193,296,409	$ 48,108,065	$ 12,535,125	$ 765,910	$ 2,228,103,439

	2020				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 914,442,354	$ 24,764,637	$ 367,261	$ -	$ 938,839,730
State and agency municipal securities	303,283,534	20,404,577	10,803	-	323,677,308
City and county municipal securities	251,568,321	12,606,422	37,741	-	264,137,002
Corporate debt securities	1,398,239,947	62,634,215	869,091	813,577	1,459,191,494
Total bonds and short-term investments	$ 2,867,534,156	$ 120,409,851	$ 1,284,896	$ 813,577	$ 2,985,845,534

Included in U.S. government and agency securities and corporate debt securities in the tables above are mortgage-related loan-backed securities, which do not have a single maturity date. For the years to maturity table above, these securities have been presented in the maturity group based on the securities' final maturity date and at a book/adjusted carrying value of $465,433,518 and fair value of $467,827,877.

The following table illustrates the fair value and gross unrecognized unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrecognized unrealized loss position as of December 31, 2021 and 2020:

	2021					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 332,868,478	$ 7,040,364	$ 9,850,292	$ 191,949	$ 342,718,770	$ 7,232,313
State and agency municipal securities	30,220,373	404,158	3,963,900	73,363	34,184,273	477,521
City and county municipal securities	31,805,872	461,402	3,870,810	93,857	35,676,682	555,259
Corporate debt securities	542,855,329	4,629,201	24,241,097	406,741	567,096,426	5,035,942
Total bonds	$ 937,750,052	$ 12,535,125	$ 41,926,099	$ 765,910	$ 979,676,151	$ 13,301,035

	2020					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 82,035,580	$ 367,261	$ -	$ -	$ 82,035,580	$ 367,261
State and agency municipal securities	4,142,640	10,803	-	-	4,142,640	10,803
City and county municipal securities	6,279,501	37,741	-	-	6,279,501	37,741
Corporate debt securities	161,236,581	869,091	69,882,733	813,577	231,119,314	1,682,668
Total bonds and short-term investments	$ 253,694,302	$ 1,284,896	$ 69,882,733	$ 813,577	$ 323,577,035	$ 2,098,473

The unrecognized unrealized losses on investments in U.S. government and agency securities, state and agency municipal securities, city and county municipal securities, and corporate debt securities at December 31, 2021 and 2020, were mainly caused by interest rate fluctuations and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for each of the securities whereby the fair value of the investment is less than its book/adjusted carrying value. The contractual cash flows of the U.S. government and agency securities are guaranteed either by the U.S. government or an agency of the U.S. government. It is expected that the securities would not be settled at a price less than the cost of the investment, and the Company does not intend to sell the investment until the unrealized loss is fully recovered. The Company assessed the credit quality of the state and agency municipal securities, city and county municipal securities and corporate debt securities, noting whether a significant deterioration since purchase or other factors that may indicate an other-than-temporary impairment ("OTTI"), such as the length of time and extent to which fair value has been less than cost, the financial condition, and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the investment. Additionally, the Company evaluated its intent and ability to retain loan-backed securities for a period of time sufficient to recover the amortized cost. As a result of these reviews, the Company recorded an OTTI of $4,606 and $2,029,239 as of December 31, 2021 and 2020, respectively, which are included in net realized capital gains (losses) less taxes in the financial statements.

A. Mortgage Loans, including Mezzanine Real Estate Loans

(1) The maximum and minimum lending rates for mortgage loans during 2021 were 1% and 1%.

(2) The maximum percentage of any one loan to the value of security at the time of the loan, exclusive of insured or guaranteed or purchase money mortgage was: 100%.

(3) The Company is not responsible for taxes or assessments on mortgage loans.

(4) The age analysis of mortgage loans and identification of mortgage loans in which the insurer is a participant or co-lender in a mortgage loan agreement is presented below:

	Farm	Residential		Commercial		Mezzanine	Total
		Insured	All Other	Insured	All Other		
a. Current year							
1. Recorded investment (all)							
(a) Current	$ -	$ -	$ -	$ -	$ 18,932,656	$ -	$ 18,932,656
(b) 30–59 days past due	-	-	-	-	-	-	-
(c) 60–89 days past due	-	-	-	-	-	-	-
(d) 90–179 days past due	-	-	-	-	-	-	-
(e) 180+ days past due	-	-	-	-	-	-	-
2. Accruing Interest 90–179 days past due							
(a) Recorded investment	-	-	-	-	-	-	-
(b) Interest accrued	-	-	-	-	-	-	-
3. Accruing interest 180+ days past due							
(a) Recorded investment	-	-	-	-	-	-	-
(b) Interest accrued	-	-	-	-	-	-	-
4. Interest reduced							
(a) Recorded investment	-	-	-	-	-	-	-
(b) Number of loans	-	-	-	-	-	-	-
(c) Percent reduced	-	-	-	-	-	-	-
5. Participant or co-lender in a mortgage loan agreement	-	-	-	-	-	-	-
(a) Recorded investment	-	-	-	-	18,932,656	-	18,932,656
b. Prior year							
1. Recorded investment (all)							
(a) Current	-	-	-	-	-	-	-
(b) 30–59 days past due	-	-	-	-	-	-	-
(c) 60–89 days past due	-	-	-	-	-	-	-
(d) 90–179 days past due	-	-	-	-	-	-	-
(e) 180+ days past due	-	-	-	-	-	-	-
2. Accruing Interest 90–179 days past due							
(a) Recorded investment	-	-	-	-	-	-	-
(b) Interest accrued	-	-	-	-	-	-	-
3. Accruing interest 180+ days past due							
(a) Recorded investment	-	-	-	-	-	-	-
(b) Interest accrued	-	-	-	-	-	-	-
4. Interest reduced							
(a) Recorded investment	-	-	-	-	-	-	-
(b) Number of loans	-	-	-	-	-	-	-
(c) Percent reduced	-	-	-	-	-	-	-
5. Participant or co-lender in a mortgage loan agreement	-	-	-	-	-	-	-
(a) Recorded investment	-	-	-	-	-	-	-

(5-9) The Company has no investments in impaired loans and has no allowance for credit losses. The Company also has no mortgage loans derecognized as a result of foreclosure.

B–C. The Company has no real estate loans, restructured debt, or reverse mortgages. The Company also has no real estate property held for the production of income or real estate property held for sale. The Company has not recognized any impairment losses on real estate property occupied by the Company as of December 31, 2021 and 2020.

D. Loan-Backed Securities

(1) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors.

(2) The Company did not recognize any OTTIs on loan-backed securities as of December 31, 2021.

(3) The Company did not have any loan-backed securites with an OTTI to report by CUSIP as of December 31, 2021. The table below represents the loan-backed securities with an OTTI for the year ended December 31, 2020, presented by CUSIP:

			2020			
1	2	3	4	5	6	7
CUSIP	Book/Adjusted Carrying Value Amortized Cost before Current Period OTTI	Present Value of Projected Cash Flows	Recognized Other-than-Temporary Impairment	Amortized Cost After Other-than-Temporary Impairment	Fair Value at Time of OTTI	Date of Financial Statement Where Reported
75383HAA9	$ 2,307,003	$ 2,040,466	$ 266,536	$ 2,040,466	$ 2,040,466	$ 44,104
44422PBY7	3,544,219	2,360,786	1,183,434	2,360,786	2,360,786	44,104
90345WAD6	227,197	187,611	39,586	187,611	187,611	44,196
Total	XXX	XXX	$ 1,489,556	XXX	XXX	XXX

(4) The following table illustrates the fair value, gross unrecognized unrealized losses, and length of time that the loan-backed securities have been in a continuous unrecognized unrealized loss position as of December 31, 2021 and 2020:

	2021
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 6,297,855
2. 12 months or longer	475,253
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	432,133,316
2. 12 months or longer	30,148,847

	2020
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 1,006,245
2. 12 months or longer	813,577
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	194,630,429
2. 12 months or longer	69,882,733

(5). The Company believes that it will continue to collect timely the principal and interest due on its loan-backed securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate changes and not by unfavorable changes in the credit quality associated with these securities that impacted the assessment on collectability of principal and interest. At each reporting period, the Company evaluates available-for-sale debt securities for any credit-related impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the expected cash flows and the underlying credit quality and credit ratings of the issuers, noting no significant credit deterioration since purchase. As of December 31, 2021, the unrealized loss on any security that the Company classified as intent to sell was not material to the Company's investment portfolio. Any other securities in an unrealized loss position as of December 31, 2021, the Company considers to be temporary.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions — Not applicable.

F. Repurchase Agreements Transactions Accounted for as Secured Borrowing — Not applicable.

G. Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing — Not applicable.

H. Repurchase Agreements Transactions Accounted for as a Sale — Not applicable.

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale — Not applicable.

J. Real Estate — Not applicable.

K. Low-Income Housing Tax Credits — Not applicable.

L. Restricted Assets

(1) Restricted assets, including pledged securities as of December 31, 2021 and 2020, are presented below:

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted From Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted From Prior Year	3 Increase/ (Decrease) (1 Minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross (Admitted & Nonadmitted) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown	$ -	$ -	$ -	$ -	$ -	- %	- %
b. Collateral held under security lending agreements	-	-	-	-	-	-	-
c. Subject to repurchase agreements	-	-	-	-	-	-	-
d. Subject to reverse repurchase agreements	-	-	-	-	-	-	-
e. Subject to dollar repurchase agreements	-	-	-	-	-	-	-
f. Subject to dollar reverse repurchase agreements	-	-	-	-	-	-	-
g. Placed under option contracts	-	-	-	-	-	-	-
h. Letter stock or securities restricted as to sale—excluding FHLB capital stock	-	-	-	-	-	-	-
i. FHLB capital stock	-	-	-	-	-	-	-
j. On deposit with states	3,913,934	3,957,745	(43,811)	-	3,913,934	<1 %	<1 %
k. On deposit with other regulatory bodies	-	-	-	-	-	-	-
l. Pledged as collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-	-
m. Pledged as collateral not captured in other categories	-	-	-	-	-	-	-
n. Other restricted assets	-	-	-	-	-	-	-
o. Total restricted assets	$ 3,913,934	$ 3,957,745	$ (43,811)	$ -	$ 3,913,934	<1 %	<1 %

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 divided by Asset Page, Column 3, Line 28

(2–4) The Company has no assets pledged as collateral not captured in other categories and no other restricted assets as of December 31, 2021 or 2020.

M. Working Capital Finance Investments — Not applicable.

N. Offsetting and Netting of Assets and Liabilities

The Company does not have any offsetting or netting of assets and liabilities as it relates to derivatives, repurchase and reverse repurchase agreements, and securities borrowing and securities lending activities.

O. 5GI Securities

The Company does not have any investments with an NAIC designation of 5GI as of December 31, 2021 and 2020.

P. Short Sales — Not applicable.

Q. Prepayment Penalty and Acceleration Fees

The following table illustrates prepayment penalty and acceleration fees as of December 31, 2021:

	General Account
1. Number of CUSIPs	131
2. Aggregate Amount of Investment Income	$ 1,612,038

R. Reporting Entity's Share of Cash Pool by Asset Type

The Company's investment in the qualified cash pool is reported in cash equivalents. The Company's investment in the qualified cash pool is $748,226 and $125,615,059 as of December 31, 2021 and December 31, 2020, respectively. The following table presents the percent share distribution by underlying asset type of the total qualified cash pool balance as of December 31, 2021:

Asset Type	Percent Share
(1) Cash	- %
(2) Cash equivalents	52
(3) Short-term investments	48
(4) Total	100 %

6. JOINT VENTURES, PARTNERSHIPS, AND LIMITED LIABILITY COMPANIES

A–B. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceed 10% of admitted assets and did not recognize any impairment write-down for its investments in joint ventures, partnerships, and limited liability companies during the statement periods.

7. INVESTMENT INCOME

A. The Company excludes all investment income due and accrued amounts that are over 90 days past due from the financial statements.

B. There were no investment income amounts excluded from the financial statements.

8. DERIVATIVE INSTRUMENTS

A–B. The Company has no derivative instruments.

9. INCOME TAXES

A. Deferred Tax Asset/Liability

(1) The components of the net deferred tax asset at December 31, 2021 and 2020 are as follows:

	2021			2020			Change		
	1 Ordinary	2 Capital	3 (Col 1+2) Total	4 Ordinary	5 Capital	6 (Col 4+5) Total	7 (Col 1 - 4) Ordinary	8 (Col 2 - 5) Capital	9 (Col 7+8) Total
(a) Gross deferred tax assets	$ 13,622,344	$ 51,329	$ 13,673,673	$ 13,575,739	$ 39,259	$ 13,614,998	$ 46,605	$ 12,070	$ 58,675
(b) Statutory valuation allowance adjustments	-	51,328	51,328	-	39,259	39,259	-	12,069	12,069
(c) Adjusted gross deferred tax assets (1a - 1b)	13,622,344	1	13,622,345	13,575,739	-	13,575,739	46,605	1	46,606
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	13,622,344	1	13,622,345	13,575,739	-	13,575,739	46,605	1	46,606
(f) Deferred tax liabilities	1,196,689	-	1,196,689	1,495,862	-	1,495,862	(299,173)	-	(299,173)
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	$ 12,425,655	$ 1	$ 12,425,656	$ 12,079,877	$ -	$ 12,079,877	$ 345,778	$ 1	$ 345,779

(2) The components of the adjusted gross deferred tax assets admissibility calculation under SSAP No. 101, *Income Taxes*, are as follows:

	2021			2020			Change		
Admission Calculation Components SSAP No. 101	1 Ordinary	2 Capital	3 (Col 1 + 2) Total	4 Ordinary	5 Capital	6 (Col 4 + 5) Total	7 (Col 1 - 4) Ordinary	8 (Col 2 - 5) Capital	9 (Col 7 + 8) Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 13,406,476	$ 1	$ 13,406,477	$ 13,451,506	$ -	$ 13,451,506	$ (45,030)	$ 1	$ (45,029)
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation. (The lesser of 2(b)1 and 2(b)2 below)	-	-	-	170	-	170	(170)	-	(170)
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	170	-	170	(170)	-	(170)
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	427,024,266	XXX	XXX	498,046,245	XXX	XXX	(71,021,979)
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	215,868	-	215,868	124,063	-	124,063	91,805	-	91,805
(d) Deferred tax assets admitted as the result of application of SSAP No. 101 Total (2(a) + 2(b) + 2(c))	$ 13,622,344	$ 1	$ 13,622,345	$ 13,575,739	$ -	$ 13,575,739	$ 46,605	$ 1	$ 46,606

(3) The ratio percentage and adjusted capital and surplus used to determine the recovery period and threshold limitations for the admissibility calculation are presented below:

	2021	2020
(a) Ratio percentage used to determine recovery period and threshold limitation amount	>300%	>300%
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$ 2,846,828,437	$ 3,320,308,299

(4) The impact to the gross deferred tax assets balances as a result of tax-planning strategies as of December 31, 2021 and 2020 is presented below:

	2021		2020		Change	
	1	2	3	4	5	6
Impact of Tax-Planning Strategies	Ordinary	Capital	Ordinary	Capital	(Col 1 - 3) Ordinary	(Col 2 - 4) Capital
(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage.						
1. Adjusted gross DTAs amount from Note 9A1(c)	$ 13,622,344	$ 1	$ 13,575,739	$ -	$ 46,605	$ 1
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
3. Net admitted adjusted gross DTAs amount from Note 9A1(e)	$ 13,622,344	$ 1	$ 13,575,739	$ -	$ 46,605	$ 1
4. Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
(b) Does the Company's tax-planning strategies include the use of reinsurance?			Yes		No X	

B. Unrecognized Deferred Tax Liabilities

(1–4) There are no unrecognized deferred tax liabilities for the years ended December 31, 2021 and 2020.

C. Significant Components of Income Taxes

(1) The current federal and foreign income taxes incurred for the years ended December 31, 2021 and 2020 are as follows:

	1	2	3
	2021	2020	(Col 1 - 2) Change
1. Current income tax			
(a) Federal	$ 354,666,489	$ 580,475,662	$ (225,809,173)
(b) Foreign	-	-	-
(c) Subtotal	354,666,489	580,475,662	(225,809,173)
(d) Federal income tax on net capital gains	3,269,301	3,230,841	38,460
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred	$ 357,935,790	$ 583,706,503	$ (225,770,713)

(2–4) The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities as of December 31, 2021 and 2020, are as follows:

	1 2021	2 2020	3 (Col 1 - 2) Change
2 Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 6,047,810	$ 6,522,551	$ (474,741)
(2) Unearned premium reserve	993,916	911,207	82,709
(3) Policyholder reserves	-	-	-
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	215,868	124,573	91,295
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables — nonadmitted	6,205,896	5,998,263	207,633
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carryforward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	158,854	19,145	139,709
(99) Subtotal	13,622,344	13,575,739	46,605
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	13,622,344	13,575,739	46,605
(e) Capital:			
(1) Investments	-	-	-
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	51,329	39,259	12,070
(99) Subtotal	51,329	39,259	12,070
(f) Statutory valuation allowance adjustment	51,328	39,259	12,069
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	1	-	1
(i) Admitted deferred tax assets (2d + 2h)	13,622,345	13,575,739	46,606
3 Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	-	-	-
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	1,196,689	1,495,862	(299,173)
(99) Subtotal	1,196,689	1,495,862	(299,173)
(b) Capital:			
(1) Investments	-	-	-
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	-	-
(99) Subtotal	-	-	-
(c) Deferred tax liabilities (3a99 + 3b99)	1,196,689	1,495,862	(299,173)
4 Net deferred tax assets/liabilities (2i - 3c)	$ 12,425,656	$ 12,079,877	$ 345,779

The other capital deferred tax asset of $51,329 for 2021 and $39,259 for 2020 consists of unrealized loss. The other ordinary deferred tax liability of $1,196,689 for 2021 and $1,495,862 for 2020 consists of discounting of unpaid losses.

The Company assessed the potential realization of the gross deferred tax asset and established a valuation allowance to reduce the gross deferred tax asset which represents the amount of the asset estimated to be recoverable via carryback of losses and reduction of future taxes. The change in the valuation allowance is attributable to the change in timing of deductibility of expenses and/or expectations for future taxable income.

D. The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate of 21% to net income before federal income taxes incurred, plus capital gains tax. A summarization of the significant items causing this difference as of December 31, 2021 and 2020 is as follows:

	2021		2020	
	Amount	Effective Tax Rate	Amount	Effective Tax Rate
Tax provision at the federal statutory rate	$ 359,205,795	21 %	$ 508,780,584	21 %
Tax-exempt interest	(1,405,256)	-	(1,345,236)	-
Health insurer fee	-	-	76,163,205	3
Other current year items	(937)	-	1,735	-
Tax effect of nonadmitted assets	(209,590)	-	9,721,655	-
Change in statutory valuation allowance	12,069	-	39,259	-
Total statutory income taxes	$ 357,602,081	21 %	$ 593,361,202	24 %
Federal income taxes incurred	$ 354,666,489	21 %	$ 580,475,662	24 %
Capital gains tax	3,269,301	-	3,230,841	-
Change in net deferred income tax	(333,709)	-	9,654,699	-
Total statutory income taxes	$ 357,602,081	21 %	$ 593,361,202	24 %

E. At December 31, 2021, the Company had no net operating loss carryforwards.

Current federal income tax recoverable of $58,751,210 and $54,904,497 as of December 31, 2021 and 2020, respectively, are included in the financial statements. Federal income taxes paid, net of refunds, were $361,782,503 and $599,500,342 in 2021 and 2020, respectively.

Federal income taxes incurred of $357,935,790 and $583,706,503 for 2021 and 2020, respectively, are available for recoupment in the event of future net losses.

The Company has not admitted any aggregate amounts of deposits that are included within Section 6603 (“Deposits made to suspend running of interest on potential underpayments, etc.”) of the Internal Revenue Service (“IRS”) Code.

F. The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group. The entities included within the consolidated return are included in the NAIC Statutory Statement Schedule Y - Information Concerning Activities of Insurer Members Of A Holding Company Group. Federal income taxes are paid to or refunded by UnitedHealth Group pursuant to the terms of a tax-sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal return of UnitedHealth Group. UnitedHealth Group currently files income tax returns in the U.S. federal jurisdiction, various states, and foreign jurisdictions. The U.S. IRS has completed exams on UnitedHealth Group’s consolidated income tax returns for fiscal years 2016 and prior. UnitedHealth Group’s 2017 through 2020 tax returns are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, UnitedHealth Group is no longer subject to income tax examinations prior to the 2014 tax year. In general, the Company is

subject to examination in non-U.S. jurisdictions for years 2015 and forward. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

G. Tax Contingencies — Not applicable.

H. Repatriation Transition Tax — Not applicable.

I. Alternative Minimum Tax Credit — Not applicable.

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–B. In the ordinary course of business, the Company contracts with several affiliates to provide a wide variety of services to the Company's members. These agreements are filed with and approved by the Division according to Management's understanding of the current requirements and standards. Within the confines of the applicable filed and approved agreements (including subsequent amendments thereto), the amount and types of services provided by these affiliated entities can change year over year.

UHS maintains a private short-term investment pool in which affiliated companies may participate (see Note 1). At December 31, 2021 and 2020, the Company's portion was $748,226 and $125,615,059 respectively and is included in cash equivalents in the financial statements.

The Company has a tax-sharing agreement with UnitedHealth Group (see Note 9).

The Company paid dividends of $1,825,000,000 and $1,500,000,000 in 2021 and 2020, respectively, to its parent (see Note 13).

The Company holds a $25,000,000 subordinated revolving credit agreement with UnitedHealth Group at an interest rate of London InterBank Offered Rate plus a margin of 0.50%. This credit agreement is subordinate to the extent it does not conflict with any credit facility held by either party. This agreement shall continue until terminated by either party, provided the agreement is subject to renegotiation every three years beginning on the third anniversary of the effective date. No amounts were outstanding under the line of credit as of December 31, 2021 and 2020.

The Company has a subordinated revolving credit agreement with UHS at an interest rate of London InterBank Offered Rate plus a margin of 0.50%. Under this agreement, UHS can borrow money on a short-term basis from the Company. The aggregate principal amount that may be outstanding at any time is the lesser of 3% of the Company's admitted assets or 25% of the Company's policyholder surplus as of the preceding December 31. The Company has received approval from the Division to admit this receivable in the financial statements. As of December 31, 2021 and 2020, the outstanding balance under this agreement is $0 and $159,000,000, respectively, which is reported in affiliated note receivable in the financial statements. The total amount of interest earned through the reporting period is $62,975 and $70,941 as of December 31, 2021 and 2020, respectively.

The Company has entered into reinsurance agreements with affiliated entities (see Note 23).

C. Transactions With Related Parties Who Are Not Reported On Schedule Y

The Company has no material related party transactions that meet the disclosure requirements pursuant to SSAP No. 25, *Affiliates and Other Related Parties* ("SSAP No. 25") that are not included in NAIC Statutory Statement Schedule Y — Part 2 Summary Of Insurer's Transactions With Any Affiliates.

D. At December 31, 2021 and 2020, the Company reported $136,370,908 and $153,928,077, respectively, as receivables from parent, subsidiaries and affiliates, which are included in the financial statements. These balances are generally settled within 90 days from the incurred date. Any balances due to the Company that are not settled within 90 days are considered nonadmitted assets.

E. The administrative services, access fees, and cost of care services provided by affiliates are calculated using one or more of the following methods: (1) a percentage of premiums; (2) use of assets; (3) direct pass-through of charges; (4) per member per month; (5) per employee per month; (6) per claim; or (7) a combination thereof consistent with the provisions contained in each contract. These amounts are included in GAE, CAE, and hospital and medical expenses in the financial statements. The following table identifies the amounts reported for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2021 and 2020, which meet the disclosure requirements pursuant to SSAP No. 25, regardless of the effective date of the contract:

	2021	2020
UHS	$ 1,362,149,310	$ 1,280,942,183
LifePrint Health, Inc.	868,322,468	866,622,870
OptumRx	661,484,312	637,166,150
naviHealth, Inc.	639,737,926	-
Optum Care Networks, Inc.	86,343,953	89,623,640
Ear Professionals International Corporation	61,985,250	51,462,810
XLHome, P.C.	55,099,282	-
OptumInsight, Inc.	48,792,450	30,473,687
United Behavioral Health	37,981,943	28,954,682

UHS provides, or arranges for the provision of, management, administrative, and other services deemed necessary or appropriate for UHS to provide management and operational support to the Company. The services can include, but are not limited to, the categories of management and operational services outlined in the Agreement, such as human resources, legal, facilities, general administration, treasury and investment functions, claims adjudication and payment, benefit administration, disease management, health care decision support, medical management, credentialing, preventative health services, utilization management reporting and expenses incurred for new business that will be effective in the subsequent year.

LifePrint Health, Inc. provides services that may include, but are not limited to, care management services to eligible members and/or arranging for the delivery of clinical services to the Company's enrollees.

OptumRx provides services that may include, but are not limited to, administrative services related to pharmacy management and pharmacy claims processing for enrollees, manufacturer rebate administration, pharmacy incentive services, specialty drug pharmacy services, durable medical equipment services including orthotics and prosthetics and personal health products catalogues showing the healthcare products and benefit credits enrollees needed to redeem the respective products.

naviHealth, Inc. provides comprehensive post-acute services and care delivery.

Optum Care Networks, Inc. provides services that may include, but are not limited to, care management services to eligible members and/or arranging for the delivery of clinical services to the Company's enrollees.

Ear Professionals International Corporation provides hearing support services.

XLHome, P.C. provides medical services to the Company's members.

OptumInsight, Inc. provides services that may include, but are not limited to, claim analytics and recovery of medical expense overpayments, retroactive fraud, waste and abuse, subrogation and premium audit services. All recoveries are returned to the Company by OptumInsight, Inc. on a monthly basis.

United Behavioral Health provides services related to mental health and substance abuse treatment.

F. The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

G. The Company is part of an insurance holding company system with UnitedHealth Group as the ultimate parent. Management believes that the Company's transactions with affiliates are fair and reasonable; however, operations of the Company may not be indicative of those that would have occurred if it had operated as an independent company.

H. The Company does not have any amount deducted from the value of an upstream intermediate entity or ultimate parent owned, either directly or indirectly, via a downstream subsidiary, controlled, or affiliated entity.

I. The Company does not have any investments in a subsidiary, controlled, or affiliated entity that exceeds 10% of admitted assets.

J. The Company does not have any investments in impaired subsidiaries, controlled, or affiliated entities.

K. The Company does not have any investments in foreign insurance subsidiaries.

L. The Company does not hold any investments in a downstream noninsurance holding company.

M. The Company does not have any investments in noninsurance subsidiaries, controlled, or affiliated entities.

N. The Company does not have any investments in insurance subsidiaries, controlled, or affiliated entities.

O. The Company does not have any investments in subsidiary, controlled, or affiliated entities or joint ventures, partnerships and limited liability companies in which the Company's share of losses exceeds the investment.

11. DEBT

A–B. The Company had no outstanding debt with third-parties or outstanding Federal Home Loan Bank agreements during 2021 and 2020.

12. RETIREMENT PLANS, DEFERRED COMPENSATION, POSTEMPLOYMENT BENEFITS AND COMPENSATED ABSENCES AND OTHER POSTRETIREMENT BENEFIT PLANS

A–D. Defined Benefit Plans — Not applicable.

E. Defined Contribution Plans — The Company participates in the UnitedHealth Group 401(k) Plan (the "Plan") for its employees. The Company is not directly liabile for these obligations. The Plan covers all employees (the "participants") who meet certain age and length of

services requirements. The Company matches 50%-100% of a particpant's elective deferral up to a maximum of 6% of a participant's annual compensation, subject to IRS limits. The Plan does not require additional contributions from the Company. The Company's expense under the Plan totaled $133,553 and $165,911 in 2021 and 2020, respectively, which is included in GAE and CAE in the financial statements.

F. Multiemployer Plans — Not applicable.

G. Consolidated/Holding Company Plans

Employee Stock Purchase Plan — The Company's employees are allowed to participate in UnitedHealth Group's Employee Stock Purchase Plan. The Company accrued an estimated expense of $7,660 and $8,112 as of December 31, 2021 and 2020, respectively, related to this plan, which is included GAE, CAE and gross paid-in and contributed surplus in the financial statements.

H. Postemployment Benefits and Compensated Absences — Not applicable.

I. Impact of Medicare Modernization Act on Postretirement Benefits — Not applicable.

13. CAPITAL AND SURPLUS, DIVIDEND RESTRICTIONS, AND QUASI-REORGANIZATIONS

A–B. The Company has 250,000 shares authorized, issued and outstanding of $14.40 par value common stock. The Company has no preferred stock outstanding. All issued and outstanding shares of common stock are held by the Company's parent, Sierra.

C. Dividend payment requirements are outlined in the domiciliary state statutes and may be further restricted by the Division.

D. The Company paid extraordinary cash dividends of $825,000,000, $150,000,000, and $850,000,000 on December 20, 2021, September 14, 2021, and March 4, 2021, respectively, to Sierra, which were approved by the Nevada Insurance Commissioner and recorded as a reduction to unassigned surplus in the financial statements.

The Company paid an extraordinary cash dividend of $500,000,000 each on December 17, 2020, September 10, 2020, and March 25, 2020, respectively, to Sierra which were each approved by the Nevada Insurance Commissioner and recorded as a reduction to unassigned surplus in the financial statements.

E. The amount of ordinary dividends that may be paid out during any given period is subject to certain restrictions as specified by state statute.

F. There are no restrictions placed on the Company's unassigned surplus.

G. The Company is not a mutual reciprocal or a similarly organized entity and does not have advances to surplus not repaid.

H. The Company does not hold any stock, including stock of affiliated companies for special purposes, such as conversion of preferred stock, employee stock options, or stock purchase warrants.

I. The Company does not have any special surplus funds.

J. The portion of unassigned surplus, excluding the change in net income and dividends, represented (or reduced) by each item below is as follows:

	2021	2020
Unrealized capital losses on investments	$ (244,421)	$ (186,946)
Net deferred income taxes	12,425,656	12,079,877
Nonadmitted assets	(29,617,641)	(28,619,594)
Total	$ (17,436,406)	$ (16,726,663)

K–M. The Company does not have any outstanding surplus notes and has never been a party to a quasi-reorganization.

14. LIABILITIES, CONTINGENCIES AND ASSESSMENTS

A. Contingent Commitments

The Company has no contingent commitments.

B. Assessments

The Company is not aware of any guaranty fund assessments or premium tax offsets, potential or accrued, that could have a material financial effect on the operations of the entity.

C. Gain Contingencies

The Company is not aware of any gain contingencies that should be disclosed in the financial statements.

D. Claims Related Extra Contractual Obligation and Bad Faith Losses Stemming from Lawsuits — Not applicable.

E. Joint and Several Liabilities — Not applicable.

F. All Other Contingencies

The Company's business is regulated at the federal, state, and local levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The Company has been, or is currently involved, in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and other governmental authorities. The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

On February 14, 2017, the Department of Justice ("DOJ") announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017,

alleges that the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, the DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters involve: indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility, or it is probable that a loss may be incurred. Although the outcomes of any such legal actions cannot be predicted, in the opinion of management, the resolution of any currently pending or threatened actions will not have a material adverse effect on the financial statements of the Company.

The Company routinely evaluates the collectability of all receivable amounts included in the financial statements. Impairment reserves are established for those amounts where collectability is uncertain. Based on the Company's past experience, exposure related to uncollectible balances and the potential of loss for those balances not currently reserved for is not material to the Company's statutory basis financial condition.

There are no assets that the Company considers to be impaired at December 31, 2021 and 2020, except as disclosed in Note 5 and Note 20.

15. LEASES

A–B. The Company is the lessee under several operating leases, most of which relate to office facilities. The rentals on these leases are charged to expense over the lease term as the Company becomes obligated for payment. The leases provide for rent escalation based on certain costs and price index factors. The Company does not have any noncancelable leases expiring at December 31, 2021. All current leases are annually renewable. There are no contingent rental payments and there are no restrictions imposed by the lease agreements.

Rent expense under operating leases, excluding imputed rent, totaled $123,806 and $34,407 in 2021 and 2020, respectively, which is included in GAE in the financial statements. In 2021 and 2020, the amount of imputed rent relating to the Company's occupancy of its own buildings, which is included in both net investment income earned and GAE in the financial statements was $1,582,724 in each year.

16. INFORMATION ABOUT FINANCIAL INSTRUMENTS WITH OFF-BALANCE-SHEET RISK AND FINANCIAL INSTRUMENTS WITH CONCENTRATIONS OF CREDIT RISK

(1–4) The Company does not hold any financial instruments with off-balance-sheet risk or have any concentrations of credit risk.

17. SALE, TRANSFER, AND SERVICING OF FINANCIAL ASSETS AND EXTINGUISHMENTS OF LIABILITIES

A. The Company did not sell any premium receivables as of the year ended December 31, 2021.

The Company sold a premium receivable, and related accrued interest, at face value to an unaffiliated third party on June 30, 2020 and received cash of $27,504,871 for the premium receivable and accrued interest receivable. There was no gain or loss recorded on the sale.

B. The Company did not have any transfer and servicing of financial assets as of the years ended December 31, 2021 or 2020.

C. No transactions involving wash sales of securities with an NAIC designation of 3 or below or unrated securities occurred as of the years ended December 31, 2021 or 2020.

18. GAIN OR LOSS TO THE REPORTING ENTITY FROM UNINSURED PLANS AND THE UNINSURED PORTION OF PARTIALLY INSURED PLANS

A. Administrative Services Only ("ASO") Plans

The Company participates in administering the Part D claim payments for select groups that offer their retirees Medicare coverage. There is no risk to the Company as a result of these transactions. These groups fund the pharmacy payments in advance of the Company's remitting payment to the PBM. As a result, the Company recorded $6,825,106 and $4,987,059 in amounts receivable relating to uninsured plans, $41,470,908 and $42,500,997 in liability for amounts held under uninsured plans, and $1,682,290 and $1,520,610 as administrative fee revenue which is netted against GAE in the financial statements as of December 31, 2021 and December 31, 2020, respectively.

The net gain from operations of the ASO uninsured plans and the uninsured portion of partially insured plans are as follows:

	2021			2020		
	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total ASO	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total ASO
a. Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	$ 343,377	$ -	$ 343,377	$ 336,757	$ -	$ 336,757
b. Total net other income or expenses (including interest paid to or received from plans)	-	-	-	-	-	-
c. Net gain (loss) from operations	343,377	-	343,377	336,757	-	336,757
d. Total claim payment volume	72,425,367	-	72,425,367	59,684,643	-	59,684,643

B. The Company participates in administering payment for certain pharmacy claims under a group Medicare program policy. There is no risk to the Company as a result of these transactions. The groups reimburse the Company for pharmacy claims subsequent to the Company remitting payment to the PBM. The Company recorded a receivable of $151,115 and $57,409 as of December 31, 2021 and 2020, respectively, which is included in the amounts receivable relating to uninsured plans in the financial statements.

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract

The Medicare Part D program is a partially insured plan. The Company recorded a receivable of $722,747,676 and $400,027,186 at December 31, 2021 and 2020, respectively, for cost

reimbursement under the Medicare Part D program for the catastrophic reinsurance and low-income member cost-sharing subsidies. The Company also recorded a receivable of $209,029,061 and $187,639,735 and also a payable of $4,441,845 and $2,518,383 at December 31, 2021 and 2020, respectively, for the Medicare Part D coverage gap discount program. The receivables and payables are recorded in amounts receivable relating to uninsured plans, respectively, in the financial statements. These Medicare subsidies are described in Note 1, *Amounts Receivable Relating to Uninsured Plans*.

19. DIRECT PREMIUM WRITTEN/PRODUCED BY MANAGING GENERAL AGENTS/THIRD-PARTY ADMINISTRATORS

The Company did not have any direct premiums written or produced by managing general agents or third-party administrators in 2021 and 2020.

20. FAIR VALUE MEASUREMENTS

The NAIC SAP defines fair value, establishes a framework for measuring fair value, and outlines the disclosure requirements related to fair value measurements. The fair value hierarchy is as follows:

Level 1 — Quoted (unadjusted) prices for identical assets in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates, etc.);
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

The estimated fair values of bonds, cash equivalents, short-term investments, and preferred stocks (collectively “investment holdings”) are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (“pricing service”), which generally uses quoted prices or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, non-binding broker quotes, benchmark yields, credit spreads, default rates, and prepayment speeds. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to a secondary pricing source, prices reported by its custodian, its investment consultant, and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company’s internal price verification procedures and review of fair value methodology documentation provided by independent pricing services have not historically resulted in an adjustment in the prices obtained from the pricing service.

In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest-level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

A. Fair Value

(1) Fair Value Measurements at Reporting Date

The following tables present information about the Company's financial assets that are measured and reported at fair value at December 31, 2021 and 2020, in the financial statements according to the valuation techniques the Company used to determine their fair values:

	December 31, 2021				
Description for Each Class of Asset or Liability	**(Level 1)**	**(Level 2)**	**(Level 3)**	**Net Asset Value (NAV)**	**Total**
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ 3,270,000	$ -	$ -	$ 3,270,000
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	3,270,000	-	-	3,270,000
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	50,758,125	-	-	50,758,125
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	50,758,125	-	-	50,758,125
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	159,189,816	-	-	-	159,189,816
Qualified cash pool	748,226	-	-	-	748,226
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 159,938,042	$ 54,028,125	$ -	$ -	$ 213,966,167
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

Description for Each Class of Asset or Liability	December 31, 2020 (Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	9,505,685	-	-	9,505,685
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	9,505,685	-	-	9,505,685
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	509,491,116	-	-	-	509,491,116
Qualified cash pool	125,615,059	-	-	-	125,615,059
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 635,106,175	$ 9,505,685	$ -	$ -	$ 644,611,860
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

(2) The Company does not have any financial assets with a fair value hierarchy of Level 3 that were measured and reported at fair value.

(3) Transfers between fair value hierarchy levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs. There were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during the years ended December 31, 2021 or 2020.

(4) The framework the Company has established for determining the fair value of the investment holdings is outlined above.

(5) The Company has no derivative assets and liabilities to disclose.

B. Fair Value Combination — Not applicable.

C. Aggregate Fair Value Hierarchy

The aggregate fair value by hierarchy of all financial instruments as of December 31, 2021 and 2020 is presented in the table below:

	December 31, 2021						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 439,165,980	$ 442,370,220	$ 174,102,007	$ 265,063,973	$ -	$ -	$ -
State and agency municipal securities	194,699,842	185,193,652	-	194,699,842	-	-	-
City and county municipal securities	238,791,837	230,704,238	-	238,791,837	-	-	-
Corporate debt securities	1,352,031,900	1,331,758,299	-	1,350,646,900	1,385,000	-	-
Cash equivalents	350,924,874	350,924,874	350,924,874	-	-	-	-
Equity (including marketable common stock)	3,413,880	3,270,000	-	3,413,880	-	-	-
Total bonds, cash equivalents, and equity	$ 2,579,028,313	$ 2,544,221,283	$ 525,026,881	$ 2,052,616,432	$ 1,385,000	$ -	$ -

	December 31, 2020						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 938,839,730	$ 914,442,354	$ 309,947,499	$ 628,892,231	$ -	$ -	$ -
State and agency municipal securities	323,677,308	303,283,534	-	323,677,308	-	-	-
City and county municipal securities	264,137,002	251,568,321	-	264,137,002	-	-	-
Corporate debt securities	1,459,191,494	1,398,239,947	-	1,459,191,494	-	-	-
Cash equivalents	680,103,643	680,103,643	680,103,643	-	-	-	-
Total bonds, short-term investments, and cash equivalents	$ 3,665,949,177	$ 3,547,637,799	$ 990,051,142	$ 2,675,898,035	$ -	$ -	$ -

D. Not Practicable to Estimate Fair Value — Not applicable.

E. Investments Measured Using the NAV Practical Expedient — Not applicable.

21. OTHER ITEMS

COVID-19 Trends and Uncertainties

The COVID-19 pandemic continues to evolve and the ultimate overall impact to the Company's financial statements is uncertain and dependent on the future pacing, intensity and duration of the pandemic, the severity of new variants of the COVID-19 virus, the effectiveness and extent of administration of vaccination and treatments and general economic uncertainty.

Throughout 2020, the Company's ultimate parent announced a number of programs to directly support people affected by the COVID-19 pandemic, including a plan to grant premium credits to the Company's fully insured commercial customers. The total amount of premium credits granted through December 31, 2020 of $2,736,251 has been reflected as a reduction to net premium income in the financial statements.

A. Unusual or Infrequent Items

The Company did not encounter any unusual or infrequent items for the years ended December 31, 2021 and 2020.

B. Troubled Debt Restructuring: Debtors

The Company has no troubled debt restructurings as of December 31, 2021 and 2020.

C. Other Disclosures

The Company does not have any amounts not recorded in the financial statements that represent segregated funds held for others. The Company also does not have any exposures related to forward commitments that are not derivative instruments.

D. Business Interruption Insurance Recoveries

The Company has not received any business interruption insurance recoveries during 2021 and 2020.

E. State Transferable and Non-transferable Tax Credits

The Company has no transferable or non-transferable state tax credits.

F. Sub-Prime Mortgage-Related Risk Exposure

(1) The investment policy for the Company limits investments in loan-backed securities, which includes sub-prime issuers. Further, the policy limits investments in private-issuer mortgage securities to 10% of the portfolio, which also includes sub-prime issuers. The exposure to unrealized losses on sub-prime issuers is due to changes in market prices. There are no realized losses due to not receiving anticipated cash flows. The investments covered have an NAIC designation of 1 and/or 2.

(2) The Company has no direct exposure through investments in sub-prime mortgage loans.

(3) The Company has no direct exposure through other investments as of December 31, 2021. Direct exposure through other investments as of December 31, 2020 is as follows:

	2020			
	Actual Cost	Book/ Adjusted Carrying Value (Excluding Interest)	Fair Value	Other-than-Temporary Impairment Losses Recognized
a. Residential mortgage-backed securities	$ 1,428,879	$ 1,428,879	$ 1,379,325	$ -
b. Commercial mortgage-backed securities	-	-	-	-
c. Collateralized debt obligations	-	-	-	-
d. Structured securities	-	-	-	-
e. Equity investment in SCAs	-	-	-	-
f. Other assets	-	-	-	-
g. Total	$ 1,428,879	$ 1,428,879	$ 1,379,325	$ -

(4) The Company has no underwriting exposure to sub-prime mortgage risk through mortgage guaranty or financial guaranty insurance coverage.

E. Retained Assets

The Company does not have any retained asset accounts for beneficiaries.

H. Insurance-Linked Securities Contracts

As of December 31, 2021, the Company is not aware of any possible proceeds of insurance-linked securities.

I. The Amount That Could Be Realized on Life Insurance Where the Reporting Entity is Owner and Beneficiary or Has Otherwise Obtained Rights to Control the Policy — Not applicable.

22. EVENTS SUBSEQUENT

Subsequent events have been evaluated through April 22, 2022, which is the date these financial statements were available for issuance.

TYPE I — Recognized Subsequent Events

Any material Type I events subsequent to December 31, 2021, have been recognized in the financial statements and corresponding disclosures.

TYPE II — Non-Recognized Subsequent Events

On February 17, 2022, the Company declared an extraordinary cash dividend of $300,000,000 to Sierra. The dividend was approved by the Nevada Insurance Commissioner on February 28, 2022 and paid from unassigned surplus on March 3, 2022.

There are no other material non-recognized Type II events that require disclosure.

23. REINSURANCE

Reinsurance Agreements — In the normal course of business, the Company enters into various reinsurance agreements with affiliated and other nonaffiliated insurers to assume reinsurance. Reinsurance assumed from nonaffiliated insurers primarily serves to expand the book of business and enhance business relations. Reinsurance assumed from affiliated insurers limits or reduces risk to the affiliated insurer. The insurer remains primarily liable as the direct insurer on all risks assumed.

The Company has an assumed excess loss agreement with Health Plan of Nevada, Inc. The Company has an insolvency-only reinsurance agreement and excess loss agreement with UnitedHealthcare Insurance Company ("UHIC").

The Company has an assumed stop loss reinsurance agreement with Canada Life Assurance Company ("Canada Life"), where Canada Life cedes and the Company assumes the amount in excess over the combined ratio 110% of the quota share reinsurance premiums Canada Life receives from UHIC. The Company has received $9,400,290 and $10,230,915 in assumed reinsurance premiums as of December 31, 2021 and 2020, respectively, which is included in net premium income in the financial statements. There have been no reinsurance claims paid associated with this agreement as of December 31, 2021 and 2020, respectively.

The effect of both internal and external reinsurance agreements outlined above on net premium income and hospital and medical expenses is presented below:

	2021	2020
Premiums:		
Direct	$ 21,391,193,077	$ 19,339,629,757
Assumed:		
Affiliate	656,816	527,723
Nonaffiliate	9,400,290	10,230,915
Net premium income	$ 21,401,250,183	$ 19,350,388,395
Hospital and medical expenses:		
Direct	$ 18,186,953,335	$ 14,880,459,962
Assumed:		
Affiliate	262,728	634,799
Net hospital and medical expenses	$ 18,187,216,063	$ 14,881,094,761

The Company recognized reinsurance incurred related to internal and external reinsurance agreements of $262,728 and $634,799 in 2021 and 2020, respectively, which are recorded as net reinsurance incurred in the financial statements.

A. Ceded Reinsurance Report

Section 1 — General Interrogatories

(1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes ( ) No (X)

(2) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor, or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

Section 2 — Ceded Reinsurance Report — Part A

(1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credit?

Yes ( ) No (X)

(2) Does the reporting entity have any reinsurance agreements in effect that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

Section 3 — Ceded Reinsurance Report — Part B

(1) What is the estimated amount of the aggregate reduction in surplus (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of all reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

The Company estimates there should be no aggregate reduction in surplus for termination of all reinsurance agreements as of December 31, 2021.

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ( ) No (X)

B. **Uncollectible Reinsurance** — During 2021 and 2020, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance** — There was no commutation of reinsurance in 2021 or 2020.

D. **Certified Reinsurer Rating Downgraded or Status Subject to Revocation** — Not applicable.

E. **Reinsurance Credit** — Not applicable.

24. RETROSPECTIVELY RATED CONTRACTS AND CONTRACTS SUBJECT TO REDETERMINATION

A. The Company estimates accrued retrospective premium adjustments for its group health insurance business based on mathematical calculations in accordance with contractual terms.

B. Estimated accrued retrospective premiums due to (from) the Company are recorded in premiums and considerations and aggregate health policy reserves in the financial statements and as an adjustment to change in unearned premium reserves and reserve for rate credits in the financial statements.

C. Pursuant to the ACA, the Company's commercial business is subject to retrospectively rated features based on the actual MLR experienced on the commercial line of business and redetermination features for premium adjustments for changes to each member's health scores based on guidelines determined by CMS. The total amount of direct premiums written for the commercial line of business for which a portion is subject to the retrospectively rated and redetermination features was $389,045,045 and $300,783,341, representing 2% and 2% of total direct premiums written as of December 31, 2021 and December 31, 2020, respectively.

Pursuant to the ACA, the Company's Medicare business is subject to retrospectively rated features based on the actual MLR experienced on the Medicare line of business and redetermination features for premium adjustments for changes to each member's health scores based on guidelines determined by CMS. The total amount of direct premiums written for the Medicare line of business for which a portion is subject to the retrospectively rated and redetermination features was $20,992,893,920 and $19,028,378,543, representing 98% and 98% of total direct premiums written as of December 31, 2021 and December 31, 2020, respectively.

The Company has contracts with employer groups that have retrospective rating features. The amount of direct premiums written subject to these retrospectively rated features was $799,697,809 and $962,756,608, representing 4% and 5% of total direct premiums written as of December 31, 2021 and 2020, respectively.

D. The Company is required to maintain specific minimum loss ratios on the comprehensive commercial and Medicare lines of business. The following table discloses the minimum MLR rebate liability for the comprehensive commercial and Medicare lines of business which is included in aggregate health policy reserves in the financial statements for the years ended December 31, 2021 and 2020:

	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Other Categories with Rebates	5 Total
Prior reporting year					
(1) Medical loss ratio rebates incurred	$ (147,707)	$ (1,525,620)	$ -	$ 30,993,448	$ 29,320,121
(2) Medical loss ratio rebates paid	-	4,726,085	-	-	4,726,085
(3) Medical loss rebates unpaid	-	479,836	-	30,993,448	31,473,284
(4) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(5) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(6) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	31,473,284
Current reporting year-to-date					
(7) Medical loss ratio rebates incurred	1,375,080	3,395,402	-	120,207,333	124,977,815
(8) Medical loss ratio rebates paid	1,375,080	3,875,238	-	-	5,250,318
(9) Medical loss rebates unpaid	-	-	-	151,200,781	151,200,781
(10) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(11) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(12) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	151,200,781

E. Risk-Sharing Provisions of the Affordable Care Act

(1) The Company has accident and health insurance premiums in 2021 and 2020 subject to the risk-sharing provisions of the ACA.

The ACA imposed fees and premium stabilization provisions on health insurance issuers offering comprehensive commercial health insurance. The three premium stabilization programs are commonly referred to as the 3Rs — risk adjustment, reinsurance, and risk corridors.

Risk Adjustment — The risk adjustment program is a permanent program designed to mitigate the potential impact of adverse selection that generally applies to non-grandfathered individual and small group plans inside and outside of exchanges. The program helps to stabilize market premiums by transferring funds from plans with relatively low-risk enrollees to plans with relatively high-risk enrollees. The data used by CMS to determine the risk adjustment transfer amount is subject to audits along with the true-up to the final CMS report, which may result in a material change to arrive at the final risk adjustment amount from the initial risk adjustment estimate recorded. Premium adjustments pursuant to the risk adjustment program are accounted for as premium subject to redetermination and user fees are accounted for as assessments.

Reinsurance and Risk Corridors — The transitional reinsurance program and risk corridors program were temporary programs which expired at the end of 2016.

(2) The following table presents the current year impact of risk-sharing provisions of the ACA on assets, liabilities, and operations:

		December 31, 2021
a.	**Permanent ACA Risk Adjustment Program**	
	Assets	
1.	Premium adjustments receivable due to ACA Risk Adjustment (including high-risk pool payments)	$ 4,029,946
	Liabilities	
2.	Risk adjustment user fees payable for ACA Risk Adjustment	86,710
3.	Premium adjustments payable due to ACA Risk Adjustment (including high-risk pool premium)	31,026,403
	Operations (Revenue & Expense)	
4.	Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	22,780,224
5.	Reported in expenses as ACA Risk Adjustment user fees (incurred/paid)	95,319
b.	**Transitional ACA Reinsurance Program**	
	Assets	
1.	Amounts recoverable for claims paid due to ACA Reinsurance	$ -
2.	Amounts recoverable for claims unpaid due to ACA Reinsurance (Contra Liability)	-
3.	Amounts receivable relating to uninsured plans for contributions for ACA Reinsurance	-
	Liabilities	
4.	Liabilities for contributions payable due to ACA Reinsurance - not reported as ceded premium	-
5.	Ceded reinsurance premiums payable due to ACA Reinsurance	-
6.	Liabilities for amounts held under uninsured plans contributions for ACA Reinsurance	-
	Operations (Revenue & Expense)	
7.	Ceded reinsurance premiums due to ACA Reinsurance	-
8.	Reinsurance recoveries (income statement) due to ACA reinsurance payments or expected payments	-
9.	ACA Reinsurance contributions - not reported as ceded premium	-
c.	**Temporary ACA Risk Corridors Program**	
	Assets	
1.	Accrued retrospective premium due to ACA Risk Corridors	$ -
	Liabilities	
2.	Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors	-
	Operations (Revenue & Expense)	
3.	Effect of ACA Risk Corridors on net premium income (paid/received)	-
4.	Effect of ACA Risk Corridors on change in reserves for rate credits	-

(3) The following table is a rollforward of the prior year ACA risk-sharing provisions for asset and liability balances, along with reasons for adjustments to prior year balances:

	Accrued during the Prior Year on Business Written before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 - 3 + 7)	Cumulative Balance from Prior Years (Col 2 - 4 + 8)
	1 Receivable	2 (Payable)	3 Receivable	4 (Payable)	5 Receivable	6 (Payable)	7 Receivable	8 (Payable)	Ref	9 Receivable	10 (Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustment receivable (including high-risk pool payments)	$ 4,627,806	$ -	$ 3,076,899	$ -	$ 1,550,907	$ -	$ (1,550,907)	$ -	A	$ -	$ -
2. Premium adjustment (payable) (including high-risk pool premium)	-	(52,173,078)	-	(845,490)	-	(51,327,588)	-	30,453,545	B	-	(20,874,043)
3. Subtotal ACA Permanent Risk Adjustment Program	4,627,806	(52,173,078)	3,076,899	(845,490)	1,550,907	(51,327,588)	(1,550,907)	30,453,545		-	(20,874,043)
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-	-	-	-	-	-	-	-	C	-	-
2. Amounts recoverable for claims unpaid (contra liability)	-	-	-	-	-	-	-	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance — not reported as ceded premium	-	-	-	-	-	-	-	-	F	-	-
5. Ceded reinsurance premiums payable	-	-	-	-	-	-	-	-	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	J	-	-
3. Subtotal ACA Risk Corridors Program	-	-	-	-	-	-	-	-		-	-
d. Total for ACA Risk-Sharing Provisions	$ 4,627,806	$ (52,173,078)	$ 3,076,899	$ (845,490)	$ 1,550,907	$ (51,327,588)	$ (1,550,907)	$ 30,453,545		$ -	$ (20,874,043)

Explanation of Adjustments

A. The risk adjustment receivable as of December 31, 2020 utilized paid claims through October 31, 2020. As of the Reporting Date, the risk adjustment receivable related to prior periods was adjusted based on the CMS' Summary Report on Permanent Risk Adjustment Transfers for the 2020 Benefit Year. The risk adjustment receivable was further adjusted based on CMS' Updated Summary Report of 2017 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers published January 15, 2021, CMS' Final Rule amending Risk Adjustment Data Validation beginning with the 2019 Benefit Year, and Benefit Year 2019 Risk Adjustment Data Validation IVA results, as well as CMS' Updated Summary Report of 2018 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers published January 20, 2022.

B. The risk adjustment payable as of December 31, 2020 utilized paid claims through October 31, 2020. As of the Reporting Date, the risk adjustment payable related to prior periods was adjusted based on the CMS' Summary Report on Permanent Risk Adjustment Transfers for the 2020 Benefit Year. The risk adjustment payable was further adjusted based on CMS' Updated Summary Report of 2017 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers published January 15, 2021, CMS' Final Rule amending Risk Adjustment Data Validation beginning with the 2019 Benefit Year, and Benefit Year 2019 Risk Adjustment Data Validation IVA results, as well as CMS' Updated Summary Report of 2018 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers published January 20, 2022.

C. N/A
D. N/A
E. N/A
F. N/A
G. N/A
H. N/A
I. N/A
J. N/A

(4) The Company does not have any risk corridor receivables or payables to present in the table below:

Risk Corridors Program Year	Accrued during the Prior Year on Business Written before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year		Differences		Adjustments		Ref	Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 - 3 + 7)	Cumulative Balance from Prior Years (Col 2 - 4 + 8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)		Receivable	(Payable)
a. 2014											
1. Accrued retrospective premium	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	A	$ -	$ -
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	B	-	-
b. 2015											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	C	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	D	-	-
c. 2016											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	E	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	F	-	-
d. Total for Risk Corridors	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -

Explanation of Adjustments

A.
B.
C.
D.
E.
F.

(5) The Company does not have any risk corridor receivables to present in the table below.

Risk Corridors Program Year	1 Estimated Amount to be Filed or Final Amount Filed with CMS	2 Non-Accrued Amounts for Impairment or Other Reasons	3 Amounts Received from CMS	4 Asset Balance (Gross of Non-Admissions) (1 - 2 - 3)	5 Non-Admitted Amount	6 Net Admitted Asset (4 - 5)
a. 2014	$ -	$ -	$ -	$ -	$ -	$ -
b. 2015	-	-	-	-	-	-
c. 2016	-	-	-	-	-	-
d. Total (a + b + c)	$ -	$ -	$ -	$ -	$ -	$ -

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

A. Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the financial statements. The following tables disclose paid claims, incurred claims, and the balance in claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, and health care and other amounts receivable (excluding provider loans and advances not yet expensed) for the years ended December 31, 2021 and 2020:

	2021		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (2,031,422,401)	$ (2,031,422,401)
Paid claims — net of health care receivables*	16,891,772,420	1,324,722,119	18,216,494,539
End of year claim reserve	2,026,129,809	14,300,085	2,040,429,894
Incurred claims excluding the change in health care receivables presented below	18,917,902,229	(692,400,197)	18,225,502,032
Beginning of year health care receivables	-	413,112,221	413,112,221
End of year health care receivables*	(441,275,542)	(10,122,648)	(451,398,190)
Total incurred claims	$ 18,476,626,687	$ (289,410,624)	$ 18,187,216,063

*Health care receivable excludes provider loans and advances not yet expensed of $128,677 and $0 for 2021 and 2020, respectively.

	2020		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (2,114,303,322)	$ (2,114,303,322)
Paid claims — net of health care receivables	13,480,774,492	1,395,257,312	14,876,031,804
End of year claim reserve	2,008,227,890	23,194,511	2,031,422,401
Incurred claims excluding the change in health care receivables presented below	15,489,002,382	(695,851,499)	14,793,150,883
Beginning of year health care receivables	-	501,056,099	501,056,099
End of year health care receivables	(411,286,679)	(1,825,542)	(413,112,221)
Total incurred claims	$ 15,077,715,703	$ (196,620,942)	$ 14,881,094,761

The liability for claims unpaid, accrued medical incentive pool and bonus amounts, and aggregate health claim reserves, net of health care and other amounts receivable as of December 31, 2020 was $1,618,310,180. As of December 31, 2021, $1,324,722,119 has been paid for incurred claims attributable to insured events of prior years. Reserves remaining for prior years, net of health care and other amounts receivable are now $4,177,437, as a result of re-estimation of unpaid claims. Therefore, there has been $289,410,624 favorable prior year development since December 31, 2020 to December 31, 2021. The primary drivers consist of favorable development of $228,680,863 in retroactivity for inpatient, outpatient, physician, and pharmacy claims and favorable development as a result of a change in the provision for adverse deviations in experience of $46,075,448. At December 31, 2020, the Company recorded $196,620,942 of favorable development. The primary drivers consist of favorable development as a result of a change in the provision for adverse deviations in experience of $47,994,130 and favorable development of $156,850,076 in retroactivity for inpatient, outpatient, physician, and pharmacy claims. Original estimates are increased or decreased, as additional information becomes known

regarding individual claims, which could have an impact to the accruals for MLR rebates and retrospectively rated contracts. As a result of the prior year effects, on a regular basis, the Company adjusts revenue and the corresponding liability and/or receivable related to retrospectively rated policies and the impact of the change is included as a component of change in unearned premium reserves and reserve for rate credits in the financial statements.

The Company incurred CAE of $624,638,171 and $587,875,291 in 2021 and 2020, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of the Agreement (see Note 10). The following table discloses paid CAE, incurred CAE, and the balance in unpaid CAE reserve for 2021 and 2020:

	2021	2020
Total claims adjustment expenses	$ 624,638,171	$ 587,875,291
Less: current year unpaid claims adjustment expenses	(16,501,338)	(16,564,375)
Add: prior year unpaid claims adjustment expenses	16,564,375	17,400,512
Total claims adjustment expenses paid	$ 624,701,208	$ 588,711,428

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid CAE in 2021.

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2021 or 2020.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2021 or 2020.

28. HEALTH CARE AND OTHER AMOUNTS RECEIVABLE

A. Pharmacy rebates receivable are recorded when reasonably estimated or billed by the affiliated PBM in accordance with pharmaceutical rebate contract provisions. Information used to support rebates billed to the manufacturer is based on utilization information gathered by the PBM and adjusted for significant changes in pharmaceutical contract provisions.

The Company evaluates admissibility of all pharmacy rebates receivable based on the administration of each underlying pharmaceutical benefit management agreement. The Company has nonadmitted and excluded all pharmacy rebates receivable that do not meet the admissibility criteria of SSAP No. 84, *Health Care and Government Insured Plan Receivables* (“SSAP No. 84”) from the financial statements.

For each pharmaceutical management agreement for which a portion of the total pharmacy rebates receivable can be admitted based on the admissibility criteria of SSAP No. 84, the pharmacy rebate transaction history is summarized as follows:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received within 90 Days of Billing	Actual Rebates Received within 91 to 180 Days of Billing	Actual Rebates Received More than 180 Days after Billing
12/31/2021	$ 320,149,019	$ 97,891,180	$ -	$ -	$ -
9/30/2021	309,184,998	310,032,392	190,693,017	-	-
6/30/2021	298,919,266	306,932,000	264,293,193	26,070,340	-
3/31/2021	288,069,321	294,079,205	226,296,059	47,886,147	4,763,373
12/31/2020	292,528,864	292,496,981	237,280,765	44,401,496	1,982,814
9/30/2020	279,414,157	285,685,222	229,388,176	39,718,562	8,348,239
6/30/2020	276,757,944	275,539,989	219,313,781	44,240,981	8,327,652
3/31/2020	284,355,004	276,717,430	116,025,351	151,687,497	8,395,273
12/31/2019	268,159,681	277,383,702	209,041,216	43,420,577	15,526,365
9/30/2019	269,072,652	271,044,722	202,007,314	52,483,774	12,404,563
6/30/2019	265,652,699	267,878,508	193,933,632	66,927,880	4,344,723
3/31/2019	256,563,905	257,396,083	211,958,256	30,737,976	12,701,031

Of the amount reported as health care and other amounts receivable, $423,774,950 and $388,651,624 relates to pharmacy rebates receivable as of December 31, 2021 and 2020, respectively.

B. The Company has nonadmitted all risk-sharing receivables from the financial statements.

The Company also admitted $173,887 and $0 for capitation arrangement receivables and $128,677 and $0 for provider advances as of December 31, 2021 and December 31, 2020, respectively, which are included in health care and other amounts receivable in the financial statements.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2021 or 2020.

30. PREMIUM DEFICIENCY RESERVES

The Company has not recorded any PDR as of December 31, 2021 or 2020. The analysis of PDR was completed as of December 31, 2021 and 2020. The Company did consider anticipated investment income when calculating the PDR.

The following table summarizes the Company's PDR as of December 31, 2021 and 2020:

	2021	
1. Liability carried for premium deficiency reserves	$	-
2. Date of the most recent evaluation of this liability		12/31/2021
3. Was anticipated investment income utilized in this calculation?	Yes [X]	No [ ]

	2020	
1. Liability carried for premium deficiency reserves	$	-
2. Date of the most recent evaluation of this liability		12/31/2020
3. Was anticipated investment income utilized in this calculation?	Yes [X]	No [ ]

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2021 and 2020, the Company had no specific accruals established for outstanding subrogation, as it is considered a component of the actuarial calculations used to develop the estimates of claims unpaid and aggregate health claim reserves.

* * * * * *

SUPPLEMENTAL SCHEDULES

EXHIBIT I:
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

7 1 4 2 0 2 0 2 1 2 8 5 0 0 1 0 0

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2021
(To Be Filed by April 1)

Of The Sierra Health and Life Insurance Company, Inc.

ADDRESS (City, State and Zip Code) Las Vegas , NV 89128

NAIC Group Code 0707 NAIC Company Code 71420 Federal Employer's Identification Number (FEIN) 94-0734860

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 5,541,555,183

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	FNMA	Bonds	$ 164,934,929	3.0 %
2.02	Goldman Sachs - FGTXX	Cash Equivalents	$ 100,079,674	1.8 %
2.03	FHLMC	Bonds	$ 96,693,343	1.7 %
2.04	JPMORGAN CHASE	Bonds	$ 26,215,353	0.5 %
2.05	MORGAN STANLEY	Bonds	$ 18,565,196	0.3 %
2.06	THE GOLDMAN SACHS GRP INC	Bonds	$ 18,285,298	0.3 %
2.07	RBC - TUGXX	Cash Equivalents	$ 18,036,989	0.3 %
2.08	NEW JERSEY ST TR - APP	Bonds	$ 16,127,446	0.3 %
2.09	BANK OF AMERICA	Bonds	$ 15,447,398	0.3 %
2.10	PORT OF SEATTLE - PRT	Bonds	$ 14,890,059	0.3 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 1,816,453,539	32.8 %	3.07	P/RP-1	$ 3,270,000	0.1 %
3.02	NAIC-2	$ 389,363,766	7.0 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 125,374,418	2.3 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 47,232,305	0.9 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 2,589,214	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 367,343,619	6.6 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 359,860,180	6.5 %
5.02	Countries designated NAIC-2	$ 4,273,039	0.1 %
5.03	Countries designated NAIC-3 or below	$ 3,210,400	0.1 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1: Cayman Islands	$ 203,191,871	3.7 %
6.02	Country 2: United Kingdom	$ 51,618,346	0.9 %
	Countries designated NAIC - 2:		
6.03	Country 1: Italy	$ 3,557,786	0.1 %
6.04	Country 2: Mexico	$ 715,253	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1: Barbados	$ 3,123,258	0.1 %
6.06	Country 2: Ivory Coast	$ 87,142	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01	HSBC HOLDINGS	1	$ 13,794,481	0.2 %
10.02	UBS GROUP	1 and 2	$ 13,337,672	0.2 %
10.03	DEUTSCHE BANK NY	2	$ 10,665,869	0.2 %
10.04	Credit Suisse	2	$ 10,454,147	0.2 %
10.05	RABOBANK	1 and 2	$ 9,552,978	0.2 %
10.06	BARCLAYS PLC	2	$ 9,418,099	0.2 %
10.07	CARLYLE GLOBAL MKT STRATEGIES - CGMS 2014-5A	1	$ 9,116,299	0.2 %
10.08	SCULPTOR CLO XXV, LTD - SCUL 2025-A	1	$ 8,500,000	0.2 %
10.09	Mountain View CLO - MVEW 2017-2A	1	$ 8,400,000	0.2 %
10.10	NISSAN MOTOR ACC	2	$ 7,737,326	0.1 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06		$ 0	$ 0	$ 0
14.07		$ 0	$ 0	$ 0
14.08		$ 0	$ 0	$ 0
14.09		$ 0	$ 0	$ 0
14.10		$ 0	$ 0	$ 0
14.11		$ 0	$ 0	$ 0
14.12		$ 0	$ 0	$ 0
14.13		$ 0	$ 0	$ 0
14.14		$ 0	$ 0	$ 0
14.15		$ 0	$ 0	$ 0

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

EXHIBIT II:
SUMMARY INVESTMENT SCHEDULE

SUMMARY INVESTMENT SCHEDULE

	Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
		1	2	3	4	5	6
		Amount	Percentage of Column 1 Line 13	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage of Column 5 Line 13
1.	Long-Term Bonds (Schedule D, Part 1):						
	1.01 U.S. governments	180,741,947	6.902	180,741,947	0	180,741,947	6.902
	1.02 All other governments	0	0.000	0	0	0	0.000
	1.03 U.S. states, territories and possessions, etc. guaranteed	37,944,961	1.449	37,944,961	0	37,944,961	1.449
	1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed	41,337,950	1.579	41,337,950	0	41,337,950	1.579
	1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	598,243,255	22.845	598,243,255	0	598,243,255	22.845
	1.06 Industrial and miscellaneous	1,331,758,296	50.857	1,331,758,296	0	1,331,758,296	50.857
	1.07 Hybrid securities	0	0.000	0	0	0	0.000
	1.08 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	1.09 SVO identified funds	0	0.000	0	0	0	0.000
	1.10 Unaffiliated Bank loans	0	0.000	0	0	0	0.000
	1.11 Total long-term bonds	2,190,026,409	83.632	2,190,026,409	0	2,190,026,409	83.632
2.	Preferred stocks (Schedule D, Part 2, Section 1):						
	2.01 Industrial and miscellaneous (Unaffiliated)	3,270,000	0.125	3,270,000	0	3,270,000	0.125
	2.02 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	2.03 Total preferred stocks	3,270,000	0.125	3,270,000	0	3,270,000	0.125
3.	Common stocks (Schedule D, Part 2, Section 2):						
	3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)	0	0.000	0	0	0	0.000
	3.02 Industrial and miscellaneous Other (Unaffiliated)	0	0.000	0	0	0	0.000
	3.03 Parent, subsidiaries and affiliates Publicly traded	0	0.000	0	0	0	0.000
	3.04 Parent, subsidiaries and affiliates Other	0	0.000	0	0	0	0.000
	3.05 Mutual funds	0	0.000	0	0	0	0.000
	3.06 Unit investment trusts	0	0.000	0	0	0	0.000
	3.07 Closed-end funds	0	0.000	0	0	0	0.000
	3.08 Total common stocks	0	0.000	0	0	0	0.000
4.	Mortgage loans (Schedule B):						
	4.01 Farm mortgages	0	0.000	0	0	0	0.000
	4.02 Residential mortgages	0	0.000	0	0	0	0.000
	4.03 Commercial mortgages	18,932,656	0.723	18,932,656	0	18,932,656	0.723
	4.04 Mezzanine real estate loans	0	0.000	0	0	0	0.000
	4.05 Total valuation allowance	0	0.000	0	0	0	0.000
	4.06 Total mortgage loans	18,932,656	0.723	18,932,656	0	18,932,656	0.723
5.	Real estate (Schedule A):						
	5.01 Properties occupied by company	50,985,245	1.947	50,985,245	0	50,985,245	1.947
	5.02 Properties held for production of income	0	0.000	0	0	0	0.000
	5.03 Properties held for sale	0	0.000	0	0	0	0.000
	5.04 Total real estate	50,985,245	1.947	50,985,245	0	50,985,245	1.947
6.	Cash, cash equivalents and short-term investments:						
	6.01 Cash (Schedule E, Part 1)	1,507,912	0.058	1,507,912	0	1,507,912	0.058
	6.02 Cash equivalents (Schedule E, Part 2)	350,924,874	13.401	350,924,874	0	350,924,874	13.401
	6.03 Short-term investments (Schedule DA)	0	0.000	0	0	0	0.000
	6.04 Total cash, cash equivalents and short-term investments	352,432,786	13.459	352,432,786	0	352,432,786	13.459
7.	Contract loans	0	0.000	0	0	0	0.000
8.	Derivatives (Schedule DB)	0	0.000	0	0	0	0.000
9.	Other invested assets (Schedule BA)	0	0.000	0	0	0	0.000
10.	Receivables for securities	3,001,069	0.115	3,001,069	0	3,001,069	0.115
11.	Securities Lending (Schedule DL, Part 1)	0	0.000	0	XXX	XXX	XXX
12.	Other invested assets (Page 2, Line 11)	0	0.000	0	0	0	0.000
13.	Total invested assets	2,618,648,165	100.000	2,618,648,165	0	2,618,648,165	100.000

OTHER ATTACHMENT

Deloitte.

Deloitte & Touche LLP
50 South 6th Street
Suite 2800
Minneapolis, MN 55402-1538
USA

Tel:+1 612 397 4000
Fax:+1 612 397 4450
www.deloitte.com

To the Audit Committee of
Sierra Health and Life Insurance Company, Inc.
2720 N. Tenaya Way
Las Vegas, NV 89128

The Management of
Sierra Health and Life Insurance Company, Inc.
2720 N. Tenaya Way
Las Vegas, NV 89128

Dear Members of the Audit Committee and Management:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the statutory basis financial statements of Sierra Health and Life Insurance Company, Inc. (the "Company") for the years ended December 31, 2021, and 2020, and have issued our report thereon dated April 22, 2022. In connection therewith, we advise you as follows:

1. We are independent certified public accountants with respect to the Company and conform to the standards of the accounting profession as contained in the Code of Professional Conduct and pronouncements of the American Institute of Certified Public Accountants, the rules and regulations of the Nevada Division of Insurance, and the Rules of Professional Conduct of the Minnesota State Board of Accountancy.

2. The engagement managing director and engagement manager, who are certified public accountants, have 17 years and 9 years, respectively, of experience in public accounting and are experienced in auditing insurance enterprises. Members of the engagement team, most of whom have had experience in auditing insurance enterprises and 28 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

3. We understand that the Company intends to file its audited statutory basis financial statements and our report thereon with the Nevada Division of Insurance and other state insurance departments in states in which the Company is licensed and that the insurance commissioners of those states will be relying on that information in monitoring and regulating the statutory basis financial condition of the Company.

While we understand that an objective of issuing a report on the statutory basis financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, the Company and insurance commissioners should understand that the objective of an audit of statutory basis financial statements in accordance with auditing standards generally accepted in the United States of America is to form an opinion and issue a report on whether the statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus, results of operations and cash flows in accordance with accounting practices prescribed or permitted by the Nevada Division of Insurance. Consequently, under auditing standards generally accepted in the United States of America, we have the responsibility, within the inherent limitations of the auditing process, to plan and perform our audit to obtain reasonable assurance regarding whether the statutory basis financial statements are free from material misstatement, whether due to error or fraud, and to exercise due professional care in the conduct of the

audit. The Company is not required to have, nor were we engaged to perform, an audit of internal control over financial reporting. Our audit included consideration of internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control over financial reporting. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatements resulting from fraud. Because of the characteristics of fraud, particularly those involving concealment and falsified documentation (including forgery), a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility that material misstatements may occur in the future. Also, our use of professional judgment and the assessment of materiality for the purpose of our audit mean that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of the Company to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and are recorded properly to permit the preparation of financial statements in conformity with accounting practices prescribed or permitted by the Nevada Division of Insurance.

The Insurance Commissioner should exercise due diligence to obtain whatever other information that may be necessary for the purpose of monitoring and regulating the statutory basis financial position of insurers and should not rely solely on the independent auditor's report.

4. We will retain the working papers (including those kept in a hard copy or electronic medium) prepared in the conduct of our audit until the Nevada Division of Insurance has filed a Report of Examination covering 2021, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Nevada Division of Insurance or its delegates, at the offices of the insurer, at our offices, at the Nevada Division of Insurance, or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Nevada Division of Insurance, photocopies of pertinent audit working papers may be made (under the control of Deloitte & Touche LLP) and such copies may be retained by the Nevada Division of Insurance. In addition, to the extent requested, we may provide the Nevada Division of Insurance with copies of certain audit working papers (such as unlocked copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by Nevada Division of Insurance or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are provided to the Nevada Division of Insurance; and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance, or outcome of your regulatory examination.

5. The engagement managing director has served in this capacity with respect to the Company since 2019, is licensed by the Minnesota State Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

6. To the best of our knowledge and belief, we are in compliance with the requirements of section 7 of the *NAIC's Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This letter is intended solely for the information and use of the Audit Committee and management of Sierra Health and Life Insurance Company, Inc. and for filing with the Nevada Division of Insurance and other state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte + Touche LLP

April 22, 2022