FINANCIAL HIGHLIGHTS

Premera’s 2012 audited financial statement is available at premera.com/financials

SELECTED BALANCE SHEET DATA

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</thead>
<tbody>
<tr>
<td>Total cash and investments</td>
<td>$1,761.3</td>
<td>$1,591.4</td>
<td>$1,435.6</td>
<td>$1,281.3</td>
<td>$1,096.5</td>
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<tr>
<td>Total assets</td>
<td>2,495.7</td>
<td>2,253.9</td>
<td>2,074.9</td>
<td>1,895.4</td>
<td>1,839.0</td>
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<tr>
<td>Net worth</td>
<td>1,307.5</td>
<td>1,148.3</td>
<td>1,065.6</td>
<td>912.8</td>
<td>728.1</td>
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<tr>
<td>Total debt</td>
<td>–</td>
<td>–</td>
<td>–</td>
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SELECTED INCOME STATEMENT DATA

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<tbody>
<tr>
<td>Total operating revenue</td>
<td>$3,344.8</td>
<td>$3,227.9</td>
<td>$3,030.2</td>
<td>$3,114.1</td>
<td>$3,297.0</td>
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<tr>
<td>Benefit expense</td>
<td>2,708.1</td>
<td>2,582.4</td>
<td>2,408.6</td>
<td>2,560.0</td>
<td>2,720.3</td>
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<tr>
<td>Commission and premium tax expense</td>
<td>116.3</td>
<td>115.5</td>
<td>107.9</td>
<td>114.1</td>
<td>128.0</td>
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<tr>
<td>General and administrative (G&amp;A) expense</td>
<td>456.6</td>
<td>439.4</td>
<td>431.2</td>
<td>406.5</td>
<td>398.8</td>
</tr>
<tr>
<td>Operating income</td>
<td>63.7</td>
<td>90.4</td>
<td>82.5</td>
<td>33.5</td>
<td>49.9</td>
</tr>
<tr>
<td>Net investment income</td>
<td>33.6</td>
<td>36.2</td>
<td>36.3</td>
<td>39.6</td>
<td>46.6</td>
</tr>
<tr>
<td>Realized gains (losses) on investments</td>
<td>20.3</td>
<td>12.1</td>
<td>33.8</td>
<td>(10.5)</td>
<td>(75.6)</td>
</tr>
<tr>
<td>Net income</td>
<td>98.2</td>
<td>110.4</td>
<td>118.8</td>
<td>49.8</td>
<td>12.6</td>
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METRICS

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<tbody>
<tr>
<td>Gross revenue</td>
<td>$7,249.0</td>
<td>$6,754.7</td>
<td>$6,163.2</td>
<td>$6,154.3</td>
<td>$6,206.2</td>
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<tr>
<td>Benefit expense ratio</td>
<td>86.1%</td>
<td>84.7%</td>
<td>84.3%</td>
<td>87.1%</td>
<td>87.0%</td>
</tr>
<tr>
<td>G&amp;A gross revenue ratio</td>
<td>6.3%</td>
<td>6.5%</td>
<td>7.0%</td>
<td>6.6%</td>
<td>6.4%</td>
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A LETTER FROM PREMERA CEO

GUBBY BARLOW

Premera finished 2012 well-positioned for the incredible changes coming to healthcare in the months ahead. The Premera team produced strong results in a period of significant market uncertainty for our industry.

I am exceptionally pleased with the work of all our associates to support the steady growth of the company, while delivering excellent service to our members and further expanding our service capabilities. At the same time, the implementation of federal healthcare reform has required substantial preparatory work as we look toward open enrollment for the Exchanges starting in October 2013, with full implementation of many related provisions of reform in January 2014.

Despite all that attention on federal reform, I cannot understate the critical need of our work at Premera, along with others in the healthcare system, to address the issue of rising medical costs. The ongoing federal debates on fiscal issues facing the nation do more to draw attention to the problem of rising expenditures on healthcare that are an increasing drain on our economy and our government’s fiscal health. That problem is clearly more than the private sector alone can solve, yet it remains an issue in which every stakeholder in the healthcare system – meaning virtually every American – has a role to play.

2012 PERFORMANCE

Premera’s membership continued to grow in 2012, ending the year at over 1.7 million members across the markets we serve, a record high for the company.

As membership has grown, we have seen the continuation of two key trends: first, the growing importance of the individual market. Premera remains the largest individual health plan in Washington state after another strong year serving our individual customers. We expect the individual market to grow substantially as the Exchanges created by federal reform are established.

The second key trend is the continued growth of the self-funded marketplace as a proportion of our overall membership and employer customer base. Our sustained progress over the last decade in developing our capabilities in this market, particularly our ability to serve national accounts, has contributed to an evolution
in our business. We now proudly administer benefits for Microsoft, Starbucks, Weyerhaeuser, the Alaska Air Group, and PACCAR, among others in this valued client base. Most recently, we significantly expanded our relationship with Amazon and are administering their full employee health plan portfolio as of April 1 of this year.

Fueled by that continued growth, self-funded customers represented 57% of our membership in 2012, up from 55% in 2011. We continue to see this trend toward self-funding accelerate as employers evaluate their options in the current market and look for means to limit their exposure to taxes, fees, and other costs associated with federal healthcare reform.

2012 FINANCIAL RESULTS

Premera’s revenue continued to grow in 2012, rising to over $7.2 billion in gross revenue – a 7.3% increase from 2011. It included $3.3 billion in net revenue (premium revenue, administrative fees, and other revenue) and $3.9 billion in medical claims managed for our self-funded customers, consistent with the strength of our self-funded business. Our operating income was 1.9% of net revenue, consistent with our historical target range of approximately 1–2%.

Two key factors played a notable role in our 2012 results. One, an increase in utilization of medical services, up from atypically low levels of utilization in 2010 and 2011. Second, we increased investments in strategic initiatives as we prepare for the new market conditions created by federal healthcare reform.

Of note, Premera continues to spend a high percentage of the premium dollar on medical claims, including 86.1 cents on claims costs for our customers in 2012 (also referred to as “medical loss ratio” or MLR). That remains consistent with our five year average of 85.6 cents.

Despite these strong overall results, we see continued volatility in the individual market. All three local health plans in Washington lost money serving the individual market in 2011 and 2012. Our primary individual brand in Washington lost $20 million over that time, which is symptomatic of the current stresses on that market.

Furthermore, we see more stress ahead on the individual market under federal healthcare reform, not less. The independent actuarial firm Milliman has confirmed in its work for the Washington State Exchange that health plans should expect to see new members in 2014 and beyond with more significant medical needs and higher claims costs than today’s individual members. This is a significant example of the challenges we expect to see in the Exchange. We are committed to serving this large, new market, but it will not be easy.

The financial volatility in the individual market is also a reminder of the narrow margins in which we operate. It spotlights the ongoing need to do everything possible to help control costs in all aspects of our use of the premium dollar.

Indeed, our ongoing work to spend our customers’ premium dollar wisely includes our sustained use of Lean methodology to improve our operational efficiency and focus on delivering what the customer values most.

Lean has evolved from an exploratory concept when we began our Lean journey in 2005. In subsequent years, it became a key feature of our core operations, eventually turning into an expanding program of continuous improvement across the company. Today, Premera’s Lean journey has evolved further so that Lean is a fundamental part of who we are as a company and how we serve our customers.

While other factors play a role in our operational efficiency, Lean has been an essential part of reducing our administrative expenses as a percentage of gross revenue to 6.3% in 2012, down from 8.8% in 2005.

PREPARING FOR EXCHANGES

Over the course of the last year, the time and resource-intensive work of preparing for the Exchanges has had a substantial impact on Premera, as with all health plans across the country. This work is complex and must be accomplished on a compressed timeline, but we intend to be ready to play our part.

In the states we serve, Washington and Oregon have commenced the task of building their Exchanges, establishing governing bodies and policy making processes to shape this substantial project, including market rules governing health plan participation in these new markets. Premera has worked successfully to be an active voice, providing input and insight as policymakers and regulators grapple with the challenging task of having Exchanges operational by October 1, 2013.

Concurrently, the issue of the federally-facilitated Exchange is also firmly on our radar since Alaska will rely on this option, in lieu of a state-run Exchange. We will be working with our customers closely as all these events unfold to guide and support them as best as possible through the implementation of the Exchanges in all our markets.
Nationally, the big question is whether the Federal and state governments will be ready to launch Exchanges on time. This is a massive undertaking, far beyond just a one-stop shop for consumers to select a health plan. The information technology infrastructure that must be built at both the federal and state level is incredibly complex. We have seen growing concern from some experts and policymakers, including from key Members of Congress, as to whether Exchanges will be fully operational as scheduled.

We continue to monitor such operational issues closely as they evolve. Meanwhile, we are working toward our own Exchange readiness and are continuing preparations to serve our customers in the individual and small group markets in this new environment.

### ADDRESSING THE CHALLENGE OF RISING MEDICAL COSTS

Implementation of federal reform will dominate news headlines and the attention of many in the healthcare system in the months ahead. Yet, we at Premera continue to believe strongly that serious work is necessary to address the challenge of rising medical costs.

To that end, we are working in collaboration with hospitals and doctors to reform the healthcare delivery system. We are committed to a shift that pays for quality of care for patients, not simply volume of services delivered as the current fee-for-service model incents. Medical home pilots are one part of this effort, but our experience is that while medical home projects to remake primary care delivery can have value, they are exceptionally difficult to bring to scale in a timely fashion.

In response, we have worked closely with a growing number of physician clinics in Washington, including The Everett Clinic, The Polyclinic, and Rockwood Clinic, to create a new program called Global Outcomes Contracting (GOC).

Global Outcomes Contracting is focused on rewarding these clinics for bending the trend of rising medical costs. In implementing this program, patients benefit from increased access to primary care and better management of chronic conditions. This early work has already impacted nearly 100,000 Premera members in the Pacific Northwest, more than any other outcomes-based programs in the region.

Premera is one of the first health plans in the country to offer this type of payment model, which rewards cost-effective, evidence-based care on a scalable basis. Initial results indicate this new approach is beginning to help moderate rising medical costs, as the first groups who are participating in this new payment model are seeing results. The total healthcare cost trends last year for our members managed by The Everett Clinic and The Polyclinic were 3–5% below the average of other Premera patients in the same region who have a regular physician, after accounting for differences in health. As a result, we are working to increase the use of GOC and related contracting programs with hospitals and clinics across our markets.

Another way we are addressing rising healthcare costs is keeping our payment policies current with the latest medical literature and best practices, ensuring the delivery of high quality, cost-effective care. Such work is part of a broader set of specific programs to control costs for our customers that yielded $37.7 million in savings in 2012.

One illustrative example is a change to how we pay for sleep studies. We found a huge number of our members participating in overnight sleep studies to evaluate conditions such as sleep apnea were doing so at overnight facilities at a cost of about $2,600 per visit, despite medical literature showing that overnight testing at home is typically more medically appropriate and costs only $300. Moreover, the at-home option is a substantially less disruptive care experience for the patient. We changed our payment policy to reflect that literature and have seen a dramatic drop in unnecessary utilization of overnight facility services. This small example illustrates how changes to improve quality of care for our members can have a significant impact, while also helping control costs.

In addition to changes in how we pay hospitals and doctors, as well as improved medical policies to pay for the most cost-effective care, we are also working with our customers to expand wellness programs and support healthier lifestyle choices. We continue to develop programs that engage our members and give them the tools they need to achieve their health goals.

We significantly expanded our work in 2012 with our employer groups to develop customized worksite wellness programs through Vivacity, our affiliate company specializing in employer wellness programs. Vivacity’s programs are proven to contribute to employee satisfaction and morale, while also helping employers control rising medical costs. We are pleased to have more employers add these programs to their benefit plans, including hands-on consulting support to assist these customers in building their own culture of health.
Left unchecked, federal healthcare spending will bankrupt the country.

Vivacity now serves employers with a total of over 275,000 employees, including both employers who purchase health coverage through Premera and those who do not. We anticipate continued growth in this service, as employers are increasingly reaching a pain point with the cost of healthcare coverage that has increased their interest in exploring new and innovative options to control costs while improving employee health.

Lastly, we have also been putting resources toward providing services for our members that support healthy living, including mobile health applications. For example, Premera is working closely with EveryMove as it develops member tools that track, incent, and reward healthy, active behavior. Our largest individual brand in Washington is the first health plan to offer EveryMove to its members. We are excited to see how this collaboration unfolds to further serve our members and support healthier lifestyle choices.

CREATING A SUSTAINABLE HEALTHCARE SYSTEM

Even as Premera works to implement federal healthcare reform, the healthcare challenges facing our region and nation transcend federal healthcare reform. The law dramatically changes how health insurance works in America, but by government’s own projections, it will not solve the healthcare cost problem. Today, the cost of America’s healthcare system is approaching one fifth of the U.S. economy. By 2020, after federal reform is fully implemented, officials estimate costs will rise by another 33%.

Beyond the direct threats to healthcare, this trend now threatens the fate of our overall economy, as seen in financial scenarios published by the U.S. Congressional Budget Office (CBO). In its most likely scenario, the CBO assumes that federal spending, already outpacing revenues by about $1 trillion, will create a growing economic crisis fueled by ballooning healthcare expenditures. Left unchecked, federal healthcare spending alone, coupled with interest on the debt, will bankrupt the country.

The underlying drivers are well documented: unhealthy lifestyles and an inefficient healthcare delivery system, aggravated by expensive new medical technologies. Variations in practice patterns have a huge impact on cost. For instance, based on Premera’s member cost estimator tool, a member needing knee arthroscopy and cartilage repair could spend an average of $11,077 at one local inpatient hospital, or $2,621 at an outpatient surgery center. These differences we see in treatment costs do not correlate to quality of care or patient outcomes and significant variations exist even among the most prominent and well respected medical groups.

In a well-functioning market, consumers would be able to assess and choose the higher value option. But healthcare is not a well-functioning market. The system relies on the supply side of the healthcare market – doctors, hospitals, government, health plans – to make accurate judgments about what customers really value. That is very hard to do anywhere, let alone with something as personal as healthcare.

We have to find a better way – a revolutionary way – to engage patients in the normal economic process of making tradeoffs on where to spend their hard earned dollars. We can shelter patients from financial hardship through insurance policies for major illness, but also give consumers the information they need to make wiser decisions, and a reason to care. This has worked well for every other walk of economic life from cars to computers, even food, from the dawn of the supply and demand curve.
We see today, even in this opaque system, that when people buy their own high-deductible insurance and pick their own doctors, they make better economic decisions, which benefit them and society as a whole. In studies of our own members, people with individual coverage who buy high deductible insurance plans spend less than employees of larger self-funded companies that offer richer benefits and lower deductibles – and more importantly, have similar health, based on our analyses of relative health risk. This is in line with independent national analysis by the internationally recognized actuarial firm Milliman showing that people who do not have out-of-pocket cost shares consume 30% more healthcare than those who do pay for a portion of the medical services they consume.

Along with our work managing healthcare costs, health plans have an imperative to make it easier for consumers to see the true costs of care so they can make smarter personal economic trade-offs. Once empowered, consumers will help drive toward the healthcare system they prefer. They will compel the healthcare finance and delivery system to transform itself – out of its own self-interest.

Government has a crucial role: not in more top-down, command and control regulation, but by refocusing its efforts to facilitate a thriving marketplace in the private sector and in Medicare, the single largest source of medical spending. As the nation’s biggest insurer, Medicare dictates how our healthcare system operates. Government’s greatest opportunity for impact is to engage nearly 50 million Medicare beneficiaries so they can be more deeply and meaningfully involved in choices about their healthcare.

The public and private sectors must find ways to put the consumer in the driver’s seat, creating a more direct opportunity for personal accountability and reward. Yes, this is a difficult discussion, but the economic threat created by our trajectory of healthcare spending leaves us no realistic alternative.

ENTERING A TIME OF CHANGE FROM A POSITION OF STRENGTH

While the healthcare system does face significant challenges, Premera emerges from 2012 in a position of financial and operational strength. We have weathered the severe economic downturn of 2008 and 2009, plus the tepid economic recovery since, and are well-positioned for future growth. That position of strength will allow us to perform the essential work of preparing for the Exchanges and implementing other provisions of federal healthcare reform. Premera has made great strides in achieving operational excellence, while making prudent investments to improve products and services for our customers. In conclusion, we are well-positioned to deliver on our mission to provide peace of mind to our members about their healthcare coverage.

H.R. BRERETON (GUBBY) BARLOW
Mountlake Terrace, Washington
April 2013
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