ATTACHMENT

#1

Table of Contents

HealthFirst TPA

October 27, 2011

RE: 2012 Stop Loss Renewal

Dear Judge Lee:

Aran has completed their annual renewal of your group insurance coverage. Their reevaluation of the rates for your group was based on the census data, nature of your plan, age and sex of your employees, the size of the group and claims experience to date. **Effective 1/1/2012** , there will be an adjustment in rates. Shown below is a comparison of your current rates and renewal rates:

Specific Deductible:	$ 45,000	$ 45,000
Contract Basis:		
EE Only	$ 114.59	$ 99.19
EE/Family	$ 259.05	$ 242.07
Contract Basis:	24/12	24/12
Aggregate Premium:	$ 10.11	$ 9.68
Aggregate Factors:		
EE Only	$ 609.26	$589.08
EE/Family	$ 1425.61	$ 1408.67

As a service to our clients, HealthFirst TPA searches the markets prior to each renewal and provides each client with the most competitive bids. We have prepared a spreadsheet outlining a comparison of your present rates with those of several other carriers from whom we obtained proposals.

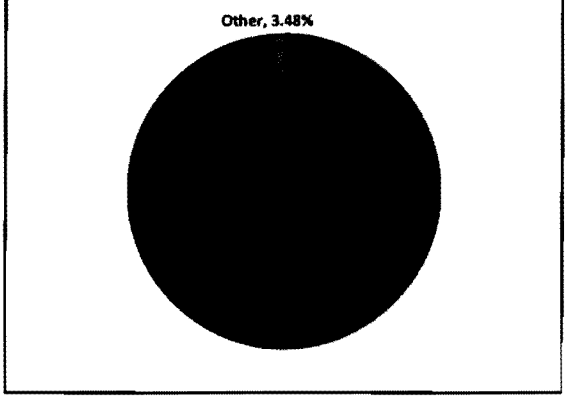
Your business is appreciated and we look forward to working with you and your staff in the coming year. Please do not hesitate to call on me if I can ever be of service in any way.

Sincerely,

Gail Norris
Sales Executive

TITUS COUNTY
Network Summary - ADP Benefits

$5,112	$4,059	$0	**0.00%**
$233,402	$2,536	$169,075	**73.24%**
$630,815	$8,955	$152,846	**24.58%**
$409,334	$78,941	$11,511	**3.48%**
$1,278,663	$90,433	$333,432	**28.06%**



*To summarize the network utilization with Titus County, the total charges Year to Date are $233,402 in the ADP network. Over $169 thousand in savings has been received by Titus County year to date with **18%** of their utilization being within the ADP network.

*If another National Network that averages 50% in discount savings would have processed the charges, it would equate to additional cost of **$52,374**, due to the ADP Network discount rate being at **73%**.

*If the Reinsurance carrier would have quoted another National Network and not the ADP Network, the stop loss premium would have increased by 16%,the savings Titus County has received from the stop loss carrier by utilizing the ADP Network is **$38,134** in fixed cost premiums. The total estimated savings of the two components is **$90508.**

TITUS COUNTY

Stop Loss Insurance Comparison Summary - $45,000 Option
Policy Period: January 1, 2012 to December 31, 2012

FIXED ADMINISTRATION COSTS	Current	Renewal	Current	Renewal
Medical Plan Administration Fee	$16.50	$18.75	$24,948.00	$25,326.00
COBRA / HIPAA Administration Fee - Conexis	$2.00	$2.00	$3,024.00	$3,024.00
Utilization Review - MM Solutions	$2.70	$2.70	$4,082.40	$4,082.40
PPO Access Fee - ADP / PHCS	$8.00	$8.00	$12,096.00	$12,096.00
Transplant Policy Premium - Single	$6.92	$7.37	$6,892.32	$7,340.52
Transplant Policy Premium - Family	$15.92	$16.96	$8,214.72	$8,751.36
TOTAL FIXED ADMINISTRATION COSTS			$59,257.44	$60,620.28

STOP LOSS INSURANCE		Current ARAN American Fidelity	Renewal ARAN American Fidelity	SLG Benefits QBE	IHS Standard Life
Specific Deductible		$45,000	$45,000	$45,000	$45,000
Employee	83	$114.59	$99.19	$100.86	$99.16
Employee + Family	43	$259.05	$242.07	$240.96	$241.81
Annual Specific	126	$247,801	$223,700	$224,793	$223,543
Contract Basis		24/12	24/12	24/12	24/12
Benefits Covered		Medical & RX	Medical & RX	Medical & RX	Medical & RX
Aggregate Rate		$10.11	$9.68	$9.76	$10.24
Annual Aggregate		$15,286	$14,640	$14,764	$15,476
Aggregate Attachment Factor					
Employee	83	$609.26	$589.08	$585.88	$579.21
Employee + Family	43	$1,425.61	$1,408.67	$1,396.00	$1,409.40
Estimated Attachment Point	126	$1,342,438	$1,313,597	$1,303,872	$1,304,144
Contract Basis		24/12	24/12	24/12	24/12
Benefits Covered		Medical & RX	Medical & RX	Medical & RX	Medical & RX
Aggregating Specific		$120,000	$120,000	$120,000	$120,000
Additional Claims Liability		$0	$0	$0	$0
Run-In Limit (if applicable)		$0	$197,040	$234,697	$195,622
Estimated Stop Loss Fixed Cost		$263,088	$238,340 -9%	$239,557 -9%	$239,019 -9%
Aggregating Specific		$120,000	$120,000	$120,000	$120,000
Additional Claims Liability		$0	$0	$0	$0
Estimated Maximum Claims Liability		$1,342,438	$1,313,597 -2%	$1,303,872 -3%	$1,304,144 -3%
Estimated Fixed Costs (Administration, OT Policy & Stop Loss)		$322,345	$298,960 -7%	$300,178 -7%	$299,639 -7%
Estimated MAXIMUM Plan Costs		$1,784,783	$1,732,557 -3%	$1,724,050 -3%	$1,723,783 -3%
Estimated EXPECTED Plan Costs		$1,396,295	$1,349,838 -3%	$1,343,276 -4%	$1,342,954 -4%
PPO NETWORK		ADP / PHCS	ADP / PHCS	ADP / PHCS	ADP / PHCS
ANNUAL MAXIMUM		$1,000,000	$1,250,000	$1,250,000	$1,250,000
LIFETIME MAXIMUM		UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED
CONTINGENCIES/NOTES		No additional liability.	No additional liability.	No additional liability.	No additional liability.

The following markets quoted but are considered uncompetitive: HCC Life, IHC Risk Solutions.

Date: 10/27/2011

TITUS COUNTY

Stop Loss Insurance Comparison Summary - $50,000 Option
Policy Period: January 1, 2012 to December 31, 2012

FIXED ADMINISTRATION COSTS	Current	Renewal	Current	Renewal
Medical Plan Administration Fee	$16.50	$16.75	$24,948.00	$25,326.00
COBRA / HIPAA Administration Fee - Conexis	$2.00	$2.00	$3,024.00	$3,024.00
Utilization Review - MM Solutions	$2.70	$2.70	$4,082.40	$4,082.40
PPO Access Fee - ADP / PHCS	$8.00	$8.00	$12,096.00	$12,096.00
Transplant Policy Premium - Single	$6.92	$7.37	$4,392.72	$7,340.52
Transplant Policy Premium - Family	$15.92	$16.99	$8,254.72	$8,751.36
TOTAL FIXED ADMINISTRATION COSTS			$59,257.44	$60,620.28

STOP LOSS INSURANCE		Current ARAN American Fidelity	Renewal ARAN American Fidelity	SLG Benefits QBE	IIS Standard Life
Specific Deductible		$45,000	$50,000	$50,000	$50,000
Employee	83	$114.59	$82.88	$76.66	$89.72
Employee + Family	43	$259.05	$202.41	$184.19	$219.06
Annual Specific	126	$247,801	$186,995	$171,393	$202,393
Contract Basis		24/12	24/12	24/12	24/12
Benefits Covered		Medical & RX	Medical & RX	Medical & RX	Medical & RX
Aggregate Rate		$10.11	$10.73	$11.44	$10.40
Annual Aggregate		$15,286	$16,223	$17,290	$15,725
Aggregate Attachment Factor					
Employee	83	$609.26	$598.79	$596.77	$590.46
Employee + Family	43	$1,425.61	$1,431.86	$1,422.13	$1,436.77
Estimated Attachment Point	126	$1,342,438	$1,335,235	$1,328,202	$1,329,471
Contract Basis		24/12	24/12	24/12	24/12
Benefits Covered		Medical & RX	Medical & RX	Medical & RX	Medical & RX
Aggregating Specific		$120,000	$120,000	$120,000	$115,000
Additional Claims Liability		$0	$0	$0	$0
Run-in Limit (if applicable)		$0	$200,285	$239,076	$199,421
Estimated Stop Loss Fixed Cost		$263,088	$203,218 -23%	$188,683 -28%	$218,118 -17%
Aggregating Specific		$120,000	$120,000	$120,000	$115,000
Additional Claims Liability		$0	$0	$0	$0
Estimated Maximum Claims Liability		$1,342,438	$1,335,235 -1%	$1,328,202 -1%	$1,329,471 -1%
Estimated Fixed Costs (Administration, OT Policy & Stop Loss)		$322,345	$263,838 -18%	$249,304 -23%	$278,738 -14%
Estimated MAXIMUM Plan Costs		$1,784,783	$1,719,073 -4%	$1,697,506 -5%	$1,723,210 -3%
Estimated EXPECTED Plan Costs		$1,396,295	$1,332,026 -5%	$1,311,865 -6%	$1,342,315 -4%
PPO NETWORK		ADP / PHCS	ADP / PHCS	ADP / PHCS	ADP / PHCS
ANNUAL MAXIMUM		$1,000,000	$1,250,000	$1,250,000	$1,250,000
LIFETIME MAXIMUM		UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED
CONTINGENCIES/NOTES		No additional liability.	No additional liability.	No additional liability.	No additional liability.

The following markets quoted but are considered uncompetitive: HCC Life, IHC Risk Solutions.

Above is for illustration purposes only and does not form a part of any contract. The plan document alone determines benefits payable. All proposals are subject to home office review.

Date: 10/27/2011

TITUS COUNTY

Stop Loss Insurance Comparison Summary - $55,000 Option
Policy Period: January 1, 2012 to December 31, 2012

FIXED ADMINISTRATION COSTS	Current	Renewal	Current	Renewal
Medical Plan Administration Fee	$16.50	$16.75	$24,948.00	$25,326.00
COBRA / HIPAA Administration Fee - Conexis	$2.00	$2.00	$3,024.00	$3,024.00
Utilization Review - MM Solutions	$2.70	$2.70	$4,082.40	$4,082.40
PPO Access Fee - ADP / PHCS	$8.00	$8.00	$12,096.00	$12,096.00
Transplant Policy Premium - Single	$6.92	$7.37	$6,852.92	$7,340.52
Transplant Policy Premium - Family	$15.92	$16.96	$8,214.72	$8,751.36
TOTAL FIXED ADMINISTRATION COSTS			$59,257.44	$60,620.28

STOP LOSS INSURANCE		Current ARAN American Fidelity	Renewal ARAN American Fidelity	SLG Benefits QBE	IIS Standard Life
Specific Deductible		$45,000	$55,000	$55,000	$55,000
Employee	83	$114.59	$73.65	$67.84	$82.58
Employee + Family	43	$259.05	$180.19	$163.44	$202.08
Annual Specific	126	$247,801	$166,330	$151,897	$186,521
Contract Basis		24/12	24/12	24/12	24/12
Benefits Covered		Medical & RX	Medical & RX	Medical & RX	Medical & RX
Aggregate Rate		$10.11	$11.64	$12.25	$10.52
Annual Aggregate		$15,286	$17,593	$18,518	$15,903
Aggregate Attachment Factor					
Employee	83	$609.26	$602.48	$602.22	$598.55
Employee + Family	43	$1,425.61	$1,440.73	$1,435.20	$1,456.47
Estimated Attachment Point	126	$1,342,438	$1,343,487	$1,340,374	$1,347,694
Contract Basis		24/12	24/12	24/12	24/12
Benefits Covered		Medical & RX	Medical & RX	Medical & RX	Medical & RX
Aggregating Specific		$120,000	$120,000	$120,000	$110,000
Additional Claims Liability		$0	$0	$0	$0
Run-In Limit (if applicable)		$0	$201,523	$241,267	$202,154
Estimated Stop Loss Fixed Cost		$263,088	$183,922 -30%	$170,414 -35%	$202,423 -23%
Aggregating Specific		$120,000	$120,000	$120,000	$110,000
Additional Claims Liability		$0	$0	$0	$0
Estimated Maximum Claims Liability		$1,342,438	$1,343,487 0%	$1,340,374 0%	$1,347,694 0%
Estimated Fixed Costs (Administration, OT Policy & Stop Loss)		$322,345	$244,542 -24%	$231,034 -28%	$263,044 -18%
Estimated MAXIMUM Plan Costs		$1,784,783	$1,708,029 -4%	$1,691,409 -5%	$1,720,738 -4%
Estimated EXPECTED Plan Costs		$1,396,295	$1,319,332 -6%	$1,303,334 -7%	$1,341,199 -4%
PPO NETWORK		ADP / PHCS	ADP / PHCS	ADP / PHCS	ADP / PHCS
ANNUAL MAXIMUM		$1,000,000	$1,250,000	$1,250,000	$1,250,000
LIFETIME MAXIMUM		UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED
CONTINGENCIES/NOTES		No additional liability.	No additional liability.	No additional liability.	No additional liability.

The following markets quoted but are considered uncompetitive: HCC Life, IHC Risk Solutions.

ARAN
INSURANCE AGENCY of ARIZONA

Stoploss Proposal Contingencies

Employer **Titus County** Quote ID 1863
Eff. Date **1/1/2012** Plan ID 2670

The terms of this offer are tentative and subject to change based on receipt, review and approval of the following:

- Proposal subject to receipt and review of final sold case documentation including completed application, disclosure statement, final census, plan document and all updated claims information. Underwriting reserves the right to make adjustments for any material change within the final documentation provided.
- Proposal assumes the continuation of the current benefit plan(s), exclusively, and the same relative distribution of members between plans.
- Proposal subject to medical review of all large claim information provided, updated information as received, and any additional information we request as a result of the aforementioned review.
- If multiple benefit plans are being offered, the aggregate factors shown are a composite of all the in force benefit plans and are being provided solely as a means to calculate the total aggregate liability for the entire group, unless otherwise noted. The actual aggregate factors will differ by benefit plan.
- Unless otherwise noted, proposal assumes there will be at least 75% eligible participation not including those employees who waived due to other coverage.
- Proposal assumes that all available claims information provided within the most recent three years has been included with the Request For Proposal.
- This proposal is based on the information supplied. We reserve the right to make changes if any of the information that the quote is based on changes.
- This quote is based on the enrollment shown on the proposal page. If the actual enrollment varies by more than 10%, we reserve the right to re-rate the case.
- Proposal assumes plan document excludes treatment for infertility except for diagnosis purposes only.
- Proposal contingent upon receipt and review of clinical information for large claimants.
- Proposal assumes municipality has waived it's rights under Texas Legislation and considers our bid subject to terms, conditions and contingencies listed. Proposal is subject to change.

This is a TENTATIVE quote based upon the information furnished in the Request for Proposal. Material deviations from any of the original information that was submitted to us may result in a change to the quoted Rates and/or Factors or withdrawal of the proposal. SLG will not be bound by any typographical errors or omissions contained herein.

Quoted terms and conditions are subject to possible revision based upon receipt and review of the requirements listed below:

STANDARD CONDITIONS

Updated shock loss information to include injuries, illnesses, diseases, diagnoses, or other losses of the type, which are reasonably likely to result in a significant medical expense claim or disability, regardless of current claim dollar amount. In addition, shock loss information should include any claimant that has incurred claim dollars in excess of 50% of the specific deductible and/or anyone who has exceeded a lifetime plan benefit of $500,000, regardless of diagnosis. Information is also needed on any claims processed and unpaid, pended or denied for any reason. Known claimants currently under Case Management, regardless of claim dollar amount must be disclosed. Please refer to our Potentially Catastrophic Loss List (found on our website @ www.slgbenefits.com), which provides examples of some, but not all, types of shock losses.

New accounts - a signed completed Disclosure Statement no earlier than 30 days prior to the effective date.

Final paid claims and enrollment through the effective date.

A complete copy of the Policyholder's Plan Document including all current Plan Amendments to confirm that the document is reflective of the Schedule of Benefits submitted during the underwriting process and contains SLG Benefits' MINIMUM Plan Document assumptions.

The selected TPA assigned to administer all claims. The TPA is subject to approval by SLG Benefits.

A complete census clearly illustrating all Cobra and/or Retirees to be covered. If they are not indicated on the census, the proposal assumes there are none covered under the plan. If retirees are eligible, this must be clearly stated in the RFP submission.

Final Rates and Factors will be based upon the actual enrollment census as of the requested Effective Date. In the event there is a greater than 10% change in enrollment between the submitted initial enrollment date and the final enrollment data, rates and factors may be recalculated.

A minimum participation level of 75% of all eligible employees is required unless otherwise noted.

ADDITIONAL CONDITIONS SPECIALLY PREPARED FOR: TITUS COUNTY,

Quote is contingent upon in-house medical review of all large claimants in order to finalize quoted terms.

Subject to updated month by month paid claims and enrollment through 11/30.

Proposal is based on current benefits and participation breakouts. Any changes to these benefits or participation could result in Re-Underwriting.

Quote assumes the use of the following UR vendor: MM Solutions.

Quote assumes the use of the following PPO vendor: Access Direct Platinum and PHCS.

PROPOSAL ACCEPTANCE PROCEDURES

1. **Identify the option sold in the space provided below. Date and sign the proposal.**
2. **Satisfy all the terms and conditions of this proposal as listed above within 15 days of the Effective Date.**
3. **Submit completed disclosure & binder premium within 15 days of the Effective Date.**

International Insurance Agency Services, LLC
10 South LaSalle Street, Suite 3450
Chicago, IL 60603
(312) 857-9100 Fax (312) 857-9109

Excess Loss Proposal Contingencies

Employer	**Titus County**	Quote ID	26371
Eff. Date	**1/1/2012**	Plan ID	32082

The terms of this offer are tentative and subject to change based on receipt, review and approval of the following:

- This is not a binder or contract of insurance.
- These estimated costs do not include any cost of health plan claim administration.
- The TPA selected must be approved by International Insurance Agency Services, LLC.
- An actively-at-work provision for employees and non-institutional confinement provision for dependents shall apply to all persons to be covered as of the effective date of the stop loss coverage. The actively-at-work provision is waived on for those claimants disclosed on the Disclosure Statement. A pre-existing condition clause shall be required with respect to future employees and their dependents
- This quote assumes that participation is at least 75%. In addition, this quote assumes LESS than 10% retiree participation (The percentage of retirees covered is less than 10% of the total covered empoyees) and that Medicare is Primary for retirees age 65 and over.
- Every employee who is disabled must be identified with complete details of the disability prior to the acceptance of this case. Every dependent who is disabled or hospital confined must be identified with complete details prior to the acceptance of this case.
- The minimum aggregate deductible is 100% of the employees and dependents covered during the first policy month times the respective aggregate attachment point factors times 12.
- Specific excess risk insurance will pay 100% of claims paid according to the claims basis in excess of the specific deductible to a maximum benefit of $1,250,000 per Treaty year. Aggregate excess risk insurance will pay 100% of claims paid according to the claims basis in excess of the aggregate deductible to a maximum of $1,000,000 for the Treaty year.
- Final acceptance of the case is subject to the approval of International Insurance Agency Services, LLC and will be based on data supplied as of the effective date of coverage. If this quote is not accepted past seven days from the proposed effective date it will have to be re-underwritten. All rates and factors are contingent upon final plan and enrollment.
- The plan of benefits shown in this quote attempts to highlight the basic schedule of benefits and may not reflect every detail specifically provided in the actual plan document.
- Updated and verified AGGREGATE claim experience of the current plan year including employee enrollment information thru 12 MONTHS on a MONTHLY basis is required (Please note: factors may be revised).
- Updated and verified SPECIFIC claim experience of the current plan year thru 11 MONTHS (12 MONTHS for specific deductibles of $75,000 and higher) is required (Please note: lasers may be placed and / or rates may be revised).
- Disclosure of all paid, denied, held, pended or unfunded claims through the date of the disclosure statement and within 30 days of the effective date.
- Size of group changes by 10% or more between census data provided at time of quote and the initial sold case census.
- A final signed plan document for the coverage period. We must review and approve all plan documents to verify that benefits correspond with those assumed when we prepared our quote. Any changes in benefits could result in changes to rates and factors.
- Completed and signed Disclosure Statement.
- Shock loss information for all past and ongoing claims during the last three years exceeding $22,500. Please provide

International Insurance Agency Services, LLC
10 South LaSalle Street, Suite 3450
Chicago, IL 60603
(312) 857-9100 Fax (312) 857-9109

Excess Loss Proposal Contingencies

Employer **Titus County** Quote ID 26371
Eff. Date **1/1/2012** Plan ID 32082

The terms of this offer are tentative and subject to change based on receipt, review and approval of the following:

the total amount of the claim, dates incurred, diagnosis and prognosis (current status). In addition, we will need details on anyone that is currently lasered.

- Any ongoing information regarding claims projected to exceed $22,500.
- Precertification reports for the most recent 90 days up to the date of Disclosure is completed and signed.
- Additional claims information is required on the following employee(s) / dependent(s). The information should include a complete diagnosis, prognosis, dates of service and current/future treatment plans. Case Management reports should be included when possible. Lasers and APS' may or may not be required depending on this information.

1. - Accepted
2. - Accepted
3. - Accepted
4. - Accepted
5. - Accepted
6. - Accepted
7. - Accepted

- Final determination of approval of individual plan participants is based on the claim status and health situation at the time of final disclosure. Change in health condition of any individual who may be tentatively approved will cause that individual to be re-underwritten.
- Confirmation that this group will utilize the following PPO network(s): Access Direct Platinum in ADP area, PHCS MultiPlan outside of ADP
- Pre Certification, Utilization Review and Large Case Management are mandatory on all groups.
- The aggregating specific is the amount of specific claims the employer is responsible for prior to reinsurance reimbursement.
- 1. Do you have retirees covered?
  2. If so, who are they?
  3. Is Medicare the primary coverage at age 65?
- Our quote assumes we reserve the right to set lasers. Therefore, the employer must waive House Bill #1627.

Accident & Health Corporate Benefits

CHARTIS

One MacArthur Place Suite 620, South Coast Metro, CA 92707 Toll Free: 800-634-7462

Organ Transplant Proposal

Employer:	TITUS COUNTY	Underwriter:	Josefina Panopio
Proposal:	93071	Sales:	Stanley Self
Producer:	HealthFirst TPA Inc.	Quote Date:	09/23/2011
Claims Admin.:	HealthFirst TPA Inc.	Quote Valid Until:	01/01/2012
Carrier:	National Union Fire Insurance	Effective Date:	01/01/2012

This proposal contemplates the utilization of the above captioned Claims Administrator. Any deviation is a materiel change of fact rendering this proposal null and void.

Summary of Coverage

Lifetime Maximum :	$1,000,000
Policy Deductible :	$0
Notification / Coordination :	See requirements in attached policy specimen
Transplant Benefit Period :	Evaluation through 365 days post transplant
Reimbursement :	* 100% of covered transplant-related costs, including organ procurement, when performed in-network. * 80% of covered transplant-related costs up to scheduled maximum amount per transplant when performed out-of-network (see policy)
Transportation :	$200 per day, $10,000 maximum for patient and companion
Experimental :	Coverage of NCI Clinical Trials Phase III and IV for adults, all phases for pediatric
Pre-Existing Requirements :	Pre-Ex is waived for current Participants (unless they are completing an established Pre-Ex Waiting Period). However, Participants added from the acquisition of a new group, affiliate, division, and/or subsidiary, are subject to a 12 month Pre-Ex Waiting Period that begins on the date the acquisition is covered under the Policy. A Pre-Existing Condition is any condition for which the Participant has within the past 24 months: been advised that a transplant may be necessary; had a transplant consultation, workup, or evaluation; been scheduled for a transplant consultation, workup, or evaluation; received or has been listed to receive a transplant; received dialysis treatments; or been diagnosed with Chronic Kidney Disease or End Stage Renal Disease. *
Other Coverage / Services :	Please refer to policy specimen
Rate :	**$ 7.37** Single * **$ 16.96** Family *
Premium :	**$ 15,738.12**
Commission :	Rates include 10% commission

* Rates and benefits are subject to state approval, and the 24 month Pre-Ex "look-back" period may vary by state.

Russ Jehs

Vice President, Organ Transplant Product Management

Organ Transplant Proposal

Employer:	TITUS COUNTY	Underwriter:	Josefina Panopio
Proposal:	93071	Sales:	Stanley Self
Producer:	HealthFirst TPA Inc.	Quote Date:	09/23/2011
Claims Admin.:	HealthFirst TPA Inc.	Quote Valid Until:	01/01/2012
Carrier:	National Union Fire Insurance	Effective Date:	01/01/2012

This proposal contemplates the utilization of the above captioned Claims Administrator. Any deviation is a material change of fact rendering this proposal null and void.

Contingencies

For All Producers / Groups

- Explanation of any upcoming significant census changes (20%) within 30 days of effective date.
- Proposal assumes at least 80% of the participants reside in Texas.
- Contract period is for 12 months from effective date.
- In the event that Plan participants are covered under a High Deductible Health Plan (as defined under Title 26, Subtitle A, Chapter 1, Subchapter B. Part VII, § 223 of the Internal Revenue Code), the Plan's Deductible Amount must be met prior to benefits being paid under the Organ and Tissue Transplant Policy.

For Non-Select Groups: In addition to the information requested above, please provide the following:

(Attached Proposal is 'indication only' based on our Pooled Producer rates. The information requested below is to determine any variance from pooled rates in order to determine our final underwriting position.)

Basic Term Life and AD & D Insurance

Proposal for: Titus County
Rate Guaranted to: March 1, 2012

Benefit Summary

	Benefit
Employee Term Life Benefit Amounts	1.5 x annual salary

Employee Benefit Reduction Schedule	**At Age**	**Benefits Reduced to:**
	65	65%
	70	50%
	75	35%

$2000 child benefit ($500 from 14 days to six months); $5,000 spouse benefit.

Cost Summary

	Monthly Rate
Employee Term Life	$0.25/$1,000
Employee AD & D	$0..35/$1,000
Dep Life Rate	$1.684 per EE with dependenet coverage

HealthFirst TPA

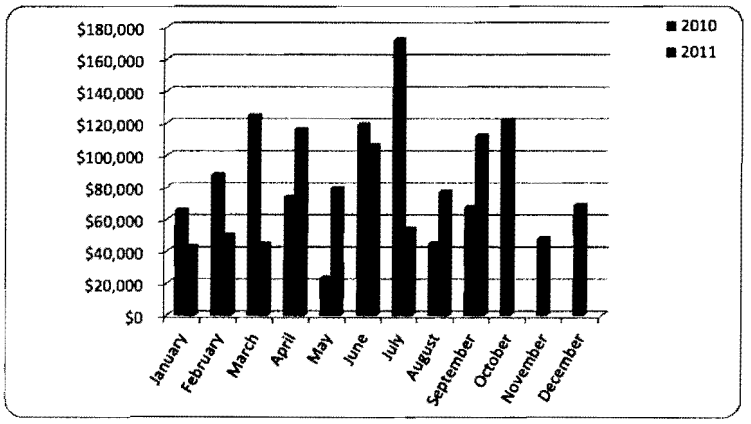
Renewal
Management Reports
for
Titus County

Renewal 2012

Titus County

Total Medical Claims Paid By Month
January 1, 2011 through September 30, 2011

	2010	2011
January	$65,859	$42,962
February	$87,945	$49,993
March	$124,614	$44,489
April	$73,870	$116,064
May	$23,372	$79,227
June	$118,661	$106,153
July	$171,893	$53,681
August	$44,737	$77,148
September	$67,622	$112,015
October	$121,782	
November	$47,871	
December	$68,665	
TOTAL	$1,016,890	$681,731

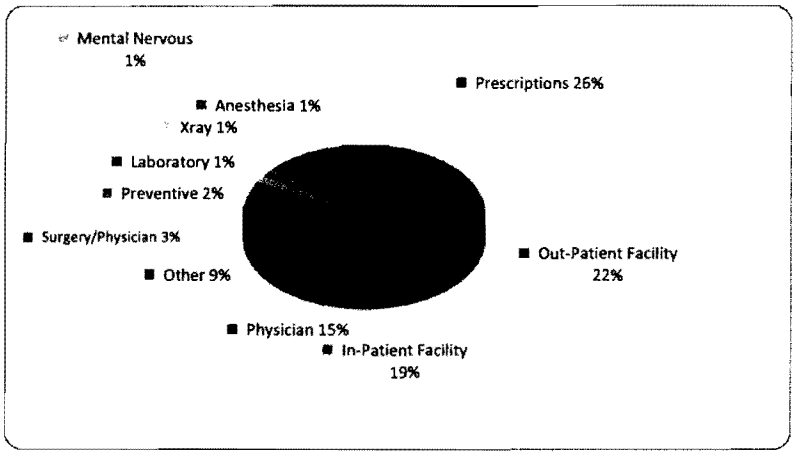


Includes prescription charges and excludes dental charges.

Titus County

Most Frequently Used Medical Charge Codes
January 1, 2011 through September 30, 2011

CHARGE TYPE	TOTAL DOLLARS PAID
Out-Patient Facility	$206,898
Prescriptions	$184,944
Physician	$92,841
In-Patient Facility	$78,549
Surgery/Physician	$49,450
Preventive	$17,026
Other	$15,123
Anesthesia	$13,935
Xray	$10,488
Laboratory	$8,492
Mental Nervous	$3,771
TOTALS	**$680,820**

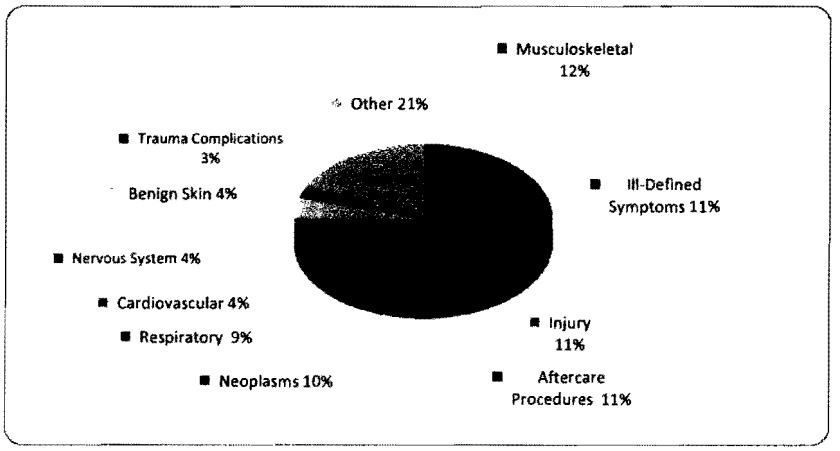


Excludes dental charges.

Titus County

Top Medical Diagnosis By Dollar Amount
January 1, 2011 through September 30, 2011

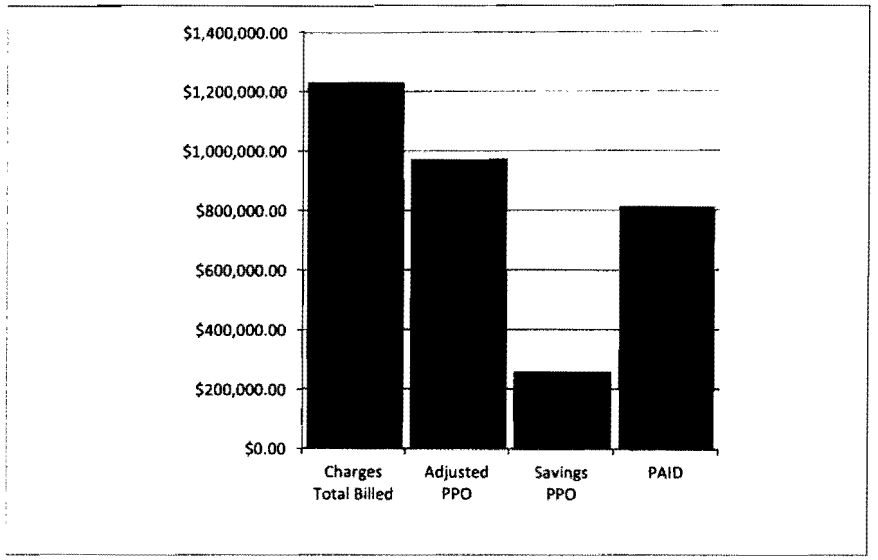
	TOTAL PAID FOR THIS DIAGNOSIS	PERCENTAGE
Female Genital	$74,810	15%
Ill-Defined Symptoms	$64,862	13%
Fracture/Dislocation/Sprain	$52,655	11%
Musculoskeletal	$52,568	11%
Respiratory	$45,364	9%
Genitourinary	$30,424	6%
Cardiovascular	$26,465	5%
Digestive	$26,537	5%
Nervous System	$21,288	4%
General Examination	$14,503	3%
Other	$87,399	18%
Prescription	$184,944	(Not Charted)
TOTALS	$680,819	



Excludes dental charges.

Titus County

PPO Savings
January 1, 2011 through September 30, 2011



	Total Billed Charges	PPO Adjusted	PPO Savings	PAID
PPO CHARGES	$766,318.23	$508,371.77	$257,946.46	$414,136.86
PMCS	$78,243.09	$71,344.66	$6,898.43	$52,345.24
NON-PPO	$51,712.01	$51,589.87	$122.14	$29,393.12
RX	$206,649.38	$206,649.38	$0.00	$184,944.38
	$1,102,922.71	**$837,955.68**	**$264,967.03**	**$680,819.60**

All Duplicate Claim Submissions Have Been Excluded From These Numbers

Total PPO Billed Charges Minus PPO Adjusted Equals PPO Savings
PPO Adjusted Equals PPO Charges Minus Network Discounts.
Other Charges Are Non-Network Billed Charges

Excludes Dental

Titus County

Top 10 Medical Providers
January 1, 2011 through September 30, 2011

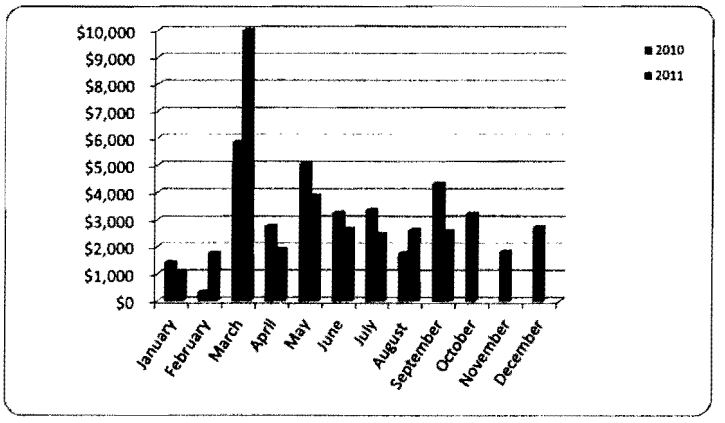
	Total Paid
Titus Regional Medical Center	$233,550
Texas Spine & Joint Hospital	$33,590
Milan Sekulic MD	$10,190
The Heart Hospital Baylor	$9,063
Carter J Moore MD	$8,060
Oscar M Reichert DO	$7,538
Roger Stuart Jr MD	$6,760
Motaz Albahra MD	$6,465
J Morris McKellar MD	$6,073
Thomas E Stanford MD	$5,849
All Others	$168,736
TOTALS	**$495,875**

Excludes Prescription and Dental charges.

Titus County

Total Dental Claims Paid By Month
January 1, 2011 through September 30, 2011

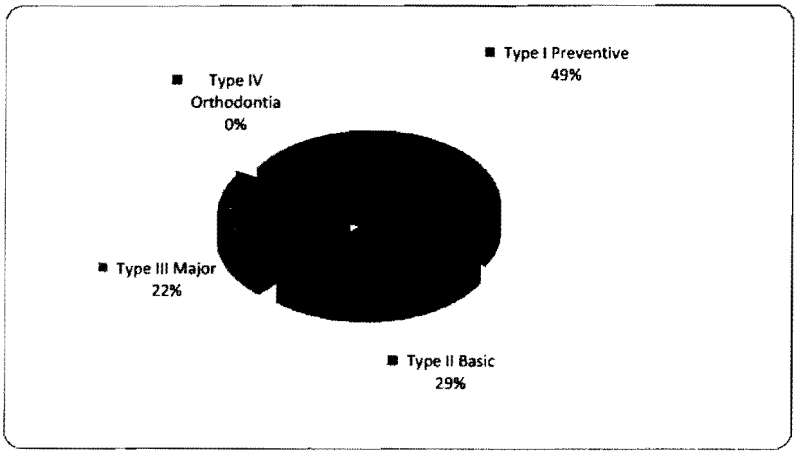
	2010	2011
January	$1,421	$1,087
February	$346	$1,767
March	$5,856	$9,999
April	$2,781	$1,907
May	$5,043	$3,888
June	$3,260	$2,655
July	$3,370	$2,471
August	$1,774	$2,624
September	$4,330	$2,582
October	$3,228	
November	$1,830	
December	$2,743	
TOTAL	$35,983	$28,979



Titus County

Most Frequently Used Dental Charge Codes
January 1, 2011 through September 30, 2011

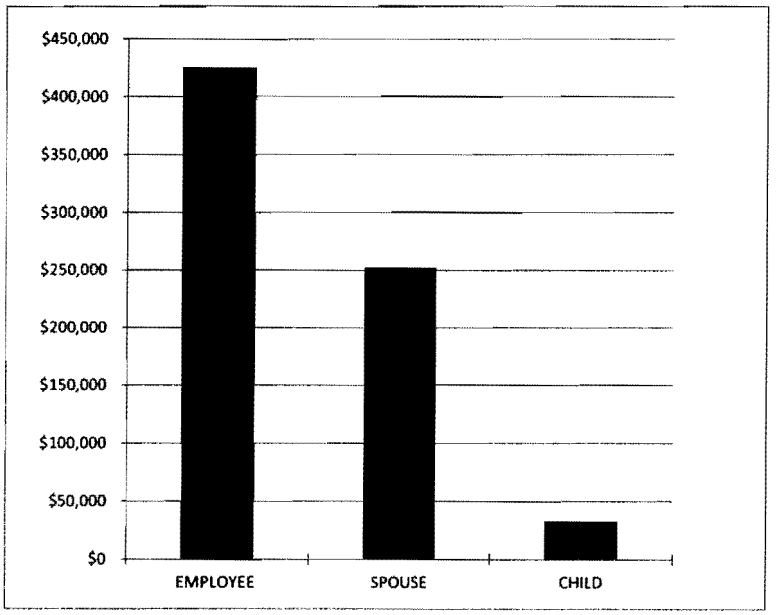
CHARGE TYPE	TOTAL DOLLARS PAID
Type I Preventive	$14,387
Type II Basic	$8,448
Type III Major	$6,245
Type IV Orthodontia	$0
TOTALS	$29,080



Titus County

Total Claims Paid by Covered Lives
January 1, 2011 through September 30, 2011

	TOTAL DOLLARS PAID OUT
EMPLOYEE	$425,003
SPOUSE	$252,208
CHILD	$32,690



MONTHLY CLAIMS EXPERIENCE REPORT

Report Date: 10/7/2011

HealthFirst TPA

Client: Titus County
Carrier: Aran Insurance Underwriters

Policy			Current Specific Coverage			Current Aggregate Coverage		Aggregate Premium	
	24/12	ISL Amount:	EE	$114.59	Min. Att. Pt.	EE	$609.26	Composite:	
Policy Number:	0000100	$45,000	EE+SP	$259.05	$1,400,927.00	EE+SP	$1,425.61	Rate:	$10.11
Policy Period:	1/1/2011-12/31/2011	Aggregating Specific:	EE+FAM	$259.05		EE+FAM	$1,425.61		
Covered:	Medical, Dental, RX	$120,000	EE+CH	$259.05		EE+CH	$1,425.61		

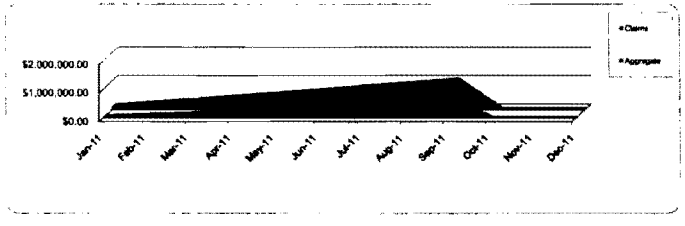
1	2				3	4	5	6	7	8	9	10	11
Month/Year	Units Covered				Aggregate Attachment Point		Total Paid Claims		Not Covered Under	Excess Aggregating Specific	Excess Specific	Net Monthly	Net YTD
	EE	EE+SP	EE+FAM	EE+CH	Month	YTD	Monthly	YTD	Aggregate Claims	Claims	Claims	Paid Claims	Claims
Jan-11	79	23	11	10	$110,858.38	$110,858.38	$44,757.24	$44,757.24	$1,087.00	$0.00	$0.00	$43,670.24	$43,670.24
Feb-11	84	21	11	12	$113,904.68	$224,763.06	$51,717.24	$96,474.48	$1,841.50	$0.00	$0.00	$49,875.74	$93,545.98
Mar-11	77	22	11	8	$105,363.03	$330,126.09	$54,380.85	$150,855.33	$13,770.05	$0.00	$0.00	$40,610.80	$134,156.78
Apr-11	86	23	12	10	$116,548.81	$446,674.90	$117,970.11	$268,825.44	$4,408.32	$0.00	$0.00	$113,561.79	$247,718.57
May-11	84	21	14	8	$112,479.07	$559,153.97	$82,239.52	$351,064.96	$4,337.72	$0.00	$0.00	$77,901.80	$325,620.37
Jun-11	88	23	14	9	$119,192.94	$678,346.91	$108,448.51	$459,513.47	$2,773.97	$0.00	$0.00	$105,674.54	$431,294.91
Jul-11	84	23	14	9	$116,755.90	$795,102.81	$55,265.97	$514,779.44	$963.93	$0.00	$0.00	$54,302.04	$485,596.95
Aug-11	89	21	14	9	$116,950.98	$912,053.79	$80,021.47	$594,800.91	$3,042.65	$0.00	$0.00	$76,978.82	$562,575.77
Sep-11	78	22	13	9	$110,249.12	$1,022,302.91	$114,671.98	$709,472.89	$2,614.66	$0.00	$0.00	$112,057.32	$674,633.09
Oct-11					$0.00	$0.00	$0.00	$709,472.89				$0.00	$0.00
Nov-11					$0.00	$0.00	$0.00	$709,472.89				$0.00	$0.00
Dec-11					$0.00	$0.00	$0.00	$709,472.89				$0.00	$0.00

Total Monthly Paid Claims (from column #6) =	$709,472.89
LESS:	
Not Covered under the Aggregate Claims (from column #7) =	$34,839.80
Excess Aggregating Specific Claims (from column #8)	$0.00
Excess Specific Claims (from column #9) =	$0.00
Aggregate Attachment Point =	$1,022,302.91
EQUALS	
Aggregate Excess Reimbursement Request =	-$347,669.82

Penetration of Aggregate Attachment Point
66%

Month/Year	Medical	Dental	RX	Enrollment
Jan-11	$23,023.86	$1,087.00	$20,646.38	123
Feb-11	$30,348.22	$1,766.50	$19,602.52	128
Mar-11	$21,073.62	$9,998.96	$23,308.27	118
Apr-11	$99,248.17	$2,008.58	$16,713.36	131
May-11	$51,107.63	$3,887.92	$27,243.97	127
Jun-11	$79,961.30	$2,654.59	$25,832.62	134
Jul-11	$51,884.50	$2,471.15	$910.32	130
Aug-11	$54,629.57	$2,623.58	$22,768.32	133
Sep-11	$84,170.87	$2,582.49	$27,918.62	122
Oct-11				0
Nov-11				0
Dec-11				0

Note: Your Excess-Loss contract contains a minimum annual aggregate provision. If enrollment decreases during the plan year, your plan may be subject to this provision. Please refer to your Excess-Loss contract for details.
Excess Specific (Stop Loss) totals contain prescription claims that are based on incurred dates.



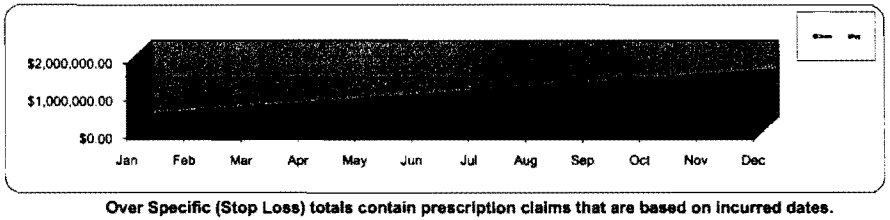
TITUS COUNTY

Aggregate Monthly Report

Plan Year:	January 1, 2010 through December 31, 2010				
Reinsurer:	IOA				
Aggregate Factor:	Employee	$615.25	Family	$1,413.30	
Min Attachment Point:	$1,437,229				
Aggregate Run In Limit:	$215,584				
Contract Basis:	24/12				
Specific Deductible:	$45,000 with $120,000 aggregating specific				

Jan	88	21	12	13	132
Feb	91	21	11	11	134
Mar	89	18	9	11	127
Apr	91	21	6	10	128
May	80	21	9	10	120
Jun	88	21	9	10	128
Jul	87	24	10	8	129
Aug	76	23	9	10	118
Sep	72	20	9	10	111
Oct	81	22	9	11	123
Nov	88	22	9	9	126
Dec	71	23	9	10	113

Jan	117923	117923	37371	1473	24380	63224	0	2133	0	61091	61091	0	0	0
Feb	116760	234683	70261	346	19622	90229	0	346	0	89883	150974	0	0	0
Mar	108463	343146	94203	5766	30244	130213	0	7297	1521	121395	272369	0	0	0
Apr	108280	451425	44445	2781	32170	79396	0	3081	8235	68079	340449	0	0	0
May	105752	557177	23272	5043	0	28315	0	5546	1491	21279	361727	0	0	0
Jun	110674	667851	69326	3260	49298	121885	0	3260	21387	97237	458964	0	0	0
Jul	112885	780737	147824	3370	22504	173697	0	3595	78371	91731	550695	0	0	0
Aug	106118	886854	29749	1774	15337	46859	0	1819	1315	43726	594421	0	0	0
Sep	99417	986271	44244	4330	23377	71952	0	5868	4490	61594	656015	0	0	0
Oct	109194	1095465	103305	3228	17498	124030	20472	3228	3189	97141	753156	0	0	0
Nov	109444	1204908	29727	1830	18469	50026	6730	1830	0	41466	794622	0	0	0
Dec	103041	1307950	41116	2743	27694	71553	9121	3320	0	59112	853734	0	0	0



Over Specific (Stop Loss) totals contain prescription claims that are based on incurred dates.

These numbers are subject to change at the end of the plan year when all adjustments and plan provisions have been resolved.

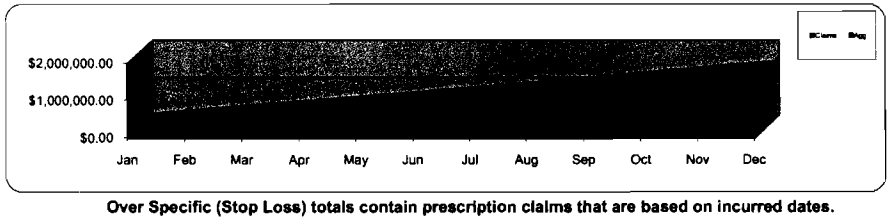
TITUS COUNTY

Aggregate Monthly Report

Plan Year:	**January 1, 2009 through December 31, 2009**				
Reinsurer:	**Alliance Underwriters**				
Aggregate Factor:	**Employee**	**$649.19**	**Family**	**$1,687.89**	
Min Attachment Point:	**$1,439,642**				
Aggregate Run In Limit:					
Contract Basis:	**24/12**				
Specific Deductible:	**$45,000 with $40,000 aggregating specific**				

Jan	84	19	9	10	122
Feb	90	20	9	11	130
Mar	92	20	9	9	130
Apr	84	20	9	10	123
May	89	17	9	11	126
Jun	92	20	10	11	133
Jul	101	13	10	11	135
Aug	83	21	10	12	126
Sep	93	22	11	11	137
Oct	91	22	13	14	140
Nov	83	23	9	12	127
Dec	84	21	11	12	128

Jan	118672	118672	126989	2031	20984	150004	0	2331	15955	131718	131718	13046	0	13046
Feb	125943	244614	62793	2196	36032	101021	0	2714	21878	76429	208147	0	13046	0
Mar	123865	368480	83725	1748	22873	108345	39139	1748	2167	65291	273439	0	0	0
Apr	120360	488839	75107	5661	17129	97897	13631	5728	0	78538	351977	0	0	0
May	120230	609069	64182	1076	20101	85359	7464	1301	0	76594	428571	0	0	0
Jun	128929	737998	81628	5914	4875	92417	2880	5914	0	83623	512194	0	0	0
Jul	122956	860955	120551	6613	26582	153747	18180	8886	0	126681	638875	0	0	0
Aug	126462	987417	383600	3256	28506	415362	349769	6526	0	59067	697942	0	0	0
Sep	134642	1122059	33904	2975	24510	61390	2106	3320	0	55963	753905	0	0	0
Oct	141783	1263841	106585	2084	21638	130307	59196	2618	0	68492	822397	0	0	0
Nov	128150	1391991	50092	4665	26000	80758	7110	4665	0	68983	891380	0	0	0
Dec	128799	1520791	111251	2388	25757	139396	16959	3580	0	118857	1010237	0	0	0



Over Specific (Stop Loss) totals contain prescription claims that are based on incurred dates.

These numbers are subject to change at the end of the plan year when all adjustments and plan provisions have been resolved.

Normative Comparison Summary

Titus County - Group ID: 0000100

Output Generated: 10/7/2011
Date Range: Check Date 1/1/2011 through 9/30/2011

Comparisons: None

Enrollments, Payments & Savings

Total Health Plan Contracts	4
Total Health Plan Members	4
Members per Contract	1.18
Average Member Age	43.33
Average Employee Age	45.68
Inpatient Facility	$102,104.14
Outpatient Facility	$216,334.41
Inpatient Professional	$18,787.44
Outpatient Professional	$343,593.61
Dental	$29,080.77
Total Plan Payment	$709,900.37
Total Charges	$1,179,163.30
Total Plan Payment	$709,900.37
Employee Responsibility	$120,554.71
Exclusions	$82,686.36
Other Insurance COB	$454.66
Overall N/W Savings Amount	$265,567.20
Overall N/W Savings Percent	24.22%

Utilization Statistics

Claim Type	Statistics	Group	Norm	% Difference	Norm Category
All Medical Claims	Services/1000 Members	975.150			
	Plan Payment/Member	$153,184.41			
	Plan Payment/Contract	$180,216.95	$8,657.67	1,981.59%	National, Overall*
	Plan Payment/Contract	$180,216.95	$5,891.13	2,959.12%	0-199 EEs*
	Plan Payment/Contract	$180,216.95	$5,782.54	3,016.57%	South Region*
Inpatient Facility	Services/1000 Members	3,825			
	Plan Payment/Member	$22,973.43			
	Plan Payment/Contract	$27,027.57			
	Admissions/1000 Members	2,700			
	Average Length of Stay (Days)	2.6			
	Days/1000 Members	6,975			
Outpatient Facility	Services/1000 Members	46,125			
	Plan Payment/Member	$48,675.24			
	Plan Payment/Contract	$57,264.99			
Inpatient Professional	Services/1000 Members	49,725			
	Plan Payment/Member	$4,227.17			
	Plan Payment/Contract	$4,973.15			
Outpatient Professional	Services/1000 Members	875,475			
	Plan Payment/Member	$77,308.56			
	Plan Payment/Contract	$90,951.25			

** Derived from: **Employer Health Benefits 2010 Annual Survey, (#8085) The Henry J. Kaiser Family Foundation, September 2010.***
This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

Per-Network Savings

PPO	Charges	Exclusions	Discount Amount	% Savings
ACS	$3,775.00	$0.00	$2,240.57	59.35%
AD	$5,112.00	$4,058.69	$0.00	0.00%
ADP	$153,646.85	$1,542.83	$108,571.96	71.38%
HCPH	$0.00	$2,178.54	($622.75)	28.59%
PHHD	$6,100.73	$1,236.23	$2,137.36	43.94%
PMCS	$72,797.72	$421.43	$7,020.57	9.70%
TXTC	$599,749.53	$6,234.67	$146,219.49	24.64%
Other	$337,981.47	$67,013.97	$0.00	0.00%
Total	$1,179,163.30	$82,686.36	$265,567.20	24.22%

In-Network Statistics

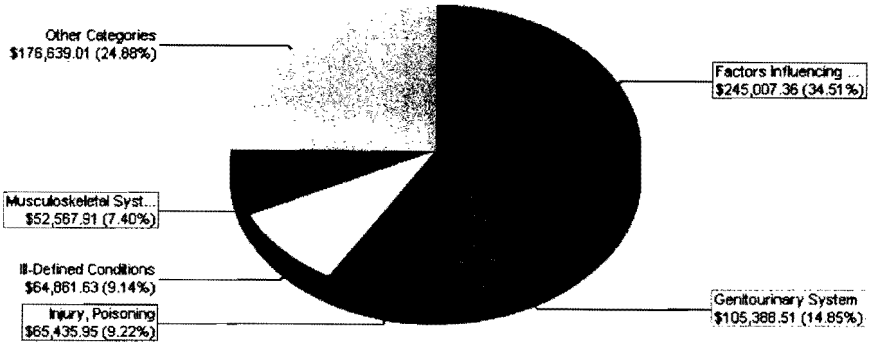
Number of Services	2762	(57.77%)
Plan Payment	$464,584.82	(65.44%)

Claim Type	% Services	Plan Payment
InpatientFacility	0.54%	21.59%
Outpatient Facility	6.84%	45.98%
Inpatient Professional	3.08%	3.23%
Outpatient Professional	89.54%	29.20%

Top Five Payees by Plan Payment

Payee	% of Payments	Payments
TITUS REGIONAL MEDICAL CENTER	32.90%	$233,550.39
CLINIC PHARMACY	19.77%	$140,324.47
TEXAS SPINE & JOINT HOSPITAL	4.73%	$33,589.95
MCKELLAR MEDICINE CHEST	4.13%	$29,301.56
BROOKSHIRE GROCERY COMPANY	2.13%	$15,121.25
All Other Payees	36.34%	$258,012.75

TOP 5 DIAGNOSIS GROUPS



Shock Claim Summary

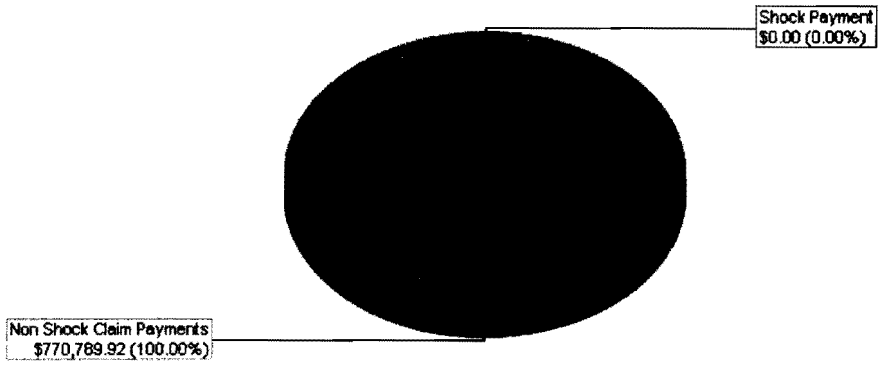
Titus County - Group ID: 0000100

Output Generated: 10/27/2011
Date Range: Check Date 1/1/2011 through 10/27/2011

Comparisons: None

Excluded Prescription Details from PBM
Included Prescription Payments from Adjudication System
Shock Claim Threshold: $45,000.00

# of members with claims above threshold:	**0**
Total Plan Payment in claims above threshold:	**$0.00**
Total Plan Payment for claimants with claims above threshold:	**$0.00**
Total Plan Payment in claims:	**$770,789.92**



Member	SSN	Total Plan Payment	Most Expensive Primary Diagnosis	Total Charge	Plan Payment	Provider

This report lists those claimants whose total paid claims during the period specified were greater than or equal to the amount shown. Entries are shown in descending order of total dollars paid. Amounts shown may not reflect adjustments or reversals made outside the specified time period shown on this report.

Shock Claim Summary

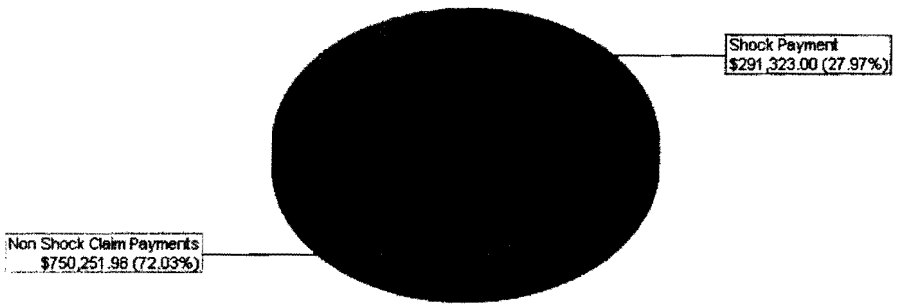
Titus County - Group ID: 0000100

Output Generated: 9/23/2011
Date Range: Check Date 1/1/2010 through 12/31/2010

Comparisons: None

Excluded Prescription Details from PBM
Included Prescription Payments from Adjudication System
Shock Claim Threshold: $45,000.00

# of members with claims above threshold:	**3**
Total Plan Payment in claims above threshold:	**$156,323.00**
Total Plan Payment for claimants with claims above threshold:	**$291,323.00**
Total Plan Payment in claims:	**$1,041,574.98**



Member	Total Plan Payment	Most Expensive Primary Diagnosis	Total Charge	Plan Payment	Provider
1	$116,751.67	V58.0 - RADIOTHERAPY ENCOUNTER	$43,174.99	$38,857.49	TITUS REGIONAL MEDICAL CENTER
		174.8 - MALIGN NEOPL BREAST NEC	$38,110.00	$27,955.29	NAYYAR T SYED MD
		174.9 - MALIGN NEOPL BREAST NOS	$15,113.29	$12,535.79	TITUS REGIONAL MEDICAL CENTER
2	$99,812.11	851.85 - BRAIN LAC NEC-DEEP COMA	$123,739.35	$72,470.27	MOTHER FRANCES HOSPITAL
		959.01 - HEAD INJURY NOS	$17,370.00	$17,370.00	MOTHER FRANCES HOSPITAL
		V68.1 - ISSUE REPEAT PRESCRIPT	$4,534.91	$4,059.91	CLINIC PHARMACY
3	$74,759.22	V57.89 - REHABILITATION PROC NEC	$313,853.95	$28,148.40	EAST TEXAS MEDICAL CENTER
		V68.1 - ISSUE REPEAT PRESCRIPT	$6,891.49	$6,366.49	CLINIC PHARMACY
		434.01 - CRBL THRMBS W INFRCT	$431,337.40	$5,372.39	EAST TEXAS MEDICAL CENTER

This report lists those claimants whose total paid claims during the period specified were greater than or equal to the amount shown. Entries are shown in descending order of total dollars paid. Amounts shown may not reflect adjustments or reversals made outside the specified time period shown on this report.

Shock Claim Summary

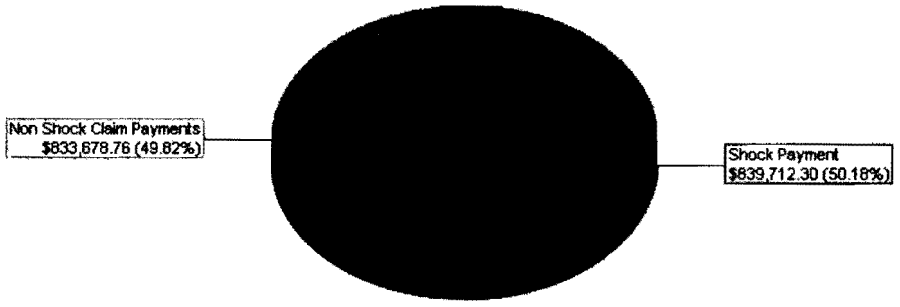
Titus County - Group ID: 0000100

Output Generated: 9/23/2011
Date Range: Check Date 1/1/2009 through 12/31/2009

Comparisons: None

Excluded Prescription Details from PBM
Included Prescription Payments from Adjudication System
Shock Claim Threshold: $45,000.00

# of members with claims above threshold:	**6**
Total Plan Payment in claims above threshold:	**$569,712.30**
Total Plan Payment for claimants with claims above threshold:	**$839,712.30**
Total Plan Payment in claims:	**$1,673,391.06**



Member	Total Plan Payment	Most Expensive Primary Diagnosis	Total Charge	Plan Payment	Provider
1	$430,693.64	220 - BENIGN NEOPLASM OVARY	$563,022.88	$325,032.10	MEDICAL CITY DALLAS HOSP
		458.9 - HYPOTENSION NOS	$22,051.95	$18,744.16	TITUS REGIONAL MEDICAL CENTER
		998.11 - HEMORRHAGE COMPLIC PROC	$13,092.50	$11,128.63	TITUS REGIONAL MEDICAL CENTER
2	$165,531.91	822.1 - FRACTURE PATELLA-OPEN	$60,942.86	$51,801.43	TITUS REGIONAL MEDICAL CENTER
		V57.89 - REHABILITATION PROC NEC	$20,666.23	$17,566.30	TITUS REGIONAL MEDICAL CENTER
		813.44 - FX LOW RADIUS W ULNA-CL	$18,916.58	$16,079.09	TITUS REGIONAL MEDICAL CENTER
3	$77,168.89	518.83 - CHRONIC RESPIRATORY FAIL	$36,011.85	$28,797.19	TITUS REGIONAL MEDICAL CENTER
		491.21 - OBS CHR BRONC W(AC) EXAC	$29,901.10	$25,411.10	TITUS REGIONAL MEDICAL CENTER
		492.8 - EMPHYSEMA NEC	$5,179.00	$4,258.43	NAEEM SILAT MD
4	$57,388.23	780 - GENERAL SYMPTOMS	$58,301.95	$57,388.23	HEALTHFIRST TPA/PHCS
5	$54,836.92	756.12 - SPONDYLOLISTHESIS	$48,983.75	$18,061.53	EAST TEXAS MEDICAL CENTER
		738.4 - ACQ SPONDYLOLISTHESIS	$18,151.50	$13,208.91	JON T LEDLIE MD
		721.3 - LUMBOSACRAL SPONDYLOSIS	$5,387.50	$4,125.49	JON T LEDLIE MD
6	$54,092.71	174.8 - MALIGN NEOPL BREAST NEC	$15,436.85	$12,511.56	TITUS REGIONAL MEDICAL CENTER
		174.9 - MALIGN NEOPL BREAST NOS	$12,693.84	$10,434.66	TITUS REGIONAL MEDICAL CENTER
		174.4 - MAL NEO BREAST UP-OUTER	$9,820.00	$7,579.45	ROSA E CUENCA MD

This report lists those claimants whose total paid claims during the period specified were greater than or equal to the amount shown. Entries are shown in descending order of total dollars paid. Amounts shown may not reflect adjustments or reversals made outside the specified time period shown on this report.

Group:	Titus County
Attention:	Debbie Rhea
Address:	100 W First
	Mt Pleasant TX 75455
Mktg Rep:	Dawn Crump
Specific:	$45,000
Plan Year:	1/1/11-12/31/111
Basis:	24/12
Date Range:	
Updated:	9/20/11 brc

Last Print Date: 9/8/11

FC - Filing Codes
O- Over Specific
H- Half of Specific
P - Potential
ES - Employ Status
A - Active
T - Terminated
C- Cobra
R - Retiree
D - Deceased
FTS-Full Time Student
COB
P - Primary
S- Secondary

FC	Cert No	EE Dep	Employment Status	COB	Primary Diagnosis	Diagnosis Code	Treatment/Comments	Amt Pd ALL Diag Incls	Amount Pended	Reason for Pended
							1/3/11, arthrocentesis, inj orphenadrine, ketorolac; 3/26/11, er visit; 7/17-7/18/11, er visit, labs, ecg, obs care; 7/30-8/3/11, er admit; 8/5-8/31/11, ovs, labs, injs orphenadrine, nalbuphine, ketorolac, hydroxyzine, kpromethazine,			
			Termed 9/1/11-cobra		Atheroscler Native Cor Art	414.01	methylprednisolone, vit b-			
			elect avail until		Cardiac Dysrhythmias	427.89	12; 8/9-8/11/11, labs chest			
H	0164	EE	11/29/11	P	Carotid Artery Occlus	433.10	xrays, ecg; rx's;	$ 41,302		

FC	Cert No	EE Dep	Employment Status	COB	Primary Diagnosis	Diagnosis Code	Treatment/Comments	Amt Pd ALL Diag Incls	Amount Pended	Reason for Pended
P	0164	SP-2	Termed 9/1/11-cobra elect avail 11/29/11	P	Iron deficiency Anemia Spondylolithesis Idiopath Scoliosis Lumbar Disc Displacement	280.9 756.12 737.30 722.10	10/18/10-8/31/11, arthrocentesis, injs betamethasone, orphenadrine, ketorolac, nalbuphine, hydroxyzine, promethazine, methylprednisolone, lincomycin, xrays spine, pelvis, hip, femur, humerus, scapula, ovs, labs; 8/18/11, mammogram, xray sinuses, chest xray, labs; rx's;	$ 11,030		
P	0278	SP-2	Active (Bill)	P	Diabetes Type II Uncomp Obstr Chronic Bronchitis Pneumonia Cervical Disc Degeneration	250.00 491.21 486 722.4	5/5/11, oph exam; 5/16-9/6/11, ovs, labs, chest xrays, psa, injs betamethasone, lincomycin, exc malig lesions, path; 5/16-5/22/11, ip hosp; rx's;	$ 20,694		
H	0143	EE	Active	P	Chronic Pancreatitis Rotator Cuff Syndrome	577.1 726.10	3/15-8/30/11, ovs, arthrocentesis, xray wrist, shoulder, injs betamethasone, appl short arm splint, appl halo cranial; 3/16/11, op emg; 4/13-8/4/11, chiro; 4/1-9/12/11, phys ther; 6/21-6/24/11, ip hosp; 8/25/11, rpr elbow; rx's;	$ 24,929		
P	0452	EE	Active	P	History Malig Rectum Malig Neopl Kidney	V10.06 189.0	1/11/11, oph exam; 1/20-8/9/11, ovs, labs, proctosigmoidoscopy, abd u/s, ct abd, pelvis; 3/10-8/3/11, chiro; rx's;	$ 1,203		

FC	Cert No	EE Dep	Employment Status	COB	Primary Diagnosis	Diagnosis Code	Treatment/Comments	Amt Pd ALL Diag Incls	Amount Pended	Reason for Pended
P	0285	EE	Active	P	Atheroscler Native Cor Art	414.01	1/4-7/18/11, ovs, ecg; rx's;	$ 2,003		
H	0533	SP-2	Active	P	Uterine Prolapse Accidental OP Laceration	618.1 998.2	2/8-8/6/11, ovs, labs, injs betamethasone, triamcinolone, hydroxyzine, diphenhydramine, methylprednisolone, ketorolac, promethazine, routine wwe, xray spine, pelvis, lumbar orthotic; 3/10-3/13/11, ip hosp, laps vag hyst; 3/21/11, abd xray; 6/24/11, urography; rx's;	$ 41,756		
H	0023	SP-2	Active	P	Sprain Rotator Cuff	840.4	1/25/11, mri any jt uxtr; 2/2-7/8/11, ovs, labs, injs lincomycin, betamethasone; 3/29/11, shoulder arthroscopy, orthotic; 5/2-6/23/11, phys ther; rx's;	$ 33,987		
P	0440	SP-2	Active	P	Brachial Neuritis Adhesive Capsulitis Shoulder	723.4 726.0	12/21/10-7/26/11, ovs, injs dexamethosone, ceftriaxone; 12/27/10, mammogram; rx's;	$ 2,000		
P	0449	EE	Active	P	Mycos Fungoid Unspec Enlargement Lymph Nodes	202.10 785.6	4/18/11, ov, inj diazepam, promethazine, nalbuphine, xray spine;	$ 175		

FC	Cert No	EE Dep	Employment Status	COB	Primary Diagnosis	Diagnosis Code	Treatment/Comments	Amt Pd ALL Diag Incls	Amount Pended	Reason for Pended
P	0166	SP-2	Active	P	Malig Neopl Breast Atheroscler Native Cor Art Lumb/Sac Disc Degeneration	174.9 414.01 722.52	9/17/10-7/8/11, ovs, labs, chest xrays, ecg, inj lincomycin, ketorolac, hydroxyzine, xrays spine, pelvis, si jts, hip, knee, tib/fib; 12/23/10, mri spine, mri brain; 4/12/11, mammogram; 5/24/11, emg; 6/6/11, B1&JT img whbdy; 7/6/11, dup scan xtrc art, mri brain, mri any jt lxtr; rx's;	$ 22,169		
H	0526	EE	Active	P	Calc Ureter	592.1	12/29/10, er visit, abd xray, ct abd, pelvis, labs; 1/3-8/3/11, ovs, labs, abd xrays, ecg; 1/5/11, lithotripsy, scope bladder & ureter, insert stent; 1/11/11, scope bladder w/rmvl stone & stent, path; rx's;	$ 25,525		
P	0563	EE	Active	P	Malig Neopl Breast Hist Malig Breast	174.9 V10.3	3/10-7/27/11, ovs, labs, routine wwe; 7/12/11, mammogram; rx's;	$ 513		
P	0542	EE	Active	P	Chronic Kidney Disease Cerv Spondylosis w/Myelop	585.4 721.1	12/27/10-6/15/11, oph exams, oph scanning, oph img, vis fld xm; 2/3/11-9/6/11, ovs, labs, xray spine, routine exam, ndl emg, ecg; 2/18/11, mri spine; 4/27/11, mammogram; 5/26/11, epidural inj, xray spine; 9/2/11, carpal tunnel surgery; 9/3-9/4/11, ambulance to er, admit; rx's;	$ 20,356		

FC	Cert No	EE Dep	Employment Status	COB	Primary Diagnosis	Diagnosis Code	Treatment/Comments	Amt Pd ALL Diag Incls	Amount Pended	Reason for Pended
P	0443	EE	Active	P	Chronic Kidney Disease Diabetes Type II Uncomp Lumbar Disc Displacement	585.9 250.00 722.10	9/1/10-8/9/11, ovs, labs, inj orphenadrine, ketorolac, hydroxyzine, promethazine; 4/11-8/29/11, epidural injs; rx's;	$ 8,620		
P	0328	SP-2	Active	P	Pneumonia	486	12/20/10-6/23/11, ovs, labs, inj lincomycin, dexamethosone; 4/3-4/7/11, er admit; 4/27/11, eeg; 5/9-9/9/11, cpap, humidifier, supplies; rx's;	$ 22,280		
P	0081	SP-2	Active	P	Monoclon Paraproteinemia Cardiac Dysrhythmia	273.1 429.9	11/4/10-8/26/11, ovs, labs, chest xrays, injs betamethasone, ceftriaxone, lincomycin, triamcinolone; 11/16/10, scope colon for dx; 8/13/11, er visit, labs; rx's;	$ 5,628		
P	0153	SP-2	Active	P	Diabetes Type II Uncomp Cirrhosis Liver Postinflamm Pulm Fibrosis Oth Ascites Chronic Persistent Hepatitis	250.00 571.5 515 789.59 571.41	11/29/10, tcat bx; 12/16/10-8/23/11, ovs, labs; rx's;	$ 1,483		
H	0173	EE	Active	P	Diabetes Type I Uncomp Cervical Disc Degeneration Periph Enthesopathy Cervical Spondylosis Osteoarth Pelvis Atrial Fibrillation Atheroscler Native Cor Art	250.01 722.4 726.8 721.0 715.95 427.31 414.01	1/14-7/28/11, ovs, labs, psa, inj betamethasone, cefazolin, meas post-voiding; 2/8/11, er visit, abd xray, labs; 2/18/11, hernia rpr; 2/21/11, path; 4/17/11, er visit, ecg, chest xray, ct head/brain, labs; rx's;	$ 26,752		

PPO Network: Access Direct Platinum 800-259-3308 PHCS out of Access Direct Platinum area/PHCS Healthy Directions out of Texas

Lifetime Maximum Benefit	**No Limit**	
Annual/Calendar Year Maximum Benefit	**$1,250,000**	
Annual Deductible accumulative ☐ Individual ☐ Family Max	**$600** **Three Individual Deductibles**	**$1,000** **Three Individual Deductibles**
Annual Out-of-Pocket Max. ☐ Individual ☐ Family Max	**$2,000**	**$4,000**
Coinsurance ☐ Plan Pays	**90%**	**60%**
Precertification for Inpatient procedures **MM Solutions 1-800-625-6834**	**$250 penalty for failure to pre-certify services**	
Physician's Fees ☐ Office Visit ☐ Hospital Visit	**$25 copay then 100%** **90%**	**60%** **60%**
Hospital Care ☐ Inpatient ☐ Outpatient (Surgery)	**90%** **90%**	**60%** **60%**
Emergency Care/Urgent Care ☐ Physician Services ☐ Facility	**90%** **90%**	**60%** **60%**
Ambulance- Air or Ground $2,000 CYM	**90%**	**60%**
Diagnostic X-ray & Routine Lab	**90%**	**60%**
Preventive Care **Routine physicals, Well Woman exams, PSA** **Well Baby Care ($750 annual max)**	**100% up to $750, then deductible and coinsurance**	**100% up to $750, then deductible and coinsurance**
Maternity Care ☐ Physician services ☐ Facility charges	**90%** **90%**	**60%** **60%**
Home Health Care - 45 visits CYM	**90%**	**60%**
Skilled Nursing Facility - 60 days CYM	**90%**	**60%**
Hospice Care - limited to: **30 days in-patient / 45 visits out-patient**	**90%**	**60%**
Prescription Drugs ☐ Generic ☐ Brand name	**$25 copay** **$45 copay ($25 copay if no generic equivalent available)**	
Mental Health Services ☐ Inpatient ☐ Physician office visits ☐ Outpatient	**90%** **$25 copay then 100%** **90%**	**60%** **60%** **60%**
Chemical Dependency Services ☐ Inpatient ☐ Physician office visits ☐ Outpatient	**90%** **$25 copay then 100%** **90%**	**60%** **60%** **60%**
Durable Medical Equipment	**90%**	**60%**
Physical Therapy	**90%**	**60%**
Chiropractor - 15 visits CYM	**90%**	**60%**

CYM - Calendar Year Max **LTM - Lifetime Maximum**

Titus Proposal Comparison Report

Plan/Projected Plan	Visits	Billed Charges	Discount	Allowed Amount	Employee/ Dependent Deductible	Out of Pocket	Employee Precent After Deductible	Plan Payment
Current 90/10 plan based on 199 member participation	2253	$1,179,163.30	$265,567.20	$913,596.10	$119,400.00	$66,000.00	$18,295.73	$709,900.37
Projected 80/20 plan based on 199 member participation	2253	$1,179,163.30	$265,567.20	$913,596.10	$149,250.00	$82,500.00	$30,452.00	$651,394.10
				Difference:	$29,850.00	$16,500.00	$12,156.27	
EE/Dependent 199							Total Savings:	$58,506.27
Members meeting out of pocket 33								

Estimated figures based off current year reporting 11/01/11 - 09/30/2011

Health

Focused Health Solutions combines innovative data analysis tools, disease-specific clinical pathways, tele-health technology, Health Risk Assessment surveys, health coaches and deep clinical expertise to achieve results.

Programs

Disease Management
- Congestive Heart Failure
- Coronary Artery Disease
- Hypertension
- Diabetes
- Anxiety
- [illegible]
- [illegible]
- Back & Neck Pain

Wellness
- Exercising for Health
- Weight Loss
- Stress
- Smoking
- Back & Neck Pain
- Blood Pressure Reduction

The growing prevalence of chronic health conditions has added significant costs to the U.S. healthcare system. Prevention and better management of chronic conditions are often cited as ways to improve health outcomes and slow U.S. healthcare spending growth or at least generate better value for the $2.1 trillion spent annually on health care in the United States.

Focused Health Solutions [illegible]

AmericanHealth

Medical Management Proposal to HealthFirst TPA

Submitted by Carrie Pope ■ Vice President, Sales
May 23, 2011

Creating Healthy Outcomes

American Health Holding, Inc. ■ 100 West Old Wilson Bridge Road, Third Floor ■ Worthington, Ohio 43085
Web www.AmericanHealthHolding.com ■ Toll-free 866.614.4244 ■ Email marketing@ahhinc.com

Table of Contents

ABOUT AMERICAN HEALTH HOLDING, INC.

Founded in 1993, American Health Holding, Inc. (American Health) believes that the combination of building partnerships with clients and delivering innovative and cutting-edge methods of containing health care costs is vital to our continued growth and development. We provide comprehensive services through a professional staff of physicians and registered nurses who are highly qualified in cost management issues including quality assurance standards.

Who We Are

- Integrated health care firm with more than 17 years of experience in medical management
- National provider of health care cost solutions and outcomes
- Privately owned, headquartered in Worthington, Ohio
- More than 400 employees
- URAC accredited for Health Utilization Management, Case Management, and Disease Management
- Licensed in all required states, servicing 2 million lives

What Makes Us Unique

- Onsite capabilities
- One-stop shop for medical management
- The preferred vendor among multiple stop-loss carriers
- Proprietary software and Milliman Care Guidelines
- Leading-edge criteria and reporting capabilities
- Client-focused flexibility, customizable programs
- Technology-oriented, web-based access
- Emphasis and commitment to quality

Who We Serve

- Third Party Administrators
- State and local governments
- Health/welfare funds
- Self-insured companies
- Reinsurance carriers and MGUs
- Health care/business coalitions
- Health insurance carriers
- Preferred Provider Organizations
- Health Maintenance Organizations
- Managed Care Organizations
- Independent Practice Associations

URAC
ACCREDITED
HEALTH UTILIZATION MANAGEMENT
CASE MANAGEMENT
DISEASE MANAGEMENT

Services you can depend on

We hold the belief that "when you've seen one customer, you've seen one customer." Because no two customers are alike, we strive to understand the unique needs and directions of our clients. We deliver a medical management process that uniquely meshes our services with what our clients need and want. Our full spectrum of medical management services includes:

- Utilization Management
- Case Management
- Specialty Case Management
- Wellness
- Disease Management
- Maternity Management
- Onsite Medical Management
- Medical Review
- Independent External Review
- Medical Disclosure
- 24/7 Physician Consultations
- 24/7 Nurse Line
- Bill Audit Services
- Out-of-Network Repricing and Negotiations

Learn more about our complete line of medical management solutions at **www.AmericanHealthHolding.com**

Population Health Management is a comprehensive strategy for improving the health of an entire population and reducing long-term health care expenses. Population Health Management is comprised of two programs—**Wellness** and **Disease Management**—that offer personal health management resources to:

- Help individuals who span the entire health continuum—from healthy and well to the presence of chronic medical conditions.
- Help individuals improve their health, taking into account their level of motivation, knowledge and skills.
- Help individuals develop achievable personal action plans.

Wellness

Targeting healthy individuals—employees and spouses—along with those at risk for developing chronic conditions, Wellness empowers participants to develop personalized goals for managing stress, improving nutrition, quitting smoking, and modifying other lifestyle behaviors that impact health. Lifestyle Coaching utilizes member-centric motivational interviewing, cognitive skill building, and behavior modification techniques to help individuals identify life goals, resolve ambivalence, and build conviction for change. Other program options include a Web Portal featuring a health assessment, symptom checker, health info center, 24/7 live nurse chat and more; at-home and onsite biometric testing, nurse advocate counseling; and onsite health seminars that address common health challenges.

Lifestyle Coaching

Lifestyle Coaching is offered to participants identified by our health assessment and further stratified by biometric results. Coaching empowers participants to develop their own personalized plans for managing stress, improving nutrition, implementing a fitness program, and modifying other lifestyle behaviors that impact health. Utilizing innovative motivation techniques, Lifestyle Coaching promotes lasting improvements in behaviors and health habits that can lower the risk for developing or exacerbating costly chronic medical conditions. We use a primary coach model to help build trusting relationships between members and their coaches.

What makes our program special is a superior ability to engage members during "teachable moments," where information meets need. We make it possible for and encourage all members who would like to work with a coach to call us and enroll—not just those at risk. Far surpassing traditional coaching or wellness services, American Health provides a holistic, member-centric, behavior-based coaching model. Its focus is on improving the total health of participants, driving greater productivity, and reducing health care costs while motivating members to adopt behaviors that enhance their personal health, well-being and quality of life. Lifestyle Coaching builds independence, self-

Program Highlights

A seamless program designed to improve and maintain the health of all members

Superior integration of data via predictive modeling, biometric screenings, and health assessments

Proven methods for empowering participants to set goals and improve lifestyle choices

Nurse advocate counseling to educate individuals identified through biometrics as being at-risk for developing chronic conditions

Online tools for participants to manage their health and track their progress in achieving personalized health goals

Onsite health seminars and live Webinar courses that focus on topics such as smoking cessation, stress management, nutrition, and the importance of health screenings

efficacy and self-care skills that help participants effectively manage their chronic condition or high-risk lifestyle behavior on an ongoing, long-term basis. This individualized coaching approach increases participants' engagement as well as their commitment to achieving smaller, incremental goals.

The reach of the Lifestyle Coaching program is expanded through the use of biometrics and referrals from other programs. The program uses a facilitative approach, synchronized with programs across our care management portfolio, to improve the health of each member whether the goal is to get healthy, stay healthy or manage a condition. The program goals are to help members take a proactive and long-lasting approach to health and wellness through modifiable lifestyle changes that serve to decrease or prevent chronic disease. Health Coaches use evidence-based preventative practices to achieve optimal outcomes, addressing the following risk factors:

- **Weight** – The weight management program focuses on increasing member's awareness of the benefits of proper nutrition and exercise and helping them learn to manage their weight through behavioral modifications, such as slowing down when eating and keeping a food diary.
- **Tobacco** – The tobacco/smoking cessation program focuses on specific, measurable and attainable goals, such as establishing a quit date and avoiding cues that lead to smoking or other tobacco use. This program addresses the behavioral difficulties inherent in tobacco cessation, including fear of failure, weight gain, and withdrawal symptoms.
- **Stress** – The stress management program teaches members to manage stress through breathing techniques, exercise, nutrition, sleep (appropriate amount and quality), and other positive behavioral changes. The stress management program also helps members address and minimize fatigue.
- **Nutrition** – The nutrition program increases awareness of the importance of proper nutrition and assists members in setting dietary goals and making lifestyle changes to promote better nutrition, such as reading labels.
- **Exercise** – The exercise program assists members in developing an appropriate exercise regime, giving consideration to factors such as age, weight and other health-related conditions. The program includes valuable educational materials on the short and long-term benefits of staying fit.

Healthy Weight Program

The Healthy Weight program is an intense, non-surgical weight management coaching solution focused on changing an individual's behavior and lifestyle choices to achieve long-lasting weight loss, reduce health risks and improve their quality of life. With Healthy Weight, the coach will make up to 10 outbound calls versus 3–5 calls in the Lifestyle Coaching model. Through access to a trusted weight management resource, education and a support network, our program supports individuals on their journey to a healthier weight. The high intensity model targets individuals with a BMI over 25 and provides them with more intense support than the weight management program included in Lifestyle Coaching. Using a whole-person approach, motivational interviewing techniques and the Transtheoretical Stages of Change Model, coaches get to know the member's unique needs, triggers and behaviors. Together, the member and the coach set realistic, achievable goals. The coach then recommends individualized tactics and provides positive, ongoing motivation and inspiration to help the member achieve long-term behavior change. The Healthy Weight program features open coaching for low, moderate and high-risk individuals, limitless enrollment so members can enroll in more than one program per year, dedicated coaches throughout the process, scheduled outbound and unlimited inbound calling for consistent access, and online tools including interactive health coach, tools and trackers.

QuitPower® Program

The QuitPower Advanced Tobacco Cessation program is a health improvement solution that focuses on creating lasting behavior change for improved health and well-being. With QuitPower, the coach will make up to 8 outbound calls versus only 3–5 calls in the Lifestyle Coaching model. In addition, members enrolled in QuitPower may receive nicotine replacement (e.g. gums and patches) as part of their program. QuitPower addresses the needs of those who need help cutting back, are contemplating quitting or those who are ready to quit. Once identified, an

individual is assigned to a dedicated Lifestyle Coach. Then, using a whole-person approach, motivational interviewing techniques and the Transtheoretical Stages of Change Model, the coach gets to know the member's unique needs, triggers and behaviors. The coach then recommends individualized tactics, and provides positive ongoing motivation and inspiration to help the person achieve behavior change and reach their unique long-term goals.

A critical component to engaging members and encouraging participation in health and wellness programs is flexibility in the communications channels available to participants. Our unique ability to send secure email messages to members participating in Lifestyle Coaching is an example of this flexibility. These email messages are personal and specific to a member's program and goals and are sent as a part of the telephonic outreach program. The emails are sent via a secure email system by a Health Coach while on the phone with the participant and relate specifically to the current coaching conversation topic. For customers who also offer the Web Portal, our Health Coaches will encourage members to take advantage of the portal's Online Health Coaching modules for additional support for topics such as nutrition, exercise, smoking cessation, weight loss, diabetes, heart health and stress management.

Web Portal

American Health's Web Portal provides participants with a wide variety of online tools and resources to help members change behaviors that negatively affect their lifestyle:

- **The health assessment** was developed by a team of physicians and experts at the University of Michigan Health Management Research Center, one of the nation's leading research facilities in studying risk reduction. It is an integral part of our Web portal, which is included with Lifestyle Coaching, and can be used as a referral mechanism for Disease Management as well as Wellness. The health assessment provides a personalized health profile that helps consumers identify health risks that will help them to adopt lifestyle behaviors that result in improved health and well-being. The health assessment is comprised of more than 50 questions pertaining to demographics, health behaviors, health status, physiological risks, psychological perception of health, readiness to change, and learning styles. Once completed, the health assessment generates a wellness profile that provides each participant with a wellness score and outlines the areas in which the participant can improve or maintain his/her health, a health analysis with targets and goals, links to online health resources, and tips for making healthy lifestyle changes. Results are used for stratification and integration to the Online Health Coach and personal health record (PHR), and are used as referral/enrollment sources for our clinical programs. Data from the health assessment is used to pre-populate those programs, as appropriate, and is used to personalize the content and messaging the participant receives throughout their online health and wellness experience.
- **The Online Health Coach** is a premier online wellness management and behavior modification coaching system. Each participant's individual risk factors, self-care and stage of change are addressed in a program tailored to his or her health risks and needs. The Online Health Coach tracks participants' progress through the various levels of the program. This clinically based design motivates participants to take steps necessary toward healthy lifestyle choices or disease self-management that are measureable and consistent: choosing a quit date, recording meals, logging time spent on a treadmill, or monitoring blood sugars. The Online Health Coach provides tailored programs to each user that address fitness, nutrition, smoking cessation, stress management, weight loss, diabetes, and heart disease (high blood pressure, high cholesterol, congestive heart failure, coronary artery disease). Members are provided the opportunity to participate in the Online Health Coaching programs based on risk factors identified in the health assessment. As they progress through a program, participants are given stage-of-change specific feedback, and must complete five program levels on their way to improve/control their condition. Each level takes a minimum of seven days to complete. These five levels correspond to the stages of readiness to maintain a healthy lifestyle in relation to their condition. In order to advance through each stage, participants must complete "Action Steps" that involve reading content about their condition, exploring their health through interactive tools, improving their behaviors, and finally

controlling their condition. At the end of each stage, an interactive quiz evaluates the participant's understanding and must be completed to advance.

- **The online personal health record** provides participants with a convenient, secure, online location to store a wide variety of health-related information such emergency and physician contact data, medical history, medications and allergies, and more. Participants can update their personal health record at any time.
- **24/7 live nurse chat** provides members with a fast, easy way to get answers to their health questions. Members can have a live, personal online discussion with a nurse about various health and wellness issues. They can learn more about fitness, nutrition, common illnesses and conditions, prevention tips, and much more—all in a confidential, secure online session.
- **Other online tools included** on the Web Portal include a symptom checker, disease and condition center, resources such as weight and health information tools, quizzes, glossaries, self-care tools, lifestyle topics, prescription drug guide, and an online health encyclopedia.

Biometric Testing

Through biometric testing, clients gain insight into their company's health state and participants are provided with information that can help them live healthier, more productive lives. This information empowers clients to identify opportunities to promote appropriate health programs that in turn help to increase employee productivity and control health benefits costs. Two options are available for biometric testing:

- **At-home biometric testing** is a convenient, cost-effective, and easy-to-use alternative to onsite biometric testing and reports HbA1c and lipid cholesterol panel results.
- **Onsite biometric testing and consultation** includes a blood pressure screening, non-fasting finger stick cholesterol and glucose test, body mass index analysis, and body fat analysis.

Nurse Advocate Counseling

With American Health's nurse advocate counseling—an optional service with our at-home biometric testing—our nurses review the data for members with abnormal results that exceed a certain threshold and then contact the members to help them interpret the abnormal results, discuss any long-term complications, stress the importance of members following up with their physicians, and identify possible lifestyle changes that can impact results. Following the initial conversation, nurses will make a second call to the members to check whether they have seen their physician to discuss the biometric results. In addition, our nurses will refer members who have been diagnosed with a chronic condition, such as diabetes, hypertension, or hyperlipidemia, to Disease Management if available. If Disease Management is not available, we will help members identify and utilize resources that are available through our Wellness program.

Onsite Health Seminars

Onsite health seminars are available to employees and address a variety of health topics, including: General Nutrition; Healthy Eating on the Run; Cooking Healthy Meals; Grocery Store Mania; Wellness for the Travel Bound; Wellness for the Weekend Athlete; Wellness in the Workplace; Prevention and Management of Osteoporosis; How to Maintain a Cardiac-Friendly Lifestyle; and Stress Management.

Onsite Flu Vaccinations

Vaccinations provide clients the best opportunity to reduce employees' chances of getting—and spreading—the flu.

Disease Management

American Health's URAC-accredited Disease Management program targets eight prevalent conditions—asthma (pediatric and adult), chronic obstructive pulmonary disease (COPD), chronic pain, congestive heart failure (CHF), coronary artery disease (CAD), diabetes (pediatric and adult), hyperlipidemia, and hypertension—for which evidence-based guidelines are established to impact health and measure improvements. The goals of the program include improving participant activation, meaning an individual's skills, confidence and abilities to manage their chronic condition(s) as determined by the Patient Activation Measure™, and effecting improvements in the health status of participants by providing education, tools, and support that promote good self-care practices and adherence to evidence-based care guidelines. Utilizing clinically proven behavioral assessment and modification tools, Disease Management provides individuals with chronic conditions the best opportunity for achieving optimal health.

Identification Process

American Health uses a monthly predictive modeling process that analyzes a client's medical and pharmacy claims data. The resulting predictions incorporate clinical factors, such as diagnoses, episode treatment groups, gaps in recommended standards of care and prescription use and other risk markers, such as timing and frequency of procedures to identify potentially high-risk individuals specific to each client's population. The predictive model is dynamic and has a distinct advantage over rules-based linear regression models. Its underlying models enable a client's data to "speak" and therefore, identify key drivers of cost and risk in its population. Additionally, the predictive model incorporates claims, pharmacy, eligibility, lab results and health risk assessment data in one model to enable higher prediction accuracy. Since the model is dynamic, it can incorporate additional data sources (e.g., Utilization Management) to further increase the accuracy of the predictions.

Because all of American Health's medical management programs are fully integrated, results from our predictive modeling used to identify candidates for Disease Management can in turn result in referrals to our other care management products such as Utilization Management, Case Management, Wellness, or Maternity Management. As previously mentioned, our ability to provide a high level of integration between our products both sets our medical management apart in the marketplace and results in early intervention, providing substantial cost savings.

Engaging Identified Members

American Health recognizes the importance of implementing an engagement model that meets the needs of the population. American Health's Disease Management program is based on an opt-in model. The engagement model includes a combination of letters and phone calls to inform members of this benefit and to encourage them to enroll if identified as high risk with one or more of the eight conditions. American Health has a flexible engagement model and is able to adjust the process to improve the member experience and thus the opportunity for increased program success. Specific populations, such as senior members, may require a modified approach and American Health is able to work closely with clients to implement a solution.

At the start of the program, American Health mails a customized letter from the group's CEO or HR Representative to each employee's home. In the letter, a client may convey any general information it chooses, such as benefits of the program, incentives for participation, or information regarding other worksite wellness programs it offers. We collaborate with our clients to craft a message specific to their needs. One week after the CEO letter is distributed, American Health mails members a second letter that describes the program and how members can

self-refer or participate. If a group purchases the Web portal, log in instructions and details are provided in this correspondence.

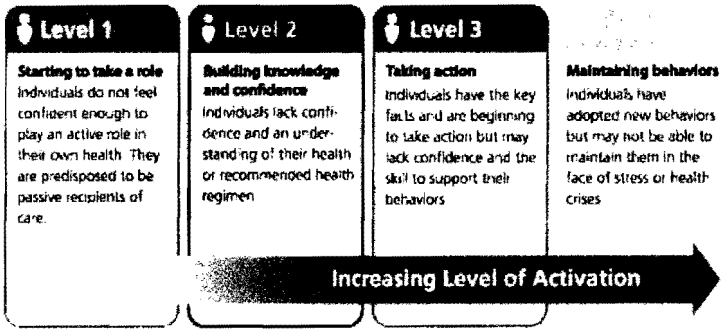
After participants are identified for Disease Management via predictive modeling they receive a phone call from an Engagement Specialist who explains the benefits of the program, answers any questions the member may have, and administers the Patient Activation Measure™ (PAM™), a unique assessment tool that effectively assesses participants' confidence and ability to self-manage their disease. The Engagement Specialist will warm transfer the member to a Nurse Coach or schedule a time for the Nurse Coach to call the member back. American Health will make four attempts to reach the member by telephone at two-week intervals. In the event a member's contact information is incorrect, we utilize a telephone number matching service in an effort to obtain accurate contact information. On the third attempt, we also send the member an email if the member's email is available. If after the fourth attempt we have not been able to reach the member, we will close the case and make a notation in iSuite.

In order to increase our ability to reach members, it is critically important that we are provided with current and comprehensive listings of member telephone numbers and addresses during the implementation process. Telephone contact with members—not only for enrollment purposes but for ongoing education and intervention—is an integral component of all of our programs.

Coaching and Counseling for Targeted Members

In order to develop a participant's individual care plan, Disease Management Nurse Coaches utilize results from the predictive modeling process as well as information obtained from participants, including clinical test results and biometric values, educational resources, and technology including the clinically-proven Patient Activation Measure (PAM). PAM is our unique assessment tool that effectively measures activation and provides Nurse Coaches insight into participants' attitudes and behaviors.

Based on results from a participant's PAM survey, our Disease Management Nurse Coaches are able to segment participants into one of four progressive activation levels that are characterized by distinct differences in the knowledge, skills, and confidence essential to managing a chronic condition:



Instead of assessing behaviors in isolation, the PAM survey recognizes that people who feel 'in charge' of their health engage in a whole range of behaviors. The PAM survey is reliable and valid for use with both consumers managing a chronic illness and for those with no disease, and has been found useful wherever consumers have a significant role to play in managing their health. The insights gained with the PAM survey can be used for predictive modeling, population segmentation, the individual tailoring of care support, and in the evaluation of program efficacy.

Based on a participant's PAM score, Nurse Coaches employ the Coaching for Activation™ (CFA™) model to set behavior-change goals and action steps tailored to each individual's capability, and use clinical evidence-based

guidelines to measure the results of outbound telephonic education and counseling. Using PAM, CFA, motivational interviewing, and other available resources, Nurse Coaches:

- Set incremental, participant-specific targets and goals for achievement
- Motivate participants and elevate their self-confidence in managing chronic disease
- Educate participants on warning signs, symptoms, and what to do if they occur
- Provide educational resources specific to the interactions and needs of each participant
- Identify ways for participants to improve and maintain their health

American Health's Disease Management program addresses eight of the most prevalent conditions. Our Nurse Coaches work with participants to educate them about their conditions and address the following topics:

- **Asthma** – The asthma program focuses on increasing awareness of a member's symptoms and when they occur; encourages the use of a daily diary to track symptoms; addresses issues regarding diet and exercise; provides information about asthma medications and the importance of good medication management; addresses barriers members may have with medication adherence; and works with members to identify causes of asthma symptoms and potential adjustments to reduce symptoms.
- **Chronic pain** - The chronic pain program helps members gain basic self-awareness of the link between behavior and pain self-management focus areas; provides education on the "Pain Gate" theory and how the 10 focus areas can be applied; raises awareness of how slight changes in behavior can lead to big improvements in health, wellbeing, and pain reduction; helps members develop skills to engage/improve communication with their providers; and teaches members how to troubleshoot, in advance, during difficult times or stressful events.
- **CAD** – The CAD program educates members on medications and how they work; discusses other health conditions caused by high cholesterol; addresses medication compliance and creates action plans to close any gaps; discusses nutrition and foods that can lower cholesterol levels as well as stress reduction strategies.
- **CHF** – The CHF program provides education on heart health and how medications can work to treat CHF; educates members on the self-identification of symptoms and behaviors that may cause the symptoms; and helps members identify opportunities to reduce symptoms through lifestyle changes such as diet and nutrition.
- **COPD** – The COPD program focuses on educating members about the signs and symptoms of COPD along with what activities can cause members to feel better or worse; encourages the use of a daily diary to track symptoms; provides education on oxygen therapy (if applicable) and on medications and how they should be taken; and addresses opportunities for improving diet and nutrition.
- **Diabetes** – The diabetes program helps members manage their diabetes and low blood sugar; provides education on targets for blood sugar, cholesterol and blood pressure; addresses the relationship between carbohydrates and blood glucose and ways to adjust carbohydrate intake; focuses on insulin self-management (if applicable); and helps build awareness of the importance of physical activity and healthy coping strategies.
- **Hyperlipidemia** – The hyperlipidemia program provides members with education on cholesterol and how to achieve healthy target ranges for cholesterol levels; addresses risk factors of high cholesterol; discusses lifestyle impacts to high cholesterol and opportunities for changes; discusses how stress may impact cholesterol levels and opportunities for stress management; and provides education on medications and how they should be taken.
- **Hypertension** – The hypertension program helps members to understand blood pressure targets and the importance of knowing their numbers; discusses how member lifestyle, activity level, diet and salt intake can impact blood pressure; and addresses different medications and how they work to lower blood pressure.

Depending on the participant's level of activation, the frequency of contacts from a Nurse Coach will vary, ranging from 4 to 12 contacts on average. Nurse Coaches take on the role of personal health coach for members who have chronic conditions, providing them with a variety of opportunities to receive motivational health counseling and condition-specific education that focuses on self-care, clinical improvements, and prevention of complications. Nurse Coaches are trained in motivational interviewing techniques and use clinically-proven tools to assess participants' confidence and ability to self-manage their health. Our Nurse Coaches have access to as much member data as is

available, including, for example, viewing a member's medical and prescription claims data when this information is provided to us. This information assists Nurse Coaches when working with members to set specific behavior-change goals and action steps that can help enhance participants' abilities to manage their condition(s) and improve clinical outcomes based on the following metrics:

- **CAD** – Beta blocker treatment after MI, diastolic blood pressure, systolic blood pressure, total cholesterol levels (may be replaced by LDL), and smoking status.
- **CHF** – Use of appropriate medication, self-monitoring of weight, flu vaccination compliance, diastolic blood pressure, and systolic blood pressure.
- **COPD** – Use of appropriate long-term medication, smoking status, and flu vaccination compliance.
- **Diabetes** – HbA1c levels, HbA1c testing, eye exam (annually), and LDL levels.
- **Hyperlipidemia** – Use of appropriate lipid-lowering medication, total cholesterol, and LDL cholesterol.
- **Hypertension** – Diastolic blood pressure, systolic blood pressure, smoking status and medication compliance in future, self monitoring of blood pressure, and adherence to an exercise program.

Condition-specific Equipment

As an option, members identified for Disease Management can receive self-management, condition-specific equipment as appropriate, which is billed through the durable medical equipment (DME) benefit. The equipment provides members with the added benefit of automatically sending up-to-date test results electronically to American Health, further enhancing the education and clinical support provided by our Nurse Coaches.

Implementation and Incentive Planning

One of the unique features of our program is our dedicated Disease Management and Wellness Consultant who provides clients with ongoing support before, during and after implementation. The Consultant is included at no additional charge and is readily available to meet with you to help kick off the program, to assist with customizing the program to fit your specific needs, to educate and communicate the program's many benefits to employees, and to provide you with ongoing evaluation and continuous support of the program. The Consultant also works with an employer's Human Resources team to assist in developing and implementing a successful incentive program, such as one that ties incentives to the company's benefit plan (e.g. waiving the co-pay for smoking cessation prescriptions), and which can help promote more active participation in the program. Most important, the Disease Management and Wellness Consultant can help clients achieve long-term success by implementing a program that is effective today and that can grow to meet the changing needs of tomorrow.

Measuring Program Impact with "Value of Investment" Metrics

American Health's methodology for measuring the impact of the Disease Management program is referred to as the value of the investment or "VOI" methodology. Drawing upon published research, our VOI methodology uses quantifiable metrics that are aligned with the goals of the program, including estimated changes in utilization based on improved member activation levels as measured by changes in participants' PAM scores, and increased compliance with evidence-based care guidelines as measured by improvements in specific clinical metrics. Drawing upon extensive research conducted around the PAM, we are able to quantify the potential financial impact of the Disease Management program based upon changes in a group's aggregate PAM score over time. Research has demonstrated that improvements in PAM scores can correlate with estimated changes in utilization and improvements in medication adherence and health outcomes. For example:

- Tailoring disease management coaching to participant PAM scores has been shown to result in a 33% decline in hospital admissions, 22% decline in emergency room visits, improvements in clinical outcomes, and increased adherence to recommended immunization and drug regimens.[1]
- Every 10 point increase in PAM may yield 1.5 fewer emergency inpatient admissions per 100 patients over a 150 day period or 3 fewer admissions per year.[2]
- Every 10 point increase in PAM may yield improvement in medication adherence between 18-32%, depending upon the chronic condition.[3]

While the above metrics can correlate with financial impact, they should not be used as a means to calculate a quantitative return on investment, nor should one assume that the metrics will lead to a return on investment because they pertain only to participants in the program, not the entire eligible population. Also, because the metrics are not mutually exclusive, they cannot be considered additive. As such, VOI metrics should be used to measure the qualitative value of the program based on evidence of health improvement and better self-management. Improvements in compliance with evidence-based care guidelines are essential to improving the health of individuals and reducing waste within the U.S. health care delivery system. Experts suggest that up to 30% of total healthcare spending could be eliminated by efforts to reduce waste without reducing quality of care and, in some instances, improving health care quality.[4] Evidence-based care guidelines are one of a number of tools available for addressing issues surrounding over- and under-utilization of health care resources.

In designing the Disease Management program, American Health identified clinical metrics that measure a population's compliance with evidence-based care guidelines that, as previously indicated, may not necessarily translate to dollar savings but are, nonetheless, an important byproduct of improved compliance with the guidelines to ensure available dollars are spent appropriately. In addition, the impact of our Disease Management program on indirect costs related to absenteeism and productivity or presenteeism, should not be overlooked. Health and productivity management experts estimate the indirect costs of poor health are two to three times the direct medical costs.[5] A primary objective of the program—to improve member activation levels—has also been associated with improved presenteeism and reduced absenteeism.[6]

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24/7 PHYSICIANS CONSULTATIONS

Our relationship with Consult A Doctor satisfies the members' need for 24/7 access to licensed physicians while reducing claim costs for benefit plans. The service provides members with peace of mind, saves time and money, and offers cutting-edge decision tools to help members take greater control of their health.

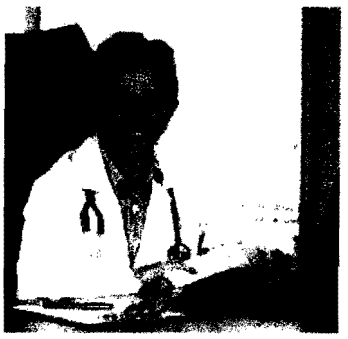
Access to Consult A Doctor's network of licensed physicians reduces unnecessary visits to the doctor or emergency room, allowing members alternatives to visiting their primary care physician for purely informational and basic reasons, such as refills. This correlates to a reduction in sick-leave absenteeism and less time off work. Members can choose to consult with a doctor by telephone in a number of ways or by secure email:

- **Telephone Medical Consultations** allow members to speak with a doctor immediately to get information, ask medical questions, and receive advice and recommendations for common symptoms and conditions.
- **Priority Tele-Consults** allow members to talk to a doctor within three hours—most often within one hour—for in-depth consultations, request prescription medication, and obtain a diagnosis or treatment plan.
- **Tele-Consults By Appointment** allow members to get in-depth consultations, request prescription medication, and obtain a diagnosis or treatment plan.
- **E-Consults** for medical consultations are always available for members to send their questions to a doctor using a secure messaging system. Members receive a response usually within a few hours and guaranteed within 24 hours.

Why Use Consult A Doctor?

The service provides members with convenient on-demand healthcare wherever and whenever they need it, as often as they need it. Consult A Doctor saves hundreds or thousands of dollars by helping avoid unnecessary doctor's office or ER visits. It also saves time by avoiding waiting for an appointment or sitting in the doctor's office. All physicians in Consult A Doctor's network are U.S.-based, licensed, board-certified, and experienced.

Consult A Doctor is typically used by members when their primary care physician is not available or accessible. Consult A Doctor can be used in a variety of ways: for around-the-clock physician care, to request prescriptions or get refills, for non-emergency medical questions or concerns, and when traveling away from home and advice is needed. Best of all, Consult A Doctor is always available—during normal business hours, nights, weekends, even holidays!



Program Highlights

Reduces claim costs for benefit plans

Licensed physicians available 24/7 365 days a year—members receive answers and treatment by secure e-mail or telephone within minutes

Offers a fast, affordable alternative for minor medical problems and helps alleviate avoidanca of health issues

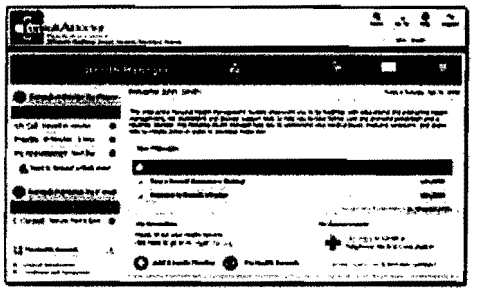
Saves time and aggravation, eliminates waiting days or weeks for an appointment

Members can securely and confidentially discuss embarrassing issues

ROI of 5:1 (based on 5% utilization by members; 10% utilization may result in ROI as high as 9:1)

Convenient 24/7 Web Access

Getting expert medical advice from a doctor has never been easier! In addition to consulting with a physician by phone or secure email, Consult a Doctor includes a one-stop health portal that features **My Personal Health Manager** which allows members to search for a specific health topic then click to consult with a doctor via phone or email. This integrated solution offers convenience and peace of mind, ensuring that individuals are never alone when they have a health care need.



My Personal Health Manager is a comprehensive online member health portal provided through our partnership with Consult a Doctor (www.consultadr.com) to empower members with educational and communication tools and resources. My Personal Health Manager provides members with access to E-mail Medical Consultations (E-Consults), where members can communicate with a doctor via secure messaging system. It also empowers members with educational and interactive health management and risk assessment and decision support tools to aid them to take better care of themselves, understand their medical issues, evaluate symptoms, assess their risks and promote healthier lifestyles and prevention, including:

- **Symptom Checker:** Our Symptom Checker is a personalized and user-friendly software designed to evaluate symptoms and display the most probable medical conditions. Questionnaires developed by physicians lead members to the top three probable conditions and, based on answers given, Symptom Checker recommends patients to seek appropriate level of care depending on the level of severity. Symptom Checker also displays available treatment options, states when self-care is appropriate and when medical attention should be sought, and allows members to review how well they manage specific conditions.
- **Health Library:** The Health Library is designed to educate members and to provide relevant medical information to make informed decisions. Members can access a comprehensive list of electronic resources that offer insight to their symptoms, conditions, and health issues, e.g., reports, articles, health-related bulletins, newsletters, and statistics. The Health Library contains information on more than 3,000 conditions, offers insight into drug interactions and provides many resources to educate members on various conditions and treatments, such as Complementary and Alternative Medicine (CAM).
- **Health Alerts:** The Health Alerts system automatically sends E-mails regarding the latest articles, news, and links tailored to a specific condition. Additionally, drug interaction alerts are sent if a new medication may interact with a member's current medication.
- **Health Risk Assessment Tools:** Consult A Doctor retrieves data on lifestyle factors and health risks, evaluates health status, generates reports, and provides information for improving health risk areas. Our tools are provided to motivate individuals to make improvements in their health and lifestyle and enable clinical staff to direct follow-up and evaluate outcomes.
- **Electronic Medical Record:** Consult A Doctor's Electronic Medical Record (EMR) is one of the most complete data collection and archiving systems available. With EMR, members are able to transmit and access their medical records, receive notifications regarding any tests, follow-up visits and medication instructions and/or refills.
- **EMR Fax to PCP:** Members can manage and update their medical records from the EMR system and electronically fax to their local doctor(s).
- **Health Monitoring:** Members can take, track, and send their vitals and/or changes in their condition daily, weekly, or monthly to keep their medical file up-to-date.

MATERNITY MANAGEMENT

The March of Dimes estimates that one out of eight babies born in the U.S. is born prematurely, and that these babies cost employers nearly fifteen times more than full-term babies in their first year of life. Large portions of health care costs are linked to complicated pregnancies or premature births. Approximately 20 percent of all newborn infants are born with medical complications and 10 percent have serious medical conditions. A recent government study found that for every $1.00 spent on prenatal care, nearly $3.50 is saved in health care costs for low birth weight babies. Additionally, $100,000 to $300,000 is saved each time a premature birth is prevented.

American Health developed its Maternity Management program in 1993 to provide education and support to expectant mothers in order to reduce instances of complications and subsequent high claims costs. Our maternity nurse specialists, on average, have 20 years of maternal and neonatal experience. They provide referred members with ongoing monitoring, assessment, and care planning based on risk status. Women with higher risks for complications benefit from a more aggressive case management program. All participants receive value-added materials, educational literature and a copy of *The Good Housekeeping Illustrated Book of Pregnancy and Baby Care*.

Healthier Babies and Moms = Lower Costs

In addition to helping to prevent birth complications, American Health offers savings to benefit plans in the following ways:

- Negotiating costs for home health care services if needed
- Capability of network steerage
- Minimizing future complications through health management and continuous assessment
- Reducing the number of work hours lost that result from complications during pregnancy and/or birth

The goals of the Maternity Management program are to decrease the number of premature and complicated births and to promote optimal delivery outcomes, which can result in minimized costs and reduced hospital readmission. The program is designed to identify members with low-risk pregnancies to provide education and support, and to aggressively manage women with high-risk pregnancies as early as possible through continual monitoring throughout the pregnancy. The program educates members on proactive lifestyle measures that reduce risk factors throughout the pregnancy, provides educational materials that address prenatal care, birth alternatives and newborn care, coordinates healthcare services, and uses creative interventions to enhance the potential for a healthy outcome for both mother and child.

Program Highlights

Educating moms-to-be on ways to reduce risk factors for themselves and their un-born children

Coordinating health services and care planning to support participants

Increasing the number of healthy mothers and babies through assessment, early intervention, and case management

Decreasing instances of premature and complicated births and subsequent high claims costs

Providing support and guidance to mothers before and after delivery

Attentive Care for Expectant Mothers

Maternity Management is initiated once a physician confirms the pregnancy and the mother-to-be chooses to participate. The participant is contacted by a Maternity Nurse Specialist, who conducts an initial assessment to determine if the woman's pregnancy is high or low risk. The Maternity Nurse Specialist develops a care plan for the participant based on her risk status, and provides her with educational material and timely, proactive phone calls in the event that the woman's risk status changes. The Maternity Nurse Specialist will also encourage participants to enroll in Abbott's StrongMoms® online program (www.StrongMoms.com) to receive additional educational mailings, weekly e-mails, access to online chat groups, and coupons, savings, and other special promotions. StrongMoms® also offers mothers-to-be the opportunity to receive a free diaper bag from a participating hospital that is loaded with free samples. If a woman develops complications during her pregnancy that require complex needs for home care, home uterine monitoring, home infusion, or other care needs, our maternity nurse specialist will open the case to formal Case Management at the client's contracted Case Management rate. After delivery, the Maternity Nurse Specialist will send the new mother a card, congratulating the family.

Data Gathering and Assessment

Maternity Management utilizes detailed psycho/social and medical assessments, coupled with physician confirmation, to determine risk status. When used in conjunction with American Health's 24/7 Nurse Line and Health Information Library, participants can receive information, nurse support and steerage to in-network providers and community resources 24 hours a day, 7 days a week. Specialized maternity newborn nurses work with home care agencies to coordinate care and services for high-risk cases when home care is needed. Costs are managed by negotiating discounts and identifying cost-effective alternatives.

Education and Training

Participants are provided with informative brochures, coupons, and a copy of *The Good Housekeeping Illustrated Book of Pregnancy and Baby Care*, the most complete and fully illustrated guide to parenting ever published. Developed with the help of nationally renowned medical experts, this dependable guide now includes updated lists of essential medical tests during pregnancy, growth and weight charts, and immunization schedules. Indispensable and reliable, this guide answers every question about pregnancy and caring for an infant.

Monitoring and Surveillance

The frequency of outbound calls to participants by the maternity nurse specialists is determined by the severity of pregnancy complications. This may result in daily contact in times of high risk or concern. Following delivery, the maternity nurse specialist will make a final call to ensure the well being of the mother and child and to answer any remaining questions the mother may have.

Standard Reporting Package

Report Name	DISEASE MANAGEMENT REPORTS	Frequency
Client reports will be available at a minimum of 120 days after the client's program start date. American Health will email reports to clients at the frequency indicated. Ad hoc reports of a more frequent nature than that which is indicated below (e.g. monthly) will be considered upon request.		
Identified Population as a Percent of the Total Population	Illustrates prevalence of the identified population for Disease Management within the entire population.	Quarterly and annually
Referral Sources Summary	Illustrates the various sources for incoming referrals. Helps identify areas for training, process improvements, and other possible interventions to increase referral rates. Note that referral sources could vary by client.	Quarterly and annually
Distribution of Identified Population	Shows the percentage of the identified population that is "participating" or engaged with a Nurse Coach, the percentage of identified members that are in the engagement process and the percentage of identified members that have declined participation. Unable to reach includes members who are nonresponsive to calls and members with missing phone numbers.	Quarterly and annually
Participation Rates within Each Primary Disease	For each primary disease, shows the percentage of members participating with a Nurse Coach out of all identified members.	Quarterly and annually
Distribution of Participants by Primary Disease	Provides a breakdown of the participation rates for each primary disease out of the total identified population. Gives a sense of distribution of diseases within the participating population.	Quarterly and annually
Reasons for Nonparticipation	Lists reasons members "opt out" of the program (e.g. confidentiality concerns, denied disease, prefer MD care only, don't perceive program as beneficial, etc.). Reasons given help guide the nature of communications to members.	Quarterly and annually
PAM™ Levels All Diseases	Depicts PAM™ levels in aggregate for all Disease Management participants, comparing a participant's baseline to the level after six months of continuous enrollment, after one year of continuous enrollment, etc.	Biannually and annually
Changes in Average PAM™ Scores by Disease	Depicts changes in average PAM™ scores for participants by primary disease, and compares baselines to levels after six months of continuous enrollment, after one year of continuous enrollment, etc.	Biannually and annually
Disease Management Participants' Compliance with Evidence-Based Care Guidelines	Illustrates the extent to which identified members are compliant with key professionally recognized care guidelines captured through the Disease Management assessments. Over time, the program should be affecting improvements in compliance among the participants. For more detailed information regarding care guidelines, refer to the report, Clinical Metrics by Disease.	Annually
Clinical Metrics by Disease	Shows changes in key disease-specific clinical metrics that are consistent with professionally recognized care guidelines for all participating members. Data in this report is collected by Nurse Coaches and, as appropriate, via biometric data transmitted to American Health (vs. claims-based).	Biannually and annually
Participant Satisfaction	Demonstrates the satisfaction and perception of the program from the participating member's point of view consistent with the DMAA's methodology.	Annually
Incentive Management	Shows the percent of the eligible population that has taken advantage of incentive-eligible activities that fall under the American Health program.	Quarterly and annually

Report Name	WELLNESS REPORTS	Frequency
Lifestyle Coaching Participation	Provides high-level figures representing the extent to which identified members are participating in telephonic Lifestyle Coaching.	Quarterly and annually
Lifestyle Coaching Clinical Outcomes Measures	Provides the percentage of participants who have achieved desired clinical outcomes.	Quarterly and annually
Member HRA Completion Report	Report shows which members have completed a Health Assessment during the initial completion period. Report includes: ▪ Member name ▪ Member ID ▪ Member's Date of Birth ▪ HA Completion Date	Monthly (available more often as requested by client) during the initial Health Assessment completion period Provided 7 days after the close of each month (or after a client's request)
Quarterly Wellness Reporting	Report includes: ▪ Health Assessment Completion Rate ▪ Health Status by Risk Count ▪ Top Health Risks Within the Population ▪ Website Activity ▪ Most Frequently Visited Online Content ▪ Online Health Coaching Participation ▪ Lifestyle Coaching Participation ▪ Lifestyle Coaching Clinical Outcomes ▪ Incentive Management ▪ Participant Satisfaction	Quarterly and annually Provided 30 calendar days after the end of quarter/year
Online Wellness Tools Utilization Report	Report shows usage of the online Wellness tools including: ▪ Registrant counts ▪ Registrant demographics ▪ Site Traffic ▪ Program Participation (Health Assessment and Online Coaching) ▪ Content Viewed	Quarterly and annually Provided 30 calendar days after the end of quarter/year
Health Risk Assessment Summary	Report provides activity and outcome information based on Health Assessment responses, including: ▪ Number of Health Assessment Participants ▪ Demographic information ▪ Risk status ▪ Health Risks Prioritized for an Individual ▪ Health Risks by Prevalence in the Population ▪ Health Problems Self-Reported ▪ Preventive Health Services ▪ Health Planning	Annually (ad hoc request) Allow at least 15 days for ad hoc request to be completed

Report Name	24/7 PHYSICIAN CONSULTATIONS REPORTS	Frequency
Utilization Report	Shows the number of services utilized by callers, such as E-consults, On-Call Consultations, Priority Consultations, and Scheduled Appointments. Data is presented by report period and year-to-date.	Quarterly

Report Name	MATERNITY MANAGEMENT REPORTS	Frequency

Report Name	MATERNITY MANAGEMENT REPORTS	Frequency
Maternity Management Summary	Aggregate report indicates the number of cases that are open, total number of women referred to the program, number of women participating in the program and if they are high or low risk, closed cases and reason for closure. A breakdown of outcome data is also provided, which includes number of premature deliveries, deliveries at term and deliveries after 42 weeks. Each category of deliveries also reflects if the mother was high- or low-risk.	Quarterly
Incentive Eligibility Report	Contains the participant's name, phone number and enrollment date, as well as the employee's name.	Monthly
Referral Sources Summary	Illustrates the various sources for incoming referrals. Helps identify areas for training, process improvements, and other possible interventions to increase referral rates.	Quarterly and annually

ATTACHMENT

#2

Titus County Independent Evaluation

SPECIAL POINTS OF INTEREST:

- **Last meeting revealed $111,256 in potential savings in Year 1.**
- **Savings potential is repeatable in subsequent years.**
- **Titus County will benefit from competitive forces in the marketplace.**
- **Potential conflict of interest identified with common ownership of all current entities**

Overview of Request:

A request was made for an independent evaluation of the Titus County Health Plan. The request initially stemmed from the awareness and concern that there is no independent consultant currently involved in the preparation and review of the renewal and plan design options.

Further interest was expressed as to whether any opportunities for savings or improvement might exist inside or outside the current structure. Brinson Benefits was retained to begin this analysis and received a fee for completion of the evaluation.

Key Findings:

1. Pharmacy Claims 141
   - Currently $[illegible] per employee per month (PEPM)
   - Client of similar size achieved the following:
     - ⇒ Reduction from $117 PEPM to $65 PEPM
     - ⇒ Savings begins immediately and can be installed by January 1
     - ⇒ Option provides expanded pharmacy locations for employees
   - Recommend funneling rebates back to the County
     - ⇒ Rebates should be $7.50-$8.00 per brand Rx filled in retail pharmacy
   - Estimated savings of $47,387, improved oversight and steerage
2. Compliance and communication materials deficient
   - Lack of distribution of plan documents is non-compliant with federal laws
     - ⇒ Review, approve and distribute plan documents and summaries
3. TPA Fee Analysis above market norms in some areas:
   - TPA administrative fee is in line with market norms — $16.50 PEPM
   - Commissions currently paid on reinsurance are $42,838.41
     - ⇒ Commissions to TPA on reinsurance, should be no more than 5% or $14,279
   - Commissions currently paid on life insurance are an estimated $3,437
     - ⇒ Commissions should be $0
   - Commissions currently paid on transplant insurance policy are $1,405
     - ⇒ Commissions should be $0
   - Paying $2 PEPM for reports not being received or utilized — $3,216
     - ⇒ Either get reports and see what you learn or cancel service
   - Quote from competitive TPA: "We usually take one of two approaches when we market the stop loss. The first is a flat 5% commission to our TPA and 10% to the broker. The other is a $2.00 stop loss interface fee and the full 15% back to the broker. As far as the Medical Administration, the range on a group of 120 lives is around $14.00."
4. Limited or no Patient Advocacy, Auditing or Reporting — county staff spends large percent of time answering questions from employees about benefits
   - ⇒ Savings potential is .33¢ of every $1.00 audited in claims
5. Dental Plan Subsidy by County is 80% of total plan costs
   - ⇒ This is a very generous investment by the county.
6. No independent medical plan market evaluation done since sometime prior to 2006 that we can see
   - ⇒ Is what you don't see costing the county?
   - ⇒ Sales Representative vs. Independent Consultant
7. No telemedicine services evaluated to potentially save plan utilization
   - ⇒ Projected savings of 25% of physician office visit charges to the plan
8. Additional opportunities to take advantage of:
   - Technology / efficiency evaluation
   - Employee benefit and wellness platform where plan documents can reside 24/7

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