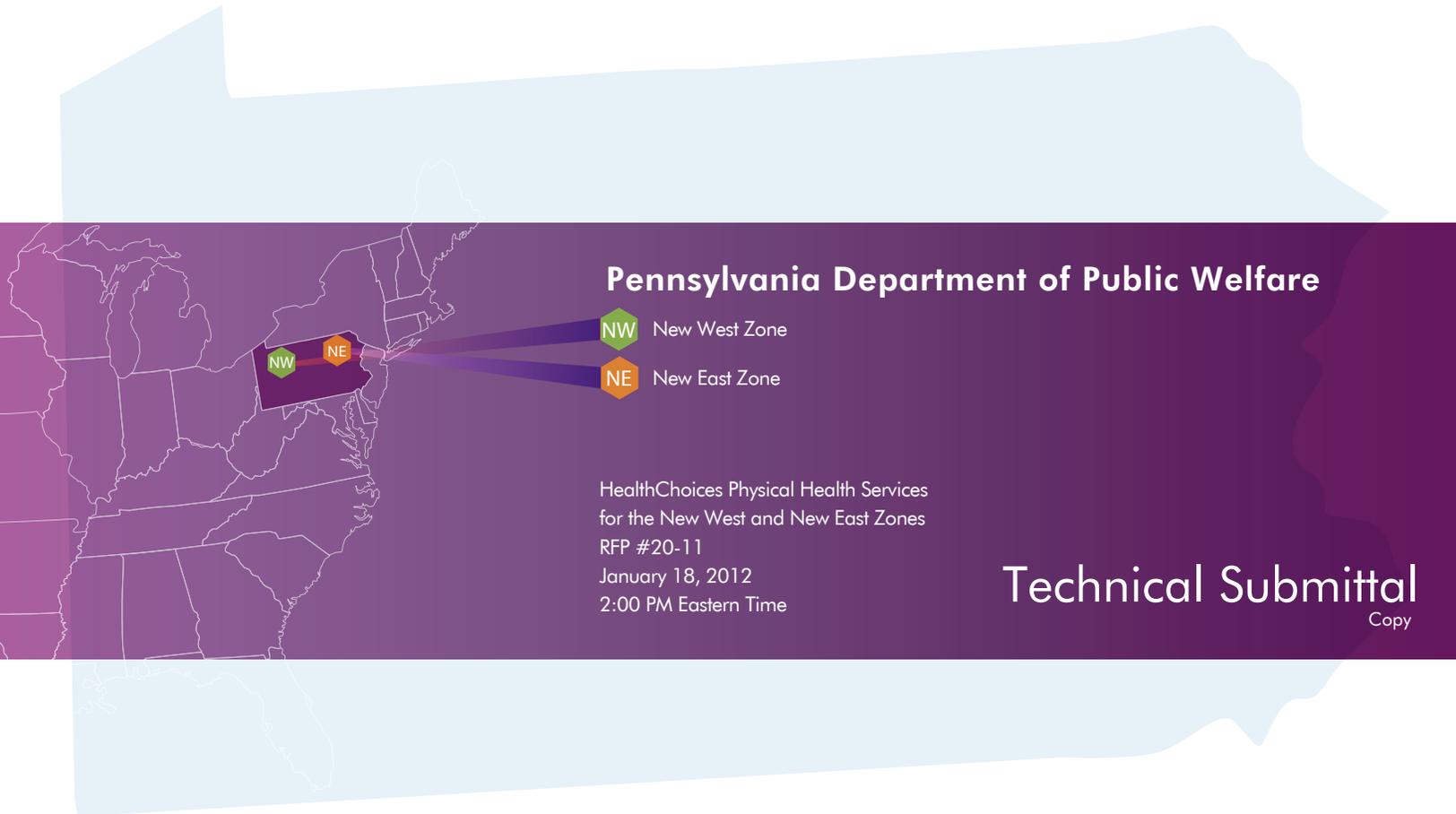
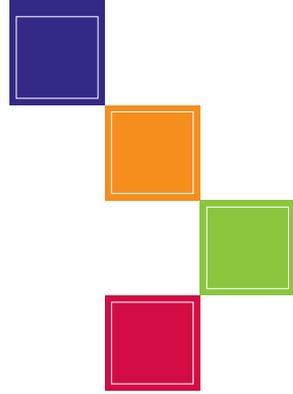




# Lighting Your Path to Good Health



## Pennsylvania Department of Public Welfare

- NW New West Zone
- NE New East Zone

HealthChoices Physical Health Services  
for the New West and New East Zones  
RFP #20-11  
January 18, 2012  
2:00 PM Eastern Time

# Technical Submittal

Copy





January 18, 2012

The Honorable Gary D. Alexander  
Secretary, Pennsylvania Department of Public Welfare  
Health and Welfare Building  
Commonwealth and Forster Streets  
Harrisburg, PA 17105-2675

Dear Secretary Alexander:

On behalf of HealthAmerica's Medical Assistance product, CoventryCares, I am pleased to submit this proposal in response to the request for the HealthChoices Physical Health Program for the New East and New West Zones. We are excited about the opportunity of growing our Pennsylvania HealthChoices Managed Care Organization. We look forward to working with the Department of Public Welfare to successfully deliver the required services that meet the needs of the HealthChoices population.

CoventryCares' mission is to be a recognized leader in providing quality, accessible and affordable health care benefits and services that maintain and improve the quality of life for our members. Our commitment to this mission has been proven in Pennsylvania through 37 years of successful operations serving commercial, Medicare and most recently, Medical Assistance members. Our focus and commitment to quality are evidenced through HealthAmerica's ranking among the nation's top health plans by the National Committee for Quality Assurance's (NCQA) Health Insurance Plan Rankings for 2010-2011.

Our goal is to expand our partnership with the Commonwealth in the HealthChoices Program and help the Department address the challenges in serving the HealthChoices population—challenges that are growing more complex under the economic pressures of the current recession. We welcome the opportunity to work with the Department to promote self-sufficiency and personal responsibility among this population. We will implement innovative and creative methods to provide information that helps these consumers become better informed and more efficient health care customers. We have detailed our qualifications and commitments in the body of the attached proposal.

As required for this transmittal letter, we are pleased to certify that we are currently under no form of suspension or debarment with respect to the federal government, Pennsylvania or any other state. We will comply with all of the requirements outlined in the Request For Proposal. The person who will serve as the primary contact for the Department's Project Officer is:

Name: Denise M. Gallagher  
Title: Vice President and General Manager  
Address: CoventryCares  
700 American Avenue Suite 300  
King of Prussia, PA 19406  
E-mail Address: dm Gallagher@cvty.com  
Phone number: 610-290-1155  
Fax number: 800-699-5098

We appreciate the opportunity to present our qualifications for, and commitment to, the HealthChoices Program. We look forward with great anticipation to the Department's decision in this matter.

Sincerely,



David W. Fields  
President and Chief Executive Officer

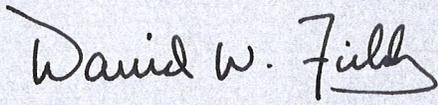
**APPENDIX D - PROPOSAL COVER SHEET  
COMMONWEALTH OF PENNSYLVANIA**

Department of Public Welfare  
Bureau of Financial Operations  
Division of Procurement  
Room 525 Health and Welfare Building  
625 Forster Street  
Harrisburg, PA 17120  
RFP# 20-11

**Enclosed in four separately sealed submittals is the proposal of the Offeror identified below for the above-referenced RFP:**

<b>Offeror Information:</b>	
Offeror Name	HealthAmerica Pennsylvania, Inc.
Offeror Mailing Address	3721 TecPort Drive Harrisburg, PA 17111-1200
Offeror Website	www.healthamerica.cvtv.com
Offeror Contact Person	David Fields
Contact Person's Phone Number	(412) 497-5885
Contact Person's Facsimile Number	(866) 341-0412
Contact Person's E-Mail Address	dwfields@cvtv.com
Offeror Federal ID Number	25-1264318
Offeror SAP/SRM Vendor Number	210572-002

<b>Submittals Enclosed and Separately Sealed:</b>	
<input checked="" type="checkbox"/>	Technical Submittal
<input type="checkbox"/>	Disadvantaged Business Submittal
<input type="checkbox"/>	Contractor Partnership Program Submittal
<input type="checkbox"/>	Mentor-Protégé Program Submittal

<i>Signature</i>	
Signature of an official authorized to bind the Offeror to the provisions contained in the Offeror's proposal:	
Printed Name	David W. Fields
Title	Chief Executive Officer

**FAILURE TO COMPLETE, SIGN AND RETURN THIS FORM WITH THE OFFEROR'S PROPOSAL MAY RESULT IN THE REJECTION OF THE OFFEROR'S PROPOSAL**

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# TECHNICAL SUBMITTAL





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# SECTION II: PROPOSAL REQUIREMENTS

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## II-1. Statement of the Problem

State in succinct terms your understanding of the problem presented or the service required by this RFP.

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### **Problem Statement**

As a participant in the HealthChoices Physical Health program in the Southeast Zone and , starting in April 2012, in the and Southwest Zone, the HealthAmerica Plan (CoventryCares) addresses problems of access, quality and cost-effective health care for Medical Assistance (MA) consumers every day. In addition, CoventryCares has the advantage of considerable experience amassed by our parent company, Coventry Health Care, Inc. (Coventry), which operates 10 Medicaid plans across the country in states with similar environments and demographics as Pennsylvania.

Through our partnership with the Department of Public Welfare (DPW), CoventryCares understands the Commonwealth's goal to mitigate the barriers MA consumers face. We stand ready to coordinate multiple programs to deliver services apart from physical healthcare so that MA consumers may overcome personal barriers to become self-sufficient, smart purchasers of services. CoventryCares has the flexibility to modify benefit packages when needed, and the ability to adopt new approaches to service coordination if DPW chooses to serve additional populations or provide additional services.

### **Improving Access to Health Care Services for MA Consumers**

To ensure MA consumers have access to primary and preventive care through a primary care provider (PCP), the following member and provider issues must be addressed.

#### ***Member Challenges***

- Economic constraints, limited housing options, complex family and social support systems, and the segmentation of community-based agencies present unique barriers to accessing appropriate care.
- Specific services needed by the Special Needs populations are not readily available and challenging to arrange. This population has numerous and specialized medical needs requiring coordination with community agencies and specialty care providers that may not exist in the New West and New East Zones.
- Lack of transportation or limited public transportation and outdated contact information result in a high rate of missed appointments.
- The prevalence of co-morbid conditions—particularly the mix of physical and behavioral health diagnoses—adversely affects the capacity to follow treatment plans, a challenge exacerbated by the lack of a medical home. For many individuals, the emergency department (ED) becomes the primary point of contact.



- Unlike other parts of the state, MA consumers in the New West and New East Zones are new to managed care and will need to learn the system and how to use the services provided by CoventryCares.

### ***Provider Challenges***

- Shortage of providers and the low number willing to contract with all selected MCOs in the New West and New East Zones present a formidable challenge
- Reimbursement rates perceived to be inadequate for handling the complex socioeconomic, physical and behavioral health issues of MA consumers limits participation among service providers
- Some providers in rural communities may not be technologically savvy or trained in managed care

### ***Maximizing Opportunities to Provide Cost-Effective Health Care***

Many MA consumers address their health care needs in ways that are not cost-effective. Preventive services and chronic conditions are often inadequately addressed, resulting in more expensive treatment over time. This pattern of care hampers the ability to stabilize and predict MA consumer spending and sustain quality health outcomes.

Breaking this cycle of care requires:

- Vigilant and effective utilization management procedures operating in conjunction with community resources to address the social issues that interfere with MA members getting appropriate care in cost-effective settings
- Working with each member to establish a medical home and being actively involved with high-risk members to build a foundation for integration of the medical home and self-management to facilitate wellness

### ***Promoting Self-Sufficiency and Personal Responsibility Among MA Consumers***

Changing the mindset of MA consumers to promote personal independence and individual empowerment requires the development of innovative new programs that are person-centered and encourage self sufficiency and personal responsibility.

The challenge is to create transparency to empower MA consumers by allowing them to control some of their own health care dollars. This will give them the ability to plan financially for their healthcare needs while selecting cost-effective, quality providers.

MA consumers will need the tools and support to “shop” for required medical services by selecting the most cost-effective healthcare settings, locations and providers, while continuing to ensure appropriate access to high quality healthcare.

CoventryCares will be flexible, innovative and creative to meet the needs of the MA consumers in the New West and New East Zones. Unlike the Southeast and Southwest Zones, the majority of the area is rural. As such it brings all the challenges of providing access to healthcare in a rural setting such as a shortage of providers, limited transportation to services and a lack of managed care experience. With the extensive background that Coventry brings to these zones, we are ready and willing to address the issues.



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## II-2. Prior Experience

In addition to relevant prior work done by your company, experience shown should include relevant work done by specific individuals who will be assigned to the New West and /or the New East Zones.

### a. Corporate Background

The Offeror must describe the corporate history and relevant experience of the Offeror and any subcontractors. This section must detail information on the ownership of the company (names and percent of ownership), the date the company was established, the date the company began operations, the physical location of the company, and the current size of the company. The Offeror must provide a corporate organizational chart as part of this section.

The Offeror must submit, as an appendix, its organization's Articles of Incorporation. If its Articles of Incorporation does not include all the information in Appendix J. Ownership Structure and Related Information, this information must also be provided.

Offerors must identify any current contracting or subcontracting relationship(s) that may result in a conflict of interest with the requirements of this RFP. Offerors must also abide by the Department's conflict of interest standards identified in Appendix E, Standard Terms and Conditions for Services and Appendix F, Department of Public Welfare Addendum to Standard Terms and Conditions.

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### Offeror Ownership and Parent Company

HealthAmerica Pennsylvania, Inc. (HealthAmerica), the Offeror, d.b.a. CoventryCares for Medicaid, is a Pennsylvania corporation and, since 1988, a 100%-owned subsidiary of Coventry. CoventryCares is our Medical Assistance program in the Southwest and Southeast Zones. Coventry, a national managed care company headquartered in Bethesda, Maryland, provides managed care services for nearly 5 million members across the country. Coventry provides a full range of insured and administrative programs to commercial and governmental employers, Medicaid agencies, Medicaid consumers, Medicare beneficiaries and other insurance companies. Since 1995, Coventry has provided customized Medicaid managed care programs to state consumers and currently serves more than 900,000 TANF, ABD, and CHIP members in 10 states.



With our longstanding focus on serving the diverse managed care needs of the country, particularly those needs facing states and their Medicaid eligibles, Coventry has an in-depth understanding of the challenges and opportunities of serving TANF, ABD and CHIP/Medicaid populations. Accordingly, CoventryCares has significant resources, including corporate resources, upon which it can draw in responding to DPW's program requirements. In April 2010, CoventryCares started operations in the Pennsylvania HealthChoices program covering the Southeast Zone. CoventryCares serves approximately 16,800 MA members in the following categories of aid:

- TANF
- SSI
- Medically Needy
- Healthy Beginnings
- Healthy Horizons
- Categorically Needy

In coordination with Coventry, CoventryCares has deployed our industry-leading administrative platform. This platform has demonstrated sustained excellence in serving members and providers with an emphasis on medical management. Our systems are currently being enhanced as we work with the Commonwealth and other states to incorporate the requirements of Health Care Reform. Further, our financial stability, focus on cost-effectiveness and proven quality programs give us the competitive advantage of operational effectiveness in our Medicaid programs.

### **Date Established and Onset of Operations**

HealthAmerica Pennsylvania, Inc. (HealthAmerica) was created in 1974 as Penn Group Health Plan (Penn Group), a nonprofit corporation with a voluntary board of directors. It was the first federally qualified HMO in the southwest Pennsylvania region and the fourth federally qualified HMO in the nation. Penn Group, a staff model HMO, opened its first office in June 1975. At the end of Penn Group's first year in business, 1,400 Pittsburghers were members of the region's first HMO. By 1978, Penn Group had about 17,000 members. On January 1, 1981, Penn Group entered into a management agreement with HealthPlans Corp. based in Nashville, Tenn. That organization changed its name to HealthAmerica and became a publicly-traded company. In 1983, membership grew to 30,000, and in 1984, HealthAmerica expanded its operations to central Pennsylvania. The expansion and addition of a network-model HMO option brought commercial membership to 50,000 in 1984. In 1985, HealthAmerica's Central Pennsylvania region became federally qualified. In 1988, HealthAmerica was acquired by Coventry.

While HealthAmerica's commercial HMO was extremely successful through the 1980s, employers began demanding alternative managed care programs that offered more choice for their employees. In response, through its sister corporation, Coventry Health and Life Insurance Company, HealthAmerica introduced the HealthAssurance PPO and the HealthAssurance Coordinated Care PPO (or POS) in 1992. In 1996, HealthAmerica began offering the Advantra HMO product for Medicare eligibles.

Throughout the late 1990s and into the early 2000s, HealthAmerica dramatically expanded its operations. In July 1995, HealthAmerica was granted a Certificate of Authority and Operating Authority to operate a Health Insuring Corporation (Ohio's version of an HMO) in six counties in eastern Ohio. In 1996, HealthAmerica acquired Aetna Health Plans of Western Pennsylvania. By the end of 1997, HealthAmerica and its affiliate companies served approximately 545,000 commercial and Medicare



members. In May 2001, a new company was established, HealthAssurance Pennsylvania, Inc., a Risk Assuming Non-Licensed Insurance Company that offers PPO and point-of-service (POS) products. In 2002, HealthAmerica acquired New Alliance Health Plan in Erie, expanding its service area into the northwestern counties and adding approximately 47,000 commercial members. The next year, HealthAmerica received approval to expand its service area in southeastern Pennsylvania. HealthAmerica began Medical Assistance operations, as CoventryCares, in April 2010.

### Physical Location and Current Size

Coventry is a Fortune 500 company with 2010 revenue in excess of \$13 billion. The Company employs more than 14,000 associates nationwide, including nearly 3,000 (21%) in Pennsylvania at eight locations throughout the Commonwealth.

Today, HealthAmerica has revenues of \$1.5 billion and is the only HMO in the Commonwealth licensed to serve all 67 counties. HealthAmerica and its affiliates provide coverage to over 458,000 members statewide, which includes approximately 17,00 CoventryCares Medical Assistance members. Coventry has nearly 3,000 Pennsylvania employees engaged in the functions listed in Figure 1:

**Figure 1: Primary Business Office Locations**

Office Location	County	Primary Business
2222 Ewing Road Moon Township, PA 15108	Allegheny	Coventry Central Services Coventry National Programs
11 Stanwix Street Pittsburgh, PA 1522	Allegheny	HealthAmerica Health Plan Services Coventry Central Services, IT
120 East Kensinger Drive Cranberry Twp, PA 16066	Butler	Coventry Central Services
4000 Crums Mill Road Harrisburg, PA 17112	Dauphin	Coventry Senior Pharmacy Program
3721 TecPort Drive Harrisburg, PA	Dauphin	HealthAmerica Health Plan Services Coventry Central Services, IT
100 State Street, Suite 120 Erie, PA 16506	Erie	HealthAmerica Health Plan Services
700 America Avenue King of Prussia, PA 19406	Montgomery	CoventryCares Outreach/Retention Coventry Workers' Comp
401 Plymouth Road Plymouth Meeting, PA 19462	Montgomery	HealthAmerica Health Plan Services Coventry Central Services

### Corporate Organizational Chart

An organizational chart showing all Coventry entities is provided as **Attachment 1**.

## Corporate History and Relevant Experience of Subcontractors

Coventry uses subcontractors to perform services, including

- 24-Hour Nurse Help Line
- Pharmacy Benefit Manager
- Identification card production
- Dental and vision

**Attachment 2** lists the subcontractors who have partnered with Coventry.

## Articles of Incorporation

Articles of Incorporation are provided as **Attachment 3**.

Refer to **Attachment 4** for Attachment J Ownership Structure and Related Information (also identified in the RFP as Appendix J) and to **Attachment 5** for a listing of the Board of Directors.

## No Conflict Statement

There are no current contracting or subcontracting relationship(s) that may result in a conflict of interest as defined by DPW's conflict of interest standards identified in Appendix E, Standard Terms and Conditions for Services and Appendix F, Department of Public Welfare Addendum to Standard Terms and Conditions. CoventryCares will abide by these terms and conditions as well as all applicable statutes, regulations and any directive issued by DPW.

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II-2.b. Corporate Experience. The Offeror must describe its experience providing similar services, including the name, address, and telephone number of the responsible official of the customer, company, or agency who may be contacted. This section of the proposal must include a description of the Offeror's:

---

Coventry brings to the New West and New East HealthChoices Zones over 37 years of managed care experience nationwide. This includes the launch and implementation of the Pennsylvania HealthChoices Southeast Zone CoventryCares Agreement. Currently, CoventryCares is preparing for the launch of our HealthChoices Agreement in the Southwest Zone. As more fully detailed in the narrative and graphics below, Coventry has a long and successful history in all forms of managed care programs including Medicaid. This significant experience demonstrates that Coventry possesses the resources, personnel and knowledge to implement and successfully administer the HealthChoices Program in the New West and New East Zones.



II-2.b.i. Qualifications and experience with Medicaid managed care systems;

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**Coventry's Medicaid Managed Care Business**

Coventry's subsidiary managed care companies are contracted to provide full-risk Medicaid Managed Care programs in Florida, Kansas, Kentucky, Maryland, Michigan, Missouri, Nebraska, Pennsylvania, Virginia and West Virginia. National in scope, yet local in focus, Coventry's Medicaid expertise helps Medicaid Agencies across the nation gain control over their health care delivery challenges and cost.

Since 1995, Coventry has been providing Medicaid Managed Care programs. On a combined basis, Coventry Managed Care Organizations (MCOs) administer Medicaid programs covering approximately 900,000 TANF, ABD, Foster Children and CHIP beneficiaries in 10 customized Medicaid managed care programs. Many of our innovative techniques and approaches for state/commonwealth governments have been derived from applying our longstanding companywide health care principles to public sector health care programs, while strongly recognizing the uniqueness and challenges of serving the Medicaid population. The Table below provides a comprehensive listing of Medicaid populations served by Coventry's Medicaid MCOs.



**Figure 2: Coventry Capitated Medicaid State Programs**

State	Enrollee Populations							
	Effective Date	TANF	ABD/SSI	Pregnant Women	CHIP	Foster Care	LTC	Dual Eligibles
Florida	1985/2007*	X	X	X	X	X	X	X
Kansas	2012*	X		X	X	X		
Kentucky	2011	X	X	X	X	X		X
Maryland	2003	X	X	X	X	X		
Michigan	1979/2004*	X	X	X	X			X
Missouri	1995	X		X	X	X		
Nebraska	2010	X	X	X	X	X		
Pennsylvania	2010	X	X	X		X		
Virginia	1996	X	X	X	X			
West Virginia	1996	X		X				

\*Year Coventry acquired

TANF = Temporary Assistance for Needy Families

ABD/SSI = Aged, Blind and Disabled

CHIP = Children’s Health Insurance Program

LTC = Long Term Care

DE = Dual Eligible

Coventry will utilize the strength of its corporate and affiliate company resources, including the experience of the other Coventry full-risk Medicaid managed care programs, to effectively provide services to DPW. Our proven programs, processes and expertise help our members in communities across the nation access health care in the right place, at the right time, and in the most cost-effective manner. We also provide the additional support needed to access community resources to gain control over their health care challenges.

Our years of experience working with Medicaid members, in combination with our highly knowledgeable clinical and administrative staff, provide our state/commonwealth clients the benefit of successfully leveraging their Medicaid programs with proven managed care technologies. Additionally, we possess Medicaid experience needed to understand the challenges public entities such as DPW face in fulfilling their health care mission.

Coventry’s innovative programs include the following elements:

- Ability to successfully integrate MA Consumers from a PCCM or Fee-for-Service model to a managed care model



## II-2: Prior Experience

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- Establishment of a medical home
- Member-centric, community-based case management models
- Integrated medical and behavioral health case management approach
- Quality disease management programs in asthma, diabetes, maternity, HIV, high blood pressure, immunizations and well-woman care
- Accreditation by National Committee for Quality Assurance (NCQA) or URAC

Coventry believes that health care is local, and we employ over nearly 3,000 people in eight offices throughout the Commonwealth of Pennsylvania. As an organization that is national in scope and local in focus, we bring the best of both to the Commonwealth. Coventry brings a proven track record with solid financial results combined with a local subsidiary company with local management to interact with all the stakeholders involved in the Medical Assistance program.

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### II-2.b.ii. Qualifications and experience operating any managed care medical program; and

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For 37 years, we have been leading the way in offering high quality health benefits to Pennsylvania managed care populations. In 1994, HealthAmerica distinguished itself as the first commercial HMO in western Pennsylvania to receive full accreditation from the National Committee for Quality Assurance (NCQA), and its commercial and Medicare HMO plans hold excellent accreditation status ratings from the NCQA.

HealthAmerica's parent, Coventry, fully supports the development of quality programs for all lines of business, including Medicaid. With strong organizational focus on accreditation, Coventry health plans have consistently achieved the highest accreditation status from the nationally recognized accrediting bodies. To date, all of Coventry's health plans with accreditation have continuously sustained their accreditation status with no lapse in standing.



Figure 3 provides the accreditation status for Coventry health plans.

**Figure 3: Coventry Health Plans (CHC) Accreditation Status**

CHC Health Plans			
Health Plan	Accreditation	Line of Business	Level
Health America/Health Assurance (HealthAmerica)	NCQA Health Plan	Commercial - HMO/POS	Excellent 11/18/11-11/18/14
Health America/Health Assurance (HealthAmerica)	NCQA Health Plan	Medicare - HMO	Excellent 11/18/11-11/18/14
HealthAmerica	NCQA Health Plan	Medicaid - HMO	Commendable 11/18/11-11/18/14
Altius (includes Wyoming and Idaho)	URAC Health UM	Commercial	Full Accreditation 6/1/11-6/1/14
Altius (includes Wyoming)	None	Medicare	N/A
Carelink	NCQA Health Plan	Commercial - HMO	Commendable 9/28/10-11/4/2013
Carelink	None	Medicaid	N/A
CHC of Delaware	URAC Health Plan	Commercial	Full Accreditation 6/01/10-6/01/13
Diamond	URAC Health Plan	Medicaid	Full Accreditation 6/01/10-6/01/13
CHC of Florida	AAAH MCO	Commercial	Full Accreditation 10/09-10/12
CHC of Florida	AAAH MCO	Medicaid	Full Accreditation 10/09-10/12
CHC of Florida	AAAH MCO	Medicare	Full Accreditation 10/09-10/12
CHC of Georgia	URAC Health Plan	Commercial	Full Accreditation 1/01/12-1/01/15
CHC of Georgia	None	Medicare	N/A
CHC of Iowa	URAC Health Plan	Commercial	Full Accreditation 6/01/09-6/01/12



II-2: Prior Experience

CHC Health Plans			
Health Plan	Accreditation	Line of Business	Level
CHC of Kansas	URAC Health UM	Commercial	Full Accreditation 2/01/10-2/01/13
CHC of Louisiana	URAC Health UM	Commercial	Full Accreditation 5/01/10-5/01/13
CHC of Nebraska	URAC Health Plan	Commercial	Full Accreditation 1/01/10-1/01/13
CHC of Nebraska	URAC Health Plan	Medicaid	Full Accreditation 1/01/10-1/01/13
CHC of Oklahoma	URAC Health UM	Commercial	included with KS URAC
CHC of Tennessee	URAC Health UM	Commercial	included with LA URAC
Coventry National Accounts	URAC Health UM	Commercial	Full Accreditation 2/01/09-2/01/12
Coventry National Accounts	URAC Disease Management	Commercial	Full Accreditation 3/01/10-3/01/13
CHC of Missouri (formerly Group Health Plan)	URAC Health Plan	Commercial	Full Accreditation 7/01/10-7/01/13
Group Health Plan	URAC Health Plan	Medicare	Full Accreditation 7/01/10-7/01/13
HealthCare USA	NCQA Health Plan	Medicaid - HMO	Commendable 8/3/11-8/3/14
OmniCare	NCQA Health Plan	Medicaid - HMO	Excellent 9/22/09-9/22/12
CHC of Illinois (formerly PersonalCare)	NCQA Health Plan	Commercial - HMO/POS/PPO	Excellent for HMO/POS and Commendable for PPO 6/28/2010-6/28/2013
PersonalCare	None	Medicare	N/A
Preferred Health Systems	URAC Health Plan	Commercial	Full Accreditation 1/01/10-1/01/13
Southern Health	NCQA Health Plan	Commercial - HMO/POS	Excellent for Commercial 5/08/09-5/08/12



CHC Health Plans			
Health Plan	Accreditation	Line of Business	Level
CareNet	NCQA Health Plan	Medicaid - HMO	Commendable for Medicaid 5/08/09-5/08/12
Other CHC Subsidiaries			
MHNet	URAC Health UM	Commercial, Medicare and Medicaid	URAC: Full Accreditation 1/01/09-1/01/12
MHNet	NCQA MBHO	Commercial, Medicare and Medicaid	NCQA: Full Accreditation 09/01/12
Concentra/CHC Workers' Comp	URAC - WC UM	Work Comp	Full Accreditation 5/01/09-5/01/12
Concentra/ Coventry Workers' Comp. Services	URAC - Case Management	Work Comp	Full Accreditation 9/01/09-9/01/12 The application for accreditation will include just 4 sites; Downers Grove, IL and Tampa, FL and Hazelwood, MO (TCM sites)

**II-2.b.iii. Experience with Other Commonwealth Agencies**

Our most relevant experience with other Commonwealth Agencies is with the Pennsylvania Department of Health and the Pennsylvania Department of Insurance. Both agencies have approved and/or issued licensure granting Coventry the right to operate managed care in all 67 of Pennsylvania’s counties.

Additionally, in 2009, HealthAmerica offered a full Private Fee-For-Service benefit for the Pennsylvania Employees Benefit Trust Fund (PEBTF) to 55,000 PEBTF retirees. HealthAmerica and its affiliates acted as the carrier that served the active employees who received their health care benefits from the PEBTF Program.

For Coventry Health Care’s Managed Care Experience (Appendix G), refer to **Attachment 6**.



II-2: Prior Experience

II-2.c. References. The Offeror must provide a list of at least three (3) relevant contracts within the past three (3) years to serve as corporate references. This list shall include the following for each reference:

- i. Name of contractor
- ii Type of contract
- iii. Contract description, including type of service provided
- iv. Total contract value
- v. Contracting officer’s name and telephone number
- vi. Role of subcontractor(s) (if any)
- vii. Time period in which service was provided

The Offeror must submit Appendix H, Corporate Reference Questionnaire, directly to the contacts listed. The references should return completed questionnaires in sealed envelopes to the Offeror. The reference individual should sign their name over the seal. The Offeror must include these sealed references with its proposal.

Trade Name	Type of Contract Payment (Capitated, Other)	Contract Description	Total Contract Value (Annual}	Contact Name and Phone Number	Role of Subcontractors, if any	Contract Duration
CareNet (Southern Health Services)	Capitated	Virginia Medallion II/FAMIS managed care program contract—Full Medicaid/CHIP benefits, excluding dental Population Type: TANF, Pregnant Women, ABD, CHIP	\$80.8 million	Mary Mitchell Mgr, Managed Care Programs 804-786-3594	Behavioral health, pharmacy, vision, and transportation	Entered program in 1996 Current Contract Duration: July 1, 2011 through June 30, 2012



Trade Name	Type of Contract Payment (Capitated, Other)	Contract Description	Total Contract Value (Annual)	Contact Name and Phone Number	Role of Subcontractors, if any	Contract Duration
OmniCare Health Plan	Capitated	Michigan Medicaid managed care program contract—Full Medicaid benefit, excluding dental, substance abuse and inpatient mental health, for Oakland and Wayne counties Population Type: TANF, Pregnant Women, ABD	\$186 million	Kathleen Stiffler 517-241-7186	Pharmacy, transportation, vision and non-chronic outpatient mental health	Entered program in 1979 First Coventry contract in 2004 Current Contract Duration: October 1, 2009 through September 30, 2012
VISTA (Coventry Health Care of Florida and Coventry Health Plan of Florida)	Capitated	Florida Healthy Kids managed care program contract—Full CHIP benefit Population Type: CHIP	\$38.9 million	Jennifer Lloyd (850) 701-6108	Behavioral health, pharmacy	Entered program in 1993 Coventry acquired in 2007 Current Contract Duration: October 1, 2008 through September 30, 2009 with three 1-year renewals through September 30, 2012

Sealed references provided for Coventry Health Care (Appendix H) are included in the Technical Submittal Original binder.



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## II-3. Personnel

The Offeror must submit a description of the MCO's overall organizational structure and its proposed organizational structure for the operation in the HealthChoices New West and/or New East Zones. The Offeror should demonstrate that all of the requirements set forth in this RFP and in the draft Agreement (Appendix A) are sufficiently addressed in the Offeror's proposed organizational structure and personnel. If the Offeror is proposing on both Zones, and if the Offeror is proposing to employ different, separate, and/or additional organizational structure(s) or personnel to address RFP requirements in each Zone, the Offeror must provide descriptions of the different, separate, and/or additional organizational structure(s) or personnel under separately tabbed sections of the Offeror's proposal clearly labeled as "Section II-3 HealthChoices New West Personnel," and Section II-3 HealthChoices New East Personnel," respectively.

An Offeror may propose to combine functions or split the responsibility for a function across multiple HealthChoices Zones, unless otherwise indicated, as long as it can demonstrate that the duties of the function will be carried out. If an Offeror proposes to combine or split responsibility, its response to this section must clearly indicate which individuals and offices will be responsible for each duty and function, and demonstrate that such duties and functions will be effectively performed and coordinated in each Zone.

Similarly, a selected Offeror may contract with a third party to perform these functions, subject to the subcontractor conditions set forth in the draft Agreement. If an Offeror proposes to engage a subcontractor to perform any of the functions discussed in this section of the RFP, Offerors may cross-reference and need not duplicate the descriptions of such subcontractors requested below in Section II-3.e of this RFP, Subcontracts. Selected Offerors are required to keep the Department informed at all times of the management individual(s) whose duties include each of the responsibilities outlined in this section.

Offerors who do not currently employ individuals responsible to perform the functions described in this section, and are therefore unable to provide names or resumes, may instead provide proposed job descriptions and the related information requested where practical. However, such offerors must take care that their responses to the Work Statement in Sections II-5 of this RFP clearly establish that qualified individuals will be employed, and their names and résumés provided to the Department, as part of the readiness review process, in time to ensure that all required functions will be performed. a. Executive Management (Section V.M of the draft Agreement) Full time positions for executive management as described in V.M. of the draft Agreement mean full time positions dedicated to the Medicaid Managed Care Program in Pennsylvania.

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For the Chief Executive Officer, Chief Operations Officer, Chief Financial Officer, Chief Medical Officer, Pharmacy Director, HealthChoices Program Manager and the Chief Information Officer, please provide the following information for each position:

1. Describe the executive's role in the organization.
2. During the most recent 36 months, how many months was this position not filled by an employee permanently assigned to the position? During the most recent 36 months, how many different people filled this position?
3. Describe the level of effort he/she provides related to each of the major program areas of contract management, financial management, quality management, utilization management, data management, consumer services and provider utilization. For all management positions specifically identified in your proposal, including the executive management positions listed above, provide:
  - Résumés of the management personnel already employed by the organization as an appendix to your proposal.
  - A job description for each management position for the proposed organizational structure for the HealthChoices New West and/or New East programs.
  - Specify where management personnel will be physically located during the time they are engaged to work.

Unless otherwise specified, the individuals in the executive management positions and those listed as key administrative personnel, shall serve in those positions in both the New West and New East Zones.

#### **Executive Management Positions:**

- Chief Executive Officer
- Chief Operations Officer
- Chief Financial Officer
- Chief Medical Officer
- Pharmacy Director
- HealthChoices Program Manager
- Chief Information Officer

#### **Executive Management Overview**

The CoventryCares executive team is committed to employing the necessary personnel to effectively execute the full range of managed care services required by DPW for the New West and New East



Zones of the HealthChoices Program. CoventryCares has an experienced group of individuals providing leadership and direction in managing our Southeast Zone business and are now in the process implementing the CoventryCares Program for the Southwest Zone of the HealthChoices Program.

The CoventryCares' executive team has strong technical and management skills necessary to effectively deliver high quality managed care services, while maintaining compliance with all relevant governmental requirements. The current CoventryCares Program executive management team, includes but is not limited to, the President and Chief Executive Officer, Chief Operations Officer, Chief Financial Officer, Medicaid Medical Director, Vice President/General Manager (VP/GM) of Medicaid, Director of Information Systems and Director of Pharmacy.

### ***Executive Management Positions***

The following represents information for the requested executive management positions that have oversight for CoventryCares HealthChoices Program. **Attachment 7** contains resumes and job descriptions for these positions.

#### ***Chief Executive Officer***

David Fields, President and Chief Executive Officer, is responsible for CoventryCares Pennsylvania HealthChoices statewide. In his role as CEO, Mr. Fields is the Administrator with authority over the entire CoventryCares operation. Mr. Fields is also responsible for HealthAmerica's statewide health plan operations in Pennsylvania consisting of a wide range of health benefits solutions for Commercial, Medicare Advantage and Individual subscribers.

Other than Mr. Fields, one individual filled the position of President and Chief Executive Officer over the most recent 36 months and this position was continuously filled with no lapse in service. As President and Chief Executive Officer, Mr. Fields is actively involved in and oversees all CoventryCares program areas, including contract management, financial, management, quality management, utilization management, sales and marketing, data management, MA Consumer services and provider utilization.

Mr. Fields maintains physical offices in Harrisburg and Pittsburgh, PA.

#### ***Chief Operations Officer***

Mary Louise Osborne, Chief Operating Officer, (COO) has statewide responsibility for CoventryCares Pennsylvania HealthChoices. In her role, she is accountable for the CoventryCares operation, including direct accountability for member outreach and marketing, health services (utilization management and case management) and compliance. Her role includes CoventryCares oversight for communications, provider relations and network management. Ms. Osborne is also responsible for HealthAmerica's Medicare Advantage programs and Individual business. In addition, she has direct accountability for utilization management, product development and operations for all statewide product lines. Ms. Osborne has been with HealthAmerica for ten years, her previous roles were Executive Vice President and Regional President for HealthAmerica Western PA. In August 2010, she was promoted to the position of Chief Operating Officer with statewide accountability.

This position was created in August 2010 Prior to the creation of the COO position, there were two Regional Presidents roles, one position dedicated to Eastern PA and the other position for Western PA. The Regional Presidents' roles were consolidated into one statewide COO role.

Ms. Osborne maintains a physical office in Pittsburgh, PA.



### ***Chief Financial Officer***

Evelyn Pendleton, in her role as Chief Financial Officer, oversees the financial management for CoventryCares as well as HealthAmerica's Commercial, Individual and Medicare lines of business, including actuarial services, underwriting and financial reporting and operations. Ms. Pendleton has been with HealthAmerica for 12 years and has oversight for the budget and accounting systems and ensures the timeliness and accuracy of all financial reports.

Other than Ms. Pendleton, one individual filled the position of Chief Financial Officer over the most recent 36 months and this position was continuously filled by a permanently assigned employee with no lapse in service.

As Chief Financial Officer, Ms. Pendleton is actively involved in the CoventryCares Southeast Zone financial management, utilization management, data management, enrollment and provider utilization. Ms. Pendleton is also actively involved in the implementation of CoventryCares participation in the Southwest HealthChoices Program.

Ms. Pendleton maintains physical offices in Pittsburgh and Harrisburg, PA.

### ***Chief Medical Officer***

Robert Mirsky, M.D. is Vice President of Medical Affairs for HealthAmerica and CoventryCares' Medicaid Medical Director (a position created in April 2010 with the award of the Southeast Zone contract). He is Board Certified in Family Practice Medicine and has a Master of Medical Management. Dr. Mirsky served as Vice President and Chief Medical Officer of Gateway Health Plan in Pittsburgh prior to joining CoventryCares and he has medical management utilization and medical expense management experience with other managed care plans. His experience also includes 10 years in private practice in New York and Florida. Dr. Mirsky's background qualifies him to serve as CoventryCares' Medical Director for all zones under the HealthChoices Program.

Dr. Mirsky joined CoventryCares in 2009 and replaced the prior Medical Director. There was no lapse in service for the Medical Director position. Dr. Mirsky is actively involved in all of CoventryCares' major clinical program components and directly participates in the oversight of the quality management, utilization management, special needs, case management, disease management programs, medical home and provider pay for performance programs.

Dr. Mirsky is an active participant in the implementation of the Southwest Zone CoventryCares HealthChoices Program. He will also be an active participant in the implementation of the New West and New East Zones.

As Medicaid Medical Director, Dr. Mirsky focuses his efforts in the major program areas of quality management, utilization management, MA Consumer services and provider utilization, medical home and provider pay for performance.

Dr. Mirsky maintains a physical office in Pittsburgh, PA.



### ***Pharmacy Director***

Heather R. Gross, Pharm.D, has been a Coventry employee since 2005. In March 2010 she became the Medicaid Pharmacy Director for the CoventryCares HealthChoices program in the Southeast Zone. Dr. Gross has over 12 years of experience in pharmacy management. Dr. Gross implemented the CoventryCares Southeast Zone pharmacy program and is responsible for its day to day operations and administration. She also develops new strategies, tactics and programs to further develop excellence in the delivery of optimal cost effective medical and prescription drug coverage. Dr. Gross is actively engaged in the implementation of the CoventryCares Southwest Zone HealthChoices Program. She will also be an active participant in the implementation of the New West and New East Zones.

This position was created in 2010 for the purpose of meeting the contractual requirement for the CoventryCares Southeast Zone program. There was no other individual who functioned in this capacity in the past. The expansion of this position to include the Southwest Zone and the New West and New East Zones can be accomplished with no adverse effect on quality of management.

Dr. Gross's efforts are focused on the management of pharmacy utilization management, management of PBM, network, formulary, member service, quality management and provider utilization.

Dr. Gross maintains a physical office location in Harrisburg, PA.

### ***HealthChoices Program Manager***

Denise Gallagher, Vice President and General Manager of CoventryCares, has over 20 years of experience in the administration of Medicaid Programs in seventeen states. Ms. Gallagher served as a Regulator in the Commonwealth of Massachusetts for their Medicaid Managed Care Program. Her background includes Director of the Neighborhood Health Plan of Massachusetts and Director of the Neighborhood Health Plan of Rhode Island. Ms. Gallagher joined Coventry in 2011. In the preceding 36 months the position of VP/GM CoventryCares was held by one other individual. There was no lapse in filling this position when Ms. Gallagher's predecessor left.

In her role as General Manager, Ms. Gallagher oversees the day to day operations of CoventryCares, including membership management, health promotion, outreach and member service. In her position, Ms. Gallagher collaborates with all operational areas to ensure contract compliance.

Ms. Gallagher maintains physical offices in King of Prussia, Harrisburg and Pittsburgh, PA.

### ***Chief Information Officer***

Sherry Thornton is Director of Application Development for Coventry Health Care, Inc. (Coventry) and is responsible for CoventryCares information systems and activities during and after implementation of the HealthChoices Program. Ms. Thornton successfully implemented the IT components supporting the CoventryCares program in the Southeast Zone in April 2010. She is currently engaged in the implementation of the CoventryCares Program in the Southwest Zone. She is involved in Pennsylvania state meetings regarding system implementation, revisions and strategies for health care reform. She serves as the IS Coordinator and is the single point of contact for all information systems issues with DPW. Ms. Thornton has over five years of experience in Medicaid health care IS applications, possessing an exceptional working knowledge of CoventryCares' operations pertaining to information systems.



During the most recent 36 months, there was one other employee who functioned in this role. In her position, Ms. Thornton focuses her efforts on the information systems associated with CoventryCares HealthChoices Program.

Ms. Thornton maintains a physical office in St. Louis, MO.

In summary, CoventryCares recognizes the requirement to have Executive positions dedicated to the Pennsylvania HealthChoices Program. CoventryCares intends to work closely with DPW to establish a membership growth and staffing strategy to achieve a cost effective and efficient operation. This collaborative strategy will allow for membership and revenue growth, while achieving the appropriate staffing levels to meet the contractual requirements.



### II-3.b. Key Administrative Positions (Section V.N of the draft Agreement)

In this section, the Offeror must identify the name and position of the person authorized to finalize an Agreement with the Department, and the name and position of the person who will have ultimate responsibility and accountability for the Agreement should one be entered into.

In addition, for each of the key administrative positions/functions listed below, provide the following information:

1. Attach a job description that includes minimum education for each staff position identified in the offeror's proposal for the proposed organizational structure for the HealthChoices New West and/or New East program.

2. Specify where these personnel will be physically located during the time they are engaged to work. Key Administrative Positions/Functions

- Quality Management Coordinator
- Utilization Management Coordinator
- Full-Time (FT) Special Needs Coordinator
- FT Government Liaison
- Maternal Health/EPSTD Coordinator
- Member Services Manager
- Provider Services Manager
- Complaint, Grievance and Department Fair Hearing Coordinator
- Claims Administrator
- Contract Compliance Officer
- Other key personnel identified by Offeror

For ease of reference, Offerors may use the chart in Appendix I, Executive Staff and Key Administrative Personnel Checklist, to ensure that their response provides all the documents and information pertaining to the Executive Management and Key Administrative positions and functions discussed in this section.

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### Authorization of Final Agreement

David Fields, CEO and President, is the individual authorized to finalize an Agreement with DPW. Mr. Fields will also have ultimate responsibility and accountability for the Agreement.

### Key Administrative Positions Overview

CoventryCares has an experienced and capable management team to provide the necessary leadership and job performance to enable the Company to be successful in the implementation of the

HealthChoices Program. David Fields has overall accountability for the services provided under the HealthChoices Program.

CoventryCares is a full-service health maintenance organization with experience and a record to perform effectively within the HealthChoices Program. With the implementation of the Pennsylvania Southeast HealthChoices program in April 2010, CoventryCares hired additional staff to support the operation of the program. Coventry will add staff for the New West and New East Zones as membership reaches levels requiring additional personnel.

In addition to the staff currently in place, CoventryCares has hired individuals to provide leadership in Community Development, Special Needs. Outreach personnel, as well as additional management and member-volume-related personnel in the areas of Health Services, Quality Improvement and Appeals have been added.

CoventryCares will keep DPW informed at all times of the management individuals whose duties include each of the responsibilities set forth in Sections II-3.a and II-3.b of the HealthChoices Agreement. The HealthChoices Program Manager will be accessible to DPW and will not be reassigned without advance notice to DPW.

### ***Key Administrative Positions***

The following represents information for the key administrative positions that will oversee the HealthChoices Program for the New West and New East Zones.

**Attachment 8** contains job descriptions for the key administrative positions identified below.

#### ***Quality Management Coordinator***

Elaina Wickas, RN, BSN, Director of Quality Improvement, is responsible for the management of the quality functions related to the medical management of care and services provided to members. She is a Pennsylvania registered nurse with experience in Quality Management Systems.

Ms. Wickas maintains a physical office in Pittsburgh, PA.

#### ***Utilization Management Coordinator***

Mary Trafican, RN, BSN, Director of Health Services, has responsibility for oversight of utilization and case management operations in Pennsylvania. This position requires interactions with all departments within the organization as well as providers, members, and various levels of CoventryCares and Coventry management. Ms. Trafican is a Pennsylvania registered nurse with significant prior Medicaid experience and education in Utilization Management Systems.

Ms. Trafican maintains a physical office in Pittsburgh, PA.

#### ***Full-Time Special Needs Unit Coordinator***

Gina Balakoff LSW is CoventryCares' Manager of Special Needs. Ms. Balakoff is a Pennsylvania-licensed social worker. She has experience in both special needs and mental health case management.

Ms. Balakoff maintains a physical office in King of Prussia, PA.



### ***Full-Time Government Liaison***

Joan Gaughan, JD has over 10 years of experience in the health care industry. Her most recent experience was as a welfare benefits plan administrator, which included oversight of regulatory compliance under ERISA. Ms. Gaughan has experience with insurance contract interpretation and analysis of coverage issues, contract administration, case management and personnel supervision. Significant areas of experience also include insurance-related regulatory compliance, EEOC and related employment law compliance.

Ms. Gaughan maintains a physical office in King of Prussia, PA.

### ***Maternal Health/EPSTD Coordinator***

Emily Perkins M.A., Health Education/EPSTD Coordinator, serves as the lead coordinator for the Southwest and Southeast Zones. She will also serve the New West and New East Zones. She educates and counsels members, providers and staff as to the rights and obligations under EPSTD and the related programs under contract with DPW.

Ms. Perkins maintains a physical office in Harrisburg, PA.

### ***Member Services Manager/Claims Administrator***

Suzanne Wilson, Manager of Service Operations, is responsible for member services and claims management. Ms. Wilson ensures that there is sufficient staffing of member services representatives to handle member inquiries with prompt resolution. Her team conducts member education and helps members to understand their plan benefits. In addition, she provides staff direction to ensure the timely and accurate processing of claims, encounter forms and other information necessary for meeting contractual requirements under the HealthChoices Program.

Ms. Wilson maintains a physical office in Newark, DE.

### ***Provider Services Manager***

Kathy Kalcevich, Director of Provider Relations, oversees provider services operations in southwest Pennsylvania. She oversees the staff that coordinates communications between the health plan and its providers. Ms. Kalcevich, supported by the Executive Management team, ensures that there is sufficient Provider Services staff available to promptly resolve provider disputes, problems or inquiries. She will serve in this capacity in both the New West and New East Zones.

Ms. Kalcevich maintains a physical office in Pittsburgh, PA.

### ***Complaint, Grievance and Department Fair Hearing Coordinator***

Kevin O'Brien, Manager of Appeals, oversees all functions of the Appeals Department. He is responsible for assisting CoventryCares members throughout the Complaint, Grievance, and Hearing processes. He has accountability for timeliness throughout the entire appeals process and for meeting all compliance requirements.

Mr. O'Brien maintains a physical office in Harrisburg, PA.



### ***Contract Compliance Officer***

Bernard Lapine is the CoventryCares Director of Regulatory Compliance. He is responsible to ensure that all HealthChoices contract requirements are implemented and monitored appropriately.

Mr. Lapine maintains a physical office in Harrisburg, PA.

### ***Director of Human Resources***

Regina Wheat, Director of Human Resources, is responsible for directing all aspects of human resources for CoventryCares, including all business lines. She is instrumental in the hiring, training and mentoring as well as all of the Employee/Employer human resources compliance requirements for the company.

Regina Wheat maintains a physical office in Harrisburg, PA.

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## Board Members

The Offeror must describe the role of board members in governance and policy making and specify the manner in which MA consumers are to be represented in an advisory and/or decision making capacity for the HealthChoices New West and/or New East Zones. In accordance with Pennsylvania Department of Health regulations, one-third of the board's membership must be "subscribers" of the MCO. Role of Board Members

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### **Role of Board Members**

The Board of Directors oversees our business in accordance with the laws of the Commonwealth of Pennsylvania. The Board's focus is driven by the Company's mission to be the recognized leader in providing quality, accessible and affordable health care services that maintain and improve the quality of life for all members and communities served. To that end, our Board of Directors is charged with the responsibility for meeting the Company's overall mission as well as specific goals and objectives as emphasized in its business plan.

CoventryCares believes that quality care and service, member retention, member satisfaction and business growth are the responsibility of every employee. We are committed to developing and delivering innovative products and services that exceed members' expectations. These key focus areas are understood and endorsed by the Board of Directors and updates are given at regular board meetings advising the directors of the status of the Company's efforts. Regular reports are given to the board for all operational areas of the Company, specifically Quality Improvement, Utilization Management, Medical Management and Finance.

In addition, to ensure that our Board of Directors is responsive to member concerns, one-third of the Board is comprised of the plan's subscribers. In order to ensure that we are responsive to our members, we have developed an Advisory Board made up of Medical Assistance members and providers, who advise us on their expectations and needs. The first meeting of the Advisory Board occurred in January 2011 and now meets on a quarterly basis. The CoventryCares Advisory Board serves in a consultative



capacity to the decision-making process in order to provide a consumer context in the development of policy and the delivery of services.

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### II-3.c. Organization

The Offeror must submit a current or proposed organizational chart so that a determination can be made as to whether the overall organizational structure reflects usual and customary business practices consistent with other managed care programs operating in the Commonwealth. Offerors need not duplicate but may cross-reference organizational charts provided elsewhere in the proposal, e.g., Section II-4.d.

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An organizational chart that reflects CoventryCares' proposed overall organizational structure, as a qualified participant in the HealthChoices Program for the New West and New East Zones, is available in **Attachment 9**. This organizational structure is consistent with customary business practices of other managed care companies operating in the Commonwealth.



II-3.d. Staffing Plans

The Offeror must include a comprehensive statement of its proposed staffing plan demonstrating how it will provide adequate staffing to address all requirements found in the RFP and the draft Agreement. Include comprehensive organizational charts that detail the number of staff and positions for each existing or proposed department within the MCO.

CoventryCares will add the following positions (Figure 4) to our existing structure to support operations in the New West and New East Zones:

**Figure 4: Additional Staffing Anticipated Based on 20,000 New Members**

Position	Staff FTE	Staff/Management	Office Location
Special Needs Unit Coordinator	1	Staff	Pittsburgh
Special Needs Unit Supervisor	1	Management	Pittsburgh
Social Worker	0.5	Staff	Pittsburgh
Maternal Health Case Manager	0.5	Staff	Pittsburgh
EPSDT Coordinator	1	Staff	Pittsburgh
Preauthorization (clinical) Specialist	1	Staff	HealthAmerica/Harrisburg
Appeals Clinical Coordinator	0.3	Staff	Harrisburg
Manager, Community Development	1	Management	Pittsburgh
Events Outreach Coordinator	1	Staff	Pittsburgh
Outreach Coordinator	1	Staff	Pittsburgh
Certified Health Educator	1	Staff	Pittsburgh
Member Service Representatives	2	Staff	Newark DE/Coventry Harrisburg
Enrollment Specialists	1	Staff	Coventry Newark DE/ Harrisburg



Position	Staff FTE	Staff/Management	Office Location
Communications Specialists	0.5	Staff	Harrisburg
Total	12.08		

Incremental staff will be added to Information Systems and Provider System Administration to ensure the successful implementation and operation of the New West and New East Zones.

### Hiring and Training

Our implementation plan addresses timing of the hiring of new staff and the training of all CoventryCares staff engaged in the HealthChoices Program.



II-3.e. Subcontracts

Provide a description of each subcontractor with responsibilities related to the provision of services to consumers including, but not limited to, the provision of medical services, and consumer services and administrative support including, but not limited to, claims processing along with an organizational synopsis of services to be provided by each of these subcontractors. Provide a separate response for each subcontract. (Limit to 2 pages for each subcontract) Note that, if the subcontract provides for any financial risk, the HealthChoices MCO will be required to comply with the subcontracting requirements set forth in Section XIII of the draft Agreement.

Figure 5 lists subcontractors utilized by CoventryCares for the provision of services to MA Consumers and administrative support. Refer to **Attachment 2** for a description of each subcontractor.

**Figure 5: CoventryCares Subcontractors**

Subcontractors	
Company Name/Address	Company Name/Address
ACS, Inc 1084 South Laurel Road London, KY 40744	AIM Healthcare Services, Inc. 1021 Windcross Court Franklin, TN 37067
Arbor Health 381 Riverside Drive Franklin, TN 37064	Block Vision 120 Fayette Street, Suite 700 Baltimore, MD 21201
Catalyst Technology 2386 Clower St., Suite C-201 Snellville, GA 30078	CDR Associates 307 International Circle, Suite 300 Hunt Valley, MD 21030
ChartPROS Four Tower Bridge 200 Barr Harbour Dr. Suite 400 West Conshohocken, PA 19428	Clark Resources 321 Front Street Harrisburg, PA 17101
Comp Partners, Inc. 4 Park Plaza, Suite 750 Irvine, CA 92614	Connolly Healthcare 950 East Paces Ferry Road, Suite 2850 Atlanta, GA 30326
Coventry Health Care, Inc. Coventry Management Services (subsidiary company) 6705 Rockledge Drive Bethesda, MD 20817	DentaQuest 465 Medford Street Boston, MA 02129
DSS Research 4150 International Plaza Suite 900 Fort Worth, TX 76109	Emdeon 3055 Lebanon Pike Nashville, TN 37214



Subcontractors	
Company Name/Address	Company Name/Address
First Recovery Group 26899 Northwestern Hwy. Southfield, MI 48034	Fiserv 255 Fiserv Drive Brookfield, WI 53045
HealthDataInsights 7501 Trinity Peak Street, Suite 210 Las Vegas, NV 89128	Healthcare Data Company, LLC 600 Bent Creek Blvd, Suite 160 Mechanicsburg, PA 17050
Ingenix 8345 Lenexa Drive, Suite 300 Lenexa, KS 66214	LabCorp 430 S. Spring Street Burlington, NC 27215
Language Line Services 1 Lower Ragsdale Dr., Building 2 Monterey, CA 93940	McKesson Health Solutions 5 Country View Road Malvern, PA 19355
MCMC, LLC 88 Black Falcon Avenue, Suite 353 Boston, MA 02210	Medco 100 Parsons Pond Drive Franklin Lakes, NJ 07417
Quest Diagnostics 3 Giralda Farms Madison, NJ 07940	RR Donnelley 111 South Wacker Drive Chicago, IL 60606
The Myers Group 1965 Evergreen Blvd., Suite 100 Duluth, GA 30096	





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## II-4. Work Statement Questionnaire

### Soundness of Approach

In this section, the Offeror will respond to the following questionnaire, taking care to be as concise as possible in its responses. In responding, the Offeror should repeat each question and then follow each question with the specific response. Please note that page limits have been established for the response to each question. While the Department will take note of an Offeror's adherence to these limits, they represent only the maximum permissible length of a response. Offerors are not required to and should not expand their responses to the maximum length if a question may be fully answered in fewer pages. All page limits apply to response text only; not to any requested documents.

Response text is to be provided using twelve (12) point Times New Roman or similar serif font, with all page margins no less than 0.5 inches.

When possible, Offerors currently participating in HealthChoices are encouraged to describe their current practices and to also describe changes or improvements to their current operations and to use examples from their HealthChoices line of business when explaining their future plans related to a question.

Offerors new to HealthChoices should provide responses on line(s) of business deemed to be most relevant. They should also describe how they would adapt their current line(s) of business to the HealthChoices Program.

If the Offeror is proposing on both Zones, any and all portions of a response to questions in Section II-4 that describe different, separate, or additional components of the response that is specifically designed to address the needs of one particular Zone as contrasted with the other should be provided under separately tabbed sections of the Offeror's proposal, and clearly labeled as "Section II-4 Work Statement Questionnaire HealthChoices New West Zone," and "Section II-4 Work Statement Questionnaire HealthChoices New East Zone," respectively. If the Offeror is proposing on both Zones and its response to any question is the same for both Zones, it need not duplicate its response for each Zone.

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## WORK STATEMENT QUESTIONNAIRE

### PLANNED APPROACH

1. Describe in detail how you will develop your network and set up operations capable of supporting membership and meeting requirements of the RFP and draft Agreement, no later than three months prior to the anticipated implementation date of 9/1/12 in the New West Zone and/or no later than three months prior to the anticipated implementation date of 3/1/13 in the New East Zone.

Describe your approach for meeting the requirements and include:

- A detailed description of your project management methodology. The methodology should address, at a minimum the following:
- Issue identification, assessment, alternatives and resolution;
- Resource allocation and deployment; and
- Reporting of status and other regular communications with the Department, including a description of your proposed method for ensuring adequate and timely reporting of information to Department personnel and executive management. (Limit to five pages)

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### Implementation of Operations

To ensure timely implementation of operations, upon notification of our selection to proceed to Readiness Review, CoventryCares will take the following steps immediately:

- Appoint an implementation project manager
- Analyze the current operational mechanisms in place and determine what changes, if any, are necessary
- Develop an implementation work plan for set up of operations
- Establish an implementation work group

CoventryCares currently utilizes an implementation project work plan that addresses operational set up. This work plan provides specific tasks in eighteen operational areas along with deadlines for each task. In our current implementation of the Southwest Zone, a weekly implementation call is held by the implementation project manager. This call is the platform for discussing the status of assigned operational tasks as well as for answering questions and addressing problems. CoventryCares then holds a weekly call with DPW which includes our project manager, network development team and the CoventryCares core team at DPW. This is the process CoventryCares intends to use for implementation of the New West and New East Zones, unless DPW requires or the implementation of the zones indicates otherwise.. Each week, task owners will be required to update the work plan with a status for each task and any barriers to completion. These updates will be discussed and deadlines will be set for resolution of any barriers to completion of the assigned tasks.



Because CoventryCares is an existing MA plan in the Southeast region and is undergoing implementation in the Southwest region, a significant amount of the operational set up is already established. This will allow for aggressive deadlines and quick turnaround in the operational implementation.

### **Network Development**

CoventryCares plans to use its existing relationships in the network development of the New West and New East Zones. The plan is currently licensed to operate in all 67 counties in the Commonwealth. This indicates the ability to continue enhancing our existing networks in the New West and New East Zones.

- Identify the regions where network development is needed and assign regional network development teams
- Identify the providers in the New West and New East who are in our existing Commercial and Medicaid network and currently contracted to provide services
- Create a work plan for recruitment of additional individual physicians and specialists
- Create a work plan for recruitment of additional ancillary providers
- Create a work plan for additional hospital recruitment

As with the operational tasks, there is an existing framework for network development that will allow CoventryCares to establish an aggressive timeline for implementation of a network that can support membership in both the New West and New East Zones.

### **Issue Identification**

The implementation strategy of CoventryCares provides for the early identification of issues as they arise. The weekly meetings of the implementation team allow for internal discussion and brainstorming when problems arise. The weekly meetings with DPW provide CoventryCares with the opportunity to discuss problems and potential solutions with our core team. Any issues not resolved immediately are assigned to a designated core team member with a resolution deadline and identified as an open issue on the implementation work plan to be reviewed weekly. CoventryCares has also used the regular meetings to provide CoventryCares staff and DPW with updates on the progress of network development. This regular contact is useful in identifying challenges in the provider network and developing a contracting strategy to meet access requirements.

### **Resource Allocation**

By establishing an implementation plan early in the Readiness Review process, CoventryCares gives its staff the opportunity to review the specific tasks assigned and allocate resources appropriately. Many CoventryCares departments form implementation modules, which are small, department specific workgroups assigned to oversee all of the department's implementation tasks. This ensures that all implementation tasks are given a high priority and are closely monitored. Where it is determined that additional CoventryCares staff is required to have an operation capable of supporting membership, a



staffing task is made a part of the implementation plan. Through early establishment of clear tasks and goals, CoventryCares has been successful in allocating our resources appropriately.

### Communication with DPW

As previously indicated, CoventryCares holds a weekly meeting with our core team at DPW to discuss all aspects of implementation. To supplement this process, CoventryCares has provided DPW with access to the implementation project manager. All inquiries from DPW that occur outside of the regularly scheduled meetings are responded to and answered promptly. During the Southeast and Southwest implementations, CoventryCares established a strong relationship with the core team and has committed to providing the same access to implementation staff and information during all future implementations.

In conclusion, CoventryCares believes that this methodology best supports a successful implementation by:

- Facilitating early identification of problems
- Allowing sufficient time for solving problems that arise
- Allowing adequate time to assign additional required resources, such as staff and vendors
- Keeping DPW well informed of the status of all implementation activities on a frequent and regular basis
- Maximizing the existing network of providers in both zones
- Building upon the operational framework already in place
- Providing flexibility and adaptability throughout the implementation process.

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#### II-4.2. Provide a work plan for implementation. At a minimum, the work plan should include:

- A description of all activities necessary to obtain required contracts for your provider network as specified in the draft Agreement; and
- An itemization of activities that you will undertake during the period between notification of selection to proceed to Readiness Review and the implementation date of 9/1/12 in the New West Zone and/or the implementation date of 3/1/13 in the New East Zone. The activities shall have established deadlines and timeframes. (Limit to four pages)

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CoventryCares will use two detailed work plans, with zone appropriate timelines, for the implementation of new MA contracts. Both work plans provide assigned tasks, deadlines and areas for task owners to share questions, problems or challenges with the CoventryCares implementation team. These grids are updated weekly and presented to the overall work group and to DPW during implementation.



## Network Development

The network development work plan has been completed with tasks and deadlines for the New West and New East Zones. Each zone will have its own regional network development team responsible for the work plan tasks.

- The New West Zone network development work plan for the is attached as **Attachment 10**
- The New East Zone network development work plan for the is attached as **Attachment 11**

## Operational Set Up

The operational work plan assigns tasks in eighteen operational areas from member service to member material development. Each zone will have an implementation team to carry out the work plan through to a successful implementation of the new zones.

- The New West Zone operational work plan is attached as **Attachment 12**
- The New East Zone operational work plan is attached as **Attachment 13**

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## Member Management

1. Describe what innovative approaches your MCO will take to promote personal responsibility among MA consumers by involving them in managing their own healthcare benefits and providing incentives that encourage wellness and healthy lifestyles. (Limit to two pages)
- 

CoventryCares believes that consumer-directed health plans with personal health accounts will be one of the most effective ways to encourage our MA members to become more involved and personally accountable for managing their own health care benefits. We have the system and process in place to implement personal health accounts when DPW is ready to address the feasibility of consumer-directed health plans with MA consumers.

CoventryCares presently uses many age- and disease-specific programs designed to promote personal responsibility and provide incentives that encourage wellness and healthy lifestyles.

## Well Visits

For completing medical and dental visits for routine and preventive care at indicated intervals, CoventryCares may offer members incentives such as gift cards of nominal value, population-specific products, and a savings account for member co-pays and deductibles. Members are responsible for obtaining appropriate documentation from their provider and submitting it to CoventryCares for their incentives.



## Movers and Shapers Program

The *Movers and Shapers Program* covers the annual membership fee to many YMCAs and wellness facilities, removing the financial barrier for joining fitness programs. Movers and Shapers is unique, because it covers the membership cost for adults and children, encouraging family participation. When members enroll in the program they receive a pedometer for tracking and increasing their physical activity levels. Partner YMCAs, class schedules, BMI calculators and other weight management educational information are available at the member website, MyCoventryCares.com.

## Member Classes

Classes are conveniently located and accessible by various modes of transportation. They are open to the community and offer activities for children so that parents can attend. Topics include smoking cessation, getting fit, lead screening, heart health, high-blood pressure, diabetes and recognizing depression.

## Disease Management (DM) Programs

CoventryCares provides MA members DM programs for diabetes, cardiovascular disease, congestive heart failure, asthma and chronic obstructive pulmonary disease. Members are identified using claims data and stratified based on acuity. Initial outreach includes member education about the disease and introduction to self-help tools. Ongoing case management is tailored with interventions based on members needs.

## Health Screenings

CoventryCares collaborates with several organizations to offer free health screenings and activities to members and the community. These activities vary from blood-pressure screenings, body mass index and massage therapy to hand-washing demonstrations so children and parents understand the value of hand washing in preventing the spread of disease.

## Rewards for Receiving Needed Preventive Care

CoventryCares will work with DPW in designing programs that are member-centered and encourage self-sufficiency and personal responsibility and accountability in making health-related decisions. CoventryCares will proactively manage and continually measure the care MA members receive to ensure it meets or exceeds the highest nationally accepted standards. CoventryCares will introduce programs that will incentivize MA members for:

- Enrolling and staying in case management and disease management programs
- Obtaining necessary preventive care, such as mammograms, wellness visits, and dental and eye care visits
- Complying with recommended treatment to manage chronic conditions, such as diabetes
- Improving health by engaging in wellness activities such as going to a gym, losing weight or completing a smoking cessation program



- Using online decision-support tools and CoventryCares call centers to increase the use of appropriate health care services

Upon approval by DPW, we will use two types of incentives to encourage members to participate in relevant programs, address chronic conditions, and maintain healthy behaviors

- Direct-to-member rewards: gift cards and population-specific products
- Savings account: accumulation of points, credits or cash to pay for co-pays, deductibles, and health and wellness equipment and services

**Social Media**

CoventryCares is employing a conservative and thoughtful approach to our social media strategy, recognizing the need to comply with HIPAA and DPW regulations and keep member information private. We are being systematic and deliberate in using these capabilities with MA members.

To date, we have piloted a Facebook presence with our managed Medicaid plans in Michigan and Maryland. Recognizing that social media may provide a more robust avenue for CoventryCares to further engage members in living healthy lifestyles, we are able to introduce a broader platform to MA members through a relationship with CaféWell, a social media company. HealthAmerica launched CaféWell to our commercial line of business in January 2010 and extended it to members in our individual plans in September 2011.

CaféWell provides consumers with a single online destination for health-related needs, including social networking, expert advice, fun fitness challenges and reliable information. Unlike general social networking sites, users can control the degree to which their identity is shared, with complete anonymity as the default. To inspire and motivate, CaféWell rewards active users with profile badges, and prizes such as gift cards, iPods and fitness-related items. We look forward to working with DPW in expanding this social networking opportunity for our MA members.

- 
2. Describe any experience your MCO has in using state of the art technology to provide your members with resources for managing their own healthcare benefits (including the use of incentives or “smart accounts.”) (Limit to two pages)
- 

CoventryCares believes the most effective ways to promote personal responsibility is through health benefit design, member education and incentives, backed by easy-to-use, decision-support tools.

Consumer-directed health plans are an example how benefit design can be used to encourage consumers to exercise greater control over how and when they use their health care dollars. These plans put some “skin in the game” for consumers and provide a financial incentive to become informed, responsible and efficient health care purchasers who continue to access the quality care they need. We have the systems, processes and member support in place to implement personal health accounts to support consumer-directed health plans when DPW is ready to address the feasibility of such plans with MA consumers.



CoventryCares either provides, or has the ability to provide, state-of-the-art technology and resources to help members manage their health care benefits. Members have access to important information online so they can compare options and make cost-effective decisions. The following decision-support tools are available now to help members make wise choices:

- **My Cost-of Care**—Region-specific data on surgical procedures, inpatient services, diagnostic tests, conditions and doctor visits
- **Hospital Quality and Cost Tool**—Coventry-specific network data that compares facilities based on multiple, consumer-selected criteria
- **Budgeting Tool**—Customizable budgeting and plan selection tools
- **Provider and Pharmacy Search**—Creates instant, personalized reports based on member-designed criteria such as geography, medical condition, age, or gender
- **Drug Information and Savings**—Combines member-specific benefits and cost and drug information based on Coventry’s formulary and guidelines

### C3 “Smart Payment” for more control over health care dollars

Most consumer-directed health plans comprise a health fund or health savings account, high-deductible medical coverage and access to tools that help consumers make informed decisions. Coventry Consumer Choice (C3) is a suite of personal health accounts with a Smart Payment feature that supports Coventry Health Care’s commercial, member-directed health plans.

C3’s “Smart Payment” feature enables members to manage reimbursements from their health fund by choosing the payment method that’s best for them. They decide whether the payment goes directly to the health care provider or to the consumer, and payment is sent automatically to the party selected. Payment can be sent as a check or via electronic funds transfer and deposited directly into the bank.

The C3 consumer-directed health care approach goes beyond typical industry standards to support members and help them understand how their plans work. C3’s member support services guide members through their choices, using member interactions as teachable moments and maximizing opportunities to educate them about the best use of their benefits. They assist members with topics such as account balances, transaction verification and payment status. More complex issues are handled by a team of specially trained Member-Coaches dedicated to C3. Member Coaches have access to members’ medical plans and account transaction information, and can fully explain how the benefit plan works, walk members through the decision-support tools and help the member become an informed health care consumer.



COVENTRY CONSUMER CHOICE



C3 and Smart Payment are transferable to other lines of business. CoventryCares is prepared to implement personal health account programs when DPW is ready to address the feasibility of consumer-directed health plans with MA consumers.

- 
3. Describe the management techniques, policies, procedures or initiatives you have implemented to promote health care equity (i.e., reductions in disparity in treatment and outcomes among disparate races and ethnic groups) for your members. Please provide evidence of success. Describe your strategy moving forward to improve performance in this area. (Limit to six pages)
- 

CoventryCares' approach to addressing racial and ethnic disparities at the ground level continues to be a comprehensive, multi-stakeholder strategy. This strategy includes the implementation of a cultural competency program based on the U.S. Department of Health and Human Services, Office of Minority Health standards, Culturally and Linguistically Appropriate Services (CLAS). We believe engaging providers, members, and community-based organizations is critical for reducing disparities. Data collection and analysis are equally important. We collect and use data directly from members, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and data supplied by DPW.

### Management Techniques

The management techniques highlighted below provide the necessary framework for our program:

- **Data Collection**—data collection and analysis is the first step in identifying disparities. The CoventryCares health information systems infrastructure enables us to synthesize data from external sources such as the state as well as data obtained directly from members. Performance metrics such as HEDIS measures, in addition to claims information, provide data that the plan can break into reportable groups such as race/ethnicity
- **Member-Centered and Culturally Sensitive Care**—care management programs are designed to offer member-specific, nurse-led interventions that meet the needs of the individual. Engaging members in self-management regimens is critical to improving outcomes. Educational materials are linguistically appropriate and available in languages other than English. Nurses are required to attend training on patient-centered interviewing
- **Provider Education**—encouraging culturally competent communication between provider and members, through provider education, staff training, translation services and the deployment of health education materials. Promote consistency of care through use of evidenced-based guidelines. Our Provider Training program includes training on diverse and special needs populations including how to obtain language translation services as well as sign language interpreters
- **Medical Home**—assisting members with locating a Medical Home is a crucial component in reducing disparities. Encouraging members to seek early and preventive care by establishing a relationship with a primary care physician is an integral part of our approach. Providers participating in CoventryCares' Shared Savings Program have added financial incentive to improve the outcomes



of their CoventryCares' members by PCMH certified by NCQA (details presented in Coordination of Care question #8)

- **Community Collaboration**—working within the communities to build strong relationships with key community leaders and organizations such as schools, religious organizations, YMCAs, boys and girls clubs, and legal advocates
- **Quality Improvement**—our strategy is built on the use of evidence-based guidelines, consistent measures of access, quality, cost and satisfaction, coordinated care programs, and health information technology

### ***Cultural Competency***

CoventryCares recognizes the role we play in reducing racial and ethnic health care disparities, along with other disparities such as age, sex, geographic location, and educational status. We promote member self-management and alignment of both member and provider incentives to create an environment that engages, educates and empowers the member.

Diversity training is provided to all employees at least annually through a program entitled “Footprints”, an online session that educates all employees about respecting the differences of others in the workplace. The presentation consists of a series of slides, case studies and questions that challenge and enhance each employee’s understanding of the importance of valuing and respecting co-worker’s differences. Additionally, CoventryCares provides Cultural Competency Training: a two hour e-learning course offered to providers as Continuing Medical Education through Quality Interactions.

We strive to hire bilingual member services and member outreach staff. Our member service staff helps members identify those providers who meet their cultural and linguistic needs. We track translation service requests as required by the contract. Tracking also helps to identify locations having greater needs for translation, giving us an opportunity to address provider recruitment needs and modify member materials.

The 24-Hour Nurse Line employs bilingual staff and uses translation services as well as support for those needing TTY and Relay services. The line is available for all callers 24/7. Services include a library of health education topics including the chronic diseases that affect the African American, Asian American and Latino populations. Members may access the library at any time via the telephone.



## Highlighted Programs

As a new MAe market entrant in the Southeast Zone as of April 2010, it is too early to produce data that quantifies our success. However, we have outlined below other Coventry Medicaid plans' activities and success stories that demonstrate our commitment to reduce disparities.

HealthCare USA, Coventry's Medicaid health plan in Missouri, received national recognition of their high risk OB and asthma disease management programs by URAC. The programs were finalists for URAC's Best Practices in Health Care Empowerment and Protection as part of its 11<sup>th</sup> Annual Quality Summit in October 2010. The high risk OB and asthma programs are summarized below.

*OmniCare, Coventry's Medical Assistance health plan in Michigan, is participating in the Center for Health Care Strategies, Inc.'s Reducing Disparities at the Practice Site: Detroit, Michigan. This Center for Health Care Strategies, Inc. initiative is focused on smaller provider practices and the critical role they play in caring for MA consumers. It is a three year project helping Medical Assistance agencies and health plans in four states (Michigan, North Carolina, Oklahoma, and Pennsylvania) partner with small practices to reduce racial and ethnic disparities and improve overall care.*

## High Risk OB

The mission of the high risk OB condition management program, "Beary Important Bundle", is to work in tandem with providers, the community and high risk OB members to increase the number of healthy moms and full term babies. Since 1995, HealthCare USA has improved care for members with high-risk pregnancies through, multi-disciplinary, OB condition management program. All pregnant members are assessed for any needs and referred to appropriate resources; however members with the greatest risk of poor outcomes related to preterm labor and delivery are offered enrollment.

Telephonic education and coordination of services are completed in collaboration with PCPs, OBs, Maternal Fetal Medicine Specialists, HealthCare USA Medical Directors and community resources.

In the first quarter of 2010 for members in the OB condition management program, all births were greater than 30 weeks estimated gestational age and in the second quarter only 4 births were in the 26- to 29-week category, with all others over 30 weeks. Comparing the percentage of births that were full-term in 2008 for the CMP program members to the 2010Q2 CMP members found an increase from 73.6% to 78.3% in 2010. This suggests the ongoing effectiveness of the high risk OB program in reducing the number of pre-term births. "Beary Important Bundle" was a pilot program that ended in 2010, so further analysis of this specific intervention isn't available.

## Asthma

Poor and minority children have a higher incidence and greater severity of asthma than the general population. To address this concern, in 2008 HealthCare USA in Missouri designed a project that tested whether providing a member incentive improved the rate of adherence to evidence-based guidelines to

improve member control of asthma through self-management. This decreased exacerbations that lead to ED visits, hospital admissions and work and/or school absenteeism. The incentive remains open to all members with a diagnosis of asthma and encourages members to:

- Visit their asthma health care provider
- Fill their asthma prescriptions
- Identify and educate an asthma rescue partner

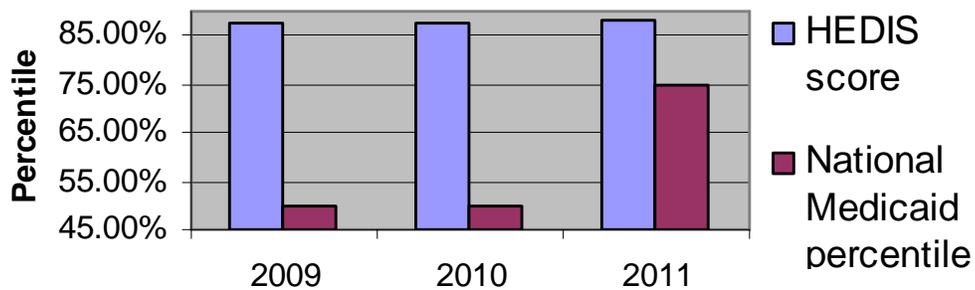
When HealthCare USA receives a completed form, the member receives a \$30 gift card.

One goal is to reduce health care disparities by improving adherence to asthma care guidelines. By improving the HEDIS measure for appropriate asthma medications we can positively impact all groups. Below are the HEDIS measure results for 2009 and 2010.

**Positive Statistics Apparent From Initial Report**

- Improved HEDIS data

**Figure 6: Use of Appropriate Medications for People with Asthma**



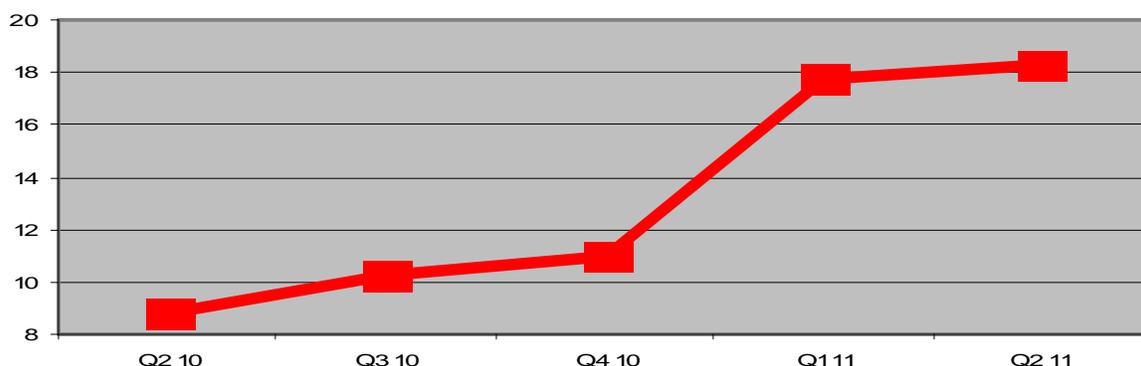
**DATA SOURCE: HEALTHCARE USA HEDIS**

- Increased use of outpatient office visits for asthma oversight

In 2010, HealthCare USA initiated quarterly monitoring of both short- and long-term indicators of improved asthma compliance and control. Increased Office Visits (OV) for asthma improve member knowledge, oversight and compliance. OV is an indicator for program success as well as a precursor to other improvements. HealthCare USA documents increasing asthma OV since the 20102Q.

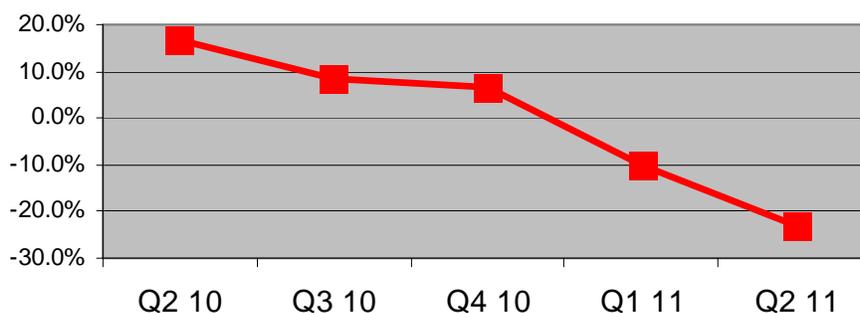


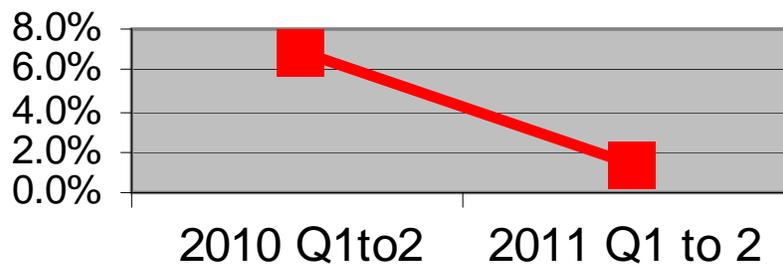
**Figure 7: Outpatient Visits/1000 Quarterly Trends 2010 and 2011**



Asthma related Emergency Department (ED) visits and admissions are the long-term indicators HealthCare USA is following. These measures, which are increasing annually, decrease only after asthma control has started improving. Though HealthCare USA didn't see immediate decreases, they did see improvement in both measures since the 20102Q. Measuring the percentage change between quarters shows the increasing rate of downward asthma ED visits and admissions/1000. This decrease in quarterly trends shows immediate and escalating decreases for admissions as documented in the chart below. Longer term, year-to-year improvements are also noted this way. As documented in the chart below, the ED visit percentage change between 2011Q1 and 2011Q2 was significantly decreased from that of the 2010Q1 and 2010Q2.

**Figure 8: HealthCare USA Asthma Admits/1000 Quarterly Trend**



**Figure 9: HealthCare USA Asthma ED Visits/1000 Year-to-Year Quarterly Trend**

### CoventryCares Strategy Moving Forward

While varying in magnitude by condition and population, disparities exist in almost all aspects of health care. CoventryCares finds that this is especially true for the population we serve. Poor health literacy, higher rates of poverty, lack of educational advantages and living in an environmentally challenged area are all factors that contribute to poor health outcomes. When layered onto the separately documented racial and ethnic health care disparities, our members are very high risk. Understanding the demographics and cultural differences of our membership, including the need for language assistance services, is essential to enhancing current programs and developing new ones.

Respecting the right of members with limited English proficiency to engage in effective communication in their preferred language is of utmost importance to CoventryCares. Our member handbook is available in all necessary languages beyond than English. We also produce audio and Braille versions, upon request. Member educational materials are also made available in alternative formats.

CoventryCares has chosen to work at the community level with hospitals, physicians, and service organizations. Working together, we can engage, educate and empower all stakeholders to improve the health and wellness of the Commonwealth's most vulnerable citizens. By embracing a grassroots, community-supported approach to identify disparities and opportunities for change, CoventryCares and our community partners can improve the health status of the communities we serve.

In addition to the implementation of our nationally recognized programs, over the course of the next three years, CoventryCares will initiate the following strategies to further meet the needs of our MA members and address our goal to reduce health disparities:

- Expand our current voluntary race and language collection
- Integrate Race/Ethnicity and Language data into the QI and reporting processes
- Implement and evaluate targeted initiatives to reduce identified disparities
- Creation of a statewide stakeholder advisory committee to review the CLAS plan and annual report
- Complete a Company wide CLAS assessment to establish our baseline
- Develop a CLAS plan to address any identified deficiencies
- Prepare and apply for NCQA Multi-cultural Health Distinction



4. Describe the management techniques, policies, procedures or initiatives you have in place to effectively and appropriately control avoidable hospital admissions. Describe your strategy moving forward to improve performance in this area. (Limit to two pages)

We use predictive modeling and provider performance software that support our Medical Management, Disease Management (DM), Case Management (CM) and Provider Pay for Performance Programs (P4P). Our ability to identify potentially avoidable admissions is key to effective overall management of inpatient utilization. The suite of analytic tools includes:

- **Coventry Care Management Tool (CMT)**-An episode-based predictive modeling and case management analytics solution designed to use clinical, risk, and administrative data to provide targeted health care services to the members at risk for admission and who may have gaps in care
- **Provider Support Tool (PST)**—A complementary solution to the CMT tool that provides select Primary Care Providers (PCPs) with comprehensive and targeted patient information to support care, health improvement and avoid admissions
- **Network Decision Support Tool (NDS)**—A decision support system that allows CoventryCares to understand trends in utilization (including emergency department (ED) visits and avoidable admissions), disease prevalence, and to create a comprehensive, high-level understanding of the value delivered by physicians, hospitals, CoventryCares' clinical programs, Shared Savings and P4P Programs

CoventryCares targets several categories of members to mitigate avoidable hospital admissions

- Chronically ill members with a high propensity for condition exacerbation and resultant admission
- Members with gaps in the physician's plan of care resulting in sub-optimal condition management
- Members with social and behavioral health needs requiring coordination of services
- Members utilizing the Emergency Department (ED) for preventive, routine or ongoing non-emergent health care needs
- Members experiencing readmissions
- Members requesting elective inpatient admissions for services that are appropriate for the outpatient setting

### ***Disease Management (DM) and Case Management (CM)***

By connecting the member, health plan, provider and outside resources, case and disease managers facilitate navigation of the medical system, and proactively prevent avoidable inpatient admissions. On a routine basis, CoventryCares members who may be using the emergency department (ED) for preventive, routine and ongoing care are identified for outreach and education by our CM and DM team to ensure they are accessing a primary care provider for non-emergent services. The member is provided access to medically necessary services with care options other than the ED. CoventryCares is currently piloting a short-term case management program to prevent admissions and readmissions. A case manager engages potential high risk members by visiting them in their home or hospital room.



### ***Shared Savings Program (SSP) and Pay for Performance (P4P)***

A key principle of our SSP is to appropriately reward participating physicians for improvements in the efficiency and quality of care. Member benefits include enhanced access to care, with open access scheduling that aids in preventing admissions. Under P4P programs, primary care providers are incentivized to educate members about the appropriate use of the ED if they have inappropriately utilized the ED 4 or more times. Each member must complete a follow-up visit with the primary care office with a clinical note documenting that the member was educated about appropriate ED use.

### ***Prior Authorization (PA) and Concurrent Review (CCR)***

We use prior authorization and concurrent review to ensure that requested services are medically necessary and performed in the most cost effective and appropriate setting. We focus on facilitating coordinated service delivery including direct admissions to a skilled nursing facility, or authorization of in-home services, in lieu of an inpatient admission whenever appropriate.

### **CoventryCares' Strategy Moving Forward**

CoventryCares will work with DPW in designing programs that are member-centered and encourage self-sufficiency and personal responsibility in health-related decisions. CoventryCares will introduce programs that will reward MA members for:

- Enrolling and maintaining participation in case management and disease management programs
- Obtaining necessary preventive care
- Complying with recommended treatment to manage chronic conditions
- Improving health and wellness by engaging in wellness activities

We may use two types of incentives to encourage members to participate in relevant programs, address chronic conditions, and maintain healthy behaviors:

- Direct to member: gift cards and population-specific products
- Savings account: points, credits or cash are accumulated to pay for co-pays, deductibles, and health and wellness equipment and services

Additionally, the Provider Support tool that supports our SSP and P4P strategic initiatives are being implemented across a broader provider population. We deployed these tools in the Southeast Zone in 2011Q2 and saw a 55% monthly decrease in year-to-year bed days and a 15% decrease in year-to-year admissions trends. Now that these approaches are in place, we would expect to achieve similar bed day and admission results in a new zone.



5. Describe the management techniques, policies, procedures or initiatives you have in place to effectively and appropriately manage the Transition of Care (TOC) for members being discharged and control hospital readmissions. Describe your strategy moving forward to improve performance in this area. (Limit to two pages)

## Management Techniques

CoventryCares employs coordinated, patient-centered management techniques, procedures and initiatives to appropriately manage the Transition of Care (TOC) for members being discharged and to control hospital readmissions. Techniques include concurrent review and discharge planning, TOC management, case management, emergency services oversight, and provider engagement.

## Procedures

- **Concurrent Review and Discharge Planning**—For members admitted to an acute, rehabilitation or skilled nursing facility, discharge planning begins on day one. In tandem with facility discharge planners, CoventryCares concurrent review staff and case managers develop a person-centered and specific discharge plan that encourages treatment plan compliance and self sufficiency.
- **TOC Management**—Members admitted to a hospital, rehabilitation or skilled nursing facility and preparing for transition to another setting are evaluated for TOC management. Members with chronic illnesses are first engaged by case managers while hospitalized or within 48 hours of discharge. Members are followed intensively post-discharge. They receive comprehensive post-discharge instructions on medications, self-care, as well as symptom recognition and management. They are reminded and encouraged to keep follow-up physician appointments. Additional interventions include:
  - Treatment plan compliance evaluation
  - Medication reconciliation
  - Initiation of personal health record for members to self-manage their medical needs
- **Case Management (CM)**—Members with ongoing complex needs and discharge planning needs are referred to our case management program for regular follow up and support post discharge. CoventryCares CM staff receives system generated flags on a daily basis for individual members who have been admitted three or more times in a rolling twelve month period. A follow up call by the CM is made within 72 hours of discharge to discuss and assess adherence to the discharge plan. Monthly summary reports of multiple admission activity assist in identifying potential increases or decreases in members with multiple admissions or the number of admissions/member. Additionally, CM outreach occurs to members identified as routinely using the ED for same or similar diagnosis to ensure they are accessing a primary care or specialty provider for preventive and ongoing care. Case managed members are monitored for gaps in care using system based analytic and predictive modeling tools. The screen shot from our Care Management Tool (CMT) displays for the case manager the member's future risk for an admission.



Risk Months rolled	Age	Future Risk	Future Risk, Inpatient	P (A)
11	22	0.39	0.58	
12	15	1.55	0.44	
12	18	2.89	1.00	
12	16	0.33	0.44	
12	13	0.22	0.44	
12	46	0.48	1.10	
12	52	0.39	0.98	

*The higher the score, the more likely a member will be admitted for an inpatient stay.*

**Provider Engagement- Shared Savings Program (SSP) and Pay for Performance (P4P)**

Key principles of our SSP and P4P programs are to reward providers who:

- Participate in a High-Performance Network (HPN)
- Attain improvements in the efficiency and quality of care through:
  - Avoidance of readmissions
  - Reduction in ED visits
  - Collaborative care coordination

CoventryCares uses a Network Decision Support (NDS) tool to understand trends by provider in utilization (including ED visits and avoidable admissions), disease prevalence, and to create a comprehensive, high-level understanding of the value delivered by physicians, hospitals, CoventryCares’ clinical programs, SSP and P4P Programs.

**CoventryCares’ Strategy Moving Forward**

To maximize performance in these areas, improve our programs and increase provider engagement in the SSP and P4P programs we will evaluate on an ongoing basis, the opportunity of adding expanded services such as office based case managers. We will also work with DPW to design member-centered programs that encourage self-sufficiency and personal responsibility in health-related decisions:

- Enrolling and maintaining participation in CM and DM programs
- Obtaining necessary preventive care
- Complying with recommended treatment to manage chronic conditions
- Improving Health and Wellness by Engaging In Wellness Activities



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6. Describe how you encourage provider usage of electronic medical records. (Limit to four pages)

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**Current Initiative for Electronic Medical Record (EMR)**

***Grants***

CoventryCares will address the EMR needs of physician offices located in rural areas of the New West and New East Zones through grants. Physician offices located in rural areas will be eligible for an EMR grant based on our evaluation of need. CoventryCares has allocated \$100,000 for these grants (\$50,000 for each zone) over the life of the contract.

***Pay-For-Performance Initiatives***

CoventryCares encourages electronic medical records (EMR) development monetarily through its pay-for-performance initiatives. As part of the Shared Savings Program (SSP), CoventryCares' Patient Centered Medical Home (PCMH) program, the select PCP practices are paid a quarterly care management fee. We encourage practices to utilize a portion of this fee to assist in the funding of the procurement and installation of an electronic medical record system. In addition, CoventryCares has a pay-for-performance program, which reimburses practices for specific quality initiatives. These monies can also be utilized for the purchase/installation of an electronic medical record system.

***Provider Contractual Obligation***

As CoventryCares continues to develop profiling tools and reports to aid the physician in the care of the members, we are looking at ways to integrate EMRs into the reporting workflow to reduce the number of non-interactive reports generated. CoventryCares recognizes there is increased quality and decreased costs with the use of EMRs in physician offices and hospitals. As a result we have recently incorporated the following contract language in our provider contracts to address the exchange of member information using EMRs: "Provider agrees to cooperate with Coventry or Payor on the reporting of performance measures, including but not limited to Healthcare Effectiveness Data and Information Set (HEDIS) measures, measures reported to URAC and NCQA, and measures related to federal or state-specific reporting. Provider agrees to provide medical records to Coventry or Payor upon request if the period for which HEDIS information is needed overlaps with the period for which a Covered Individual is or was enrolled with Coventry or a Payor. Provider agrees to provide this information in the format requested by Coventry, including either copies of medical records, or on-site access to both paper and electronic records. Provider agrees to work with Coventry to identify the most efficient means for gathering medical records, including options for remote access to electronic medical records and electronic data exchange from the electronic medical record.

***Support of EMR Implementation***

CoventryCares supports the exchange of data between CoventryCares and provider through DirectProvider.com. Using DirectProvider.com, a provider can view a member's Personal Health Record (PHR), which includes claims for:

- Pharmacy



- Radiology and diagnostic testing
- Lab data
- ED visits
- Specialty visits
- Outpatient procedures
- Hospitalizations

Also reported are referrals and authorizations for which CoventryCares is expected to be the payor. In addition, the PHR includes member-entered personal health information, including:

- Usage of medication, including over-the-counter and/or homeopathic, self-administered treatment
- Allergies
- Immunizations history
- Family history
- Member-reported results such as weight, blood pressure, and blood glucose

This functionality is provided at no cost to CoventryCares providers. Figure 10 shows the DirectProvider.com home page.

**Figure 10: DirectProvider.com Home Screen**





*Navigator Care*, CoventryCares' case management system, captures not only transactional information, but also clinical values and case plans for members. These case plans are also available for viewing by participating CoventryCares providers through DirectProvider.com.

CoventryCares' approach with EMRs will be the same used to encourage the use of the electronic submission of claims—combining provider education with financial incentives. We currently hold office in-services and also include articles on EMR in newsletters and Fax Blasts. In addition, we will work closely with the Commonwealth on any Pennsylvania-specific programs concerning the implementation of EMRs.

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7. Describe your plan's approach to utilization management, including:

- Lines of accountability for utilization policies and procedures and for individual medical necessity determinations;
- Data sources and processes to determine which services require prior authorization and how often these requirements will be re-evaluated;
- Process and resources to develop utilization review criteria;
- Prior authorization processes for Members requiring services from non-participating providers or for members who require expedited prior authorization review and determination due to conditions that threaten the Member's life or health; and
- Processes to ensure consistent application of criteria by individual clinical reviewers. (Limit to six pages)

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### **Approach to Utilization Management**

CoventryCares provides coverage for all services that are medically necessary. We will determine medical necessity when we receive an order or a request for a service from the MA member's treating physician. CoventryCares considers each request based on each individual MA member's covered benefits, clinical presentation and local delivery system. The type, scope, frequency, intensity, and duration of a medical item or service must:

- Meet DPW definition of medical necessity
- Not exceed the member's need
- Be consistent with the member's diagnosis and treatment
- Encourage self-sufficiency and personal responsibility

### **Lines of Accountability for Utilization Policies and Procedures and for Individual Medical Necessity Determinations**

Prior authorization, concurrent review and case management are techniques employed by the utilization management department to ascertain that healthcare services are provided at the highest level quality of



care. The CoventryCares Health Services department is composed of a team of clinical and other professionals who serve in the capacity of coordinators or facilitators of medical care and social services for the MA membership. The department's organizational chart details the hierarchy of operations and responsible supervisory personnel.

The health services team is comprised of:

- **Chief Medical Officer (CMO)** has overall responsibility for statewide medical management programs including the development and implementation of the strategic medical management plan and quality improvement programs. The CMO reports to the Chief Executive Officer of the Plan.
- **Medical Assistance Medical Director** is accountable to coordinate, advise, and execute decisions related to policy and procedures and implementation of the Health Services Program. The Medical Director provides clinical direction and support to the Health Services Department and peer review of referred cases for medical appropriateness determinations and quality of care issues. Only a Medical Director has the authority to render a medical necessity denial. The Medical Director may consult with specialists for expert clinical opinions in order to render a definitive determination. CoventryCares has access to all Coventry-employed, board-certified physicians for assistance with reviews and decisions. Through a corporate contract with independent review organizations, the Medical Director can alternatively consult with board-certified physicians possessing appropriate clinical expertise in treating an MA member's condition or disease. The Medical Assistance Medical Director reports to the Chief Medical Officer.

Peer-to-peer discussions enhance communication between the Medical Director and the physician community and promote provider and MA member satisfaction. A peer-to-peer discussion is an opportunity for the Medical Director and the treating physician to review additional clinical aspects of a case and the local standards of practice. These discussions may lead to a reversal of an adverse determination. A peer-to-peer discussion may also help distinguish appropriate alternatives to a service that was not authorized.

- **Vice-President of Health Services** is a registered nurse who is responsible for the strategic direction, management, and oversight of the operations of the Health Services Department. Additional responsibilities include the overall coordination, implementation and monitoring of activities to yield quality driven, compliant, efficient and cost effective results. The Vice-President of Health Services reports directly to the Chief Operating Officer.
- **Directors of Health Services** are registered nurses who are responsible for oversight of the various medical services programs, i.e., all utilization review, prior authorization and complex case management activities. The Directors of Health Services report to the Vice President of Health Services.
- **Manager of Health Services** is a registered nurse who is responsible for day-to-day operations of the medical management division and staff of the Health Services Department. This individual is accountable for monitoring, evaluation, and improving the performance of the prior authorization process, as well as training of the staff. The Manager reports to the Director of Health Services.
- **Manager of Prior Authorizations** reports to the Director of Health Services and is responsible for the day-to-day operations of the prior authorization division and the prior authorization



representatives. This individual is accountable for monitoring, evaluating, and improving the performance of the prior authorization and referral process.

- **Prior Authorization Supervisors** are responsible for the daily supervision of prior authorization to include the telephone/fax authorization and retrospective claim review processes. He/She serves in an active managerial role to assist in the development, implementation and evaluation of the utilization management process. The Prior Authorization Supervisor (s) reports to the Manager of Prior Authorizations.
- **Concurrent Review Supervisors** are registered nurses responsible for the daily supervision of concurrent review to include the telephone/fax authorization and retrospective claim review processes. They serve in an active managerial role to assist in the development, implementation and evaluation of the utilization management process. The Concurrent Review Supervisor(s) report to the Director of Health Services.
- **Case Management Supervisors** are registered nurses responsible for the daily supervision of case management to include all case management / member outreach programs. He/She serves in an active managerial role to assist in the development, implementation and evaluation of the case management process. The Case Management Supervisor(s) report to the Director of Health Services.
- **Complex Case Managers** are registered nurses responsible for the assessment, planning, implementation, coordination, monitoring, and evaluation of options and services to meet an individual MA member's health care needs. The Complex Case Managers report to the Case Management Supervisors.
- **Concurrent Review Coordinators** are registered nurses who are responsible for the utilization management of the hospitalized MA member. These individuals also assist in discharge planning. The Concurrent Review Coordinators report to the Concurrent Review Supervisors.
- **Prior Authorization Coordinators** are Registered Nurses or Licensed Practical Nurses who are responsible for the prior authorization process including elective inpatient admissions, outpatient services and durable medical equipment. This position reports to the Manager of Health Services.
- **Prior Authorization Representatives** perform assigned duties, including telephonic interaction with providers, building prior authorization transactions for medical review, contacting specialty care providers, and monitoring member eligibility. This position reports to the Manager of Prior Authorizations.

### **Data Sources and Processes to Determine Which Services Require Prior Authorization and How Often these Requirements Will be Re-Evaluated**

The foundation of CoventryCares utilization management program is the series of NCQA accredited policies and procedures that guide daily operations and program updates. These policies and procedures are governed by the CoventryCares UM/QI committee that oversees, evaluates and monitors the results of activities and reports to the HealthAmerica (CoventryCares) board of directors. All services requiring authorization policies and procedures are evaluated for continuing applicability annually, or more frequently, if necessary. These policies and procedures are also submitted to DPW's Prior Authorization Review Panel for review and approval on at least an annual basis and with any updates or changes.



### Services Requiring Prior Authorization

CoventryCares requires prior authorization on services where there is high cost, high technology and over-utilization or abuse patterns. Services requiring prior authorization include:

- Inpatient Facility admissions: acute, rehabilitation and Skilled Nursing Facility (SNF)
- Physical therapy, speech therapy and occupational therapy
- Home Health Services
- Hospice
- Outpatient surgery
- Outpatient diagnostics
- Pulmonary/Cardiac rehabilitation
- Non-emergency ambulance transport
- Durable Medical Equipment/ Orthotics/prosthetics
- Observation Care
- Experimental/Investigational services
- Supply sensitive, high technology radiology services- MRIs, MRAs, CT scans, PET scans
- Care (non-emergent) provided by out-of-network providers

Providers can determine which procedures require prior authorization by visiting [Direct Provider.com](http://Direct.Provider.com).

Policies and procedures guide the Health Services Department in evaluating medical necessity and in approving medical services within the scope of benefit coverage. The policies and procedures of the Utilization Department are reviewed and updated as needed, and at a minimum on an annual basis, through the Utilization Management/Quality Improvement (UM/QI) Committee. National criteria sets, such as InterQual, are updated annually by licensed contract. Information system updates and any materials associated with the national vendor are distributed to the staff as the annual updates are received. Additionally, on an annual basis the UM/QI Committee reviews and endorses the plan's continued use of the InterQual Criteria Sets for each upcoming year.

### Process and Resources to Develop Utilization Review Criteria

The decisions and actions of the Utilization Management Department team are based on medical practice standards and guidelines, employer and government contracts/agreements, and state/federal law and regulations. CoventryCares utilization program assures that inpatient and outpatient resources are used in an efficient, cost effective manner. We make our medical management decisions based on sound medical evidence that is reviewed at least annually and updated as new criteria are released. To assist in making determinations, CoventryCares uses InterQual criteria, technology assessments developed by Coventry, and Medical Director judgment.

The criteria, policies and procedures used by the Utilization Management Department include:



- InterQual’s Review Systems (ISD, SAC/SNF, ISP, ISX, and DME criteria sets)
- Utilization Management Department Policy and Procedure Manual
- CoventryCares Clinical Guidelines
- Coventry Policy and Procedures
- Coventry Technology Assessments

Annually and on an as-needed basis CoventryCares UM/QI Committee reviews and updates the policy and procedure manual and clinical guidelines. Our committee has internal medical director representation and provider network physician input. Recently, network specialist providers collaborated with the CoventryCares medical director to develop enhanced criteria for knee and hip replacement surgeries, in-home sleep studies and elective cardiac catheterization procedures. This approach provides CoventryCares clinical insight from the field experts, cooperation with the prior authorization programs, and establishes professional relationships. We believe that use of standardized criteria and evidence based guidelines is in the best interest of our MA members.

**Prior Authorization Processes for Members Requiring Services from Non-Participating Providers or for Members Who Require Expedited Prior Authorization Review and Determination Due to Conditions that Threaten the Member’s Life or Health**

- *Out-of-Network*—The Utilization Management nurse will investigate the out-of-network request and collect the clinical information. Service requests of this type must include: the out-of-network provider being requested, service being requested, anticipated course of treatment, detail on the rationale services are necessary with the non-network provider, any in-network options available and any explanations of extenuating circumstances or additional detail.

The requests are forwarded to the medical director for review and determination. Determinations by the medical director for coverage of out-of-network care are considered medical necessity determinations and follow the process of medical director review for medical necessity. Each request is given individual consideration and review.

- *Expedited*—In the event that the provider requests prior authorization before rendering services for a life or health threatening situation, CoventryCares prior authorization team will take the request and apply criteria for a determination. If clinical detail is not readily available, the requestor may also fax the information, where it is immediately reviewed by a nurse. If a determination to approve cannot be made based on the criteria, the nurse escalates the discussion to a medical director to obtain the medical necessity determination.

CoventryCares overarching goal in utilization management is to provide a gateway to high quality health care services through a coordinated network of specialists, facilities and other healthcare providers. Our medical necessity review process is not intended to limit service, but rather to better assure that our members receive medically necessary, quality care that meets or exceeds the highest nationally accepted standards and benchmarks in the most appropriate and least restrictive setting. CoventryCares has an in-depth understanding and respect for the challenges and opportunities of serving low-income and complex needs populations. CoventryCares collaborates and shares best practices with subject matter experts, expedites the integration of Federal (CMS) and State (DPW



and DOH) regulations, and partners with local community-based stakeholders to implement programs efficiently and effectively that positively impact the Commonwealth's MA consumer population.

### **Processes to Ensure Consistent Application of Criteria by Individual Clinical Reviewers**

CoventryCares ensures the appropriateness of our decisions and the consistent application of criteria by individual clinical reviewers through:

- Employment of appropriately licensed clinical professionals with appropriate experience
- Intensive training of clinical staff and ongoing monitoring of individual decision-making and member service skills
- Online medical necessity criteria, policies and procedures for authorization, regulations and standards
- A clinical management system that facilitates accurate documentation
- Inter-rater reliability reviews and case audits for nurses and Medical Directors
- Daily intensive integrated case reviews with Medical Directors, Case Management, Special Needs Unit, and Concurrent Review staff
- Monitoring of over- and under-utilization
- NCQA review which includes audits on medical necessity determinations and inter-rater reliability

The management staff of the Health Services department has direct responsibility for ensuring that prior authorization, case management, disease management and concurrent review nurses correctly and consistently apply UM criteria and guidelines.

Inter-rater reliability studies are conducted for all professional staff involved in the UM decision making process. Each reviewer is required to select the appropriate criteria/guideline and make decisions based on their application of coverage criteria. Reviewers scoring below the minimum standard of 85% are provided additional education and testing to verify the reviewer can competently apply the criteria. In addition, the Health Services Department's performance is assessed at least annually to identify knowledge deficit trends and opportunities for improvement. If 25% of the staff members fail to respond correctly, a global knowledge deficit is assumed and subsequent additional training and re-testing for the entire staff is carried out. HealthAmerica has received passing NCQA scores on the inter-rater reliability standard for each of our NCQA accreditation reviews, and most recently for our CoventryCares product. We maintain a firm commitment to quality reviews and determinations.



### ***Clinical Performance Measures***

1-14 (answers to be provided using Appendix K(1), K(2), or K(3) Provide HEDIS® rates for the following 14 measures:

1. Controlling High Blood Pressure
2. Comprehensive Diabetes Care: HbA1c Poorly Controlled
3. Comprehensive Diabetes Care: LDL Control <100
4. Prenatal Care in the First Trimester
5. Frequency of Ongoing Prenatal Care: >81 Percent of the Expected Number of Prenatal Care Visits
6. Breast Cancer Screening (Ages 42-69 years)
7. Cervical Cancer Screening (Ages 24 to 64 years)
8. Cholesterol Management for patients with Cardiovascular Conditions: LDL-C Controlled<100
9. Annual Dental Visits (Ages 2-21 years)
10. Well-Child Visits in the First 15 Months of Life
11. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
12. Adolescent Well-Care Visits
13. Lead Screening in Children
14. Emergency Department Utilization

The HEDIS® rates for the 14 measures above must be provided as follows:

- Offerors currently participating in the HealthChoices Program who have been participating in the HealthChoices Program prior to April 1, 2010 should provide 2009 and 2010 HealthChoices HEDIS® rates for the HEDIS® performance measures displayed in Appendix K(1).
- Offerors currently participating in the HealthChoices Program who began participating on or after 4/1/2010 and Offerors who operate as a Commercial Pennsylvania HMO, must provide 2009 and 2010 HEDIS® rates for the HEDIS® performance measures displayed in Appendix K(2) for a Commercial line of business as an HMO in Pennsylvania.



- Offerors who do not participate in the HealthChoices Program and who do not operate as a Commercial HMO in Pennsylvania must provide 2009 and 2010 HEDIS® rates for the HEDIS® performance measures displayed in Appendix K(3) for one Commercial HMO line of business they operate in another state. A Commercial HMO line is the commercial product line for the following: the Offeror, a related party possessing at least 50% common ownership, or any parent company of either the Offeror or the related party. If the commercial product lines are operated by a related party or a parent company, the Offeror must provide information on the extent of overlap between key managers and organizational units whose work affects the HEDIS scores.

CoventryCares began participating in the HealthChoices Program on 4/1/2010 and operates as a Commercial Pennsylvania HMO. Appendix K (2) is attached as **Attachment 14** and provides the required HEDIS data for the commercial population. The only HEDIS measures not included in the attachment, that are included in the MA HEDIS measures, are:

- 9. Annual Dental Visits (Ages 2–21 years)
- 13. Lead Screening in Children

## 15–26. Proposed Strategies and Approaches

### Management of Clinical Performance Measures

CoventryCares recognizes the importance and challenges of ensuring members in rural service areas access appropriate preventative health care. To assist both members and providers in this area CoventryCares uses a multi focal approach.

#### *Member Education*

Member education empowers MA members with an understanding of recommended care. Member education is available:

- In focused Disease Management programs
- In general member materials
- On the member web portal
- From a member's PCP

To help ensure participation in member focused programs, CoventryCares will work with DPW in designing programs that are member-centered and encourage self-sufficiency and personal responsibility in health-related decisions. CoventryCares will proactively manage and continually measure the care MA members receive to ensure it meets or exceeds the highest nationally accepted standards. CoventryCares will introduce programs that will reward MA members for:

- Enrolling and maintaining participation in case management and disease management programs.



- Obtaining necessary preventive care, such as mammograms, wellness visits, dental and eye care visits
- Complying with recommended treatment to manage chronic conditions, such as diabetes
- Using online decision-support tools and CoventryCares call centers to increase the use of appropriate health care services

### ***Member Incentives***

We may use two types of incentives to encourage members to participate in relevant programs, address chronic conditions, and maintain healthy behaviors:

- Direct to member: gift cards and population-specific products
- Savings account: points, credits or cash are accumulated to pay for co-pays, deductibles, and health and wellness equipment and services

### ***Provider Incentives***

An incentive for providers to reach out to members with gaps in care is our CoventryCares Shared Savings Program. The program is defined in Coordination of Care (question #8). Key to the program is a requirement to achieve targets in each provider P4P measure.

### ***Member Identification***

In addition to member education and incentives CoventryCares has two data mining tools available to identify members who have not had recommended care. These tools are used to focus health plan and provider outreach toward members needing care.

- **Network Decision Support Tool (NDS)**—NDS is used to search our data warehouse and develop provider specific, gaps in care reports. These gaps in care reports can either be used by the health plan for targeted outreach or given to the Members PCP for follow up.
- **Provider Support (PST)**—PST is available to select PCPs in a web application and can be accessed directly from a contracted provider's office. With the PST a provider is able to identify individual members assigned to their practice that are in need of preventative care and provide appropriate outreach.

### **Forward-Thinking Approach**

This is our general approach to identify and assist members to access needed care. Details for recommended care in rural areas are provided for each measure.

While this approach will enhance our management of these Clinical Performance Measures for MA members, our current commercial HEDIS and NCQA scores are a testament to our success in encouraging all members to access care. In 2011 our quality results are:

- NCQA onsite review and HEDIS score resulted in an Excellent Accreditation



- Commercial Health Plan is ranked 30th in the nation and remains one of the highest rated health insurance plans according to NCQA Private Health Insurance Plan Rankings, 2011-2012

We look forward to this same level of success with our MA member population.

### Next Steps

CoventryCares will continue to investigate new and innovative methods, including telemedicine and mobile vans, to address the specific needs of the rural MA population. In addition, CoventryCares realizes that many of our programs being designed for rural populations may also benefit suburban and urban MA populations, and we plan to explore the feasibility of transferring variations, elements or entire programs to the rest of our Pennsylvania membership.

### Clinical Performance Measure Questions 15–26

Specifics for each of the clinical performance measure questions (15–26) follow.

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15. Describe your proposed strategy for controlling high blood pressure in members who reside in a rural service delivery area who are ages 18 to 85 years old and have been diagnosed with hypertension. (Limit to two pages)
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Hypertension affects 29% of Pennsylvanians and the prevalence is increasing.<sup>1</sup> Of those with hypertension, only 78% are aware of their diagnosis and only 68% are under treatment.<sup>2</sup> Of those treated, only 64% have blood pressure less than 140/90, which is still not fully controlled.<sup>2</sup> That leaves almost 50% of those with hypertension at risk for complications such as stroke and heart attack.

### Identification

As described in the Clinical Performance Measures introduction, CoventryCares suite of analytic tools provides key information allowing us to assist members towards successful self-management of their hypertension. The Coventry Care Management Tool identifies members lacking recommended care, who can then be accessed by both the plan and the PCP using our Provider Support Tool. This allows complementary review for untreated members. Member previously unknown to have hypertension are also identified through:

- Daily Case Rounds with staff from all Health Services Departments
- Care Managers through communication with members and providers

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1 *Healthy People State Data Set. Healthy People 2020.* Pennsylvania Department of Health. Harrisburg, PA. Accessed from the World Wide Web on January 1, 2012 @ [http://www.portal.state.pa.us/portal/server.pt/community/health\\_statistics/14136](http://www.portal.state.pa.us/portal/server.pt/community/health_statistics/14136)

2. *Hypertension awareness, treatment, and control—continued disparities in adults: United States, 2005–2006.* NCHS Data Brief No. 3. Hyattsville, MD: National Center for Health Statistics; 2008.



- Provider referrals and member self-referrals

## Problems and Solutions

Once diagnosed, obstacles to achieving blood pressure control include lack of symptoms, knowledge and monitoring resources, and inability to self-manage. In rural settings obstacles are greater due to all travel distances, solo-practice PCPs with limited time and assistance for patient education, and restricted access to other informational resources. CoventryCares will create programs specifically designed to assist members in rural populations progress towards self-management of their hypertension.

- **Access Tools**—Using Geo Access tools CoventryCares will assess locations of both providers for and members with hypertension. Identifying areas with high numbers of hypertensive members and low numbers of available providers, we will provide up to two home health Skilled Nursing Visits for each member, who will assess the member’s clinical condition and create a coordinated plan of care with the member’s PCP.
- **Education**—The skilled Nursing Visits will include education on the disease process, consequences and opportunities for the member to assist in management. If the nurse assesses a member requires additional, medically necessary Skilled Nurse Visits due to specific circumstances such as language difficulties, a request can be sent to CoventryCares Case management/Special Needs Unit (SNU) with documentation of the issues.
- **Ongoing Monitoring:** Using the blood pressure monitor and cuff, routine telephonic supervision with the PCP will be established. Providers will have incentives to comply with this program for several reasons:
  - Telephonic monitoring can be accomplished predominantly through office staff communications. The physician is responsible to check the transcribed numbers and adjust medications as needed.
  - The program supports CoventryCares’ P4P hypertension incentives with documentation of improved control
  - Providers participating in CoventryCares’ Shared Savings Program have added financial incentive to improve the outcomes of their CoventryCares’ members

Each member will be given the name and telephone number of a CoventryCares Case manager to contact if issues or concerns arise.

## Next Steps

Using our suite of analytic tools, CoventryCares will work toward collaboration with the PCPs to assess both the compliance and outcomes of members using these services. Possible data sources include pharmacy claims and blood pressure trends. These could be compared to CoventryCares yearly HEDIS results and members with similar disease levels who are not using these services, both in and outside of rural service areas.



16. Describe your proposed approach to achieve appropriate HbA1c control and cholesterol management for members with diabetes who reside in a rural service delivery area. (Limit to two pages)

Diabetes affects over 10% of Pennsylvanians. This is higher than the national prevalence, of less than 9%.<sup>3</sup> It's the seventh leading cause of death, but is a contributing cause for twice as many deaths.<sup>4</sup> Of those with diabetes, only 73% are diagnosed.<sup>4</sup> Diabetes is the leading cause of kidney failure, foot and leg amputation, and new-onset blindness for adults, and increases the risk for many other diseases such as heart attack and stroke.<sup>4</sup> A known risk factor for diabetes is poverty; the lower one's income, the greater the chance of eventually being affected by diabetes.<sup>5</sup>

### Identification

As described in the Clinical Performance Measures introduction, CoventryCares suite of analytic tools provides key information allowing us to assist members towards successful self-management of their diabetes and cholesterol. The Coventry Care Management Tool identifies members lacking recommended care, who can then be accessed by both the plan and the PCP using our Provider Support Tool. This allows complementary review for untreated members. Member previously unknown to have diabetes are also identified through:

- Daily Case Rounds with staff from all Health Services Departments
- Case managers through communication with members and providers
- Provider referrals and member self-referrals
- Behavioral Health Referrals

### Problems and Solutions

Diabetes control can be measured with quarterly HGBA1C levels. Maintaining accepted cholesterol levels is key to preventing heart attacks and strokes associated with diabetes.

Once diagnosed, obstacles to achieving diabetes and cholesterol control include lack of monitoring resources, high cholesterol symptoms and regular blood tests. In rural settings obstacles are greater due to all travel distances, solo-practice PCPs with limited time and assistance for patient education, and restricted access to other informational resources. CoventryCares will create programs specifically designed to assist members in rural populations progress towards self-management of their diabetes and cholesterol.

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3 *Statehealthfacts.org*. Kaiser Family Foundation. Accessed from the World Wide Web on January 1, 2012 @ <http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=2&rgn=40&ind=70&sub=22>

4 *Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011. Accessed from the World Wide Web on January 1, 2012 @ [http://www.cdc.gov/diabetes/pubs/pdf/ndfs\\_2011.pdf](http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf)

5 *The burden of diabetes in Pennsylvania, 2010. Behavioral Risk Factors Surveillance System*. Pennsylvania Department of Health. Harrisburg, PA.



- **Access Tools**—Using Geo Access tools, CoventryCares will assess locations of both providers for and members with diabetes. Identifying areas with high numbers of diabetics and low numbers of available providers, we will provide up to two skilled nursing visits for each member who will assess the member’s clinical condition and create a coordinated plan of care with the member’s PCP.
- **Education**—The series of American Diabetic Association education classes at hospitals or community health centers are difficult in rural areas due to the distant travel. The skilled nursing visits will include this standard education as well as opportunities for the member to assist in management. If the nurse assesses a member requires additional, medically necessary Skilled Nurse Visits due to specific circumstances such as language difficulties, a request can be sent to CoventryCares Prior Authorization with documentation of the issues.
- **Facilitating Self-Management**—The nurse will provide a glucose monitor and instruct on its use at the first visit. At the second visit, the nurse will assess proper use of the equipment and disease knowledge. If appropriate, blood will also be drawn for HGBA1C and cholesterol testing during any visit. We will also team up with local businesses to offer incentives as described in the Clinical Performance Measures introduction, to encourage members to comply with recommended treatment to manage chronic conditions.
- **Ongoing Monitoring**—Using the glucose monitor, routine telephonic supervision with the PCP will be established. Skilled nursing visits will be approved without Prior Authorization every three months to obtain blood samples. Medically necessary skilled nursing visits required more frequently than every three months can be arranged through Case Management/SNU.

PCPs will receive incentives to comply with this program for these reasons:

- Telephonic monitoring is done predominantly through the office staff. The physician is responsible to note and respond to results as needed.
- CoventryCares’ P4P incentives support the documentation of improved control and of members’ diabetes and cholesterol.
- Providers participating in CoventryCares’ Shared Savings Program have added financial incentive to improve the outcomes of their CoventryCares’ members (details presented in Coordination of Care question #8).

Each member will be given the name and telephone number of a CoventryCares Case manager to contact if issues or concerns arise.

If a nurse is making visits to members in an area distant from facilities and where diabetics are due for blood tests, CoventryCares will arrange for the nurse to also draw blood at the diabetics’ homes, when appropriate.

## Next Steps

Using our suite of analytic tools, CoventryCares will work toward collaboration with the PCPs to assess both the compliance and outcomes of members using these services. Possible data sources include pharmacy claims, lab claims, and HGBA1C and cholesterol results. Lab results and medication fills could be compared to CoventryCares yearly HEDIS results and members with similar disease levels who are not using these services, both in and outside of rural service areas.



17. Describe the proposed approach you will use to care manage pregnant women in rural service delivery areas to ensure they receive prenatal care in the first trimester and to ensure they receive “81 percent or greater” of the expected number of prenatal care visits. (Limit to two pages)

In Pennsylvania, 72% of all mothers started prenatal care in the 1<sup>st</sup> trimester vs. 83% nationwide.<sup>6</sup> The percentage of Pennsylvania women receiving timely prenatal care has been decreasing since 2004.<sup>7</sup> Only 66% of Pennsylvania women received adequate prenatal care throughout their pregnancy.<sup>7</sup> These statistics put Pennsylvania newborns at risk for complications such as preterm deliveries and low birth weight, which can lead to lifelong medical problems.

### Identification

The first step in successful care management of pregnancy in rural areas is the early identification of pregnant members. CoventryCares identifies member through:

- Pennsylvania Medical Assistance Obstetric Needs Assessment Forms (ONAF)
- Daily Case Rounds with staff from all Health Services Departments
- Case managers through communication with members and providers
- Provider referrals and member self-referrals

### Problems and Solutions

Once identified, obstacles to achieving successful care management of pregnancy include difficulty arranging a timely initial appointment and the inconvenience of attending the numerous appointments, especially if the member has experienced previous normal pregnancies and is caring for other children. In rural settings obstacles are greater due to travel distances and the shortage of Obstetricians in Pennsylvania that often increases the travel requirements.

CoventryCares will work with local facilities, providers, the other MCOs serving the Zones and ACCESS Plus to collaboratively implement regional Centering Prenatal Care sites.

Centering Prenatal Care is group prenatal care provided by a Certified Registered Nurse Midwife (CRNP). The groups meet monthly for at least an hour. Each meeting is focused on a relevant pregnancy topic introduced and explained by the CRNP. Group members are given the opportunity to ask question, exchange information and viewpoints, and express their own feelings about the topic, as well as any other issues they have. During the session, each woman is escorted by an aide to weigh and measure herself, dip her urine sample, and use the ultrasound or stethoscope to hear her baby’s heartbeat. Centering Prenatal Care has been proven through evidence based studies to have improved birth outcomes vs. traditional prenatal care.

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<sup>6</sup> *Statehealthfacts.org*. Kaiser Family Foundation. Accessed from the World Wide Web on January 1, 2012 @ <http://www.statehealthfacts.org/profileind.jsp?ind=44&cat=2&rgn=40&cmprgn=1>

<sup>7</sup> *Healthy People State Data Set. Healthy People 2020*. Pennsylvania Department of Health. Harrisburg, PA. Accessed from the World Wide Web on January 1, 2012 @ <http://www.portal.state.pa.us/portal/server.pt?open=514&objID=590079&mode=2>



- **Access Tools**—By providing many appointments on the same day, transportation is easier to arrange and members are able to share the more costly transportation resources often required in rural areas.
- **Education**—Centering Prenatal Care is proven to have greater patient satisfaction and the resultant improved information retention vs. traditional prenatal care

In Philadelphia, a coalition of Obstetricians meets on a regular basis to discuss issues such as early and comprehensive prenatal care. CoventryCares looks forward to working with Obstetricians in the New West and New East Zones to arrange an appropriate venue for similar discourse. We continue our educational efforts through case management, written materials, community support, and much more.

- **Facilitating Self-Management**—The member’s self-examination empowers her to own her pregnancy. Expressing her health care views and experiences to the group increases self-esteem. We will also team up with local businesses to offer incentives as described in the Clinical Performance Measures introduction, to encourage members to comply with recommended standards for management of pregnancy.
- **Ongoing Monitoring**—Centering Prenatal Care has been proven through evidence based studies to have better compliance with appointments and improved birth outcomes vs. traditional prenatal care.

### Next Steps

Using our suite of analytic tools, CoventryCares will work toward collaboration with the Obstetricians to assess both the compliance and outcomes of members using these services. Possible data sources include lab, provider and hospital claims, and ONAF forms. Results will be the number of women receiving early prenatal care and the percentage of completed vs. recommended visits for pregnant members. These will be compared to CoventryCares yearly HEDIS results and pregnant members not using these services, both in and outside of rural service areas.



18. Describe the approach you will use in a rural service delivery area to ensure access to mammograms to screen for breast cancer for women ages 42-69 years old. (Limit to two pages)

On any given day in Pennsylvania, 25 women were diagnosed with breast cancer. On average, 6 of these women have a risk factor.<sup>8</sup> Breast cancer is the most common cancer in women and remains in the top five causes of death for females over 40 years old for all age groups.

**Figure 11: Breast Cancer Statistics for Pennsylvania vs. the United States**

Breast Cancer		
	PA	US
Incidence: Rates/100,000 <sup>9</sup>	123	120
Screening <sup>10</sup>	74%–77%	75%–78%
Deaths: Rates/100,000 <sup>11</sup>	24	23

As described in the Clinical Performance Measures introduction, CoventryCares suite of analytic tools provides key information allowing us to assist members towards successful self-management of their preventive care. The Coventry Care Management Tool identifies members lacking recommended care, who can then be accessed by both the plan and the PCP using our Provider Support Tool. This allows complementary review for untreated members. Members are also identified through:

- Case managers through communication with members and providers
- Provider referrals
- Member self-referrals.

### Problems and Solutions

Once identified, obstacles to provision of accessible mammograms include difficulty arranging a convenient appointment and fear of the test with its possible discomfort and results. In rural settings obstacles are greater due to all travel distances. CoventryCares will create programs specifically designed to assist members in rural areas progress towards self-management with preventive screenings.

<sup>8</sup>Breast cancer statistics. Pennsylvania Breast Cancer Coalition. Ephrata, PA. January 2011.

<sup>9</sup> Statehealthfacts.org. Kaiser Family Foundation. Accessed from the World Wide Web on January 1, 2012 @ <http://www.statehealthfacts.org/profileind.jsp?ind=469&cat=10&rgn=40>

<sup>10</sup> Statehealthfacts.org. Kaiser Family Foundation. Accessed from the World Wide Web on January 1, 2012 @ <http://www.statehealthfacts.org/profileind.jsp?ind=479&cat=10&rgn=40>

<sup>11</sup> Statehealthfacts.org. Kaiser Family Foundation. Accessed from the World Wide Web on January 1, 2012 @ <http://www.statehealthfacts.org/profileind.jsp?ind=471&cat=10&rgn=40>



- **Access Tools**—CoventryCares will use a mobile mammography van to improve access. Ideally, we would collaborate with the other MCOs serving the Zones and ACCESS Plus to rent or purchase a communal van. This would allow the maximum return on investment, conserve scarce resources and provide a highly needed service to all Pennsylvania MA consumers. The van will be utilized at a variety of venues such as provider offices, shopping centers, churches and community centers, providing pre-scheduled mammograms. If done collaboratively, a single event would provide services for all Pennsylvania MA consumers regardless of their coverage.
- **Education**—To battle the fear associated with mammograms, special outreach efforts will be made through CoventryCares staff, and possibly contracted outreach workers, to educate members on the benefits of mammograms and risks of declining the screening test, and answer their questions.
- **Facilitating Self-Management**—Since the van will be available in venues frequented by groups of women, members will be encouraged to schedule a mammogram along with a friend. This encourages the two women to support each other and gives them a feeling of mutual accomplishment. We will also team up with local businesses to offer incentives as described in the Clinical Performance Measures introduction, to encourage members to achieve preventive health care goals.

### Next Steps

Using our suite of analytic tools, CoventryCares will work toward collaboration with the PCPs and Obstetricians to assess the outcomes of this program. Possible data sources include radiology claims and provider records. Results will be the percentage of women ages 42–69 years old in rural service areas screened for breast cancer. This can be compared to CoventryCares yearly HEDIS results and members with similar demographics, both in and outside of rural service areas.

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19. Describe the approach you will use in a rural service delivery area to ensure access to Pap tests to screen for cervical cancer for women ages 24 to 64 years old. (Limit to two pages)

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This year, over 500 Pennsylvania women between 35 and 55 years of age will be diagnosed with cervical cancer.<sup>12</sup> These women were exposed to the virus that caused their cancer 10 to 30 years earlier. Pap smears sometime during that interval would have alerted the women's doctors to their higher cancer risks. They could have undergone treatment and been cured. Now, one out of three of those women will die.<sup>15</sup>

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12 Number of cancer cases, age-adjusted incidence rates and 95% confidence intervals by race and year, Pennsylvania female residents, 2008. Pennsylvania Cancer Incidence and Mortality Annual Report. Bureau of Health Statistics and Research. Pennsylvania Department of Health Harrisburg, PA. Accessed from the World Wide Web on January 1, 2012 @ [http://www.portal.state.pa.us/portal/server.pt/gateway/PTARGS\\_0\\_2\\_75493\\_14136\\_596531\\_43/http%3B/pubcontent.state.pa.us/publishedcontent/publish/cop\\_hhs/health/content/internet/health\\_statistic\\_research/health\\_statistics/bhsr/cancer\\_statistics\\_files/Cancer\\_Incidence\\_and\\_Mortality\\_2008.pdf#Breast](http://www.portal.state.pa.us/portal/server.pt/gateway/PTARGS_0_2_75493_14136_596531_43/http%3B/pubcontent.state.pa.us/publishedcontent/publish/cop_hhs/health/content/internet/health_statistic_research/health_statistics/bhsr/cancer_statistics_files/Cancer_Incidence_and_Mortality_2008.pdf#Breast)



**Figure 12: Cervical Cancer Statistics: Pennsylvania vs. the United States**

Cervical Cancer		
	PA	US
Incidence: Rates/100,000 <sup>13</sup>	8.4	7.9
Screening <sup>14</sup>	81%	81%
Deaths: Rates/100,000 <sup>15</sup>	2.6	2.4

### Identification

As described in the Clinical Performance Measures introduction, CoventryCares suite of analytic tools provides key information allowing us to assist members towards successful self-management of their preventive care. The Coventry Care Management Tool identifies members lacking recommended care, who can then be accessed by both the plan and the PCP using our Provider Support Tool. This allows complementary review for untreated members. Members are also identified through:

- Case managers through communication with members and providers
- Provider referrals
- Member self-referrals

### Problems and Solutions

Once identified, obstacles to provision of accessible Pap tests include difficulty arranging a convenient appointment and fear of the test with its possible discomfort and results. In rural settings obstacles are greater due to all travel distances. CoventryCares will create programs specifically designed to assist members in rural populations' progress towards self-management of their preventive screenings.

- **Access Tools**—CoventryCares will use a mobile van manned by Certified Nurse Practitioners to provide Pap tests. Ideally we would collaborate with the other MCOs serving the Zones and ACCESS Plus to rent or purchase a communal van. This would allow the maximum return on investment, conserve scarce resources and provide a highly needed to service all Pennsylvania MA consumers. The van will be utilized at a variety of venues such as provider offices, shopping centers, churches and community centers. If done collaboratively, a single event would provide services for all Pennsylvania MA consumers, regardless of their coverage.

13 *Statehealthfacts.org*. Kaiser Family Foundation. Accessed from the World Wide Web on January 1, 2012 @ <http://www.statehealthfacts.org/profileind.jsp?ind=473&cat=10&rgn=40>

14 *Statehealthfacts.org*. Kaiser Family Foundation. Accessed from the World Wide Web on January 1, 2012 @ <http://www.statehealthfacts.org/profileind.jsp?ind=475&cat=10&rgn=40>

15 *Statehealthfacts.org*. Kaiser Family Foundation. Accessed from the World Wide Web on January 1, 2012 @ <http://www.statehealthfacts.org/profileind.jsp?ind=482&cat=10&rgn=40>



- **Education**—Educational brochures announcing the new van service and describing the benefits of the test will be created and widely distributed. Special outreach efforts will be made through CoventryCares staff and possibly contracted outreach workers, educating members on the benefits of Pap tests and answering their questions.
- **Facilitating Self-Management**—Since the van will be available in venues frequented by groups of women, members will be encouraged to bring along a friend for support and, if appropriate, similar testing. This encourages the two women to support each other and gives them a feeling of mutual accomplishment. We will also team up with local businesses to offer incentives as described in the Clinical Performance Measures introduction, to encourage members to achieve preventive health care goals

### Next Steps

Using our suite of analytic tools, CoventryCares will work toward collaboration with the PCPs and Obstetricians to assess the outcomes of this program. Possible data sources include lab and provider claims, and provider records. Results will be the percentage of women ages 24–64 years old in rural service areas screened for cervical cancer. This can be compared to CoventryCares yearly HEDIS results and members with similar demographics, both in and outside of rural service areas.

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20. Describe the plan you propose to use in a rural service delivery area to provide disease management services for members with cardiovascular disease; including but not limited to cholesterol management. (Limit to two pages)
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Although the rate is steadily declining,<sup>16</sup> heart disease remains the number one cause of death in the United States.<sup>17</sup> National averages are approximately 10% better than Pennsylvania statistics.

### Identification

CoventryCares’ suite of analytic tools provides key information s to assist members in successful self-management of their Cardiovascular Disease through monitoring compliance regarding recommendations for known risk factors such as high cholesterol and hypertension and medication refills. We identify members lacking recommended care, who can then be accessed by both the plan and the PCP using our Provider Support Tool for complementary review for untreated members. Members previously unknown to have cardiovascular disease are also identified through:

- Daily Case Rounds with staff from all Health Services Departments

16 National Center for Health Statistics. Health, United States, 2010: *With Special Feature on Death and Dying*. Hyattsville, MD. 2011. Accessed from the World Wide Web on January 2, 2012 @ [http://www.cdc.gov/nchs/data/10.pdf#030](http://www.cdc.gov/nchs/data/hus/10.pdf#030)

17 Table 9. *Death rates by age and age adjusted death rates for the 15 leading causes of death in 2007*. National Vital Statistics Support. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Accessed from the World Wide Web on January 2, 2012 @ [http://www.cdc.gov/NCHS/data/nvsr/nvsr58/nvsr58\\_19.pdf](http://www.cdc.gov/NCHS/data/nvsr/nvsr58/nvsr58_19.pdf)



- Care Managers through communication with members and providers
- Concurrent Review and Discharge Planning Nurses
- Provider referrals and member self-referrals

## Problems and Solutions

Cardiovascular disease is affected by many controllable factors such as hypertension and high cholesterol. Maintaining accepted blood pressure and cholesterol levels is instrumental in managing cardiovascular disease.

Once diagnosed, obstacles to managing cardiovascular disease include lack of monitoring resources, high cholesterol and hypertension symptoms and regular blood tests. In rural settings obstacles are greater due to all travel distances, solo-practice PCPs with limited time and assistance for patient education, and restricted access to other informational resources. In addition to enrollment in DM for cardiovascular disease which provides benefits such as educational tools and Case Management, CoventryCares will create programs specifically designed to assist members in rural areas progress towards self-management of their cardiovascular disease.

- **Access Tools**— Using Geo Access tools CoventryCares will assess locations of both providers for and members with cardiovascular disease. Identifying areas with high numbers of appropriate members and low numbers of available providers, we will partner with local businesses and community resources to hold health events that include testing such as serum cholesterol and HGB A1C levels, and blood pressure. Identifying members with heart disease and uncontrolled risk factors, CoventryCares will provide up to two Skilled Nursing Visits for each member who will assess the member's clinical condition and create a coordinated plan of care with the member's PCP.
- **Education**—The health fairs noted above will provide education on the disease process, counseling regarding diet and exercise. Sessions can actually demonstrate some heart healthy food prep, simple exercises to do with common items at home and relaxation techniques. The Skilled Nursing Visits will include education on the disease process, consequences and opportunities for the member to assist in management. If the nurse assesses a member requires additional, medically necessary Skilled Nurse Visits due to specific circumstances such as language difficulties, a request can be sent to CoventryCares Prior Authorization with documentation of the issues.
- **Facilitating Self-Management**—The nurse will provide a generic digital blood pressure monitor and cuff and instruct on its use at the first visit. At the second visit, the nurse will assess proper use of the equipment and disease knowledge. We will team up with local business to offer population specific products to encourage members to comply with recommended treatment to manage chronic conditions. If appropriate, blood will also be drawn for cholesterol testing during any Skilled Nurse Visit. We will also team up with local business to offer incentives as described in the Clinical Performance Measures introduction, to encourage members to comply with recommended treatment to manage chronic conditions.
- **Ongoing Monitoring**—Using the blood pressure monitor and cuff, routine telephonic supervision with the PCP will be established. Skilled Nursing Visits will be approved without Prior Authorization every three months to obtain blood samples for cholesterol and HGB A1C levels.



Medically necessary Skilled Nursing Visits required more frequently than every three months can be arranged through Case management/SNU.

PCPs will receive incentives to comply with this program for these reasons

- Telephonic monitoring is done predominantly through the office staff. The physician is responsible to note and respond to results as needed
- CoventryCares' P4P incentives support the documentation of improved control and of members' diabetes and cholesterol
- Providers participating in CoventryCares' Shared Savings Program have added financial incentive to improve the outcomes of their CoventryCares' members

Each member will be given the name and telephone number of a CoventryCares Case Manager to contact if issues or concerns arise.

### Next Steps

We will work with the PCPs to assess compliance and outcomes of members using these services. Data sources include pharmacy and lab claims, and cholesterol and blood pressure results. These will be compared to CoventryCares yearly HEDIS results and similar members who are not using these services, both in and outside of rural service areas.

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### 21. Describe your proposed strategy to ensure access to a dentist for an annual dental visit for 2 to 21 year olds who reside in a rural service delivery area. (Limit to two pages)

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In the United States, tooth decay affects 33% of children ages 3–5 years old, and over 50% of children 6 to 15 years old.<sup>18</sup> Risk factors for going without routine dental care and having dental problems include low income, low educational level, being disabled and living in a rural area.<sup>19</sup>

For all children in Pennsylvania:<sup>20</sup>

- 74% of 3rd grade students have no sealants on their permanent first molar teeth
- 53% of 3rd grade students have experienced dental cavities
- 27% of 3rd grade students have untreated tooth decay

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18 *Healthy People 2020*. Federal Government Web site managed by the U.S. Department of Health and Human Services. 200 Independence Avenue, S.W., Washington, DC 20201. Accessed from the World Wide Web on January 2, 2012 @ <http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=32#186>

19 *2004 Behavioral risk factor surveillance survey oral health results. Behavioral Risk Factors Surveillance System*. Pennsylvania Department of Health. Harrisburg, PA.

20 *Focus area 21 - oral health. Healthy People 2010. Pennsylvania Department of Health. Harrisburg, PA*. Accessed from the World Wide Web on January 1, 2012 @ <http://www.portal.state.pa.us/portal/server.pt?open=514&objID=590079&mode=2>



## Identification

As described in the Clinical Performance Measures introduction, CoventryCares suite of analytic tools provides key information allowing us to assist members towards successful self-management of their pediatric dental services. The Coventry Care Management Tool identifies members lacking recommended care, who can then be accessed by both the plan and the PCP using our Provider Support Tool. This allows complementary review for untreated members. Members are also referred by their providers as well as being self-referred.

## Problems and Solutions

Once identified, obstacles to provision of accessible pediatric dental services include a lack of sufficient providers in specific geographies, difficulty arranging a convenient appointment and coordinating out-of-office appointments with signed parental permission slips. We realize in rural settings the obstacles of arranging a convenient appointment and lack of sufficient providers is greater due to travel distances. CoventryCares will create programs specifically designed to assist members in rural areas progress towards self-management with preventive screenings.

- **Access Tools:** CoventryCares will use a mobile dental van to improve access. This can be accomplished in several ways. We can work with our dental vendor to provide a van at appropriate venues such as schools and local sporting events. As other MCOs use the same vendor, we can collaborate with one or more MCOs serving the Zones and ACCESS Plus to provide increased benefit to Pennsylvania MA consumers while realizing decreased costs. Ideally we will collaborate with all other MCOs serving the Zones. This would allow the maximum return on investment, conserve scarce resources and provide a highly needed to service all Pennsylvania MA consumers. The van would then be able to provide pediatric dental services for all Pennsylvania MA consumers, regardless of their coverage.

Obtaining parental permission slips is the second component of access. Permissions slips will be distributed and collected at the beginning of each school year. The verbiage will validate them for 12 months. Using this process, children will have year-round permission for dental care.

- **Education:** Dental vans can only provide screening and preventive care. Children needing treatment services will be referred to dental care providers. Parents should be aware of this when they sign the permission slips. Family education sessions providing information on the impact of poor dental care and how to avoid them as well as how to conduct routine care will be provided through mailers, on the website, and during visits to the dental van.
- **Facilitating Self-Management:** After receiving several consecutive annual dental exams, getting routine dental care becomes part of a child's expected care and the family's routine. Younger children entering the program will assume they need a yearly dental check-up by the time they reach adolescence. Since they started regular dental care early, their teeth and gums will be healthier, requiring less reparative care throughout their teenage years and adulthood. We will also team up with local business to offer incentives as described in the Clinical Performance Measures introduction, to encourage members to achieve preventive health care goals.



## Next Steps

As mentioned in the introduction to Clinical Performance Measures Questions 15–26, CoventryCares will continue to investigate new and innovative methods to address the specific needs of a rural MA population.

- 
22. Describe how you will ensure access to well-child visits in the first 15 months of life for those who reside in a rural service delivery area. (Limit to two pages)
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## Identification

As described in the Clinical Performance Measures introduction, CoventryCares suite of analytic tools provides key information allowing us to assist members towards successful self-management of their preventive care. The Coventry Care Management Tool identifies members who have not had recommended care, who can then be accessed by both the plan and the PCP using our Provider Support Tool. This allows complementary review for untreated members. Members are also referred by their providers as well as being self-referred.

## Problems and Solutions

Once identified, obstacles to provision of well child visits in the first 15 months of life include difficulty arranging convenient and timely appointments and the inconvenience of attending the numerous required appointments especially if the parent has other children. We realize in rural settings these obstacles are greater due to travel distances. CoventryCares will create programs specifically designed to assist members in rural areas progress towards self-management with preventive screenings.

- **Access Tools:** CoventryCares will use Geo Access tools to assess the location of both members in the first 15 months of life and available providers. We will identify areas with high numbers of these members and low numbers of available providers. We are considering several interventions. One is partnering with local religious organizations, sports clubs, schools, and other organizations for joint community health events that include annual well child visits. Due to the proximity of the members to each other and to the site, provision of group transportation would be considered. CoventryCares would like to collaborate with MCOs serving the Zones and ACCESS Plus. This would allow the maximum return on investment, conserve scarce resources and provide a highly needed to service all Pennsylvania MA consumers. An alternative program could be locating a geographic cluster of applicable members including children up to 7 years old. By sending a Certified Registered Nurse Practitioner to a volunteer home or nearby site, numerous well checks can be accomplished. Incentives for local businesses could increase participation.
- **Education:** Group events provide interactive educational opportunities and a chance to share and exchange experiences.
- **Facilitating Self-Management:** By bringing health care to the member's community, the member learns that health care can start locally. We will also team up with local business to offer incentives



as described in the Clinical Performance Measures introduction, to encourage members to achieve preventive health care goals.

- **Ongoing Monitoring:** These programs for provision of well child visits in the first 15 months of life can either continue into or be combined with ongoing annual well child visits through 7 years old. Well child visits become a part of the family's routine. Since they started preventive care early, these children should be healthier throughout their teenage years and adulthood.

## Next Steps

Using our suite of analytic tools, CoventryCares will work toward collaboration with the PCPs to assess compliance with recommended pediatric preventive services. Data sources include provider and lab claims. These will be compared to CoventryCares yearly HEDIS results and similar members who are not using these services, both in and outside of rural service areas. Case Managers will be assigned to members with compliance issues.

- 
23. Describe how you will ensure access to well-child visits in the third, fourth, fifth and sixth years of life for those who reside in a rural service delivery area. (Limit to two pages)
- 

## Identification

As described in the Clinical Performance Measures introduction, CoventryCares suite of analytic tools provides key information allowing us to assist members towards successful self-management of their preventive care. The Coventry Care Management Tool identifies members who have not had recommended care, who can then be accessed by both the plan and the PCP using our Provider Support Tool. This allows complementary review for untreated members. Members are also referred by their providers as well as being self-referred.

## Problems and Solutions

Once identified, the main obstacle to provision of well child visits in the third through sixth years of life is difficulty arranging convenient appointments that include long travel times, coordinated with a parent's work schedule, especially if the parent has other children. CoventryCares will create programs specifically designed to assist members in rural populations progress towards self-management with preventive screenings

- **Access Tools:** CoventryCares will use Geo Access tools to assess the location of both members in the third through sixth years of life and available providers. We will identify areas with high numbers of these members and low numbers of available providers. We are considering several interventions. One is partnering with local religious organizations, sports clubs, schools, and other organizations. for joint community health events that include annual well child visits. Due to the proximity of the members to each other and to the site, provision of group transportation would be considered. CoventryCares would like to collaborate with the other MCOs serving the Zones and ACCESS Plus. This would allow the maximum return on investment, conserve scarce resources and



provide a highly needed to service all Pennsylvania MA consumers. An alternative program could be locating a geographic cluster of applicable members, possibly including infants up to age 15 months old. By sending a Certified Registered Nurse Practitioner to a volunteer home or nearby site, numerous well checks can be accomplished. Incentives for local businesses could increase participation.

- **Education:** Group events provide interactive educational opportunities and a chance to share and exchange experiences.
- **Facilitating Self-Management:** By coming to the member's community, the member learns that health care can start locally. We will also team up with local business to offer incentives as described in the Clinical Performance Measures introduction, to encourage members to achieve preventive health care goals.
- **Ongoing Monitoring:** These programs for provision of well child visits in the third through sixth years of life can either stand alone, continue from, or be combined with well child visits in the first 15 months of life. Mothers and young children entering the program will naturally assume the child involved needs a yearly check-up by adolescence. It becomes part of the child's expected care and the family's routine. Since these children started preventive care early, they should be healthier throughout their teenage years and adulthood.

### Next Steps

Using our suite of analytic tools, CoventryCares will work toward collaboration with the PCPs to assess compliance with recommended pediatric preventive services. Data sources include provider and lab claims. These will be compared to CoventryCares yearly HEDIS results and similar members who are not using these services, both in and outside of rural service areas. Case Managers will be assigned to members with compliance issues.

- 
24. Describe how you will ensure access to primary care practitioners for well-care visits for 12 to 19 year olds who reside in a rural service delivery area. (Limit to two pages)
- 

### Identification

As described in the Clinical Performance Measures introduction, CoventryCares suite of analytic tools provides key information allowing us to assist members towards successful self-management of their preventive care. The Coventry Care Management Tool identifies members who have not had recommended care, who can then be accessed by both the plan and the PCP using our Provider Support Tool. This allows complementary review for untreated members. Members are also referred by their providers as well as being self-referred.



## Problems and Solutions

Once identified, the main obstacles to provision of well child visits for 12–19 year-olds include, difficulty arranging convenient appointments, lack of knowledge of the need for care, lack of parental support, long travel times that work with school schedules, and persuading the child to keep the appointment. We realize in rural settings these obstacles are greater due to travel distances. CoventryCares will create programs specifically designed to increase access to and compliance with well child visits for 12 to 19 year-olds.

- **Access Tools:** CoventryCares will use Geo Access tools to assess the location of both members 12–19 years old and available providers. We will identify areas with high numbers of these members and low numbers of available providers. We are considering several interventions. One is partnering with local sports clubs, churches, schools, community centers and other local organizations for joint community health events that include annual well child visits. Events could be held immediately after school to alleviate transportation issues. Conversations with local adolescents will help define appropriate activities and develop population specific products to attract participants.

Obtaining parental permission is the second component that is needed to assure access. Permissions forms will be distributed and collected at the beginning of each school year. The verbiage will validate them for 12 months. Using this process, children will have year-round permission for well child visits.

CoventryCares would like to collaborate with the other MCOs serving the Zones and ACCESS Plus. This allows the maximum return on investment, conserve scarce resources and provide a highly needed service to all Pennsylvania MA consumers.

- **Education:** Topics specific to adolescents can be presented, ending with a Question and Answer period. Group presentations provide unique opportunities and a chance to share and exchange experiences.
- **Facilitating Self-Management:** By coming to the member's community, the member learns that health care can start locally. Adolescents have the opportunity to discuss topics they may not otherwise feel comfortable mentioning or have access to appropriate information. By participating in these programs, these adolescents will grow into adults who assume preventive health care is a routine part of life. We will also team up with local business to offer incentives as described in the Clinical Performance Measures introduction, to encourage members to achieve preventive health care goals.
- **Ongoing Monitoring:** Information about CoventryCares' programs and outreach services need to be available, both openly and in private areas such as bathrooms. Adolescents may have questions or issues they prefer not to discuss at the time but may want to call later for assistance.

## Next Steps

Using our suite of analytic tools, CoventryCares will work toward collaboration with the PCPs to assess compliance with recommended pediatric preventive services. Data sources include provider and lab claims. These will be compared to CoventryCares yearly HEDIS results and similar members who are not using these services, both in and outside of rural service areas. Case Managers will be assigned to members with compliance issues.



25. Describe how you will ensure that children who reside in a rural service delivery area receive one or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday. (Limit to two pages)

The Bell curve of Blood Lead Levels (BLL) vs. age reaches its peak in children aged 1-5 years.<sup>21</sup> Though both the prevalence and levels have been decreasing, certain risk factors are found in some Pennsylvania MA consumer populations. Children who are part of low-income families, live in older homes or belong to minority populations are particularly at risk.<sup>22</sup> Recent studies have raised concern even for children whose lifetime peak blood levels were consistently less than 10 µg/dL.<sup>25,26,23</sup> Though lead exposure accounts for only a small decrease in cognitive ability and intellectual impairment, it has a cumulative effect when added to other risk factors such as social and environmental issues often found among low income populations.<sup>26,27</sup>

### Identification

As described in the Clinical Performance Measures introduction, CoventryCares suite of analytic tools provides key information allowing us to assist members towards successful self-management of their preventive care. The Coventry Care Management Tool identifies members who have not had recommended care, who can then be accessed by both the plan and the PCP using our Provider Support Tool. This allows complementary review for untreated members. Members are also referred by their providers as well as being self-referred.

### Problems and Solutions

Once identified, obstacles to provision of lead blood tests include, difficulty arranging convenient appointments especially if the parent has other children and the fact that testing is a low priority for these MA consumers. We realize in rural settings these obstacles are greater due to travel distances. CoventryCares will create programs specifically designed to assist members in rural populations progress towards self-management with preventive screenings.

- **Access Tools:** CoventryCares will use Geo Access tools to assess the location of both members lacking testing and available providers. We will identify areas with high numbers of these members and low numbers of available providers. We will co-sponsor local health events that include lead blood tests. This could be done with local child-friendly attractions or by partnering with local religious organizations, sports clubs, schools, etc. Due to the proximity of the members to each other

21 Policy Statement. *Lead exposure in children: prevention, detection, and management.* Committee on Environmental Health, American Academy of Pediatrics. Pediatrics 2005;116(4):1036-46.

22 Bernard, S.M. and McGeehim, M.A. *Prevalence of blood lead levels  $\geq 5$  µg/dL among US children 1 to 5 years of age and socioeconomic and demographic factors associated with blood levels 5 to 10 µg/dL,* third national health and nutrition examination survey, 1988-1994. Pediatrics 2003;112(6):1308-13.

23 Koller, K.; Brown, T.; Spurgeon, A. and Levy, L. *Recent developments in low-level lead exposure and intellectual impairment in children.* Environ Health Perspect. 2004 June; 112(9): 987-994.



and to the site, provision of group transportation would be considered. CoventryCares would like to collaborate with MCOs serving the Zones and ACCESS Plus. This would allow the maximum return on investment, conserve scarce resources and provide a highly needed to service all Pennsylvania MA consumers.

- **Education:** It is essential to provide information to PCPs and members regarding the risks of elevated BLL and the ease of the test. Presenting information in several formats reinforces the message. This could be done during a “BLL Awareness Month” with brochures, posters, and talks by CoventryCares clinical personnel at local venues.
- **Facilitating Self-Management:** By bringing health care to the member’s community, the member learns that health care can start locally. These programs for provision of lead blood tests can be combined with annual well child visits for further increased awareness and participation in preventive health care. We will also team up with local businesses to offer incentives as described in the Clinical Performance Measures introduction, to encourage members to achieve preventive health care goal.
- **Ongoing Monitoring:** It is possible in a small community for behavioral changes to spread quickly. Monitoring BLL testing statistics over time in targeted areas may reveal additional information regarding health care strategies in small communities.

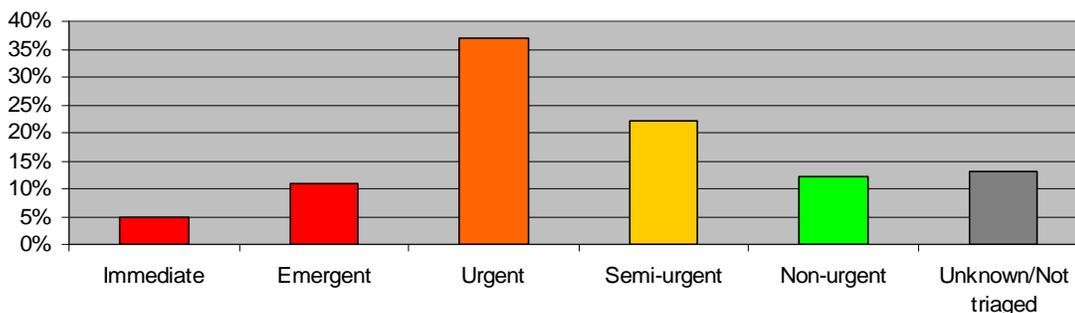
### Next Steps

As mentioned in the Clinical Performance Measures introduction to Questions 15–26, CoventryCares will continue to investigate new and innovative methods to address the specific needs of a rural MA population.



26. Describe the initiatives you will implement in a rural service delivery area to educate members and providers about the appropriate use of hospital emergency departments. (Limit to two pages)

**Percentage of U.S. Emergency Department Visits by Acuity Level**



SOURCE: GAO ANALYSIS OF NCHS DATA<sup>24</sup>

	PA	US
<b>ED visits/1000</b>	477	415
<b>Inpatient admissions from ED</b>	18%	15%
<b>Hospital admissions/1000</b>	146	116

PENNSYLVANIA ANNUAL STATISTICS<sup>25,26</sup>

**Problem Analysis**

Increases in Emergency Department (ED) utilization have several notable characteristics that need to be acknowledged to determine optimal approaches to this issue.

- **Non-urgent visits are increasing, emergent medical visits are stable, and trauma visits are decreasing.** There tends to be little awareness of the differentiation between emergent, urgent and non-urgent medical problems. MA consumers need to be educated on the value of obtaining care for non-emergent problems in settings other than the ED.

24 *Hospital Emergency Departments: Crowding continues to occur, and some patients wait longer than recommended time frames.*, GAO-09-347. (Washington, D.C.: April, 2009). Accessed from the World Wide Web on January 2, 2012 @ <http://www.gao.gov/new.items/d09347.pdf>.

25 *National Hospital Ambulatory Medical Care Survey: 2008 Emergency Department Summary Tables*. Table 23. Disposition of emergency department visits: United States, 2008. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Accessed from the World Wide Web on January 2, 2012 @ [http://www.cdc.gov/nchs/data/ahcd/nhamcs\\_emergency/nhamcsed2008.pdf](http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/nhamcsed2008.pdf)

26 *Emergency services capability and utilization by facility & county excluding Federal hospitals. Data from the Annual Hospital Questionnaire*. Bureau of Health Statistics & Research. Pennsylvania Department of Health. Harrisburg, PA. Reporting period: July 1, 2009 through June 30, 2010.



- **Highest traffic in the ED is during daytime hours.** Despite having an assigned PCP, members still end up in the ED for non-emergent problems when medical offices are open. This is driven both by members going directly to the ED without calling their PCP and by providers sending members who call with acute but non-urgent problems.
- **Utilization varies by age group.** Highest ED utilizing groups are members over 64 years of age and children under 12 years old. In Pennsylvania, almost 1 out of 5 ED visits results in an admission. Targeting these age groups and educating them regarding age-specific issues gives the highest return for our efforts.
- **Proximity issues in rural areas.** In rural settings, these issues are exacerbated by travel distances. An ED may be significantly closer than the member's PCP.

## Solutions

- **Member Focus**
  - Distribute direct-to-member, population specific products such as magnets, t-shirts, cloth baby wipes, eyeglass wipes, week-long pill boxes and cards with "CoventryCares", 24-hour nurse hot-line phone number and a memorable phrase about ED use
  - Meet with seniors and mothers at their local gathering places for formal and informal education and discussions on ED utilization
  - Create targeted brochures listing medical problems in each category (emergent, urgent, non-urgent), with the 24-hour nurse hot-line phone number for prominent display in relevant venues
  - Team up with local businesses to offer incentives as described in the Clinical Performance Measures introduction, to encourage members to achieve effective and efficient health care
- **Provider Focus**
  - Review incentives for lower avoidable ED use
    - CoventryCares Shared Savings Program encourages health care similar to a Medical Home. Awards are given for improved outcomes and cost-effective care such as decreased avoidable ED utilization
    - CoventryCares P4P includes improvement in specified HEDIS outcomes including decreased ED utilization
  - Assistance with setting up schedules allowing for acute/urgent appointments
  - Review lists of expected emergent, urgent and non-urgent diagnoses
  - Review financial incentives for lower avoidable ED use through our P4P and Shared Savings Program programs

## Next Steps

As mentioned in the introduction to Questions 15–26, CoventryCares will continue to investigate new and innovative methods to address the specific needs of a rural MA population.



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## Waste, Fraud and Abuse

1. Describe the internal controls you will implement to detect potential waste, fraud and abuse within your own organization. (Limit to two pages)
- 

CoventryCares has existing policies and programs in place to prevent and detect fraud, waste, and abuse. Those policies and internal controls include a comprehensive Anti-Fraud and Abuse Plan as well as a detailed Program Integrity Plan that meets requirements of applicable state and federal law, including but not limited to 42 CFR § 438.600 to 438.610 and additional requirements as described in Subtitle F, Section 6501 through 6507, of the Patient Protection and Affordable Care Act (PPACA) of 2010.

As a subsidiary of Coventry, CoventryCares receives support for many elements of the Program Integrity Plan. However, CoventryCares retains responsibility for ensuring implementation of this Integrity Plan, and provides oversight of all activities related to Program Integrity. CoventryCares works closely with Coventry's Member Services and Special Investigative Unit ("SIU") for health care fraud prevention, detection, and investigation. CoventryCares' Compliance Officer, MA staff and the Coventry Corporate Medicaid Compliance Officer are responsible for the Program Integrity Plan. Health Plan staff are accountable to Senior Management and responsible to coordinate with DPW and any other state/federal authorities on any fraud or abuse case.

Additionally, in accordance with the Deficit Reduction Act, Coventry maintains policies and materials for the purpose of educating employees, supervisors, and managers, as well as providers, subcontractors and subcontractors' employees about health care fraud laws, Coventry's policies and procedures for preventing and detecting fraud and abuse and the rights of employees to act as whistleblowers. These policies and other Coventry policies relating to the prevention and detection of waste, fraud and abuse are in the Coventry Employee Handbook that can be found and utilized by Coventry employees on the Coventry intranet.

Regarding the Coventry Compliance and Ethics Program Code of Business Conduct and Ethics:

- All new Coventry employees complete training within 30 days of hire
- All employees receive yearly education and training on these policies

Employees are required to report any suspected violations of the Code of Business Conduct and Ethics and to their immediate supervisor or manager, the Chief Compliance Officer, a Compliance Officer or the Comply Line. If the employee wishes to remain anonymous, the employee may report his/her suspicions via the Coventry Health Care Compliance Program Comply Line: 1-877-242-5463

Several corporate policies are designed to ensure employees conduct Coventry business in a legal and ethical manner. These policies are designed in part to detect, prevent and investigate embezzlement, internal theft and other forms of employee fraud. The following are among the various policies:

- Coventry Health Care Policy of Reporting of Potential Issues or Areas of Noncompliance
- CHC Policy on Federal and State Government Agency Requests for Information, Audits, Interviews, Searches, and Other Contacts with CHC Regarding CHC or Affiliates
- Coventry Health Care Policy on Federal and State Government Agency Requests for Information, Audits, Interviews, Searches, and Other Contacts with CHC regarding a third party



- Coventry Health Care Policy on Employee Training
- Code of Business Conduct and Ethics

Additionally, policies are maintained specific to contractual obligations such as immediately notifying DPW, in writing, if it terminates or suspends an employee as a result of suspected or confirmed fraud or abuse.

Human Resources, in consultation with the Waste, Fraud and Abuse Department and Coventry SIU, as appropriate, shall help ensure that appropriate and consistent disciplinary action is taken against any employee responsible for any misconduct or non-compliance, as well as any employee responsible for the failure to prevent, detect, or report any violation.

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2. Describe the types of fraud detection methods you will use to detect provider waste, fraud and abuse. (Limit to two pages)

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Coventry employs various controls to identify and manage waste, fraud and abuse. Among those are fraud control solutions including StarsSentinel™, a paid claims data and lead generation software from ViPS®, a General Dynamics Information Technology Company and a post payment review software from HealthCare Insight® (HCI), a division of Verisk Health, Inc. The specific primary controls are:

- Raw data extraction and extensive data mining from the Coventry Data Warehouse
- Basic edits and audits of claims processing system
- Predictive modeling to identify aberrant billing
- Analytics to review historical and current billing data
- Post payment reviews including stratification of providers against their peers
- Scored provider billing practice comparisons
- Specialty practice comparisons
- Procedural billing comparisons against clinical guidelines
- Rules based post-payment analysis

Coventry relies on the following areas and additional monitors:

- Utilization Management
  - Reviewing for quality issues
  - Oversight of PCP referrals
  - Monitoring member utilization
  - Special Needs Department
  - Case Management
  - Quality Management Audits
  - Reviewing authorizations for home health care and durable medical equipment
- Credentialing/Re-credentialing
  - Checking State Licensure Boards to ensure the provider has no disciplinary actions



- Verifying provider has a non-encumbered DEA license
- Verifying provider education, training history and board certification
- Verifying Medicare Opt-Out Listing to be sure the providers can legally bill federal and state funded programs
- Checking the National Practitioner Databank
- Checking the OIG List of Excluded Individuals/Entities (LEIE) and the GSA Excluded Parties List System (EPLS)
- Claims Processing
  - Claims checks and edits
  - Code Reviewers
- Vendor Management
  - Coventry requires its pharmacy, dental and vision vendors to provide safeguards to prevent fraudulent activities. Coventry will review such third party's waste, fraud and abuse program to ensure the third party provides proper fraud and abuse training to its employees assigned to Coventry's account, to the extent such third parties are not Coventry entities and incorporated or included in this training process. Coventry will also follow any specific requirements or protocols for such third party delegation as may be required by its contract with the state Medical Assistance agency.
  - Additionally, Coventry requires our vendors to report on a regular basis the results of their waste, fraud and abuse activities and findings to include:
    - Documented Program Integrity Plan
    - Number of member, vendor and provider-related issues
    - Number of retractions (reversals) resulting from FWA Issues
    - Total referrals made to law enforcement or to DPW's Bureau of Program Integrity
    - Number of issues referred from health plan
    - Total dollar amount recouped as a result of retractions
    - Total number of waste, fraud and abuse issues handled

Additionally, the Special Investigations Unit (SIU) will perform the following activities to protect CoventryCares from Fraud and Abuse activities to prevent unnecessary cost to the Pennsylvania MA program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care:

Performs audits to review the following:

- Duplicate claims
- CPT quantity billing issues
- Date of death reviews



- Disenrollment reviews
- Reviews of state and federal exclusion lists
- Peer review ranking reports to identify outlier providers and members including referral activities
- Star Sentinel VIPS paid claims data and lead generation software
- HCI Post Payment Review software
- Periodic audits with an emphasis being placed on audits identified in the yearly Office of the Inspector General Work Plan

The SIU also utilizes our Pharmacy Benefits Manager, Medco to perform the external auditing functions. A more detailed description of these activities can be found in our program integrity plan (available upon request).

A representative of the SIU attends periodic regional and national conferences and seminars on fraud and abuse detection and prevention. The SIU will also continue their support and membership in the National Health Care Anti-Fraud Association.

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3. Describe the activities you will undertake to safeguard against potential member fraud. (Limit to two pages)

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Coventry Health Care, Inc. employs various methods to prevent member waste, fraud and abuse. Among those methods includes guidance set forth in 55 PA Code §1101.91 and 1101.92 regarding MA Consumer prohibited acts, criminal penalties & civil penalties. A Member Restriction Program is employed to detect and deter member misutilization, fraud and/or abuse. This program restricts members to one primary care physician (PCP), one hospital and/or one participating pharmacy of the member's choice for a period of five years.

Member utilization patterns will be reviewed against established criteria to identify patterns of misuse, fraud or abuse of medical and pharmacy services on a monthly and ad hoc basis. The review and process include the following:

***Criteria***

A member is identified for review if any of the following criteria are satisfied:

- Member gets prescriptions filled at >3 pharmacy locations within one month
- Member has prescriptions written by >4 physicians per month
- Member receives >10 therapeutic agents per month
- Member fills prescriptions for > 4 controlled substances per month
- Member obtains refills (especially on controlled substances) before recommended days supply is exhausted
- Duration of narcotic therapy is > 30 consecutive days without an appropriate diagnosis



- Prescribed dose outside recommended therapeutic range
- Same/Similar therapy prescribed by different prescribers
- No match between therapeutic agent and specialty of prescriber
- Fraudulent activities (forged or altered prescriptions or borrowed benefit cards)
- More than 3 admissions to more than 1 hospital *in last 6 months*
- More than 3 ED visits in > 90 days with little or no Primary Care Physician follow up
- Same/Similar services or procedures in outpatient setting within one year

### ***Referral Review***

Referrals of suspected mis-utilization or abuse, including but not limited to those made by the Plan's physician/pharmacy providers, the Plan's Pharmacy Services Department, Member/Provider Services, Special Investigations Unit, Case Management/Special Care Unit, Quality Management, Medical Affairs and DPW, are reviewed for potential restriction.

### ***Identification of Misuse***

Once a member is identified for this program, and misuse, fraud or abuse can be documented and has met DPW's approved restriction criteria, the member is restricted or "locked-in" to a Primary Care Practitioner (PCP), pharmacy and/or inpatient hospital for a period of up to five (5) years. Restriction to one provider type helps to more effectively manage the identified members' total health care and reduce the incidence of mis-utilization and abuse, while ensuring coordination of care and providing for medical management.

### ***Lock-In and Notice to Providers***

If a member enrolled in the Member Restriction Program chooses a PCP, Hospital or Pharmacy as their restricted provider, CoventryCares will notify that provider with a letter of notice identifying the CoventryCares member MA Consumer (by name and CoventryCares ID number). The letter will identify the PCP the member must use for primary care services and to obtain specialist referrals, and/or the pharmacy at which he/she must receive prescription medications, and/or the name of the hospital at which they must receive elective hospital services.

### ***Emergency Services***

In an emergency situation, the restricted CoventryCares member may seek care at the nearest Emergency department. The evaluating hospital will be notified of the member's assigned inpatient hospital through DPW Eligibility Verification System (EVS). In the event that a member restricted to a PCP and an inpatient hospital presents to the Emergency department of a hospital other than the assigned inpatient hospital and the member requires an inpatient admission, the member must be transferred to his/her assigned inpatient hospital once the member has been stabilized and, in the judgment of the treating physician, the member is clinically stable for transfer.



### ***Making a Referral of Suspected Misuse, Fraud or Abuse***

CoventryCares participating health care providers who suspect member misuse or abuse of services can make a referral to the Member Restriction Program by calling the CoventryCares Fraud and Abuse Hotline at 1-866-806-7020.

- 
4. Describe how you use consumer verification techniques regarding the cost of inpatient and outpatient services to detect provider waste, fraud and abuse. (Limit to two pages)
- 

CoventryCares will not tolerate fraud, waste or abuse in any of its relationships with internal or external parties. Verification of Services (VOS) in the Pennsylvania Medical Assistance Program is required by the Code of Federal Regulations (CFR) 42 CFR 455.20 (a), which states: “The agency must have a method for verifying with MA Consumers whether services billed by providers were received.”

In accordance with the above requirements, and approval by DPW, verification is made to guarantee that services reimbursed in the CoventryCares program were furnished to CoventryCares members by employing the following procedures:

#### **Procedure**

Each quarter, CoventryCares claims department extracts a statistically valid sample of claims that were paid for CoventryCares members in that quarter. Sensitive services such as behavioral health, are excluded from the sample. Within 45 days of the close of the quarter, a listing of all paid claims, with the exception of the claims falling into the exclusion listing, is pulled. A random sample is selected based on statistical validity. Member Services provides the random sample list to the attention of the Fraud Department.

Within 60 days of the close of the quarter, a verification of services letter is sent to members on the list. If the member did not receive the care, the member is asked to call Member Services. If Member Service receives a call indicating the member did not receive the services, they will track receipt of the call in Navigator and forward the information to the Fraud Department for handling.

If it is found that services were not furnished, appropriate referral and follow-up action per the contract with DPW will be taken. Such action may include referring to Coventry’s Special Investigations SIU, contacting law enforcement, or contacting the state Medical Assistance agency.



### **Management to Control Costs**

1. Demonstrate how you monitor the performance of your subcontractors to ensure all Agreement responsibilities are met. Provide sample reports showing any actions taken to improve performance and ensure positive results. Describe any sanctions or penalties that apply if the subcontractor fails to perform up to the expectations of your organization. Attach sample performance monitoring reports. (Limit to two pages)
- 

### **Monitoring Performance**

CoventryCares' Delegated and Vendor Oversight Committee (DVOC) oversees the contractual obligations of our subcontractors. The committee reviews monthly and quarterly subcontractor activity reports and makes recommendations for Corrective Action Plans (CAPs) as needed. The DVOC is chaired by Quality Improvement staff and is comprised of managers or their designees from the following areas:

- Claims/Member Service
- Government Programs
- Credentialing
- Pharmacy
- Quality Management
- Finance
- Health Services
- Compliance
- Medical Administration
- Marketing
- Network Management
- Appeals Unit
- Other departments, as needed

### **Sample Reports**

Through the delegated oversight process, CoventryCares utilizes our subcontractor agreements, and regular and frequent interaction between the responsible key personnel and subcontractor, to identify and address any issues arising from the relationship. CoventryCares' dedicated personnel continuously monitor these subcontractor relationships by performing detailed reviews of performance standards and various reporting requirements. Performance reports include the following measures:

- Paid and denied claims reports for appropriate timeframes
- Weekly claims inventory, aging, and average value
- Telephone/service metrics
- Timely loading of eligibility files
- Network access standards



- **Complaint Resolution**

At least quarterly, CoventryCares requires each subcontractor to submit periodic performance reports, compliance reports and ad hoc reports, as required by performance or function. Reports include separate lines of business, as applicable.

Managers of each functional area review subcontractor reports for compliance with contract terms. Subcontractor reports are reviewed at the monthly DVOC meeting and non-compliant subcontractors are placed on a formal CAP, if deemed necessary by the committee. Management works directly with the subcontractor on the implementation and monitoring of the CAP in accordance with strict and defined date parameters for timely resolution. The DVOC monitors the CAP monthly to ensure that progress is being made and ultimate compliance by the subcontractor is being achieved.

The DVOC makes recommendations to the Utilization Management/Quality Improvement (UM/QI) Committee, which ensures:

- Regulatory compliance with all State, Federal and NCQA requirements
- Review of quarterly reports
- Compliance with all processing and oversight procedures
- Regular monitoring and verification of compliance of delegated activities and contractual obligations

Recommendations regarding contract performance and compliance are reported monthly by the DVOC to the UM/QI Committee comprised of the following key health plan individuals:

- Chief Executive Officer
- Chief Operating Officer
- Medical Director(s), Chair
- Legal Participation
- Participating Physicians
- Quality Improvement Director and Manager
- Department Leads
- Compliance Office
- Behavioral Medical Director(s)

### **Sanctions or Penalties**

The DVOC prepares summaries of the annual oversight delegate visits, and presents them to the UM/QI and Credentialing Committees. If corrective action is deemed necessary based on the subcontractor's performance related to Medicaid, CoventryCares immediately notifies the subcontractor of these deficiencies and establishes appropriate procedures to correct any non-compliance matters. If subcontractors are unable or unwilling to implement necessary corrective action within a predetermined period of time, financial and legal remedies are then sought. Sanctions may include financial penalties or termination of the Agreement, if deemed necessary. The agreements with the existing subcontractors contain provisions that allow for financial penalties to be enforced or termination of the Agreement for non-performance of contract requirements and/or the inability of the subcontractor to meet established performance standards. CoventryCares will only execute agreements with subcontractors who meet our



rigorous due diligence criteria. Please refer to **Attachment 15** for a sample performance monitoring report.

- 
2. Describe your method and process for capturing third party resource and payment information from your claims system for use in reporting cost-avoided dollars and provider-reported savings to the Department. Explain how you will use such information. Describe the process you use for retrospective post-payment recoveries of health-related insurance as well as your process for adjudicating a claim involving an auto accident. (Limit to four pages)
- 

Existing processes in our current Southeast Zone will also be implemented in the New West and New East Zones and currently comply with the Commonwealth's cost avoidance and Third Party Liability (TPL) requirements. These processes confirm that the Commonwealth is the payor of last resort, where federal or private health insurance type resources are available. CoventryCares complies with TPL procedures defined by Section 1902(a)(25) of the Social Security Act, 42 U.S.C. 1396(a)(25) and implemented by DPW.

### **Capturing and Reporting**

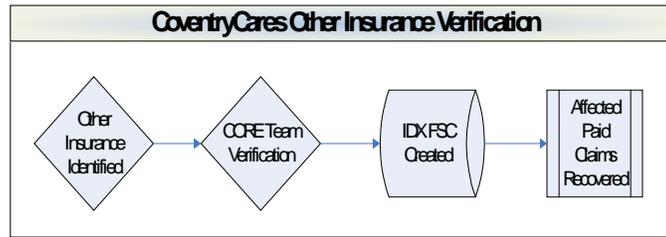
CoventryCares employs both internal and external services for the identification of other primary insurance held by the member. These processes are important to avoid improper payments and to obtain recoveries for our MA product. Various approaches assist in capturing TPL information for the adjudication and accurate payment of claims. CoventryCares complies with DPW's requirements to receive and report any unmatched TPL information.

CoventryCares staff, with direct member and provider contact, are trained to identify and verify insurance information. Members are educated through the member handbook and new "member welcome calls" regarding their responsibility to notify CoventryCares and the Commonwealth of any third party coverage. Upon contact with member services' staff, members are asked to verify other insurance information on an annual basis, or at each point of contact if more often than annual. This contact is documented in our member service console, Navigator.

Evidence of other insurance information received during the claims payment process facilitates TPL identification. Select Claims Examiners and Member Service staff receives a Core Coordination of Benefits (COB) course. Staff passing this course have authority to coordinate claims and add other insurance indicators to the IDX system. This team is responsible for confirming whether a member has other coverage and the coverage type. Based on the outcome of the investigation, the information is loaded into IDX. Figure 13 depicts this process.



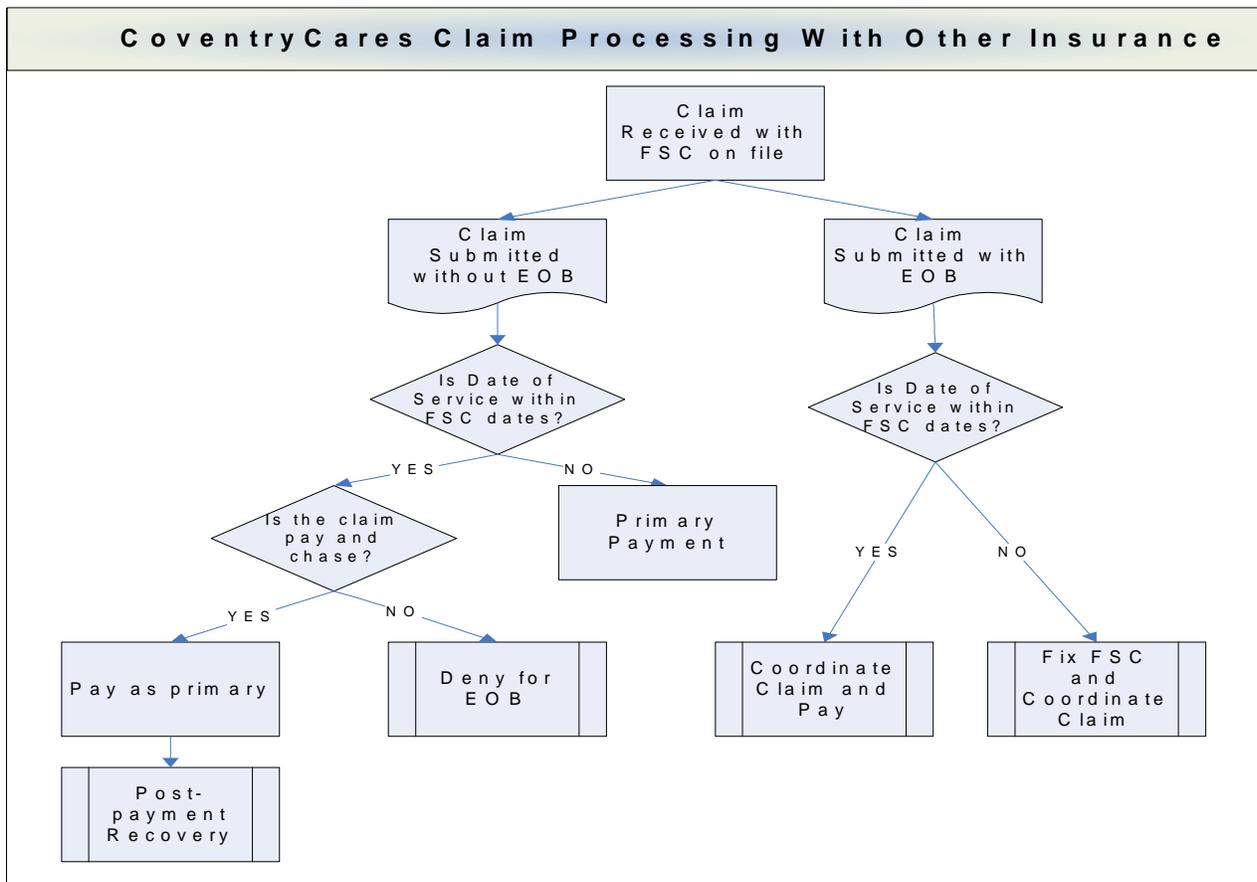
**Figure 13: Other Insurance Verification**



**Information Application**

TPL information is maintained in IDX, Coventry’s integrated claims/enrollment management system. Other insurance information is directly linked with the member’s file as a Financial Status Classification (FSC). The FSC is date-sensitive, details the member’s specific insurance information, and is prioritized to ensure CoventryCares remains the payor of last resort. Figure 14 shows the Claims Processing with Other Insurance process.

**Figure 14: Claims Processing with Other Insurance**





During the claim adjudication process, IDX auto-captures payor information using the FSC, and claims payment is coordinated. Whether received through electronic filing of secondary claims or paper remittance advices sent with a claim, the primary payments are stored in the claim, allowing IDX to assign cost savings and disclose proper adjudication payments and denial reasons. Figure 14 depicts this process.

Edits are programmed in IDX to process clean claims with prenatal or preventive pediatric care, including EPSDT services, and services to children having medical coverage under Title IV-D child support order. We agree to pay such services, cost-avoiding only when a primary carrier has been identified.

CoventryCares complies with the submission of all cost-avoided funds and reported savings, and is prepared to submit data in the requested formats, as identified by the HealthChoices Physical Health Agreement.

### **Retrospective Post Payment Recoveries**

Coventry contracts with an external recovery vendor, First Recovery Group, to handle third party liability collections for occupational disease and workers' compensation. A TPL or subrogation recovery occurs when the recovery vendor determines another party was responsible for the insured's injuries and medical expenses and seeks reimbursement from the responsible party.

The recovery vendor receives monthly data feeds of paid medical and pharmacy claims experience, as well as member and provider demographic information, from CoventryCares. The vendor investigates an exhaustive set of diagnostic and trauma codes, procedural, and billing codes to identify cases that have a potential to be related to workers' compensation and occupational disease.

Once a potential workers' compensation or occupational disease case is identified, the recovery vendor sends correspondence to members to obtain clarification of the facts surrounding the medical expenses. Members can complete the questionnaire and return it via the postage paid return envelope that is included with the questionnaire, or call the recovery vendor toll-free member service line. If contact is not achieved, up to four member questionnaires are sent at 21-day intervals. If the member does not respond to the series of four questionnaires, or the information received is incomplete, the recovery vendor will, at a minimum utilize the following methods of case investigation:

- ISO ClaimsSearch—National Tort database of filed third-party liability claims
- Court Records—A compilation of both state and federal court records covering civil suits filed in state courts and suits filed in federal court
- Other Outside Databases—A variety of internal and external databases examples which include address correction tools
- Media Sources
- Outreach to the member
- Outreach to first responders, providers, homeowners, businesses and prosecutors

After gathering all pertinent data, the vendor will determine if another party was responsible for the insured's injuries and seek reimbursement from the responsible party as allowed by state legislation and



the member agreement. The recovery vendor furnishes multiple monthly reports detailing subrogation activity, including cases open and under investigation, cases closed with and without recovery, member response reports, and member complaint reports.

A coordination of benefits (COB) recovery occurs when one of our vendors or member service staff identifies other primary insurance that was not discovered during the claim payment process and recovers overpayments made to providers or individuals. Sources of COB recoveries include:

- Other commercial insurance
- Medicare
- End-Stage renal Disease (ESRD)
- Pay and chase
- Employer plans for the working aged

Once a potential COB case is identified, overpaid amounts are pursued directly from the primary payor. In addition, overpaid amounts may also be pursued directly from the provider. CoventryCares' system is updated with the other insurance information to enable future cost avoidance. Multiple monthly reports are produced, detailing COB activity including members under investigation and dollars recovered.

Coventry holds monthly telephonic meetings with all recovery vendors and conducts at a minimum, semi-annual on-site meetings. Attendees to the on-site meetings include but are not limited to account management from each vendor and the Directors and Vice President from Coventry's Service Operations. Coventry has experienced extremely favorable outcomes using this investigation and recovery approach. Both TPL and COB recoveries are monitored and reported to CoventryCares on a monthly basis and discussed at monthly meetings dedicated to recovery activities.

### **Adjudication of an Auto-Accident Claim**

When a member is involved in an auto-accident or other injury, the resulting care may be another insurer's responsibility. CoventryCares pays claims involving an auto accident as primary. Procedures are in place to notify and assist DPW's TPL Division to obtain recoveries.

CoventryCares will continue to follow our proven TPL processes for operations in the Commonwealth to preserve and protect health care entitlement funds and minimize inappropriate benefit payout. CoventryCares will continually collaborate to identify opportunities to enhance processes based on specific circumstances.

- 
3. Describe any other cost-saving programs/initiatives you have implemented in the last 36 months and provide information on cost-savings realized related to these programs/initiatives. Please identify cost-savings plans you have planned, but not implemented. (Limit to four pages)
- 

CoventryCares believes strongly that quality health care and cost efficiencies are paramount in achieving the Commonwealth's goals of stability and predictability of Medical Assistance spending



while maintaining high quality. Following best practices, we manage and measure both medical care and utilization to produce better clinical outcomes. This leads to better health and decreased cost.

For several years, Coventry identified a group of Health Care Initiatives (HCIs). HCIs are interdepartmental cost-savings projects. When CoventryCares started operations, it joined the company's monthly HCI meetings. Many existing HCIs were applicable to Pennsylvania MA and were adopted by CoventryCares. CoventryCares also created new HCIs, either specific to Pennsylvania MA or applicable across all lines of business. The collaboration between Commercial, Medicare and Medicaid lines of business has led to an innovative combining of meaningful initiatives with targeted results.

Figure 15 shows the various CoventryCares' past, current and future HCIs.



**Figure 15 CoventryCares' HCIs**

HCI	Start Date	Description	Estimated Savings PMPM
Injectibles / Infusion Management	Oct-10	Utilizing cost-efficient site of service to deliver intravenous medication	\$0.48
In-home sleep studies / APAP	Apr-11	Utilizing Alternating Positive Airway Pressure (APAP) vs. Continuous Positive Airway Pressure (CPAP).	\$0.02
Coordinating claims edits across LOB's	Jun-11	Applying standard industry code editing	\$0.02
Lab Reductions	Jul-11	Unit cost improvements.	\$0.13
Preferred Contracting—Implantables	Jul-11	Contracting with preferred providers to achieve the best pricing for implantable medical devices.	\$0.20
ICORE	Oct-11	Implementing Prior Authorization for chemotherapy and specified intravenous drug for review by appropriate specialists.	\$0.25
CNO Member Transition	Oct-11	Identifying CNO members eligible for other Medical Assistance categories or SSI and assisting them with the transition.	n/a
Phys E&M Coding—Audit Reports	Oct-11	Auditing of claims for up-coding patterns	\$0.05
IVIG / Nufactor	Dec-11	Contracting with a single preferred provider to achieve the best pricing.	n/a
Medical Home Model	Dec-11	Patient-centered Medical Home to drive quality and efficiency	n/a
Cap Vendor Change—Vision	Jan-12	Changing vision subcontractor for improved pricing	\$1.04
Rx Formulary Changes	Jan-12	Savings from formulary changes	n/a
Physician Extender	Jan-12	Adjusting reimbursement for CRNPs and PAs to industry standards	n/a
Pre Admission Testing	Jan-12	Bundling pre-admission testing provided within 72 hours of a procedure into the procedure fee	n/a



II-4: Work Statement Questionnaire

HCI	Start Date	Description	Estimated Savings PMPM
Urgent Care Buildout	Feb-12	Contracting with additional area Urgent Care providers as part of our ED avoidance program	\$0.76
DME to Pharmacy	Apr-12	Provide selected low-mid cost / high volume DME items directly to members through pharmacies with quantity limits but no required Prior Authorization	n/a
Cardiac Cath Prior Auth	Apr-12	Implementing a Prior Authorization policy on elective cardiac catheterizations.	n/a
Improved HEDIS Scores	Apr-12	Working with Quality and Community Outreach on interventions to improve HEDIS outcomes	n/a
Ambulance Vendor	TBD	Contracting with Ambulance vendor for non-emergent transports	n/a
<b>Coventry HCIs</b>			
Edits—annual updates	Jan-12	Changes in our claims processing using new edits from iHealth and Bloodhound	n/a
Recoveries, COB, F&A,	Jan-12	Recouped dollars through Recoveries, Coordination of Benefits and Fraud and Abuse.	n/a
CMCM—Co-Morbid Case Mgmt	TBD	New Coventry Case Management program addressing complex members.	n/a
ECM—Enhanced Case Mgmt	TBD	New Coventry Case Management program providing standard best practices, goals, measurements of success, recording protocol, etc.	n/a
Observation Mgmt	TBD	Case Management	n/a
Observation Mgmt	TBD	Authorization Management	n/a

Reviewing financials for each HCI is essential to determine the amount, or lack, of its success. CoventryCares’ membership is just now reaching adequate numbers to create a financial baseline. The plan is to implement all HCIs now that sufficient members have enrolled. The savings noted above are estimates based on assumptions from CoventryCares first 18 months of operations.



### *Coordination of Care*

1. Describe the procedures and processes you have in place for coordination of care to ensure a smooth transition for MA consumers who transfer between delivery systems during the initial enrollment and auto assignment period, as well as throughout the ongoing program. (This includes the current ACCESS Plus Program) (Limit to two pages)

CoventryCares understands the importance of a smooth transition between delivery systems during the initial enrollment and auto assignment period. At times it can be difficult to reach current members during initial enrollment and auto assignment. Once they become consumers, CoventryCares is committed to locate these members in order to transition them from previous delivery systems.

Upon initial enrollment as well as throughout the ongoing program, whether choosing or auto-assigned to CoventryCares, for all members we:

- Mail Member Kits
- Perform Health Risk Assessments (HRA)
- Make Welcome/Outreach Phone Calls
- Collaborate with other Physical Health MCOs—either the losing or gaining organization
- Perform Behavioral Health Collaboration
- Engage professional relationships with the County Offices of Children Youth and Families and Juvenile Detention Centers
- Review DPW-submitted claims data for new enrollees if available
- Share information with DPW regarding medically fragile children, Special Needs members, member lock-in program members, waiver enrollees
- Coordinate prior authorization
- Perform case management assessments/program enrollment
- Perform daily intensive case rounds that includes the entire physical health care management team—special needs unit, case management, concurrent review, fraud and abuse, pharmacists as necessary, and medical directors



2. Describe the procedures and processes you have in place to ensure continuity of care whenever a MA consumer transitions between and among delivery systems. (This includes the current ACCESS Plus Program) (Limit to two pages)

CoventryCares is committed to ensuring the continuity of care whenever a member transitions between and among delivery systems.

### Identification

Identification is the first step in ensuring the member has continuity of care when transitioning between delivery systems. CoventryCares employs several processes to identify members transitioning to or from CoventryCares and a different delivery system.

These processes include but are not limited to receipt of:

- File transfers from the Department of Public Welfare (DPW)
- Inter Managed Care Organization (MCO) transfer form
- Inquiry from MA consumer to the Special Needs Unit (SNU) or Member Service organization
- Referrals from the Behavioral Health Managed Care Organization (BH-MCO)
- Referrals from the County Offices of Children Youth and Families
- Referrals from Coventry Cares internal outreach coordinators, prior authorization nurses, concurrent review nurses, appeals representatives and the quality team

### Transition

After identifying a MA consumer transitioning between systems, it is important to understand the MA consumer's needs and ensure there are no gaps in care to ensure a smooth transition. All MA consumers are outreached to by either an internal outreach coordinator, case manager or a special needs unit representative. Outreach is initiated at the time the MA consumer becomes effective with CoventryCares. We discuss the member with the prior delivery system, when appropriate, to understand the health care needs.

The member is also empowered at this time to be more accountable and select a PCP of his/her choice. This allows the member freedom of choice and more control over his/her healthcare services. As required, the Special Needs Unit may also do a visit to the member in his/her home or facility to ensure that needs are met and the transition is seamless.

If an member is accessing care from an out of network provider, we contact the provider to discuss the importance of continuity of care and attempt to bring the provider into the network or enter into a limited provider agreement. If full network participation is not achieved the member will be transitioned to an in-network provider when appropriate.

Not only is it important for CoventryCares to recognize MA consumers that are transitioning to our program, it is important to assist a member in transferring to a different HealthChoices MCO or delivery



system. CoventryCares is committed to working with other MCO's to ensure continuity of care and a seamless transition.

### Success Story

Jane D., a MA consumer transitioning from a different MCO to CoventryCares had several medical and behavioral health needs and was in active treatment. The previous MCO contacted the special needs unit and completed the inter MCO transfer form prior to Jane becoming effective with CoventryCares. This prepared the special needs unit team to understand the needs and challenges facing Jane. The special needs unit was able to facilitate the scheduling of Jane's MD appointments, refilling of active prescriptions and education about the medical issues as soon as she became effective with the plan. The special needs unit was also able to attend a doctor's appointment with Jane to build a relationship with her. While Jane has been challenging, the special needs unit continues to work with her to ensure that her needs are met.

Additionally, during the transition and ongoing interaction with Jane, the special needs unit's goals were to empower her to become responsible for her own health care needs. The special needs unit has been effective in the execution of this process and there has been a significant improvement in compliance with the physician's plan of care. Jane has been taking personal accountability for her own care by keeping doctor appointments and staying compliant with refilling prescriptions independently.

In an effort to ensure continuity of care for members transitioning between and among delivery systems, CoventryCares will work with DPW in designing programs that are member-centered and encourage self-sufficiency and personal responsibility in health-related decisions. CoventryCares will introduce programs that will reward members through incentive programs as described in Member Management Question 4 for:

- Enrolling and maintaining participation in case management and disease management programs
- Obtaining necessary preventive care
- Complying with recommended treatment to manage chronic conditions
- Improving health and wellness by engaging in wellness activities

Using online decision-support tools and CoventryCares call centers to increase the use of appropriate health care services.

- 
3. Describe the procedures and processes you will have in place for coordination of care with all current Pennsylvania waiver services and programs (listed and described in Appendix A, "Draft HealthChoices Agreement," Exhibit O, "Description of Facilities and Related Services," and Exhibit P, "Out-of-Plan Services." (Limit to two pages)
- 

CoventryCares understands how crucial it is to coordinate care with all current Pennsylvania waiver services and programs because many times MA consumers are a very vulnerable population. There are times when specific needs can be met outside of MA. Other needs may not be PA MA benefits under the



consumer's plan but are covered by a waiver. CoventryCares works to ensure all special needs individuals continue to receive high quality, necessary health services in conjunction with other agencies and organizations.

### **Exhibit O, Description of Facilities and Related Services**

CoventryCares is aware that many of our members need to be placed in different facilities dependent upon their needs. CoventryCares is committed to ensuring that these members receive appropriate and timely treatment during their stay at the facility and transition from these facilities seamlessly.

Members utilizing waiver programs or facility services are identified in numerous ways:

- Notification by DPW
- Concurrent Review
- Claims data (updated monthly)
- Notification from member/member's family
- Provider notification
- Authorization request
- Collaboration with waiver and community based organizations

When a member is identified as being in a facility or related service, the Special Needs Unit (SNU) or case management team reaches out to the member or the facility to ensure care coordination. The team will reach out to do the following:

- Determine any current medical, social or behavioral health needs
- Determine if the member will transition to a different service delivery system and discuss seamless coordination
- Form a relationship with the member, caregiver or facility

If the team is unable to reach the facility or the member, or it is a challenging issue, the case manager or SNU will attempt to do an in person visit. CoventryCares encourages in person visits, when appropriate, to assist members in care coordination especially with members who are receiving waiver services or are confined to a facility.

If a member is receiving care from a non participating provider, the SNU or case manager will contact the provider to form a relationship as appropriate. This is to establish a limited provider agreement or to recruit the provider to become a participating provider. This will ensure there are no gaps in care for the member.

The discharge plan is critical to care coordination with these facilities. If a member is transitioning to a home environment, the case manager and SNU will facilitate required medical and social services prior to discharge. Once the member is transitioned home, the case manager or the SNU will conduct a home visit, if appropriate, to make sure all needs are being met and to assess any further needs. If the member is transferring to a different service delivery system, the special needs unit or case manager will provide appropriate information to the new service delivery provider to ensure coordination of care.



**Exhibit P, “Out-of-Plan Services”**

When a member is placed in out of plan services such as a transitional care home, medical care foster services, early intervention services, and or waiver programs, CoventryCares ensures the member’s care coordination is a team effort and not disconnected because different systems are involved. These members are identified using the same techniques as noted above.

The non-participating provider is engaged to discuss the medical necessity of the services, provide authorization if required, establish a limited provider agreement, recruit for participation in the network, and collaborate on care coordination and discharge planning.

Upon identification of that a member is receiving out of plan services, the special needs unit or case manager will outreach to the member and or caregiver. At a minimum, the team will assess the following:

- Current environment (home or facility) and current medical needs
- Details of out of plan services and contact information
- Caregivers, social supports, and social needs

Upon completion of the assessment and agreement from the member to care coordination, the case manager or SNU will outreach to the appropriate parties to form a working relationship and assist in making sure the member’s needs are met. CoventryCares believes in personal interaction and if appropriate will meet the member and appropriate parties to ensure care coordination. Once all needs are met the case manager or SNU will outreach to the member and other appropriate parties at least monthly to monitor the continued delivery of services and ensure coordination of care.

CoventryCares is committed to providing outstanding service to meet the member’s needs.

CoventryCares believes working with the different systems as an active team member is the most effective approach to successfully assist members in not only meeting their needs, but empowering consumers to take responsibility for their own health care needs.

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4. What are your processes for transitioning and coordinating care for membership 21 years and under as they age into adult categories of assistance that may provide less service coverage? Describe your strategy moving forward to improve coordination of care. (Limit to two pages)
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CoventryCares is dedicated to transitioning and coordinating care for members 21 years and under as they age into adult categories. It is imperative to transition these members successfully because they will no longer receive all EPSDT benefits. Members who require assistance are:

- Medically fragile children and young adults
- Healthy young adults
- Children aging out of foster care



## Medically Fragile Children

Early identification is the key to a successful transition to adult services from EPSDT covered services and shift care nursing. CoventryCares process for transitioning and coordinating care for these members includes:

- Notification and collaboration with DPW for transition starting as early as age 14 years based on certain medical conditions
- Scheduling team and family meetings to bring all service providers together for coordination of care (this may include: the member, family/caregiver, home nursing agency personnel, community organizations, waiver program representatives, social services, behavioral health, DPW, SNU and case management)
- Identification of required medical, financial, behavioral and adult provider needs
- Facilitating application for potential waivers, community resources and other appropriate funding sources
- Identification of potential adult service providers in the member's geographic location for consideration by the member/family/caregiver
- Contacting the selected provider to initiate service for the member
- Arranging transportation if required
- Facilitating the continued relationship with the current pediatrician if a suitable adult provider is not identified (during the transition phase, the member may visit both his/her current pediatric medical provider and the adult medical provider without visit or calendar date limitations)
- Monthly follow up by the SNU or case manager for a minimum of two months

## Healthy Young Adults

The process for transitioning and coordinating care for a Healthy Young Adult losing his/her EPSDT services at age 22 years includes:

- Assisting the members in locating willing adult practitioners in the member's geographic area
- Presenting all available options to the member to empower him/her to make a solid informed decision regarding preventive and illness related medical services
- Arranging transportation if required by the member
- Follow up after the transition has occurred to answer any questions or concerns the member may have

CoventryCares continues to look at new and innovative approaches to the transitioning and coordination of care for both Medically Fragile Children and the Healthy Young Adults. CoventryCares is committed to ensuring required medical services are coordinated.

In an effort to ensure a smooth transition for both Medically Fragile Children and the Healthy Young Adults, CoventryCares will work with DPW in designing programs that are member-centered and



encourage self-sufficiency and personal responsibility in health-related decisions. CoventryCares will introduce programs that will reward members through incentives as described in Member Management Question 4 for:

- Enrolling and maintaining participation in case management and disease management programs.
- Obtaining necessary preventive care
- Complying with recommended treatment to manage chronic conditions
- Improving health and wellness by engaging in wellness activities
- Using online decision-support tools and CoventryCares call centers to increase the use of appropriate health care services

### **Aging Out of Foster Care**

Perhaps the most stressful period for children in Substitute Care is the period surrounding their 18<sup>th</sup> birthday. These youth need to decide whether to leave the Public Welfare system or remain by continued enrollment in an educational activity. Assistance with the transition period is essential to the child's overall health and wellbeing. This includes both the time leading up to the decision and adjusting life by themselves in the "real" world or in the environment of a new school.

CoventryCares continues to look at new and innovative approaches to the transitioning and coordination of care for both Medically Fragile Children and the Healthy Young Adults. CoventryCares is committed to ensuring required medical services are coordinated. CoventryCares' SNU is equipped to assist these youth through this difficult and frightening phase. Transitioning starts several years prior to age 18, as a case manager forms a relationship with the youth and starts promoting self-sufficiency. Our SNU staff also assists the member locate and access available resources specific for those transitioning out of Foster Care.

Pennsylvania's Independent Living Program is a state-administered, program for foster children ages 16-21. It teaches them skills to live on their own for when they will no longer be under the care of a Children and Youth agency. The Chafee Education and Training Grant (ETG) Program offers grants to Pennsylvanians aging out of foster care who are undergraduates at an approved post-secondary institution. The Orphan Foundation of America helps Foster Children attend college and vocational school, focusing on scholarships and mentoring. The Jim Casey Youth Opportunities Initiative forms community partnerships around the country with the goal of helping those leaving foster care become financially literate, gaining experience with the banking system, assets for education, housing and, health care, and access to educational, training, and vocational opportunities.



5. Describe your plan to create, maintain, and continuously improve collaboration with HealthChoices Behavioral Health Managed Care Organizations (BH-MCOs). Include a description of methods you will use to exchange information relevant to ensuring care coordination using behavioral health utilization data provided by the Department. (Limit to two pages)

Since entering the Southeast Zone in April of 2010, CoventryCares established and maintained ongoing collaboration with the HealthChoices Behavioral Health Managed Care Organizations (BH-MCOs). Our SNU and case managers communicate directly with case managers from the BH-MCOs and behavioral health community organizations to coordinate service delivery for members with behavioral health needs. The SNUs of both CoventryCares and Community Behavioral Health meet monthly to discuss particularly challenging MA members.

To improve collaboration:

- CoventryCares will partner with and meet monthly with other BH-MCOs as individual members with medical and behavioral needs are identified. We will invite the BH-MCOs to join our daily inpatient case reviews to discuss MA members with co-morbid physical and behavioral health illnesses.
- The SNU, in conjunction with the BH intensive case manager, will arrange transportation for medical treatment for MA members.
- The special needs unit and case managers will be engaged to complete home, shelter and hospital visits to assist MA members with medical and behavioral health needs and coordinate their care.

CoventryCares proactively identifies MA members with co-existing medical and behavioral needs through:

- Data files received from the BH-MCOs
- Health Risk Assessment (HRA) data
- Claims data
- Prospective risk modeling
- Utilization management (UM) process outputs, including discharge planning
- Pharmacy file feeds received from DPW to identify and alert the BH-MCO of members who may have issues with non-adherence to anti-psychotics and mood stabilizers, multiple prescribers for BH medications or, over- and under-utilization (e.g., inadequate dosage of antidepressant medications or more than 3 atypical antipsychotics)

We also coordinate with the BH-MCOs to seek referrals on MA members being followed for BH inpatient or outpatient treatment. Such a collaboration occurred on case Robert D., where our special needs unit worked with the BH-MCO when Robert moved to Philadelphia from Florida (See Success Story below.). Robert was living in a shelter with his guardian who is HIV+. The special needs unit worked in collaboration with the BH-MCO, and the Commonwealth, for Robert and his family to get housing and to get Robert enrolled for educational services through a specialized classroom. The special



needs unit collaborated with the PCP to provide Robert with ADHD medications prior to getting established with a psychiatrist. Robert is currently going to weekly therapy appointments, and monthly to see the psychiatrist. Robert is also involved in the head injury program (HIP) through the Department of Health and Human Services.

CoventryCares continues to look at new and innovative approaches to collaborating with the HealthChoices BH-MCOs to ensure required medical and behavioral health services are coordinated to meet the needs of the member.

Moving Forward CoventryCares will work with DPW in designing programs that are member-centered and encourage self-sufficiency and personal responsibility in health-related decisions. CoventryCares will introduce programs that will reward members through incentive programs as described in Member Management Question #4.

- Enrolling and maintaining participation in case management and disease management programs
- Obtaining necessary preventive care
- Complying with recommended treatment to manage chronic conditions
- Improving health and wellness by engaging in wellness activities
- Using online decision-support tools and CoventryCares call centers to increase the use of appropriate health care services

### Success Story

Such collaboration occurred on case, Robert D., where our SNU worked with the BH-MCO when Robert moved to Philadelphia from Florida. Robert was living in a shelter with his guardian who is HIV+. The SNU worked in collaboration with the BH-MCO, and the Commonwealth, for Robert and his family to get housing and to get Robert enrolled for educational services through a specialized classroom. The SNU collaborated with the PCP to provide Robert with ADHD medications prior to getting established with a psychiatrist. Robert is currently going to weekly therapy appointments, and monthly to see the psychiatrist. Robert is also involved in the head injury program (HIP) through the Department of Health and Human Services.

CoventryCares continues to look at new and innovative approaches to collaborating with the HealthChoices BH-MCOs to ensure required medical and behavioral health services are coordinated to meet the needs of the member.

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6. Describe the process you will use to coordinate with County Offices of Children, Youth and Families to ensure that Children in Substitute Care receive necessary services. (Limit to two pages)
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To provide individualized services to a population with diverse needs addressed by multiple disciplines, CoventryCares SNU manager is the single point of contact and liaison with the County Offices of Children Youth and Families. We ensure that children in foster care or juvenile detention have access to



and are receiving, preventive healthcare including Early Periodic Screening Diagnosis and Treatment (EPSDT), routine dental care, lead screening, and behavioral health services.

### **Process to Ensure Service Delivery**

CoventryCares takes a proactive approach to ensure that these children receive necessary services and eliminate gaps in care. CoventryCares uses the information received from the Commonwealth eligibility file to identify members in foster care or juvenile detention centers. These members are also identified by the health risk assessment (HRA), the EPSDT outreach coordinator and the SNU. Any member identified in substitute care is contacted to determine if case management or SNU services are required. The case manager or SNU works in conjunction with the county OCYF liaison to coordinate service delivery. CoventryCares is responsible for the physical health and coordinating with behavioral health needs during the first 35 days of a member's placement in a juvenile detention center.

CoventryCares uses an analytic tool to identify through claims data members lacking certain preventive care services. Upon identification, we send notice letters to both the member's PCP and the Administrator of the County Office of Children, Youth and Families, advising of any missed visits. The SNU manager collaborates with the liaison for County Offices of Children Youth and Families to make sure that services are available and obtained.

Ongoing and follow-up health care and treatment is determined and arranged based on individually-identified needs. Ancillary health care services such as specialist, pharmacy, inpatient care, diagnostic imaging and physical therapy are coordinated through our vendors and medical partners in the community.

CoventryCares works to engage families and youth to ensure healthy development and access to healthcare services. Our case managers and SNU work directly with the County Children and Youth Administrator, foster family or juvenile detention center to provide education on available services and to encourage and coordinate EPSDT, routine dental care, lead screenings, and behavioral health services. Through our case management program and SNU, we have developed working relationships with the County Assistance Offices to ensure that if there are member address changes or relocations, we are able to locate and continue to follow the member.

### **Success Story**

In Southeastern Pennsylvania, SNU and the Philadelphia County OCYF have an effective working relationship. Sandy P. was identified as being in substitute care and pregnant. The OCYF informed CoventryCares of her case worker and SNU was able to make contact and offer services. Sandy P. was referred to an obstetrical case manager who is following her case to ensure she is getting the required prenatal care to support a healthy delivery for Sandy and her baby.

In an effort to ensure that Children in Substitute Care receive necessary services, CoventryCares will work with DPW in designing programs that are member-centered and encourage self-sufficiency and personal responsibility in health-related decisions. CoventryCares will introduce programs that will reward members through incentive programs as described in Member Management Question 4 for:

- Enrolling and maintaining participation in case management and disease management programs



- Obtaining necessary preventive care
- Complying with recommended treatment to manage chronic conditions
- Improving health and wellness by engaging in wellness activities
- Using online decision-support tools and CoventryCares call centers to increase the use of appropriate health care services

7. Describe your process for care coordination to ensure that members receive adequate in-home services to divert them from entering long term care facilities. (Limit to two pages)

CoventryCares shares the Commonwealth's goal to help chronically ill, disabled and elderly Medical Assistance (MA) members remain at home or in the community as long as possible. We actively promote home and community based services through discharge planning and case management activities as well as provider education programs. The special needs unit and case management teams have expertise in the physical and psycho-social needs of the elderly, disabled and ventilator dependent members.

CoventryCares is committed to maximizing the member's home health care benefits as well as community resources and alternative funding methods to allow the member to remain in the community in the least restrictive setting possible to meet the member's health care needs.

### Case Management

Our case managers and SNU actively assist members in locating services such as home health, waiver programs and community resources, allowing members to stay in their communities. Our case manager and SNU work with members, their caregiver, and when appropriate, the waiver representative to select approved service providers and arrange for delivery of services. For members who remain with the CoventryCares after qualifying for waiver services, case managers periodically follow up to confirm they are receiving services that meet their needs.

Members may be referred to case management or the SNU for a home and community based services assessment and assistance. They are identified through several sources, including: prior authorization and concurrent review coordinators; case management; family; PCP; community-based organizations; or by the members themselves.

CoventryCares utilizes the health risk assessment (HRA) to identify adult members who may benefit from comprehensive community-based services. The HRA also assists in identifying pediatric members who are ventilator dependent or require shift nursing services. Case managers focus on ensuring required services are received and appropriate waiver services are accessed to keep the individual in the home setting.

When we receive a prior authorization request for home health nursing, long-term care, or the therapy modalities, our prior authorization process determines medical necessity and the case manager follows



up with the member. Our provider education staff also provides training to long-term care facilities to make them aware that we have case managers for long term care needs and to enlist their support in referring members to us for an assessment for home and community based services. We also include information on home and community based services in the provider manual and on the provider website.

Regardless of the source of the referral, a case manager educates members and caregivers on available options and helps them to determine the best set of services to encourage self-sufficiency and that will allow them to live safely in the community instead of a nursing home.

### **Discharge Planning**

CoventryCares' concurrent review nurses work with hospital discharge planners to ensure discharge plans meet the medical and social requirements of members. Our concurrent review nurses use evidence based medical necessity guidelines for determining appropriateness of care. Member's benefits are maximized to allow the highest quality level of care in the community as possible. Members are referred to the CoventryCares' case management team for additional follow up, helping prevent readmissions or subsequent admissions to long term care facilities.

CoventryCares is committed to assisting members in offering services to avoid long term care admissions. Our processes are designed to promote self-sufficiency, maximize the use of home healthcare benefits, prevent long term care facility placement, comprehensively coordinate with community services to prevent decline and support the member in managing his or her health care needs in the home or community environment.

### **Success Story**

CoventryCares has successfully assisted Levi P's family in keeping him home rather than placing him in a transitional care or medically fragile home. Levi is 18 months old, but he was born prematurely with several medical conditions. Shift nursing care and infusion services in the home were provided to prevent institutionalization. The shift nurses educated his mother on how to care for him. The SNU has visited Levi and his family and has attended several medical appointments. English is the family's second language, so the SNU assisted in accessing the language line and bi-lingual physicians when appropriate. The entire medical team has effectively assisted in keeping this family together and Levi is thriving in the comfort of his home.

In an effort to ensure that members receive adequate in-home services to divert them from entering long term care facilities, CoventryCares will work with DPW in designing programs that are member-centered and encourage self-sufficiency and personal responsibility in health-related decisions. CoventryCares will introduce programs that will reward members through incentive programs as described in Member Management Question 4 for:

- Enrolling and maintaining participation in case management and disease management programs
- Complying with recommended treatment to manage chronic conditions
- Using online decision-support tools and CoventryCares call centers to increase the use of appropriate health care services



8. Describe the procedures and processes you will have in place to comply with Department requirements related to the Enhanced Medical Home (EMH) model (as described in Appendix A, “Draft HealthChoices Agreement,” Exhibit M(1), “QM/UM Program,” under Standard V, Letter F). (Limit to two pages)

**Embedded Case Managers in High Volume Practices (HVPs)**

We will work collaboratively with other PH-MCOs and the Department to efficiently and effectively embed case managers in HVPs. We intend to contribute our pro rata share of resources, either the care management function or funding, to the HVPs in a manner that assures a meaningful impact on the health of our members.

CoventryCares has three programs that supplement the contractual requirements:

- Our company’s Shared Savings Program (SSP; see program description below) provides a per member per month (PMPM) care management payment to select practices across all of our lines of business. HVPs could receive funding proportional not only for their MA members, but also for their entire practice population. This would more fully support the overhead necessary to be a successful Enhanced Medical Home. To the extent that PMPM payments are made to HVPs for their MA members through our SSP, we would deduct that from funding required from DPW.

<b>CoventryCares Shared Savings Program (SSP)</b>	
<i>Program Features</i>	<i>Program Goals</i>
<ul style="list-style-type: none"> <li>• Up-side only shared savings opportunity</li> <li>• PMPM care management fee to providers</li> <li>• Practice support</li> <li>• Tools and analytics</li> <li>• Clinical and Provider Relations</li> <li>• Local learning collaboratives to maximize provider-payor and provider-provider communication and best practices</li> </ul>	<ul style="list-style-type: none"> <li>• Improve the quality of care provided to consumers</li> <li>• Increase satisfaction of consumer</li> <li>• Appropriately reward Participating Providers for improvements in the quality and efficiency of care provided to consumers</li> <li>• Provide an environment which supports physician collaboration and the principles of evidence based medicine</li> </ul>

- Our Care Management Outreach Nurses (CMONs) serve as embedded case managers and Transition of Care (TOC) nurses, as well as handling additional interventions. These specially trained nurses contact high risk consumers face-to-face in their homes, as well as during provider visits, medical testing and inpatient stays. This enables CMONs to uniquely identify and resolve previously unknown barriers to care such as psycho-social concerns and practical issues in the member’s environment. By connecting the health plan, providers and outside resources, CMONs facilitate navigation of the medical system, and proactively prevent unnecessary ED visits and inpatient admissions.



- CoventryCares plans to assign an Outreach Coordinator to HVPs that meet a minimum threshold number of MA members to assist the HVP with:
  - Identification of MA members with gaps in care
  - Outreach to MA members to arrange for needed care
  - Administration of applicable MA consumer and provider incentive programs

### **Transition of Care (TOC) nurses to work with high volume health systems**

The focus of our TOC program is on members at high risk for re-admission to an acute care, rehabilitation or skilled nursing facility and who transition to another setting. Case managers engage the MA members by visiting them in their hospital room prior to discharge, or contacting them in their homes within 48 hours of discharge. Case managers then perform weekly telephonic outreach for up to 30 days after discharge. The goals of TOC management are:

- Timely physician follow-up
- Medication reconciliation
- Initiation of personal health records to enable MA members to self-manage their medical needs

### **Working with HVP(s) to achieve NCQA Medical Home recognition**

We are prepared to participate actively with HVPs, other PH-MCOs and DPW in initiatives that support HVP achievement of NCQA Medical Home recognition. We will provide support for achievement of such recognition. In addition, SSP care management pmpm payments, as described above, could be used to support HVP achievement of recognition.

### **Participation With Regional Learning Network Collaboratives**

We will dedicate resources to participate in designated activities related to regional learning network collaborative which are one of the four pillars of the EMH. These collaborative were established under Governor Rendell's program known as Pa Prescription for Pennsylvania. Learning Collaboratives are meetings for training on how to transform managed care delivery of services to conform to the patient-centered Medical Home and Chronic care models. CoventryCares will participate in these ongoing seminars.



9. What methods do you use to ensure the quality of care delivered by out-of-network providers? Describe any potential barriers and the resolution process. (Limit to two pages)

When a CoventryCares member requires services of an out-of-network provider, we attempt to contract with the provider or set up a Limited Provider Agreement.

The Limited Provider Agreement provides a framework for CoventryCares' expectations:

- Payment provisions
- Quality of care, including sharing of member medical records
- Medical management, utilization management processes
- No-balance billing of the member

### Quality of Care

Any potential quality issue identified with an out-of-network provider is reported to the Quality Improvement department.

CoventryCares has an established process for tracking and reporting Quality of Care issues and Adverse Events for all services provided to our members. Events are identified through coding on claims data and referrals from our clinical team. The Quality Improvement (QI) Department investigates any identified issues including care provided by out-of-network providers. Quality of care concerns may also be identified through member complaint calls.

### Resolution

When an Adverse Event or member complaint is received regarding an out-of-network provider it is investigated and documented. The provider or facility may be contacted and medical records may be requested for more information about the event. If, after review by the QI team the case can be resolved, it is closed. If the case is of a more serious nature, it is forwarded to a Medical Director for additional review. The Medical Director may close the case after review or recommend that it be presented to the QI/UM Committee for peer review. In each case, all information is documented and saved for reference in the event the provider is considered for future referral.

### Potential Barriers to Ensuring Quality

Providers not contracted or credentialed with CoventryCares are used on an exception-only basis. Out-of-Network providers without a Limited Provider Agreement (e.g. family planning) have no contractual obligation to comply with CoventryCares requests for information to investigate complaints. Limited Provider Agreements are employed to communicate our expectations for compliance with quality improvement procedures to ensure quality of care in these instances where out-of-network providers deliver care to CoventryCares members.



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## Pharmacy

1. Describe your approach to control pharmacy costs. Describe programs/initiatives that have been successful at controlling costs. (Limit to three pages)
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CoventryCares' approach to ensuring cost control is to employ a dynamic process through the Pharmacy and Therapeutics (P&T) Committee. The committee is responsible for the development of policies that impact unit cost, access, dispensing rules and transactional controls combined with unit cost contracting focused on net price for retail, specialty and generic drugs. CoventryCares has assembled a "best-in-class" pharmacy team by building on the extensive managed care experience of HealthAmerica and our corporate parent, Coventry, to ensure quality care, as well as cost-effectiveness for the HealthChoices Program. Each team member contributes to controlling pharmacy costs:

- CoventryCares' Medical Assistance and P&T Committees establish policies impacting unit cost, access and dispensing rules
- The Clinical Call Center facilitates P&T policies requiring prior authorization by providers
- CoventryCares collaborates with our Pharmacy Benefits Manager (PBM), Medco Health Solutions, Inc. (Medco), to develop collaborative utilization programs
- Medco rebate services and pharmacy provider network ensure unit cost focus and execution

CoventryCares recognizes our responsibility to ensure DPW approval for our cost control policies. CoventryCares' formulary policies and procedures are fully compliant with the HealthChoices program's guidelines as set forth in Exhibit BBB (1)—Drug Formulary Guidelines—of this RFP and are currently approved in good standing with DPW for members in our other HealthChoices Zones.

With 37 years of experience providing commercial and Medicare health care solutions in the Commonwealth of Pennsylvania, as well as CoventryCares' current experience with MA in the Southeast Zone. We round out our solution for the Pennsylvania HealthChoices Program with our pharmacy benefits administrator, Medco. Medco has an ongoing contractual relationship with Coventry to support our provider network and drug rebate negotiation, contracting, invoicing and collection process for our multiple market areas.

### Cost Containment Measures

Pharmacy costs continue to increase annually. Inflation in branded drugs accelerated to an all-time high of 9.2%, nationally, in 2009. Key drivers are:

- Introduction of new specialty drugs for chronic and/or common diseases
- Introduction and market expansion for high-cost injectable medications for chronic diseases
- Inflation on existing drugs at several multiples of the Consumer Price Index
- Utilization increases effective

Effective methods of cost containment are essential to maximize program dollars while still allowing the improvements in care that new medications may provide.



Our pharmacy program offers proven cost containment measures. In the Southeast Zone, many of these measures are developed and monitored under the auspices of the CoventryCares and Coventry National Medicaid P&T Committees.

The CoventryCares MA P&T Committee has developed a formulary of therapeutically appropriate and cost-effective pharmacy products, grounded in evidence-based guidelines, FDA data, national standards and cost-benefit evaluations that meets the needs of members and providers and is currently utilized in the Southeast Zone.

#### **Our Proven Cost Containment Measures**

- Formulary Management
- Prior Authorization
- Dose Optimization and Quantity Limits
- Generic Medications
- Coordination of Benefits
- Unit Cost

### **Formulary Management**

Coventry, HealthAmerica and CoventryCares are continuously focused on balancing cost and quality to ensure the best value while maintaining positive outcomes for our members.

Effective formulary management is dependent upon providing sufficient choice to meet medical needs, while maintaining enough market shares to impact unit cost requirements. For example, Lexapro<sup>®</sup>, one of the top selling drugs in the United States and the last branded drug in its therapeutic class does not offer the same clinical value as the generic alternatives. Through formulary management Coventry has successfully steered 95% of this therapeutic class utilization to a generic drug in 2011Q3. These generic medications offer a lower cost alternative to Lexapro without sacrificing clinical efficacy or outcome.

### **Prior Authorization**

Prior Authorization (PA) is a method of pharmacy benefit administration designed to encourage cost-effective use of drugs. Traditionally, drugs clinically suited to PA requirements consist of high-cost and/or high utilized drugs subject to misuse, abuse or over-utilization. The development of clinical criteria for PA ensures that at-risk medications are used in the most cost-effective and medically necessary situations. When developing PA criteria, CoventryCares ensures that PA requirements do not compromise the quality of care provided to members.

PA protocols are an effective tool in influencing prescribing patterns. As an example, CoventryCares has appropriately managed the use of the asthma medication Singulair, when used to treat allergy symptoms, to those members who have failed treatment with oral non-sedating antihistamines, Claritin OTC or Zyrtec OTC, and generic corticosteroid nasal sprays. This approach provides a positive health outcome by promoting proven and more effective therapy ahead of a more expensive branded medication.

### **Dose Optimization and Quantity Limits**

Many of today's newer drugs are approved by the Food and Drug Administration (FDA) as safe and effective when taken in one tablet or capsule daily. Many of these drugs are priced identically regardless of strength. For example, the drug Lexapro costs approximately \$180 when two 10mg tablets are prescribed compared to \$90 when one 20mg tablet is used, resulting in an additional annual cost of \$1,080 without improvement in outcomes. CoventryCares' DPW-approved list of agents subject to dose



optimization includes once daily drugs as indicated above and drugs following manufacturers' maximum approved doses and drugs with standard dosing regimens in treatment guidelines.

Quantity limits prevent unsafe utilization and waste by limiting the quantity of a drug that can be dispensed at a given time. For example, broad spectrum antibiotics are typically limited to a 10 or 14 day supply, the duration of treatment for most infections, to minimize the potential for overuse. Medications for aborting migraine headaches, when used too frequently, actually cause a migraine, so quantity limits prevent access to unsafe quantities of these medications.

### Generic Medications

A generic medication is chemically equivalent to its brand name counterpart in form, function and effect. The formulary actively promotes generic medications through covering only the generic product to an A/B rated Formulary Brand Name Drug and promoting generic therapeutic alternatives for branded medications not yet available generically. Accordingly, CoventryCares average generic fill rate (GFR) exceeded 81% for 2010 and is approaching 83% YTD for 2011, making CoventryCares from HealthAmerica a leading performer in among Coventry's Managed Medicaid plans in GFR and besting the Coventry National Medicaid GRF averages for both 2010 and 2011 YTD.

**Generic Fill Rate**  
CoventryCares average generic fill rate exceeded 81% for 2010 and is approaching 83% YTD for 2011.

When placing a brand drug on our formulary, we keep an eye on the drug's future generic availability in addition to its efficacy and safety. This ensures as new generics emerge CoventryCares is positioned to immediately reap the benefits of this enhanced value. Furthermore the outlook for new generics in 2012 is strong. We will further improve our GFR and value of CoventryCares formulary options as drugs in highly utilized drugs become generics. Avapro and Avalide, Geodon and Seroquel are all presently brand formulary agents which will close out 2012 as equally effective but less expensive generics.

### Coordination of Benefits (COB)

MA is always the payor of last resort. All resources or payments are considered prior to CoventryCares. CoventryCares recognizes the importance of this fiscal responsibility. The Medco claims adjudication system supports COB functionality available in the current HIPAA Pharmacy Transaction Standard, NCPDP v.5.1, and is used in pharmacy administration for CoventryCares claims. This process avoids cost at the point of sale and "pay and chase."

### Unit Cost

Realizing low unit cost is ultimately a result of contracted pricing, policies impacting actual agents used and the effective integration of quantity and dosing claim edits at the point of sale.

Coventry includes Medco in its pharmacy team to ensure the highest level of expertise and focus is provided to acquisition cost contracting for drugs through retail and specialty channels. Medco's national network capabilities ensure the CoventryCares' HealthChoices program has a strong foundation of network pricing.



## Waste, Fraud and Abuse

Appropriate prevention and detection of potential fraud waste and abuse of a members benefits is an important element in controlling costs. In addition to the Prior Authorization and Dose Optimization and Quantity Limits to control waste as noted above. The responses to the Waste Fraud and Abuse section of this RFP further detail how CoventryCares controls for this potential inappropriate spend.

2. Describe your policies, procedures or processes for conducting both retrospective and prospective drug utilization review within the MA Program's Drug Utilization Review guidelines. Provide evidence of success. Describe your strategy moving forward to improve performance in this area. (Limit to four pages)

Our formulary clinical rules and prior authorization rules are always centered around assuring the most appropriate medication is used. For example, we have been able to take advantage of new generics within the atypical antipsychotic area that became available in 2011 and early 2012, as well as new ADHD generic medications—both of which will yield significant cost reductions for these high-volume medications.

CoventryCares partners with our PBM, Medco Health Services (Medco) to provide the Commonwealth of Pennsylvania with outstanding pharmacy management services for the HealthChoices Program. The CoventryCares pharmacy team brings the clinical expertise and tools necessary to support all aspects of prospective drug utilization review (ProDUR) and retrospective drug utilization review (RetroDUR) programs, as it currently operates in the Southeast Zone

The objectives of our drug utilization review (DUR) programs include:

- Meet the OBRA '90 mandates for performance of these functions at the point of sale as ProDUR and RetroDUR to review performance and perform identified interventions.
- Prospectively and retrospectively review member and provider activity to determine conformance with therapy regimens, evidence-based medical guidelines, and practice protocols. In addition, we focus on the claims data to identify necessary new clinical edits or to detect any potential for fraud and abuse, by either the member or the provider.

### CoventryCares Drug Utilization Review Goals

- Reduce the incidence of preventable adverse drug events
- Promote efficacious and cost-effective therapy
- Reduce the incidence of mis-billing, fraud and medication abuse

Key to a successful ProDUR and RetroDUR program is the availability of tested and reliable technical tools to support the process. Medco's point-of-sale (POS) and clinical management systems support the ProDUR process. Utilizing Medco's claims data, Coventry's dedicated Data Support Team supports the analysis and intervention processes required for successful RetroDUR. CoventryCares has a strong integrated, clinical management team that understands DUR and actively seeks out opportunities for improving care by analyzing data and implementing programs that improve quality of care and member access.



### **Retrospective Drug Utilization Review (RetroDUR)**

CoventryCares has a RetroDUR systems logic to identify and profile members, pharmacy providers, prescribers and disease states based on our extensive experience in managed care. State-specific historical data is used to identify trends of interest and variables that can be used as reliable predictors of subsequent outcomes. RetroDUR programs include the standard member exception-based program, as well as pharmacy provider, prescriber, and disease state profiling. The RetroDUR is supported by a fully integrated data warehouse of both pharmacy and medical data. Our RetroDUR program addresses both high-risk and high cost/utilization drug therapies for the drugs and therapies of the member population. The proposed RetroDUR program for both members and pharmacy providers/prescribers provides trend information needed to educate pharmacists and prescribers by identifying excessive, inappropriate, or medically unnecessary drug usage.

Both provider profiling and member-focused RetroDUR are utilized by internal staff to identify trends in provider prescribing practices and member behavior, including over-utilization. The poly-pharmacy feature of RetroDUR also identifies potential over-utilization of resources by members. The provider profiling and member-focused RetroDUR Criteria Exception reports are utilized to identify areas in which there is deviation from normal prescribing and utilization as defined by individual criteria.

Integrating CoventryCares' experience and knowledge with the functionality to perform RetroDUR from Medco's POS claims system produces powerful processing capabilities. These capabilities provide easy and efficient access to complex health care management and analysis information (medical and pharmacy) through menu-driven queries for our CoventryCares members. The HAP tool in Medco's POS system can be used to identify and stratify members that are either high-risk or high utilizers due to diseases or co-morbidities. Once data is analyzed, CoventryCares' staff determines the member's applicability for inclusion in the integrated case management program. Once identified, these members are tracked within the CoventryCares Navigator Care tool, which is used by clinical case management staff to track all members' activities, schedules, claims and interventions.

Intervention opportunities are identified by the clinical review panel, and DPW-approved intervention letters are sent to the prescribers and providers as appropriate. The lock-in process may also be utilized in cases where certain types of member over-utilization are identified.

### **Prospective Drug Utilization Review (ProDUR)**

Pre-dispensing drug utilization review activities are an integral component of our overall commitment to safety and quality. Our strategy is straightforward and effective, and is applied at the time of prior authorization or at the POS. We use prescription claims and other available data to engage providers and pharmacists as team members in member care.

A unique feature of Medco's claims system is to integrate medical claims data with prescription claims data using a sophisticated set of clinical rules and edits to create a member-specific Health Action Plan (HAP). The HAP identifies potential interventions, to CoventryCares' staff, to improve quality of care, including but not limited to, duplications in therapy, omissions in therapy or gaps in care and compliance and/or adherence concerns. The HAP also identifies potential saving opportunities by presenting therapeutic alternative situations.

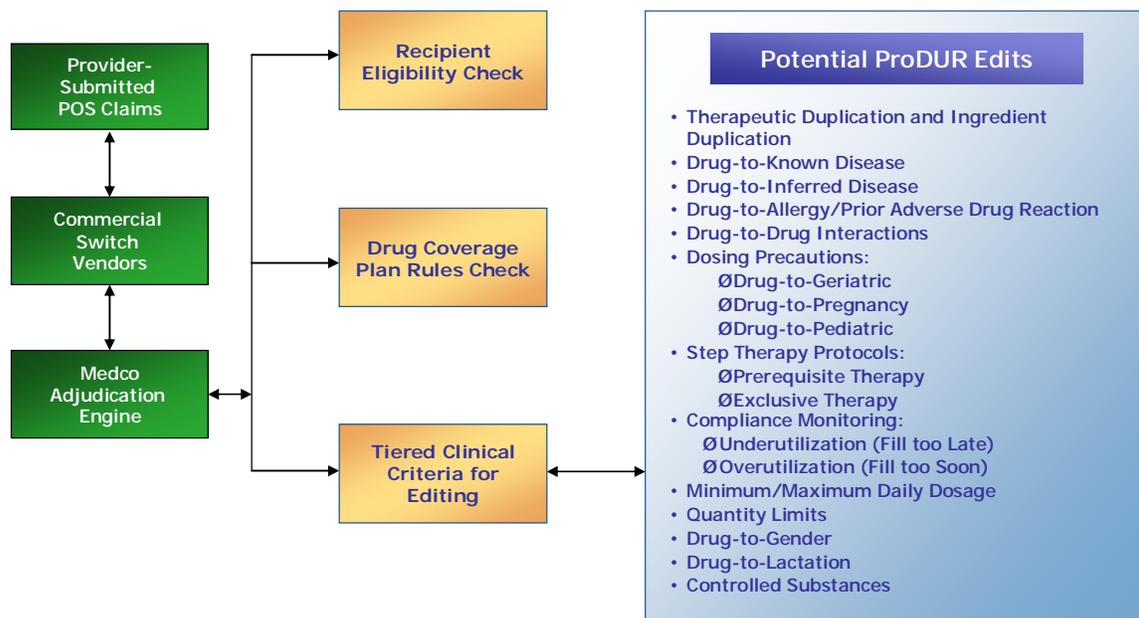


Our ProDUR is a fully integrated component of the Medco POS system, providing a process to apply DUR criteria and standards approved by DPW DUR Board. Through the Medco POS system, we apply selected ProDUR criteria at the point of sale to ensure that only appropriate alerts or denials are transmitted to the pharmacy provider. ProDUR edits are able to be modified using the rules-based structure of the system. CoventryCares' DUR database and algorithms are updated per the required schedule. All new criteria are reviewed by DPW DUR Board. This online, real-time table-driven system has the flexibility to allow changes to be made when needed.

Retail pharmacy claims are transmitted electronically via the POS system and are evaluated according to approved criteria against each member's record (profile). Claims histories include current, historical, paid and denied claims data. If a clinical problem is identified, an alert message is transmitted online to the dispensing pharmacist. The POS system allows us to determine whether these alerts are (1) informational only; (2) use the indicator to cause the claim to deny; or (3) allow an electronic denial/override process at the dispensing pharmacy in accordance with the latest NCPDP standards to capture outcome and intervention codes.

Medco and CoventryCares work collaboratively to create a hierarchical system of clinical rules. In addition to standard therapeutic classifications, drugs can be grouped in any other logical manner, including by disease state or by DPW DUR Board-defined grouping (e.g. all biotech drugs for arthritis). We maintain the ProDUR database and associated algorithms as First DataBank (FDB) criteria are updated with each new file upload from FDB. Figure 16 illustrates the ProDUR process.

**Figure 16: ProDUR Process Flow**





## **DUR Board Participation**

CoventryCares fully understands the roles and responsibilities identified by OBRA '90 and looks forward to continued collaboration with DPW on the administration of the program.

CoventryCares' policies and procedures are fully compliant with the MA Program's guidelines as set forth in Exhibit BBB(2)—DUR Guidelines of this RFP.

## **Provide Evidence of Success and Strategy Going Forward**

Medco assists in supporting both RetroDUR and ProDUR programs for CoventryCares MA enrollees. CoventryCares works with Medco to implement our standard clinical and fiscal edits in the ProDUR system at the point of sale. The focus of our ProDUR program is to identify at the point of sale how to support the member and the provider to ensure both quality and safety in the drug dispensing process. In addition, the ProDUR system looks for any occurrences of potential fraud or abuse or areas where educational intervention may be needed with providers. The POS system is flexible, easily configured and supports all of the CMS-identified ProDUR problem types. We typically implement the most important problem types in our initial implementation and then refine these edits based on the findings of the ongoing program. These edits include: Drug-Drug interaction, Early Refill—looking for potential over-utilization, High Dose Alerts, Therapeutic Duplications and Ingredient Duplication.

In 2010, CoventryCares' first year of supporting the HealthChoices Program in the Southeast Zone, Medco's ProDUR solutions sent 22,641 alerts to dispensing pharmacists on prescription claims. Action was taken by the pharmacist on 7,382 of these alerts, which produced a total of \$157,976 savings. Additionally, for 2011 through October, the ProDUR system sent 56,319 alerts with 19,384 actions resulting in \$519,899 in savings.

Due to the effectiveness of our ProDUR editing program at the point of sale, CoventryCares sees less opportunity for additional savings in the RetroDUR program. We use RetroDUR to validate the success of our ProDUR edits, determine any need for additional refined edits, or determine any drugs or classes of drugs that may need to be part of the prior authorization process. Previous analysis of the RetroDUR process showed a savings of 0.5%-1% of total drug spend.

Both of these approaches to drug utilization management have a broader impact on the prescription drug program through the "sentinel effect", where behavior in the provider network is altered and subsequently impacts drug spend.

Additionally, when negative issues are discovered through this monitoring, a corrective plan is developed, an intervention is designed to correct the issue, and then the intervention's effects are measured, using a standard Quality Improvement process.



3. Describe your pharmacy prior authorization process, including the following:
  - How are prior authorization criteria developed?
  - How are requests for prior authorization made?
  - How do providers (pharmacies and prescribers) and consumers learn about the authorization process and criteria? (Limit to four pages)

### **Development of Prior Authorization Criteria**

CoventryCares' prior authorization process is governed by the National Medicaid P&T Committee of our corporate parent, Coventry, in collaboration with the CoventryCares' P&T Committee. In deciding what drugs to put on the prior authorization list, the P&T Committees consider the safety, effectiveness and cost of the drugs, as well as the medical literature.

Medical literature is in the form of practice treatment guidelines and articles published in peer-reviewed medical journals addressing the subject. Some drugs are relegated to prior authorization because they have only limited medically necessary applications and prior authorization allows us to assure the medication is being utilized in the most appropriate manner. In cases where new clinical data are published, but not yet incorporated into the practice guidelines of the medical organization, we evaluate the data and, where indicated, work through the P&T Committees to change the prior authorization criteria.

CoventryCares continues to expand on and draw from the extensive formulary management experience, and clinical knowledge of Coventry's Clinical Pharmacy Team in the development and implementation of medically appropriate and clinically effective prior authorization services for the Pennsylvania HealthChoices Program. CoventryCares' DPW-compliant policies and procedures support the prior authorization process for selected drugs, including those that are not on the formulary. Medco's pharmacy claims system is able to facilitate the prior authorization process at the point-of-sale (POS). Additionally, CoventryCares has a fully integrated Prior Authorization IT solution called Drug Prior Authorization System (DPAS), which permits for the quick and efficient processing of prior authorization requests submitted to the health plan.

### **Requesting Prior Authorizations**

Pharmacy coverage decisions are made after safety, efficacy and relevant patient and physician-specific factors receive careful consideration. Prior authorization Request Forms, which include the criteria for prior authorization, are available at the website, by calling the voice recognition phone line, or by calling the Clinical Pharmacy Call Center, located in Harrisburg.

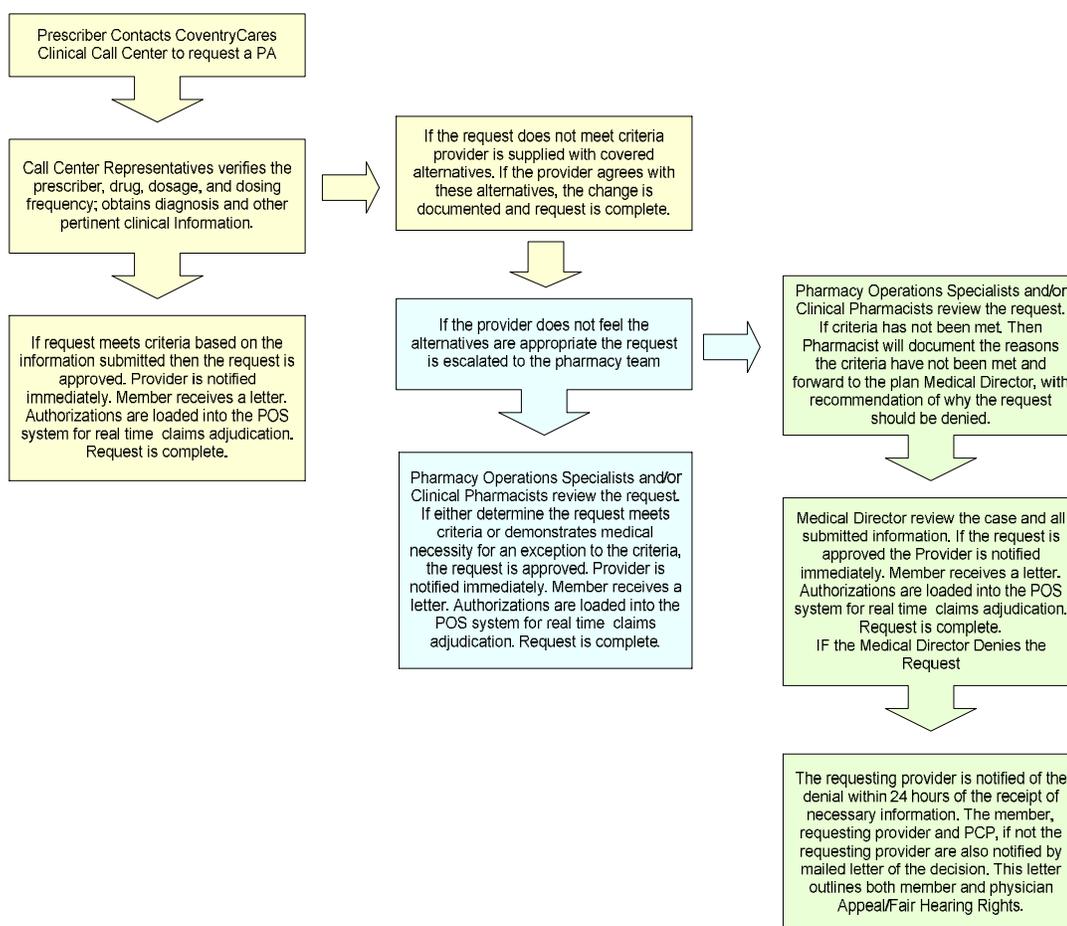
Providers may submit a Prior Authorization request related to pharmacy coverage by fax, telephone or mail. A dedicated provider line is provided to facilitate this process. These requests are reviewed by the Clinical Pharmacy Call Center. Staff are comprised of specifically skilled and trained Member Communications Specialists (MCSs) all of whom are required to be certified pharmacy technicians (CPhT). In addition to the Harrisburg call center, we have additional call centers across the country, which provide back-up support when needed, ensuring that we always provide exceptional member services.



Prior Authorization requests meeting criteria are approved by the call center staff and entered in the system for real-time use at the point-of-sale. Faxed requests that are approved by the call center result in a fax back to the requesting provider. All Prior Authorization approvals result in a fax to the provider.

Requests that do not meet criteria are forwarded directly to the Pharmacy Department, comprised of the Operation Support Specialists and the CoventryCares Pharmacy Director for resolution. If the Pharmacy Team determines the case should be approved, the approving team member will issue the authorization for the request and immediately notify the requesting provider. If the criteria has not been satisfied or if sufficient evidence of medical necessity has been provided to make an exception to the criteria based on patient-specific factors, the request is sent to the plan Medical Director. (RE-WRITE) The Medical Director will review the entire request file and will decide whether the request for Prior Authorization should be approved or denied. Only a Medical Director can ultimately deny a request. Each denial will be communicated to the requesting provider within 24 hours of receiving all necessary information, and the formal letter of denial will inform the provider and member of their right to appeal. Our Prior Authorization process is outlined in Figure 17.

Figure 17: Proven Prior Authorization Process



There will occasionally be unique situations that require special consideration for members. CoventryCares is fully compliant with the requirements stipulated in the *Pennsylvania HealthChoices Managed Care Operations memorandum HCALL-01/2008-002* regarding the providing of a 72-hour or 15-day supply (as applicable) of medications if a prior authorization decision cannot be made within the required 24 hour timeframe. The point of sale pharmacy provider may submit a series of pre-determined codes as part of the online claim transaction in order to identify the emergency condition. This process allows the member's prescribing provider to start the Prior Authorization process without interruption or delay in access to the prescribed medications. If a dispensing pharmacy uses the appropriate "emergency" or transition fill codes, the Medco claims system will allow the claim to pay if all other conditions are met.

CoventryCares, through the Medco system, provides automated prior authorization functionality within the claims adjudication system. This feature allows for information submitted by the pharmacy provider on the claim and data in the patient's medication history to be applied during the claims transaction. These edits include a look-back for certain medications in the member's claims history. Additional features utilize patient demographic data to apply to criteria, such as age and gender. The efficiency of this system increases as CoventryCares develops a more robust claims history for our members.

### **Methods for Providers (Pharmacies and Prescribers) and Member to Learn About the Authorization Process and Criteria**

A critical factor in ensuring the success of a prior authorization program is the clear articulation of the criteria. CoventryCares understands the importance of keeping both providers and members aware of the prior authorization process and criteria. Detailed information is provided at our Web site, [www.mycoventrycares.com](http://www.mycoventrycares.com). This information includes criteria that are easily accessible using the drug name and includes the approved indication, dosing levels, quantity limitations, and the coverage policy.

Communication to pharmacy providers includes online messaging at the point of sale. Fax blasts are also used to convey important information, such as urgent drug recalls and network changes. All communications to program stakeholders will be made in compliance with the requirements set forth in this RFP in terms of timeliness, content and media.

#### ***Providers***

CoventryCares' approach to educating and training medical providers emphasizes compliance with contract standards, including prior authorization processes and criteria. CoventryCares conducts provider education and training utilizing a provider education program continually enhanced throughout HealthAmerica's long history of service in Pennsylvania. A dedicated and qualified staff of Provider Relations Representatives conducts the training, using various venues and media to maximize effectiveness and provider convenience. We assign each representative to a specific territory to cultivate relationships and provide local feedback to the plan.

All new medical providers receive an initial training program. Thereafter, they receive ongoing training, as needed. Formulary and Prior Authorization updates are communicated via provider newsletters, Friday Fax Blasts (see below for examples) or the website, [www.myCoventryCares.com](http://www.myCoventryCares.com). Providers are notified of formulary changes, including physician-specific letters that identify which of their patients would be affected by the change



## II-4: Work Statement Questionnaire



**FRIDAY FAX**

This Week, Friday, May 3<sup>rd</sup>, 2010...

**Formulary Additions**

Below are formulary additions, effective immediately:

Drug name	Tier
Prilosec XL <sup>®</sup>	1
Orlistat <sup>®</sup>	2
Chlorzoxal <sup>®</sup>	3

paracetamol only 1000 mg

Newly marketed drugs:

Drug Name	Tier
Fingert <sup>®</sup>	3
Vidista <sup>®</sup>	3

Specialty Drug Additions:

Drug Name	Tier
Coventry <sup>™</sup>	3
Amplify <sup>™</sup>	3

\*Specialty requires prior approval before coverage or Standard & Special Prior Auth Req.  
\*\*Specialty requires prior approval before coverage or Standard Prior Auth Req.

If you need additional information, or have any questions or concerns, please contact your Provider Relations Representative:

Lead Name	Phone	Email	Service Area
Leah Henery	(844) 355-1341	leahh@coventry.com	Allegheny, Beaver & Monaca, Cameron, Chatham, Clearfield & Lawrence Counties
Kelly Weigand	(844) 355-1350	kellyw@coventry.com	Allegheny, Beaver & Monaca, Cameron, Chatham, Clearfield & Lawrence Counties; Jefferson, Franklin, Mercer & Putnam Counties; Schuylkill, Adams, York, Lancaster, Berks & Chester Counties; York, Adams, Lancaster, Berks & Chester Counties; York, Adams, Lancaster, Berks & Chester Counties
Maria Sherman	(844) 355-1350	marias@coventry.com	Allegheny, Beaver & Monaca, Cameron, Chatham, Clearfield & Lawrence Counties; York, Adams, Lancaster, Berks & Chester Counties; York, Adams, Lancaster, Berks & Chester Counties
Travis Stiller	(844) 355-1350	travisst@coventry.com	Allegheny, Beaver & Monaca, Cameron, Chatham, Clearfield & Lawrence Counties; York, Adams, Lancaster, Berks & Chester Counties; York, Adams, Lancaster, Berks & Chester Counties
Jean Harshbarger	(844) 355-1341	jeanh@coventry.com	Allegheny, Beaver & Monaca, Cameron, Chatham, Clearfield & Lawrence Counties; York, Adams, Lancaster, Berks & Chester Counties; York, Adams, Lancaster, Berks & Chester Counties



**FRIDAY FAX**

This Week, Friday, October 29th, 2010...

**Four-Tier Pharmacy ~ \$3 Generics**

HealthAmerica is pleased to offer a Fourth Pharmacy Tier that will make available certain Generic Drugs for a low \$3 co-pay. This new benefit will be available for new groups or upon renewal for existing groups.

To maximize your members benefits and reduce their out-of-pocket expense, please see the listing of applicable generics on our website at [www.healthamericacy.com](http://www.healthamericacy.com). Select Health Care Solutions, Prescription Coverage, Formulary Documents, **\$3 Generics Tier 1A Drug List**.

For additional savings opportunities, members can take advantage of their mail-in pharmacy benefit for these \$3 generics. A 90-day supply would be just two-\$3 co-pays. Providers can write a 90-day supply prescription and members can access the Medco Mail Order Form on our website under Formulary Documents.

To verify if a member has a Four-Tier Pharmacy Benefit you can contact customer service at 800.752.4165 or log onto [direct.provider.com](http://direct.provider.com).

If you do not have Internet access, contact your Provider Relations representative to receive a copy of the newsletter, or any of the documents on our website, via USPS mail.

If you need additional information, or have any questions or concerns, please contact your Provider Relations Representative:

Lead Name	Phone	Email	Service Area
Leah Henery	(844) 355-1341	leahh@coventry.com	Allegheny, Beaver & Monaca, Cameron, Chatham, Clearfield & Lawrence Counties
Kelly Weigand	(844) 355-1350	kellyw@coventry.com	Allegheny, Beaver & Monaca, Cameron, Chatham, Clearfield & Lawrence Counties; Jefferson, Franklin, Mercer & Putnam Counties; Schuylkill, Adams, York, Lancaster, Berks & Chester Counties; York, Adams, Lancaster, Berks & Chester Counties
Maria Sherman	(844) 355-1350	marias@coventry.com	Allegheny, Beaver & Monaca, Cameron, Chatham, Clearfield & Lawrence Counties; York, Adams, Lancaster, Berks & Chester Counties; York, Adams, Lancaster, Berks & Chester Counties
Travis Stiller	(844) 355-1350	travisst@coventry.com	Allegheny, Beaver & Monaca, Cameron, Chatham, Clearfield & Lawrence Counties; York, Adams, Lancaster, Berks & Chester Counties; York, Adams, Lancaster, Berks & Chester Counties
Jean Harshbarger	(844) 355-1341	jeanh@coventry.com	Allegheny, Beaver & Monaca, Cameron, Chatham, Clearfield & Lawrence Counties; York, Adams, Lancaster, Berks & Chester Counties; York, Adams, Lancaster, Berks & Chester Counties

### Members

CoventryCares apprises our members of prior authorization processes and criteria through welcome packets, welcome calls, and member newsletters. Members may also go to [www.myCoventryCares.com](http://www.myCoventryCares.com) to access the formulary and related policies.

#### 4. In regard to pharmacy point of sale, explain:

- Who adjudicates your pharmacy claims?
- How do you ensure adequate oversight and monitoring of the pharmacy claims processor, including fraud and abuse and encounter data?
- Are all outpatient medications processed through pharmacy claims? If not, what other method of claims processing is used (e.g., professional claim with HCPCs codes)? (Limit to three pages)

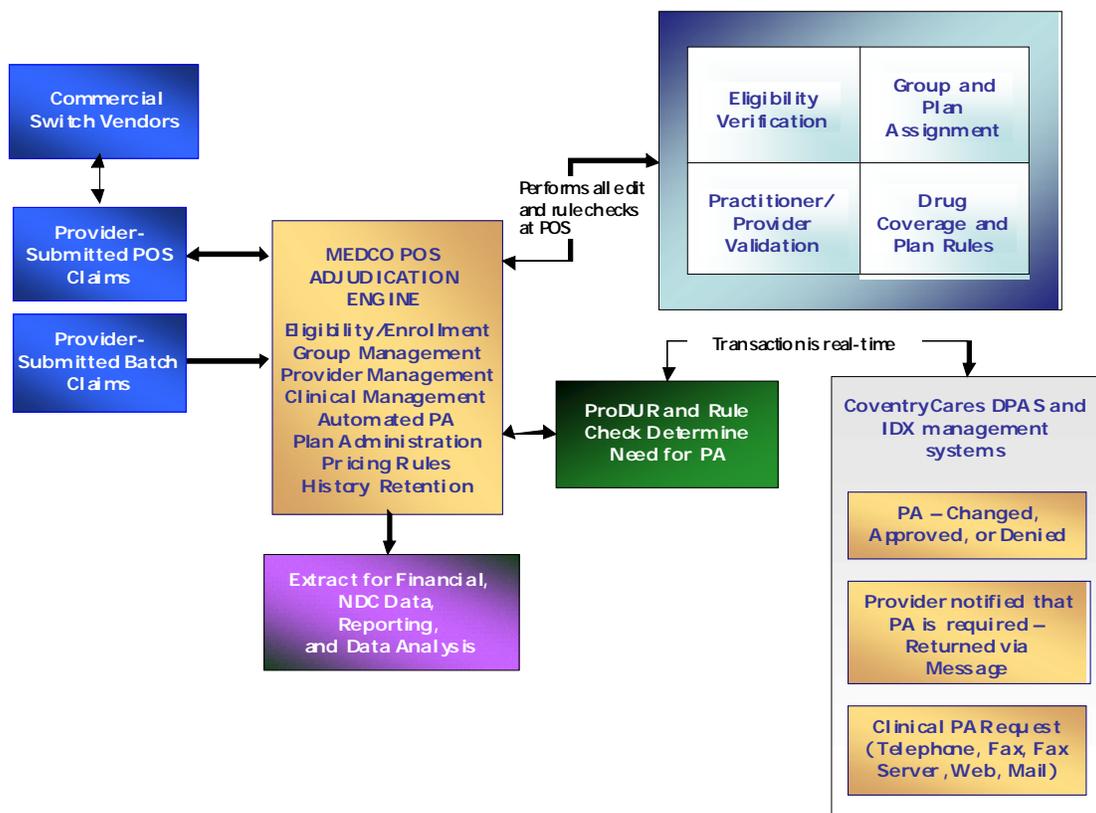
### Pharmacy Claims Adjudication

CoventryCares has contracted with Medco Health Solutions (Medco) as our Pharmacy Benefits Manager (“PBM”) to adjudicate pharmacy claims for the HealthChoices Program. Medco’s claims adjudication engine is used to construct rules related to payment for pharmacy services.

Medco’s system stores member eligibility, provider data, pricing rules, historical data, and all associated drug coverage parameters. The system uses provider status, applicable prior authorizations, associated rules and edits, third party liability, and prospective drug utilization review (ProDUR) to govern claims adjudication. The system also has the capability to support limitless reimbursement methodologies, including variable dispensing fees and fees for professional services and provider incentives.

Recognizing the dynamic needs of Medicaid programs, the pharmacy claims system accommodates adding, changing or removing claim adjudication processing components. The following Figure 18: Claims System Flow illustrates the system flow of Medco’s claims adjudication system.

**Figure 18: Claims System Flow**



Recognizing the dynamic needs of Medicaid programs, the pharmacy claims system accommodates adding, changing or removing claim adjudication processing components. The following Figure 18 illustrates the system flow of Medco’s claims adjudication system.



## **Oversight and Monitoring of Pharmacy Claims Processor, Including Fraud and Abuse and Encounter Data**

CoventryCares personnel take full responsibility for ensuring that Medco is compliant with its responsibilities in serving the pharmacy needs of the HealthChoices population.

CoventryCares uses a number of regular interactions with Medco to ensure appropriate oversight of our pharmacy claims processor, including reporting, reconciliations and regular meetings. Daily, weekly, and monthly transmissions, reporting, and reconciliations are performed between CoventryCares pharmacy director and Medco as they relate to membership eligibility and claims (pharmacy and medical). Any discrepancies or issues are logged for correction/resolution.

Bi-weekly conference calls are held with CoventryCares pharmacy director and Medco personnel. In partnership with CoventryCares, Medco maintains an issues tracking grid, which is reviewed and updated on a weekly basis. The individual issues are reviewed and action steps are initiated for successful and timely resolution. Quarterly face-to-face meetings including clinical and operational personnel, representing all lines of business and Medco, are also held.

Other performance reports include daily, weekly, and monthly Phone Metrics, Grievance Reports (consumer pharmacy complaints) and quarterly Medco Resolution Data (paper claims, payment disputes, etc.). The processing of all claims (paper and retail) must meet or exceed established industry standards.

CoventryCares' financial personnel review the Quarterly SOX (Sarbanes-Oxley) financial accounting audit reports. CoventryCares and Medco are subject to and comply with quarterly SOX reporting responsibilities. Medco provides standard monthly management reports identifying key metrics and program statistics. Medco performs both actual on-site and desk audits of the pharmacy network through a comprehensive audit program.

Fraud and abuse detection activities are performed at both the CoventryCares and Medco organizations. CoventryCares utilizes the services of Coventry's Central Services Special Investigations Unit (SIU). The scope of the SIU's review includes services provided by Medco. Additionally, Coventry through our extensive experience in the Medicaid arena, has developed analytic tools to monitor claims/encounter activity for potential abuse by either the member or the provider. This information is regularly reviewed and reported to DPW as appropriate for our current MA Southeast Zone experience.

### **Encounter Data**

Medco is required to submit encounter data like all other subcontractors. Pharmacy encounters follow NCPDP format standards and are verified through SeeBeyond, our software verification program. Encounter data is provided to ensure compliance with the reporting requirements of the Federal Drug Rebate Program and will be submitted to DPW in the necessary format and timeframes. DVOC provides subcontractor oversight for compliance with contract standards including timely submission and accuracy of encounter data.



## Processing of Outpatient Medications

The majority of outpatient medications are processed through Medco's point-of-sale (POS) system. Currently, claims for medications that are administered in a doctor's office are processed by CoventryCares as part of a CMS-1500 submission. CoventryCares will retain the applicable NDC information obtained through these professional claims for inclusion in our reporting of encounter data to meet the requirements of DPW.

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### 5. Describe your specialty pharmacy program. Describe your future plans, including plans to purchase and effectively manage specialty drugs. (Limit to 3 pages)

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CoventryCares utilizes Medco Health Solutions, Inc. (Medco) and its fully-integrated specialty pharmacy division, Accredo, to facilitate our specialty pharmacy program. Accredo has created models of care for patients with chronic and complex conditions and assists members through unique Therapeutic Resource Centers (TRCs). CoventryCares provides access to these TRC resources for our members needing specialty pharmacy services.

Accredo's experience managing chronic conditions partnered with CoventryCares' clinical management criteria and knowledgeable professionals produces an ideal partnership for effectively managing a high-cost, high-risk pharmacotherapy arena. Accredo uses patient care teams staffed by pharmacists, registered nurses, pharmacy technicians, and patient care representatives—each with therapy-specific training for a focused level of service. When necessary, CoventryCares case managers coordinate with the Accredo patient care teams.

The TRCs are customized for individual member therapeutic needs; the therapy management program covers the spectrum of care—from proactive monitoring of therapy to counseling on effectively managing side effects.

## Individualized Counseling

For new prescriptions, Accredo pharmacists offer to counsel each patient (or caregiver) by telephone, explaining the medication, its storage requirements, adverse effects, precautions, dosing parameters, and instructions for use.

Regular follow-up and ongoing assessment are performed by the Accredo care team, through contact with members or designated caregivers prior to each new and refill shipment to arrange delivery, to monitor therapy outcomes, and to encourage therapy adherence. CoventryCares utilizes Accredo to provide the majority of specialty drugs to our members.

This program has several core principles:

- Use of providers who can guarantee availability of the drugs
- Have an established process for delivery directly to the member or physician's office
- Allow for connection, usually by telephone, between member and provider



- Ensure the foregoing at effective unit-cost pricing

This program seeks to improve the care of high-risk and high-cost members by optimizing their pharmacotherapy and other aspects of their care. These members are at risk for costly drug-related problems and are also receiving high-cost pharmacotherapy. The program’s comprehensive approach acts as a safety net to catch any problems that might not be detected in case management. Participation is expected to be associated with statistically significant and clinically relevant improvements in the use of key evidence based therapies. Our program utilizes both concurrent data collection and decision support modules.

We continue to evaluate the developing trends within the specialty arena and use a comprehensive management strategy to extract the highest value from these products. The CoventryCares pharmacy staff reviews not only newly approved medications but also monitors the manufacturers’ drug development pipelines for new and emerging treatments. This information is used to craft forward-looking specialty medication management strategies whereby CoventryCares can provide access to these medications, while ensuring the following:

- They are only utilized when medically necessary
- The risk-benefit ratio in relation to cost and availability of comparable alternatives produces a positive clinical value to our members and DPW

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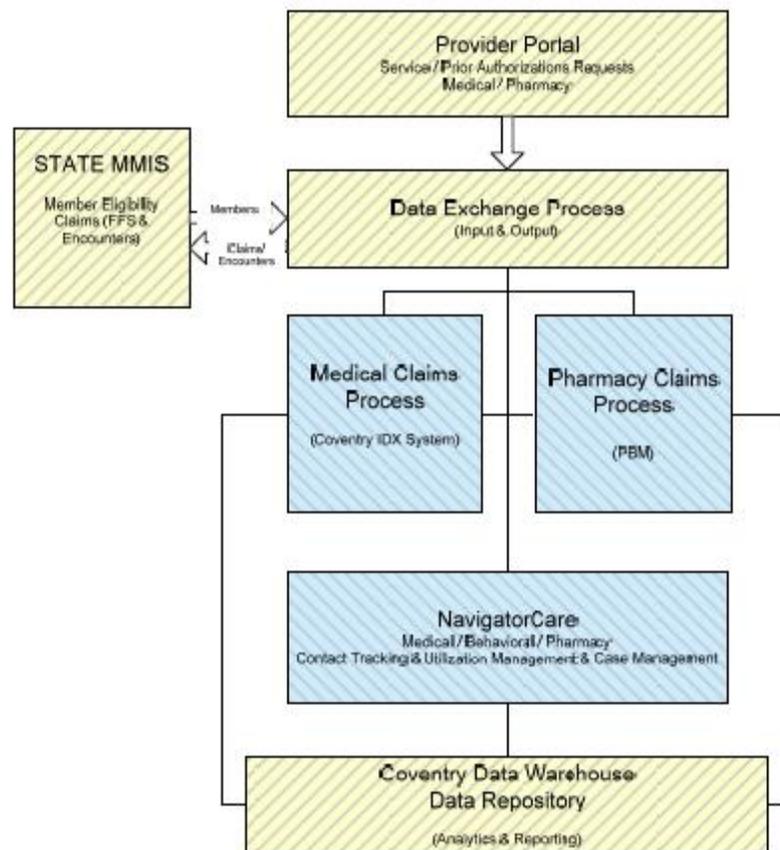
6. Describe how your pharmacy claim information is coordinated with medical claim data to provide comprehensive care management. (Limit to 2 pages)

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CoventryCares approach to care management integrate and coordinates information from many sources—key to facilitating provider care and coordinating other needs of our MA members in the most timely and efficient manner. CoventryCares’ case managers use the NavigatorCare system to collect pharmacy claims and medical data retrieve to enhance the effectiveness of the personnel supporting case management and care facilitation.

CoventryCares’ standard practice for incorporating pharmacy claims information with other claims data and clinical values is shown in the below Figure 19. All transactional information, whether medical claims or pharmacy claims, is stored in the Coventry Data Warehouse (CDW). We have an established standard process for importing claims transactions from pharmacy vendors. The CDW allows for complete data integration of live and historical data, transparent reporting, and supports predictive modeling and, importantly, comprehensive case management.



**Figure 19: Pharmacy Claims Information Incorporation**

As data is filtered for predictive modeling, both medical and pharmacy data passes through clinical rules engines based on clinical algorithms and rules defined for each disease. Risk points are attached to each identified morbidity (for example, obesity, diabetes, hypertension). The risk score points are totaled for each member and are used to stratify the member into a low, moderate or high risk category. The results of this stratification are fed directly into the case manager's dedicated NavigatorCare system to inform the case manager of the member status. This dynamic process is invaluable for case managers to identify high risk individuals for the examination of medication compliance issues and possible medication interactions and to support and strengthen the individualized care plans. Having a complete medication history alerts the case manager to co-morbidities, especially with behavioral health conditions.

The NavigatorCare tool also supports entry of prescription drugs that have not been processed by the pharmacy claims processor but are reported by the member or their caregivers. Furthermore, CoventryCares has established relationships with major laboratory vendors and receives lab results, which are also made available to clinical staff in the NavigatorCare system.

Pharmacy data is the most real-time information available to the case managers, which allows for a proactive approach to managing members who do not refill prescriptions or are utilizing multiple



physicians for a single condition. Medication adherence is key to stabilizing members with chronic conditions. Case managers can make a call to the member to ask if the member needs assistance with refilling prescriptions or can identify the barriers preventing the member from following the prescribed medication regimen. In the MA population, it is important to take the extra step to perform outreach and assist with social, financial or familial barriers that prevent the member's self-sufficiency and compliance with their care plans. Data analysis and reporting are performed with both medical and pharmacy claims data using the CDW query and reporting tools or through standard reports in the NavigatorCare management tool. This analysis provides Pennsylvania HealthChoices with the ability to identify "best practices" within the provider community in addition to identifying areas for physician detailing to improve practice patterns.

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7. Describe how you will use the CMS Drug File to ensure access to all drugs covered under the MA Program and compliance with data reporting requirements for the Federal Drug Rebate Program. (Limit to four pages)

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The policies and procedures that govern the inclusion or exclusion of medications from the CoventryCares formulary for the HealthChoices Program are under the auspices of the Pharmacy and Therapeutics (P&T) Committee process. In general, these policies govern the constitution of our committees, the frequency with which they make determinations and the criteria used in making those decisions.

Our drug formulary fosters appropriate, safe and cost-effective drug therapy and meets the coverage requirements set forth in Exhibit BBB (1) of this RFP. The formulary:

- Includes a range of drugs of those therapeutic categories and subcategories currently covered by DPW's FFS Pharmaceutical Services Program
- Includes coverage of over-the-counter (OTC) medications
- Allows access to all non-Formulary drugs, other than those excluded by DPW's FFS program, and subjects them to Prior Authorization consistent with the requirements of this RFP
- Excludes coverage for all Drug Efficacy Study Information (DESI) drugs as defined by the FDA
- Excludes only those drug categories permitted under Section 1927 (d) (2) of the Social Security Act

All drugs included in the CMS Drug file are accessible to members either as formulary agents or via the prior authorization process guidelines set forth in Exhibit BBB (1) of this RFP. We have been able to leverage the point-of-sale pharmacy claims adjudication systems of our PBM, Medco, to facilitate transitional or temporary fills of prescription medications to prevent disruption in therapy should prior authorization be required.

The CMS Drug list is provided as a guide that includes a representative NDC for each major class of drug. This list is utilized by the plan and Medco to monitor the drugs that are covered and make sure we are compliant with a sufficient breadth of drugs on the formulary and with reporting requirements of the Federal Drug Rebate program. This information is submitted to DPW in the necessary format and timeframes and is retained and referenced as needed.



Medco is responsible for the actual invoicing and reconciliation of manufacturer rebate payments. CoventryCares provides direct oversight of this process.

Manufacturer rebates are coordinated and administered by Medco's pharmaceutical rebating and consulting staff using FRP (Formulary Rebate Processing). Through this system, Medco staff tracks and reports on each pharmaceutical manufacturer contract, generates rebate invoices, generates prescription level reporting for auditing, maintains accounts receivable, collects payments, and resolves payment discrepancies. All rebate invoices are sent out to each of the pharmaceutical manufacturers on CD within 90 to 120 days after the end of the invoicing quarter.

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### *Management Information Systems*

1. Provide a general systems description, including:

- A systems diagram that describes each component of the management information system and all other systems that interface with or support it;
- How each component will support the major functional areas of HealthChoices (In-Plan Services; Coordination of Care; Member Services; Maternity Care Payments; Complaint, Grievance and Fair Hearings; Pharmacy; Special Needs; Provider Network; Provider Services; Service Access; Quality Management/Utilization Management (QM/UM); Claims
- Payment and Processing, and; Encounter Data Reporting System).
- (Limit to ten pages, including the diagram)

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CoventryCares supports the Pennsylvania HealthChoices information systems needs in the Southeast Zone, and will do the same for the New West and New East Zones through the centralized Information Technology (IT) organization of our corporate parent, Coventry. A seasoned staff of experienced employees delivers information systems services and successfully meets the standards specified by each of our Medicaid markets. We look forward to implementing the HealthChoices Physical Health program for the New West and New East Zones continuing to demonstrate our capabilities to serve HealthChoices members.

Coventry's IT organization commits to supporting the infrastructure, technology, and workflow needs of each Medicaid health plan in order to ensure that members, providers, Medicaid agencies, and other stakeholders are properly served. We understand that the information systems we provide are key components of CoventryCares' overall foundation for enabling the health plan to provide optimal services to all stakeholders.

To support the Commonwealth's goal of improving access to health care services for MA Consumers, CoventryCares has efficient, user-friendly systems in place for providers. Processes that affect how providers receive timely payments and online services that enable them to easily obtain claims information are essential for CoventryCares to continue having high provider satisfaction and retention. Coventry's claims management system, IDX, and provider Web portal, [www.DirectProvider.com](http://www.DirectProvider.com), have

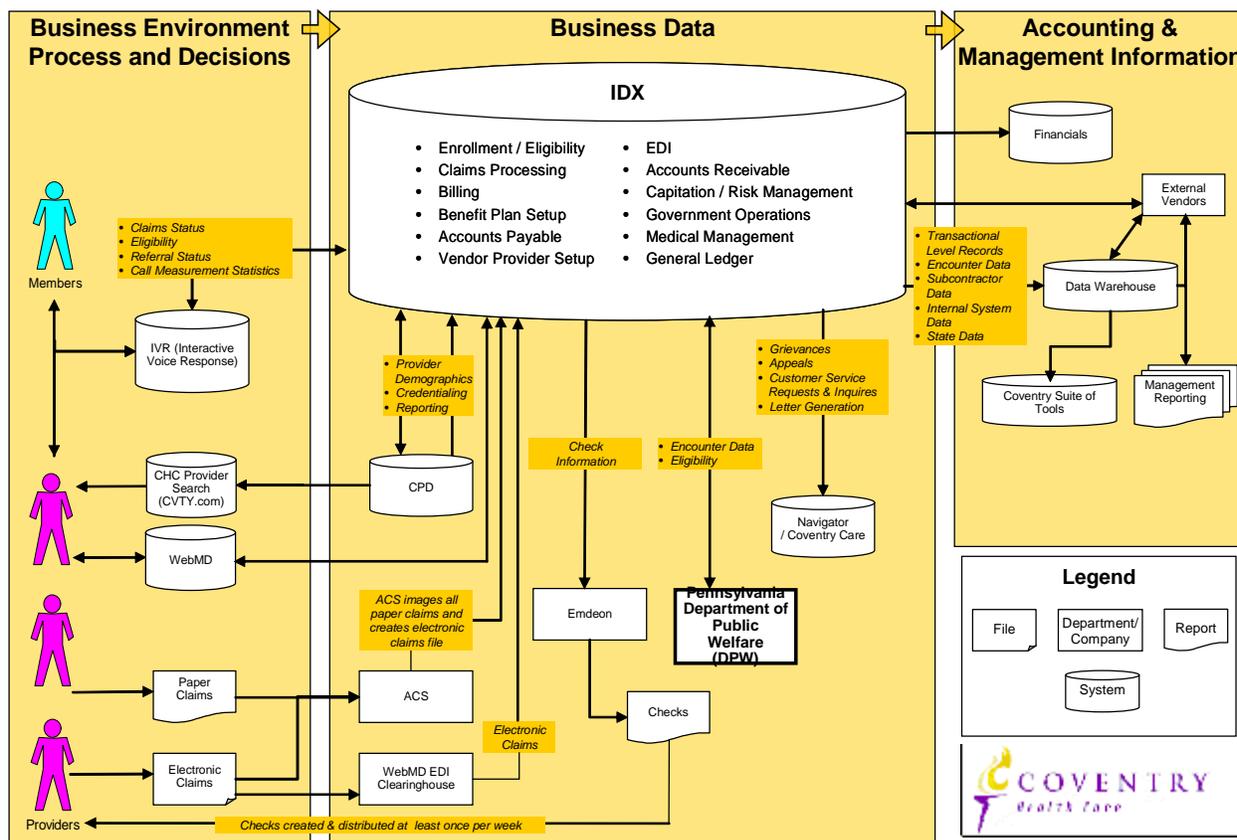


the processing strength and capabilities to enhance CoventryCares' relationship with our provider network and help ensure that high quality providers are available to enhance our members' access to care.

CoventryCares has systems in place to support the Commonwealth's goals to improve the quality of health care available to MA Consumers and to maximize opportunities to provide cost-effective health care. The ability of CoventryCares' case and disease managers to identify members with avoidable hospitalizations, high ED utilization, and other key indicators is critical for both ensuring members' care needs are appropriately addressed and that care is provided in the most cost-effective setting. Coventry's care management system, Navigator Care, as well as IDX and the Coventry Data Warehouse, have the functions and reporting mechanisms to assist case managers, other medical management staff, and quality improvement staff with members' case plans, care coordination, and condition/disease management needs.

Figure 20 illustrates the major system interfaces and information flows among project entities.

Figure 20: Systems Interface and Information Flow Diagram



Throughout the rest of this question and other questions in the Management Information Systems section, more details are provided regarding our extensive information systems. Our following systems description illustrates how our systems interface with other entities and how our various components

support the major HealthChoices functional areas in the Southeast and Southwest Zone. The same infrastructure will be utilized for the new Zones.

### **IDX—In-Plan Services, Maternity Care Payments, Provider Network, Service Access, Claims Payment and Processing (including Maternity) and Encounter Data Reporting**

Our core system, IDX, serves as the backbone of managed care processing and uses powerful relational database technology. Navigator (our internal communication system), Navigator Care (Care Coordination Management System), web portals, CPD, and the CDW all reference this system for information such as eligibility, authorizations and claims.

IDX is a fully integrated, scalable application that encompasses all aspects of our Medicaid, Medicare, and commercial lines of business. This is our core transactional system that manages in-plan services, benefit usage tracking, enrollment and eligibility, provider contracts, fee schedules, provider network affiliations, claims payment and processing (including Maternity), encounter data reporting, premium billing and reconciliation.

IDX updates Navigator and Navigator Care eligibility data, authorization, and claims data each time a user requests a view of one of those items. Each IDX field is individually mapped to a corresponding field in Navigator.

The IDX architecture is Client/Server based and highly scalable. Coventry's health plan servers are clustered and share redundant, network-attached storage devices. IDX uses high performance post-relational database technology that is suited to heavy transaction loads and high growth requirements. IDX has accommodated the continuous growth of all lines of Coventry's business for over a decade and is ideally suited to accommodate our anticipated growth well into the future.

### **Navigator—Member Services, Complaint/Grievance/Fair Hearings, Service Access**

Coventry has designed and built its own custom system, (Navigator—a consumer relationship management tool) which is used to document all contacts from consumers and to track and manage all work related to those contacts. Navigator documents and tracks incoming and outgoing contacts. Any required follow-up or additional activity related to the contact is auto-generated to the appropriate area for fulfillment. The system monitors for evidence of completion of the activity.

Navigator maintains individual contact histories for all members, employer groups and providers, as well as external entities. Each and every member contact coming into or out of each Coventry health plan, including correspondence and e-mail contacts, is maintained for a comprehensive contact history regarding the member.

Navigator interacts with the Coventry source administrative and claim system, IDX, to provide real-time data regarding eligibility, contracted providers, authorizations and claims.

Navigator contains modules that apply specifically to appeals and clinical management. These modules are accessed through special user permissions to protect the data. Both have a selection of reports that provide information specific to the topic. The appeals module manages all aspects of an appeal from a member or provider from initiation to resolution, including timeliness of response. Data elements required for state-mandated reporting are provided for appeals.



### **Navigator Care—Coordination of Care, Quality Management/Utilization Management, Special Needs**

Condition/disease management and complex case management are tracked in a dedicated module called Navigator Care. Navigator Care interfaces with IDX to locate candidates for these programs and solicit participation. Navigator Care monitors their ongoing participation and contact with health plan case managers. Programs supported include: 14 Disease Types (Asthma, Diabetes, etc.), Case Management and Condition Management, Member Reminders (Flu Shots, disease-specific, etc.) and Medical Assistance (EPSDT).

Navigator Care contains over 70 member assessment questions that are used as detailed analytic tools for monitoring member goals and self management. Case managers conduct goal planning with members to support member self-management. This information is available to providers via [www.DirectProvider.com](http://www.DirectProvider.com). A member's provider has the ability to update/comment on the member's progress and suggest alternative goals/objectives.

### **Coventry Provider Database (CPD)—Provider Network and Services**

CPD maintains provider information for over 860,000 providers, of which over 17,000 are Medical Assistance providers, and captures key provider data (PIN, multiple office addresses, products, practices, etc.), ensuring data quality and preventing duplication. The CPD is the source of Coventry's HEDIS<sup>®</sup> provider measurement data, which is audited according to NCQA HEDIS<sup>®</sup> Compliance Audit<sup>™</sup> specifications. This application is used to generate provider directories, both on paper and on the Web. Web directories are updated on a weekly basis, complete with languages spoken, directions to offices and whether new patients are being accepted.

CPD is the master system for provider credentialing and contracts. Once providers are entered in CPD, they may be entered for claims processing and payment in IDX. It is also the source system for [www.DirectProvider.com](http://www.DirectProvider.com), Coventry's provider Web portal (described below). In addition, member service representatives are able to view CPD information through Navigator when providers call for support or information.

### **DirectOrovider.com—Provider Services**

Directprovider.com is Coventry's secure provider portal. This portal offers registered providers the ability to check a member's eligibility and benefits, inquire about claims, submit authorizations, view member ID cards and view remittance advices. This service is available at no cost. Directprovider.com is linked to the IDX system for the most recent data and status updates.

### **My Online Services (MOS)—Member Services**

My Online Services is Coventry's member portal. It is an easy-to-use member-friendly tool that allows members to access member service. My Online Services offers the user the ability to view his/her personal and eligibility information; update his/her PCP; view and print his/her ID card; view benefits, claims and authorizations; search for a provider or specialist; access decision support tools such as hospital quality comparisons, respond to questions through an (HRA) and enter personal health



information through a Personal Health Record (PHR). In addition, members may access KidsHealth, an online health education and wellness tool.

MOS draws its information in real time from the IDX system, so the user may see the most up-to-date data upon logging onto the portal. If a member requests to update his/her PCP or address information, the request is routed to Navigator for review and final update by a member service representative. The request and follow-up are tracked within Navigator, and the actual change is recorded within IDX for full traceability.

### **Coventry Data Warehouse (CDW)—Reporting, Data Transmissions, Pharmacy**

The CDW is an Oracle-based enterprise-wide data repository supporting decision making at the health plan and corporate levels. It is used to meet State and Federal reporting mandates. CDW derives its data from the transactional systems and integrates third party encounter data from a variety of areas, such as from a state's contracted pharmacy vendor. The CDW is refreshed on the last day of each month with a snapshot of application system data.

The warehouse supports reporting via multiple data marts. These data marts are accessed by management and staff to develop reports and further analyze data to monitor and constantly improve the delivery of services to our membership. Behavioral health claims and pharmacy claims data from DPW's vendors is loaded to the CDW weekly.

### **Coventry Suite of Tools**

#### ***The Coventry Care Management Tool (CMT)***

The Coventry Care Management Tool (CMT) and Predictive Modeling Tool (PMT) comprise a multi-dimensional, episode-based predictive modeling suite that supports both Medical Management and Underwriting. Its capabilities include:

- Medical Management (CMT)
  - Identify members at greatest risk for future healthcare problems
  - Understand key clinical drivers of risk—support steering for appropriate programs
  - Identify care opportunities—members with gaps in care, complications and co-morbidities
- Underwriting(PMT)
  - Information on health risk for groups and individuals is used to enhance the underwriting process
- Products hosted by Coventry

#### ***Network Decision Support (NDS)***

The Network Decision Support (NDS) is a Coventry-hosted, provider-focused application that measures provider performance, analyzes overall cost and use, evaluate quality of care, and understand health risk.



**Provider Support Tool (PST)**

The Provider Support Tool (PST) is a vendor-hosted (Optum) reporting application that presents patient-centric information, which enables physicians to view more comprehensive history of a member across care providers.

These systems remain synchronized using interfaces, rather than manual data entry. This approach ensures that data integrity and consistency are maintained. Figure 21 summarizes system interfaces and includes the trigger/type of interface and frequency.

Coventry IT staff are familiar with and are well-prepared to continue to work with DPW to ensure all interfaces and information flows continue to be implemented effectively. We look forward to maintaining the support of the technology needs of CoventryCares’ HealthChoices membership, providers, DPW, and other stakeholders in all Zones.

**Figure 21: Summary of System Interfaces**

Interface	Source	Target	Frequency	Trigger	Direction	Type
Eligibility	IDX	Navigator	Real Time	Automated	One Way	P2P*
Eligibility	IDX	Navigator Care	Real Time	Automated	One Way	P2P
Eligibility	IDX	My Online Services	Real Time	Automated	One Way	P2P
Eligibility Inquiry and Response	IDX	Directprovider.com	Real Time	Automated	Bi-directional	Engine
Eligibility Inquiry and Response	IDX	Emdeon Office	Real Time	Automated	Bi-directional	Engine
Eligibility	IDX	CDW	Batch, monthly	Automated	One Way	P2P
Eligibility Updates	State	IDX	Batch, daily	Automated	One Way	Engine
Eligibility	IDX	State	Batch, daily	Automated	One Way	Engine
Authorizations	Navigator Care	IDX	Batch, daily	Automated	One Way	P2P
Authorizations Inquiry and Response	IDX	Emdeon	Batch, daily	Automated	One Way	Engine
Authorizations Inquiry, Update and Response	IDX	Directprovider.com	Real Time	Automated	Bi-directional	Engine
Authorizations Update	Directprovider.com	IDX	Real Time	Automated	One Way	Engine
Authorizations	IDX	My Online Services	Real Time	Automated	One Way	P2P
Authorizations	IDX	CDW	Batch, monthly	Automated	One Way	P2P
Reports	IDX	Directprovider.com	Batch, monthly	Automated	One Way	P2P
HRA Results	My Online Services	CDW	Batch, Daily	Automated	One Way	P2P
HRA Results	CDW	Navigator Care	Real Time	Automated	One Way	P2P
Claims Inquiry and Response	Emdeon Office	IDX	Real Time	Automated	Bi-directional	Engine
Claims Inquiry and Response	Directprovider.com	IDX	Real Time	Automated	Bi-directional	Engine
Claims	IDX	CDW	Batch, monthly	Automated	One Way	P2P
Remittance Advice	IDX	Directprovider.com	Batch, twice weekly	Automated	One Way	Engine



Interface	Source	Target	Frequency	Trigger	Direction	Type
Remittance Advice	IDX	Emdeon Office	Batch, twice weekly	Automated	One Way	Engine
Encounters	IDX	State	Batch, monthly	Automated	One Way	Engine
Claims View	IDX	My Online Services	Real Time	Automated	One Way	P2P
Provider ID File	CPD	State	Batch, weekly	Automated	One Way	P2P
Provider ID File	State	CPD	Batch, weekly	Automated	One Way	P2P
Enrollment Reconciliation	IDX	State	Batch, monthly	Automated	One Way	Engine
Premium Payment	State	FTP site	Batch, monthly	Automated	One Way	P2P
Lab	Lab vendor	CDW	Batch, monthly	Automated	One Way	P2P
Pharmacy	Pharmacy vendor	CDW	Batch, weekly	Automated	One Way	P2P
Behavioral Health	BH vendor	CDW	Batch, weekly	Automated	One Way	P2P

\* P2P = POINT-TO-POINT

Figure 22 illustrates the external and internal connectivity of our systems to the Pennsylvania Medical Assistance System.

Figure 22: Network Diagram

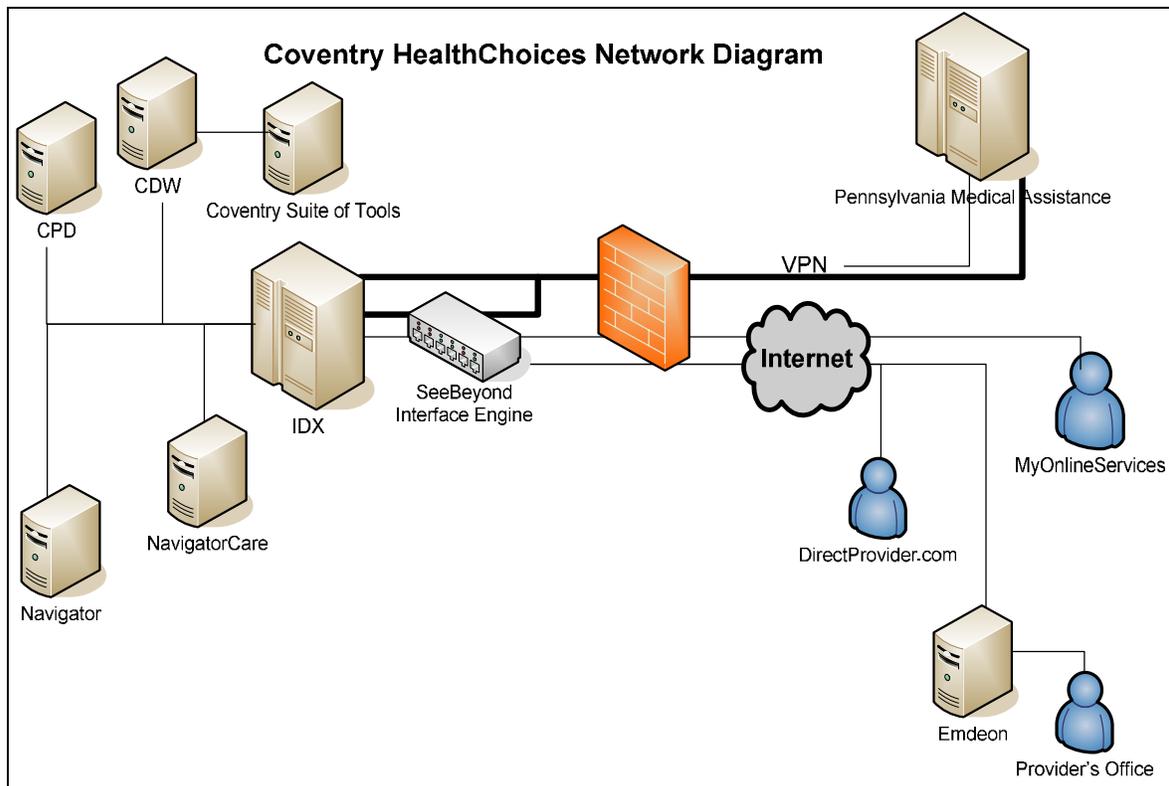
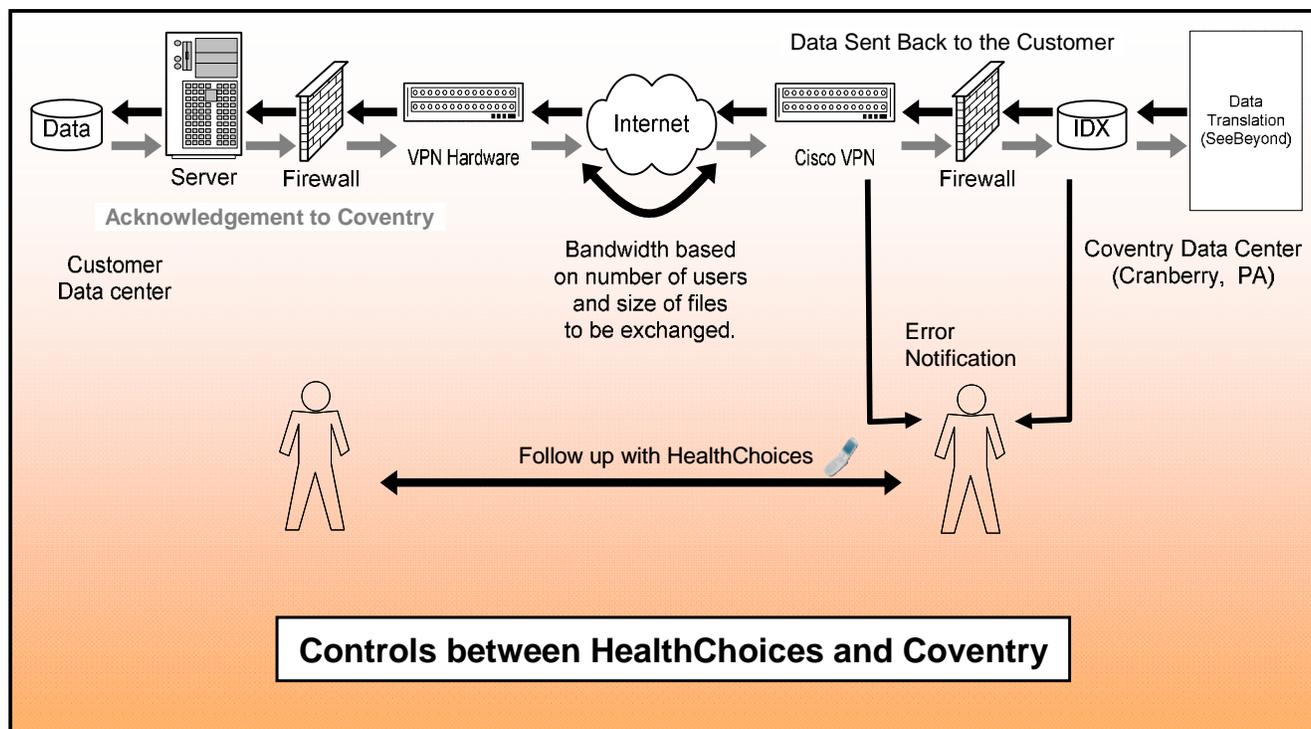




Figure 23 depicts Coventry’s internal controls.

**Figure 23: Internal Controls Diagram**



- Describe any modifications or updates to your Management Information System (MIS) within the next year that will be necessary to meet the requirements of this Agreement, and your plan for their completion. (Limit to four pages)

CoventryCares’ management information system is administered by the Information Technology (IT) department of CoventryCares corporate parent, Coventry. Because of our experience in the Southeast Zone, CoventryCares does not anticipate the need to implement many changes to our current internal systems to support the New West and New East Zones. However, we will review and implement any additional required interfaces for encounter reporting, inbound claims processing, inbound eligibility filing, the inbound premium payment files and outbound eligibility reconciliation.

Based on the review of the RFP, its attachments and multiple discussions with the various business units supporting the additional Zones, we will develop project documentation upon the award. This includes the one-time data feeds and ongoing interfaces.

The data feed is developed and tested in the same way as an ongoing interface. This includes the creation of a detailed System Change Document describing the functional approach and the technical changes required to put the feed in place. IT and the affected operational units work together to document and test the data.



In detail, our implementation steps are:

- Conduct a comparison of the companion guide to ensure we will meet state requirements and identify any elements that are specific to the new Zones.
- Any new elements identified will be added to our current system fields.
- Create a System Change Document detailing the functional and technical requirements of the new process.
- Obtain business unit approval of the functional requirements.
- Build any cross reference tables and develop code in a development system.
- IT analysts develop detailed system testing plans.
- Developers complete the new code and complete unit testing if needed.
- Upon successful unit testing by the developers, move code to the test environment for system testing by IT analysts against their test plans.
- Operational unit analysts develop their test plans for End-to-End testing.
- Coventry IT will request a larger test file(s) from DPW for a full range of testing scenarios.
- Once IT analysts complete system testing, Coventry business units and IT will work with the Commonwealth to execute the End-to-End testing plans. This test runs through the entire process from file transmission from DPW, receipt at Coventry, working edits and final reporting.
- At any point, if an error is found or an adjustment required, the process returns to the earlier step until the issue is resolved.
- Once the End-to-End testing is completed successfully, the business unit provides written approval, and the code can be moved live (via our standard Code Move Process).

Unit testing is performed prior to running any of the simulations. The primary purpose of unit testing is to ensure that the data can be loaded into IDX regardless of any edits and corrections that would normally occur during a simulation or the live conversion/consolidation.

A detailed list of questions, known as the "Business Requirements Document," is utilized as the starting point for gathering information from CoventryCares. The document is prepared with business and health plan participation, and all answers are documented by the assigned project team. The project team holds regular meetings to launch the project activities, and members of the health plan and IT teams review all documentation to obtain consensus on the project. The project team continues to stay engaged throughout the life of the project to ensure targets and timelines are met.

### **Analyzing the Business**

Project Team members review responses to the business requirements document, as well as clarify additional questions and concerns regarding the project. The Project Team becomes familiar with the business needs and begins to formulate the necessary project plan. Any necessary inbound and outbound files are identified, specifications are created and the required data fields are mapped to IDX.



### Setting Up IDX and Building Files

The two main parts of development on an expansion project are setting up IDX and building the required input and output files for business partners. Files are built to extract and load any information that is needed.

### Testing—Unit, Simulation, and Integration

In the beginning of unit testing, each piece of IDX is set up or a file is tested to be sure that it is working properly. As testing progresses, it focuses on how these changes work with other parts of the system. This testing is completed by the IT programmers and analysts.

The simulation is an actual test run of what should take place during live execution but, unlike unit testing, Project Team members and their business partners will validate the data on files and that the functionality on IDX is working properly. Simulations include testing with live data when possible and completing full business cycles on IDX. The Project Team addresses challenges encountered during the simulations at weekly team meetings, as well as individual module meetings. Issues are logged and tracked, and a detailed timeline of tasks and activities is maintained throughout the entire expansion process.

Integration testing is the final validation before "go-live." A test environment is set up for full function testing by all the business partners. The environment mimics the final set up for live execution and allows the consumer to perform all functions and processes, as they plan to do once the project "goes-live."

- 
3. What is the current capacity of your MIS/claims processing? Explain your process to readily expand your MIS/claims processing should the capacity of either be exceeded through enrollment of program members. (Limit to two pages)
- 

Coventry is an experienced Medicaid provider, serving more than 900,000 Medicaid managed care enrollees in ten states and over nearly 5 million members across all other lines of business. In 2010, Coventry used its blend of technologies and information systems to process 4.6 million Medicaid claims on the IDX platform and successfully transmit encounter data to states in their preferred formats. For 2011, 5.4 million Medicaid claims have been processed. Our Information Technology (IT) staff is committed to meeting the standards of the East and West Zones with the highest level of dedication and service as we do in the Southeast Zone and will do in the Southwest Zone.

### Current Capacity

Our systems are constantly monitored for adequate capacity and availability. Coventry maintains a minimum of 30% excess space on our systems to ensure there is no disruption to our membership. Based on our current system usage and storage availability, the capacity of Coventry's MIS/Claims Processing will not be exceeded from enrollment of additional membership.



Figure 24 shows the capacity for our major MIS and claims processing systems. Descriptions of each resource were described in our response to question number 1 in this section.

**Figure 24: MIS/Claims Processing Resources, Capacity and Usage**

Resource	Total Capacity	% In Use for Current Accounts
IDX	4 TB	50%
Navigator/ Navigator Care	361 GB	50%
DirectProvider.com (Front End)	3 Linux servers, two of them have 4 CPUs and 24 GB memory each, and the other has 2 CPUs and 16 GB memory	40%
DirectProvider.com (Back end)	2 AIX Unix machines, each with 2 CPUs and 8 GB memory	10%–20%
My Online Services	2 Linux servers, with 4 CPUs and 24 GB memory each	30%
Coventry's Public Web Site	3 Linux servers, with 4 CPUs and 16 GB memory each	20%
CDW	5.8 TB	65%
CPD	223 GB	50%

### Process for Expanding Capacity

System capacity usage and projected growth for our MIS/Claims Processing are formally reviewed on an annual basis. Based on projected growth in membership, Coventry staff calculates the average claims, authorizations, member and provider calls, and other transactions processed on a per member basis. The resulting numbers indicate our expected growth for the coming year. Storage is purchased accordingly. System enhancements are implemented on a quarterly release cycle. New storage is added to existing systems as part of the release planning process.



4. Explain your process for ensuring your subcontractors meet the same MIS requirements for which you are responsible. (Limit to three pages)

Coventry has a comprehensive program to manage our subcontractors and guarantee performance to state Medicaid agencies. This program includes contractual language to obligate subcontractors to MIS contract requirements and standards. This includes performance standards and guarantees, testing and reporting requirements, subcontractor audit support requirements, and defined interface and management responsibilities.

Before entering into an agreement with a subcontractor, Coventry carefully verifies that all subcontractors have information systems capabilities and processes, as applicable to their contract functions, that are equivalent to those described for Coventry in our detailed responses to this RFP specifically addressed within the Management Information Systems section of the Work Statement Questionnaire. As demonstrated with our Southeast and Southwest Zone Readiness Reviews, CoventryCares has successfully met the MIS subcontractor requirements and will continue to do so as a result of our ongoing subcontractor monitoring process.

Our Medicaid health plans are very accustomed to using the regulatory standards of URAC and the NCQA standards for monitoring subcontractors' compliance and performance. Our Medicaid health plans have a rigorous oversight process, which includes monthly meetings held by the DVOC as described in further detail in "Management to Control Costs" Question 1. The DVOC is chaired by Quality Improvement staff and is comprised of managers from the following departmental areas: The DVOC is chaired by Quality Improvement staff and is comprised of managers or their designees from the following areas:

- Claims/Member Service
- Government Programs
- Credentialing
- Pharmacy
- Quality Management
- Finance
- Health Services
- Compliance
- Medical Administration
- Marketing
- Network Management
- Appeals Unit
- Other departments as needed

During the monthly DVOC meetings, agendas are set, actions assigned and minutes are taken with follow-up items reviewed in detail at subsequent meetings. The minutes from the DVOC meetings are reported quarterly to the Utilization Management/Quality Improvement (UM/QI) Committee for further review. Annual audits are performed with each subcontractor to ensure full compliance with each regulatory body. Claims and encounter data information from our subcontractors are audited monthly to ensure accuracy and completeness. The results from these reviews and annual audits are then reviewed during the monthly DVOC meetings where it is determined whether the subcontractors are in compliance with regulatory and health plan requirements. In addition, during the monthly DVOC



meetings, agendas are set, actions assigned and minutes are taken with follow-up items reviewed in detail at subsequent meetings. The minutes from the DVOC meetings are reported quarterly to the Utilization Management/Quality Improvement (UM/QI) Committee for further review.

When issues are identified through the DVOC, a recommendation for a Corrective Action Plan (CAP) may be made, if deemed to be necessary by the committee. Management will then work directly with the subcontractor on the implementation and monitoring of the CAP in accordance with strict and defined date parameters for timely resolution. The Quality Improvement (QI) Department oversees the CAP and sets expectations for the subcontractor to report its progress on a regular basis. In the case of an MIS issue, appropriate Coventry Information Technology (IT) staff would be involved for ensuring ongoing oversight monitoring activities.

For example, a vital component of subcontractor performance monitoring is evaluating encounter data submissions. While a subcontractor adjudicates claims for its own services, the subcontractor is required to submit encounter data to the health plan allowing the creation of consolidated reports for appropriate reporting to the PA Medical Assistance agency. As part of this process, we require subcontractors to submit control files with their submitted encounter files. The control files are then compared with the submitted file to ensure the integrity of the data prior to processing. When the received files are processed, the data fields are reviewed at the field level to verify that all required data elements are present, each field has the correct data type, related fields are completed properly and the control fields in the headers and trailers match. If any errors are found, the file is immediately returned to the subcontractor for any necessary corrections and ultimate resubmission. These errors generate an alert to both the operational and information systems staff for follow up. By immediately following up on these errors, we are able to correct them as they occur and prevent the same errors from recurring during future submissions. This then becomes a more efficient and timely process to ensure the integrity and completeness of the encounter data.

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5. Describe the capability your management will have to access a database of service information to create ad hoc reports for both MCO management and the Department. Include a description of the system and software, an overview of the data that will be held, and the resources and the capability you will have to use large amounts of data to create ad hoc reports. (Limit to five pages and list of reports)
- 

CoventryCares uses the comprehensive database and reporting systems of our corporate parent, Coventry. We have extensive capabilities for generating reports, which currently supports management and reporting for the Southeast Zone and soon to be used in the Southwest, Zone. The primary source for monthly, quarterly and annual report trending is the Coventry Data Warehouse (CDW). Reporting from the CDW can be accomplished through both standard reporting datamarts primarily using Cognos cubes and through BI-Query for ad-hoc reporting. Both of these technologies are further described below.

Cognos is the vendor of choice for Coventry's multidimensional cube reporting solution. Cognos, an IBM company, is the world leader in Business Intelligence and Performance Management solutions. Coventry began working with Cognos nearly 10 years ago and has built a comprehensive selection of



integrated data marts/cubes and reporting packages supporting clinical, financial, utilization, profiling, and other analysis and reporting solutions.

Today, Coventry updates on a monthly basis approximately 30-40 Cognos cubes that contain nearly 500 reports. Most of the reports are refreshed on a monthly basis and reporting can be summarized quarterly and annually. Some reporting applications use the term “Employer Group.” For Coventry Medicaid plans most “Employer Group” reports are available, and the “Employer Group” for Medicaid is the State Medicaid contract.

The Cognos cubes and reports are accessible to various Coventry users, including management and operational areas, for review, analytics, trending and, in some cases, detailed drill through. Because of the flexibility and power of the Cognos tools, users have the ability to create their own reports, filter, sort, rank, graph and drill through to detail data as needed without relying upon Information Technology (IT) resource assistance.

Coventry also uses a product called BI-Query by Open Text, which is a graphical model and tool that allows end users to develop ad hoc queries. Coventry continues to expand users and tool sets for decision support. Currently, this product supports over 400 active users across corporate departments and health plans and supports 40,000+ queries per month.

In addition, within each of our core applications such as Navigator, Navigator Care, IDX and CPD, there are comprehensive reporting capabilities. Our Navigator and NavigatorCare applications were developed internally with reporting enhancements being a major objective. These applications rest upon a SQL database and are integrated with Business Intelligence’s Web Intelligence application. Again, users may modify reports for their own analysis, if needed. Navigator reports encompass the Member Service Organization’s handling of member and provider contacts. Topics include time to resolve issues, issue types, issue trends, and agent level reports. Navigator Care reports reflect the activities and outcomes of our Disease and Case Management programs.

### **Overview of the Coventry Data Warehouse (CDW)**

The CDW is an enterprise data warehouse environment. The primary data sources include IDX, Medco, Navigator Care, BenefitExpress and all major vendors involved in the membership, clinical management and claims processing. The CDW is comprised of a large relational repository of detailed information and contains data at the detail level, summary level, and business subject data marts level. A transformation rules engine is used to standardize data across health plans, IDX source systems and vendors. The CDW is used to support various operational processes that require access to large volumes of data. These include pharmacy invoice and Medicare/Medicaid premium reconciliations. It also supports a monthly production cycle with over 50+ key deliverables that include data mart builds, State/Federal reporting, CMS, and Prescription Drug Event (PDE) reconciliation. The primary goal of the CDW is to be an enterprise source of data to support the business in making informed decisions to improve clinical and financial outcomes.

### **Overview of Data Reporting and Types of Data**

Cognos is a tool that allows users to access summarized corporate and health plan data in a multidimensional format (cubes). Cognos has a user-friendly Windows Interface that allows users to



create new (ad hoc) reports or open existing (standard) reports quickly and easily without any programming knowledge. Ad hoc reports are used to retrieve information from the cube in a one-time use format. Standard reports can be run at any time and will retrieve data quickly in the same displayed format each time. Cognos uses summarized data sets in a format called a Cube. Cubes are organized data sets which allow for OLAP (Online Analytical Processing) by looking at snapshots of data for a specific time period. Cubes organize data into a group of viewpoints or perspectives called dimensions.

Users are able to do multiple tasks using a Cube, such as:

- Explore and report corporate and health plan data
- Filter, sort and/or rank the data
- Use preset calculations
- Highlight data based on specific criteria
- Chart and graph data

Described below are some additional features and functionality of Cognos.

- Users can analyze performance measures across different dimensions or perspectives. Coventry has standardized core dimensions across various cubes to provide uniform tagging of data for like data analysis and reporting. Dimensions answer the “Who, What, Where and When” questions about the business. Examples of dimensions are plans, locations, products, periods, etc.
- Measures are the quantitative indicators that determine performance of a business or segment of business. Measures are the only quantitative data contained within a Cube. All data other than measures are qualitative (describe the business).

Some examples of standardized financial measures adopted by Coventry include:

- Per Member Per Month (PMPM) Measures—Allowed \$, Billed \$, and Paid \$
- Dollar and Unit Cost Measures—Allowed \$, Billed \$, and Paid \$
- Unit and Per 1,000 Measures—Units, Procedures, Claims, Approved Days, and Utilization

Some examples of clinical measures adopted by Coventry Disease Management include:

- ED Visits per 1,000
- Admits per 1,000
- Readmits per 1,000
- Outpatient Visits per 1,000

### **Resources Available for Supporting the Coventry Data Warehouse, Data Marts and Reporting**

Coventry’s Business Intelligence and Information Management departments, which are two divisions within the IT department, support data warehousing, Cognos trend and outcomes reporting throughout Coventry. Collectively these two departments have seasoned IT and analytical professionals. These professionals include individuals with Cognos administration/development and report writing skills, data warehouse developers, and senior health care consultants. The IT team partners very closely with the



Financial and Medical Management corporate teams as programs are expanded and enhanced to ensure appropriate data capture, trending and monitoring.

### List of Monthly, Quarterly, Annual and Ad-Hoc Reports

**Attachment 16** lists monthly, quarterly, annual and ad hoc reports. Each of the listed reports is refreshed monthly and reporting can be summarized quarterly and annually.

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6. Describe the capability you will have to access your subcontractor's information to create ad hoc reports for subcontractor oversight and for the Department upon request. (Limit to three pages)
- 

CoventryCares utilizes the comprehensive database and reporting systems of our corporate parent, Coventry. Outside vendor data applies to a large subset of data that is loaded to the CDW which includes claims-related data outside of the normal IDX transactional system (such as laboratory claims, vision claims, foreign claims, radiology claims, pharmacy claims, etc.). It also includes specific wellness-related data (such as health risk assessment data, nurse line data, wellness online program management data, etc.).

The data feeds provided by outside vendors are contracted with Coventry, at a corporate or health plan level. At a corporate level, Coventry loads 203 files per month with a total of almost 25 million records. On a yearly basis, 2,430 files are loaded with over 300 million records.

The data feeds are loaded into the CDW via automated processes, scheduling tools, and the standard data warehousing team's technology. All data feeds are loaded to the CDW into stand-alone data staging tables for data storage purposes on a preset schedule (monthly, bi-weekly or weekly), based on the data warehouse production control team's schedule. These tables contain data by multiple vendors for one single area. After the data are stored in the staging tables, an automated process is run to transfer data from the staging tables to the end target tables. Lastly, the data is then transferred via a flash snap process from the target tables to the BI Query tool, where end users can access the data directly.

Coventry end users that have access to the CDW also have access to these standalone data tables for ad-hoc querying and reporting, via the BI Query tool. There are also pre-established downstream reporting applications that incorporate the vendor data into their respective processes for further data analysis and reporting. These applications are owned and maintained by various Information Technology teams. Some examples of these applications are: HEDIS® reporting, the Navigator Care system, pharmacy Cognos cube, and Episode Treatment Group reporting. HealthAmerica, in conjunction with our Delegated Vendor Oversight Committee (DVOC), will access these various reporting resources to create ad-hoc reports for PA HealthChoices subcontractor oversight.



7. Describe your approach for ensuring complete encounter data is submitted accurately and timely to the Department consistent with required formats. (Limit to two pages)

To submit accurate and complete claim/encounter data to DPW, CoventryCares will duplicate its current HIPAA-compliant claim/encounter data process that incorporates HealthChoices-specific requirements at the level of detail and definition specified by the current HealthChoices Agreement and summarized below. Coventry's specialized teams, knowledgeable in the HIPAA 837 claim/encounter processing, will consult with DPW during implementation to obtain, document, test and implement HealthChoices-specific rules. Coventry is actively submitting data via PROMISE using established protocols. All data transmission methods are compliant with HIPAA and HealthChoices standards throughout the contract.

### Ensuring Accurate Submission

Coventry's provider contracts will require the submission of capitated data to the level used for fee-for-service claims. CoventryCares does not anticipate using PCP capitation for HealthChoices, and we have instituted and enforce policies for providers that specifically define requirements for data quality and timeliness, as well as specific sanctions if requirements are not met.

We apply rigorous internal and automated controls to acquire and process claims and encounters. The quality of the data we will submit to DPW, as well as the accuracy of our claims payment processes, are direct results of the integrity and validity of data that enters our systems. CoventryCares accepts claims electronically and via paper. The Coventry EDI Team tracks, loads and processes EDI files from the clearinghouse, which submits both a claims file and a validation file. EDI team business analysts review the automated validation, which is done by compliance software that checks for invalid codes and missing data elements. This process checks the claims file against the validation file and rejects non-matching files. The clearinghouse must submit corrected files according to service level agreements. The clearinghouse and EDI Team receive email notifications of all exception situations.

Claims undergo a series of rigorous system edits to verify the validity, integrity and completeness of the data. Incomplete claims or those that do not meet the industry standard "clean claim" definition are pended for review by a Technical Claims Specialist. CoventryCares uses industry-standard, integrated claims auditing tools to capture provider submission errors and verify the clinical accuracy of professional claims.

Internal Audit Coordinators from the Quality Improvement and Reporting Audit Departments perform random claims and auto-adjudication audits every two weeks and monthly, respectively, to monitor accuracy of claim payments. Claims audits address initial keying, IDX set up, and all source documentation including: provider contracts, employer benefit plans, claim images, and re-pricing contracts. Audit reports are distributed upon audit completion. This internal audit process also allows for ease in providing information to external auditors, such as for a Coventry-initiated audit.

To maintain data integrity, Coventry's internal controls closely monitor the execution of batch processes. Operators monitor batch jobs for completion 24 hours a day, 7 days a week. Exceptions are routed to an operator alert console, where the production consultant enters them into Coventry's problem management reporting system using a priority level designation. We also manually monitor mission-critical jobs run in batch.

The PC(PC) logs job history and corrective actions. Logs are automatically reviewed using the Tidal Software Job Scheduler. This tool enables production consultants to setup rules-based alerts depending on



the contents of the log files. These preset rules look for information such as error and system messages, values of critical variables and job status. When the criteria in the rules are met, alerts are reported to the operations alert console. Production consultants also review logs pertaining to critical processes. The PC and a Production Shift Lead confirm that both automated and manually-scheduled jobs run successfully. All activity performed by a PC is also recorded via keystroke logging.

The encounter file is extracted from IDX via the Infinimed Claim Extract screen, using HealthChoices-specific rule banks and specifications. The encounter and maternity extracts are scheduled to be automatically generated by operations jobs. The jobs run every Wednesday morning at 4am and the process pulls claims that have been frozen by night jobs within the Monday through Sunday of the week prior.

The extract process pulls all eligible claims frozen by night jobs within the specified date range. The claims are processed through the rule bank to determine which are to be skipped or sent, and if any of the data must be modified. The files are generated in a VMS directory with the naming conventions specific to HealthChoices. After the files are generated the ops jobs will transfer them to Boris where they are retrieved by SeeBeyond for translation to HealthChoices specific requirements.

There are four reports available to monitor claims affected by established Rules and Edits active for the creation of the 837 Outbound encounters for both the PA Medical Assistance and PA Maternity files including: Delete/Skip Report by Date frozen by Night Jobs, Delete/Skip Report by Run, Claim data affected by Rules/Edits by Date(s) frozen by Night Jobs, and Claim data affected by Rules/Edits by Run

We have also created an 837 information report to provide information about the encounters that are going to be sent. SeeBeyond will generate the report when it generates the 837 Outbound files. This report reconciles the 277 and 837, and obtains claim counts for each file to be sent to report the counts to Hewlett Packard.

CoventryCares has established escalation procedures in the event an error or other problem occurs with outbound encounter files. Email notifications will be received for each file that is received and delivered using the CoventryCares encounter distribution list and EDI production support teams. Failure notifications are also delivered to a similar distribution list.

The EDI production support team will address any failure notification and contact the SeeBeyond team as necessary if relating to trading partner issues. If SeeBeyond encounters a problem during the conversion of an IDX extract file to an EDI 837 file, a subcontractor file issue, or the EDI 997 process, the SeeBeyond Team opens a Priority 3 Remedy ticket and assigns the ticket to CVTY EDI Production Support. If the file itself is not delivering or picking up (depending on file type) and there is no message or email notification but the State is indicating that it was delivered then a ticket would be entered to check the FTP / Boris site.

### **Ensuring Timely Submission**

CoventryCares has established automated job processes to ensure encounter data files are created and forwarded to DPW in a timely manner according to the schedule provided by DPW and in accordance with HealthChoices-specific requirements.

### **Subcontractors**

Sub-contractors submit the encounter files for vision, dental, and pharmacy claims. All subcontractors have incorporated HealthChoices-specific requirements at the level of detail and definition specified by the current HealthChoices Agreement.



8. The MCO will be required to have a data completeness monitoring program and submit a data completeness monitoring plan as described in the Agreement. Describe your approach to providing this data completeness monitoring plan. (Limit to three pages)

To submit accurate and complete claim/encounter data to DPW for the PA HealthChoices Program CoventryCares and all subcontractors will utilize the current HIPAA-compliant claim/encounter data process, which is currently in place for the Southeast Zone. This process includes a data completeness monitoring plan, a copy of which is included as **Attachment 17**.

CoventryCares has established automated job processes to create and send encounter data files to DPW in a timely manner according to the schedule provided by DPW and in accordance with HealthChoices-specific requirements. We understand the importance of submitting complete encounter data. In all Coventry's current Medicaid markets, the goal is to work with each state to ensure an optimal encounter data acceptance rate is achieved. A process has been initiated and implemented for the Southeast, soon to be implemented in the Southwest, Zones to monitor, research and resubmit encounter activity to maintain acceptance rate.

### **Approach for Providing Data Completeness Plan**

All claim encounters rejected by the State are reviewed by the Medicaid Reporting Team comprised of business analysts, claims processors, information systems analysts and certified professional coders for encounter correction. Trending and root causes of encounter rejects are examined on at least a monthly basis to address systemic issues related to procedures, processes, providers or systems to continuously improve submission of accurate, complete and accepted claims.

One example of CoventryCares implementing a change to improve encounter submission can be directly correlated to DPW's request to not submit encounters to PROMISE if the newborn has not yet been assigned a Medicaid ID. A change to the internal temporary ID being assigned to newborns was implemented which forced the encounter to pend and not submit to PROMISE. This change to the process ensured newborn records will be submitted to PROMISE only after the newborn's Medicaid ID has been assigned.

Subcontractors reconcile encounter data in the same manner as the health plan using the report method described above. Also, we require subcontractors to submit control files with their submitted encounter files. The control files are compared with the submitted file to ensure its data integrity prior to processing. When the received files are processed, the data fields are reviewed at the field level to verify all required data are present, each field has the correct data type, related fields are completed properly and the control fields in the headers and trailers match. If any errors are found, the file is returned to the subcontractor for correction and resubmission. These errors generate an alert to both the operational and information systems staff for follow up. By following up on any errors immediately, we are able to correct errors as they occur and prevent the same errors from recurring. Subcontractors may face termination of contract for failure to provide contractually agreed upon encounter data.



9. How will you ensure and verify that providers and subcontractor(s) submit timely, accurate, complete and required encounter data elements to you for subsequent transmission to the Department? How often will you verify the data? (Limit to three pages)

To submit accurate and complete claim/encounter data to DPW, CoventryCares will duplicate its current HIPAA-compliant, PROMISE-certified, claim/encounter data process as summarized below. Further, we will incorporate any additional HealthChoices-specific requirements at the level of detail and definition specified by the HealthChoices Agreement. CoventryCares has assigned a specialized team, knowledgeable in the HIPAA 837 claim/encounter processing, to this effort.

### **Timeliness**

CoventryCares has established automated job processes to ensure encounter data files are created and forwarded to DPW in a timely manner according to the schedule provided and in accordance to HealthChoices-specific requirements.

Providers are subject to timely submission requirements as well. Most physician and ancillary providers are required to submit clean claims within 60 days from the date of service. Facility agreements require submission either 90 or 120 days from the date of service. When assuming secondary claim liability, submission is accepted within 120 days from the Third Party Liability (TPL) determination notice. Non-participating providers must submit claims within 180 days from the date of service, or the date of TPL determination notification.

### **Accuracy**

CoventryCares complies with all HIPAA Transaction and Code Set standards for the electronic processing of covered transactions. We partner with the clearinghouse, Emdeon, which enforces industry-accepted standards for the validity and integrity of claims/encounters and other data.

CoventryCares is committed to maintaining compliance with HIPAA, industry standards and HealthChoices data quality standards throughout the term of the contract. CoventryCares uses industry-standard, integrated claims auditing tools to capture provider submission errors and verify the clinical accuracy of professional claims. For example, we use Bloodhound's ClaimCheck to audit for correct coding combinations. Claims undergo a further level of automated auditing using iHealth Technologies software, which examines claims data as a whole to avoid overpayments and identify billing errors.

### **Completeness**

CoventryCares has instituted and enforced powerful policies for providers, which specifically define requirements for data quality and timeliness, as well as specific sanctions if requirements are not met. Standard provider contracts specify the encounter submission requirements and the penalties associated with failing to meet those requirements. All providers, including capitated providers, must adhere to encounter submission requirements.

Encounter reports are balanced against performance logs by total members and charges.



## Required Elements

- Coventry applies rigorous internal and automated controls to acquire and process claims and encounters. The quality of the data we will submit to DPW, as well as the accuracy of our claims payment processes, are direct results of the integrity and validity of data that enters our systems. Providers receive education and materials explaining billing requirements and required fields through several venues. Initially, provider relations walks newly contracted providers through all billing and contract requirements. The provider manual, available in hardcopy and online to all providers, provides an outline of the requirements. Additionally, providers are offered training and additional documentation to improve billing accuracy and efficiency. Eligible received claims undergo a series of rigorous system edits to verify validity, integrity, and completeness of all data elements that include requirements unique to each state Medicaid market:
- **Member matching and eligibility**—confirms member eligibility on the dates of service; identifies newborns who require addition into the system.
- **Provider matching**—validates NPI against provider name; edits validate potential mismatches.
- **Third party liability**—checks for other insurance, if other insurance was billed, if service is pay-and-chase, and if an explanation of benefits (EOB) from the other insurer was submitted with the claim.
- **Correct coding**—uses Bloodhound’s ClaimCheck and iHealth Technology software, customized with contract/health plan requirements.

Extensive mitigating controls improve identification of encounter errors prior to adjudication.

## Subcontractors

Coventry has a comprehensive program to manage our subcontractors and guarantee performance to HealthChoices; this program includes contractual language to obligate subcontractors to prime contract requirements, performance standards and guarantees, reporting requirements, subcontractor audit support requirements and defined interface and management responsibilities. Before entering into an agreement with a subcontractor, Coventry verifies that all subcontractors have information systems capabilities and processes, as applicable to their contract functions.

A key method of monitoring subcontractor performance is evaluating encounter submissions. While a subcontractor will adjudicate claims for its services, the subcontractor is required to submit those encounters to us to create consolidated reports and for reporting to DPW. As part of this process, we require subcontractors to submit control files with their submitted encounter files. The control files are compared with the submitted file to ensure data integrity prior to processing. When the received files are processed, the data fields are reviewed at the field level to verify all required data are present, each field has the correct data type, related fields are completed properly and the control fields in the headers and trailers match. If any errors are found, the file is returned to the subcontractor for correction and resubmission. These errors generate an alert to both the operational and information systems staff for follow up. By following up on any errors immediately, we are able to correct errors as they occur and prevent the same errors from recurring.



## Verification of Data

Claim encounters are accepted electronically and via paper. The Coventry Electronic Data Interchange (EDI) Team tracks, loads and processes EDI files from the clearinghouse, which submits both a claims file and a validation file. EDI Team Business Analysts review the automated validation, which is done by compliance software that checks for invalid codes and missing data elements. This process checks the claims file against the validation file and rejects non-matching files. The clearinghouse must submit corrected files according to service level agreements. The clearinghouse and EDI Team receive email notifications of all exception situations.

To maintain data integrity, Coventry's internal controls closely monitor the execution of batch processes. Production consultants from the Operations Department oversee all IDX batch processing, including encounter data processing and transmission. An automated scheduling tool runs jobs. Operators monitor batch jobs for completion 24 hours a day, 7 days a week. Exceptions are routed to an operator alert console, where the Production Consultant enters them into Coventry's problem management reporting system using a priority level designation. We also manually monitor mission-critical jobs run in batch.

Production batch processes generate log files that track each process. The Production Consultant logs job history and corrective actions. Logs are automatically reviewed using the Tidal Software Job Scheduler. This tool enables production consultants to set up rule-based alerts depending on the contents of the log files. These preset rules look for information such as error and system messages, values of critical variables, and job status. When the criteria in the rules are met, alerts are reported to the operations alert console. Production consultants also review logs pertaining to critical processes. The Production Consultant and a Production Shift Lead confirm that both automated and manually-scheduled jobs run successfully. All activity performed by a Production Consultant is also recorded via keystroke logging.

Coventry supports secured data transmission methods, including file transfer protocol (FTP), Network Data Mover (NDM), and IBM tape cartridge. We will make system modifications necessary to correct any data exchange errors and be compliant with HIPAA and HealthChoices standards throughout the contract.

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10. How will you manage the non-submission of encounter data by a provider or subcontractor? Will it result in any assessment of penalties? If so, please describe. (Limit to two pages)

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CoventryCares encounter data are the foundation of many CoventryCares initiatives including, but not necessarily limited to, our provider incentive program, EPSDT program and Quality Management/Utilization Management (QM/UM) processes. Encounter data are accessed from claims submitted by providers seeking payment for their services and care.

Submission of encounter data is specifically defined in the provider contract indicating that a provider must submit Encounter Data for all services provided to MA Covered Individuals within ninety (90) days of the date of service, no matter whether reimbursement for these services is made by CoventryCares either directly or indirectly through capitation. Primary care physicians who serve MA



Covered Individuals under the age of twenty-one (21) shall report Encounter Data associated with EPSDT screens to CoventryCares within ninety (90) days from the date of service.

Contracted providers are reimbursed on a fee-for-service basis; so it is important for providers to submit all claims data, which translates into encounter data. We do understand however, that CoventryCares members will utilize federally-funded organizations, such as Mobile Health Units, Schools, and vans. They will also utilize the Public Health Units and Health Fairs. For these organizations, we will form partnerships to review records and collect appropriate data. The Quality Improvement / HEDIS team is sending the CoventryCares membership to various providers, collecting data, and tracking it in a database for easy access.

Provider Relations emphasizes the importance of provider submission of all encounter data for CoventryCares through our training sessions, individual office visits and during phone conversations with the providers. We encourage the use of electronic claim submission to enhance encounter data collection.

CoventryCares' Providers are paid on a fee for services basis, if the provider does not submit complete and accurate claims in a timely manner, their claims will be denied and the member is held harmless. The provider will not be paid for services rendered. During the discussion with the provider regarding the non payment of the claim, we educate the provider of the importance of submitting claims in a timely manner and the value of the incentives for submitting encounters and claims.

When CoventryCares does identify deficiencies related to claim accuracy, completeness, and overall submission, we work with the provider to develop a Corrective Action Plan. The plan will identify the findings, required actions, timeframe and monitoring approach and frequency. **Attachment 18** provides an example of a Correction Action Plan completed for DentaQuest.

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11. Describe in detail your process for utilizing the daily, weekly, and monthly files to manage your membership. Include the process for resolving discrepancies between your membership data and the above files. (Limit to four pages)
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CoventryCares, along with its corporate parent, Coventry manages membership by utilizing the 834 Daily Membership File, 834 Monthly Membership File, weekly Enrollment/Disenrollment Reconciliation File and Pending Enrollment File. We process more than 150 monthly file uploads from a variety of sources for our Medicaid health plans, demonstrating the ability to manage membership files according to state-specific requirements. Staff experienced with HIPAA 834 enrollment transactions currently work with DPW to ensure the successful integration of all business rules, technology standards and submission requirements into our system.

### Utilization of Membership Files

In support of our member-focused approach to member service, CoventryCares draws upon proven resources and systems to support the needs of our diverse membership, while maintaining cost effectiveness. CoventryCares accepts the ANSI X12N 4010A1 HIPAA 834 format, as well as proprietary formats and Web-based transactions. Furthermore, CoventryCares has successfully tested



and is ready to accept enrollment files in 5010 format. All enrollment files are loaded and processed into the claims management system, IDX, within 24 hours or the next business day.

The Information Technology (IT) Department validates and translates new enrollment files against companion guide specifications using the SeeBeyond application. Files in valid 834 format are then processed into an IDX-intelligible format. SeeBeyond substantiates information received in the original transaction by validating trading partner authentication and HIPAA compliance.

### **File Upload**

Once validated, 834 enrollment files are loaded into the IDX system by the Enrollment Department. Each record contains indicators for benefit plan number, group number and product type, which identifies individuals as a HealthChoices member. Data for members deemed new to CoventryCares load electronically with the effective date specified on the 834 Enrollment File. These members are assigned a unique, CoventryCares -specific, system-generated number used to identify the member within IDX. All 834 Enrollment File records that match existing membership in IDX are compared and, based on the variables contained in the 834 Enrollment File, automatically update the member's demographic data. Member records received without a termination date on the 834 Enrollment File is verified in Pennsylvania's CIS system then loaded into IDX.

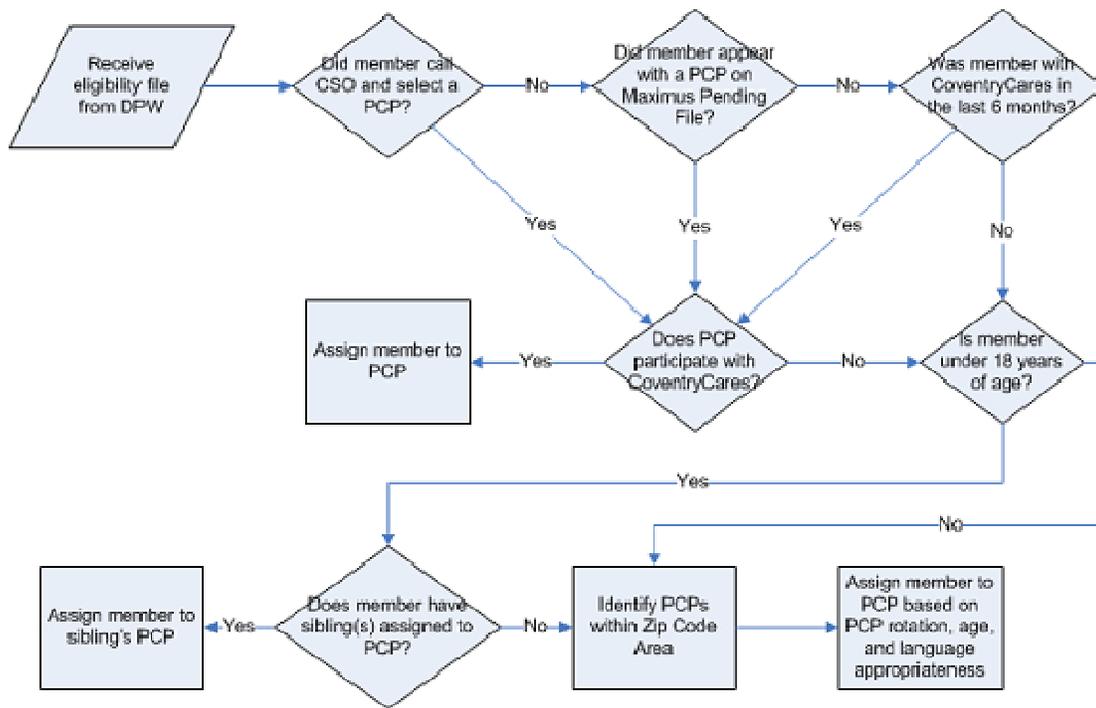
At the same time, any Third Party Liability (TPL) information indicated on the 834 Enrollment File is loaded into IDX. TPL information is directly connected with the member's file as a Financial Status Classification (FSC). The date-sensitive FSC identifies the member's specific insurance information. Each insurance type is automatically assigned as the primary carrier for the TPL's effective dates, ensuring that MA is the payor of last resort.

### **PCP Assignment**

Sophisticated enrollment logic begins with the goal to preserve the member's existing Primary Care Provider (PCP) relationship. To ensure our members have a PCP who will meet their needs and goals, the weekly Pending Enrollment file is utilized to obtain a member's PCP of choice. This information is compared to each Daily 834 Enrollment file to identify active members. Once the enrollment is received, the member's selected PCP is loaded into IDX.

If the member's PCP choice is not obtained within 15 days from their eligibility date, the member's history is reviewed to confirm whether the member had a CoventryCares MA contract in IDX within the previous six months. When a previous contract is identified, the member is reassigned to the previous PCP if participating in CoventryCares' provider network. In cases where the member is new to CoventryCares and did not choose a participating PCP, or we are unable to successfully match a participating PCP, the member is assigned to a PCP based on age, gender, zip code, family case unit, and language compatibility. Figure 25 illustrates this process.



**Figure 25: Primary Care Provider Assignment Process**

CoventryCares recognizes that special needs members may best be served by a specialty physician who adopts the duties and responsibilities of a PCP. Comprehensive policies and procedures guide this process and provide assurance that the assignment is in the member's best interest.

### Discrepancy Resolution

Upon conclusion of the 834 Daily Enrollment File upload, member reports are generated for all new contracts created and terminated in IDX to reconcile the previous day's 834 Enrollment File. Total membership volumes are validated and any discrepancies are immediately researched.

The 834 Monthly Membership Enrollment File upload logic includes termination by omission logic. This logic cancels or terminates any member enrolled on a previous 834 Enrollment File who is not on the current monthly full. Members with future effective dates are excluded from this logic. After this file is loaded into IDX, a reconciliation process is completed comparing the IDX membership to the full file membership.

CoventryCares has routine processes to assess the success of the file upload, as well as identify discrepancies. System capabilities and advanced reconciliation processes continue after the file upload. The electronic enrollment process uses intelligent member matching logic to detect and prevent duplication of members in the system. IDX matches on name (full or partial), MA number, date of birth, gender and Social Security Number (SSN). Members matching on fewer than four criteria are routed to an Enrollment Representative for investigation via edit report.



Following each enrollment file upload, daily and monthly, an edit report is produced for manual intervention. The edit report identifies discrepancies resulting from unsuccessful member matches or invalid PCP selections. These edits are immediately reviewed for resolution. Any edits that are unable to be resolved within 24 hours are escalated to DPW for resolution using the 834 discrepancy e-mail process.

CoventryCares continuously monitors the enrollment process to ensure efficiency, accuracy and effectiveness. We recognize that both the County Assistance Office (CAO) and DPW require notification of membership changes. As part of our ongoing partnership with the CAO and DPW we will submit notification of membership changes in the formats defined in the HealthChoices Agreement.

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12. Explain in detail your process for providing membership information to each of your subcontractors (dental, vision, etc.). Include the subcontractor's name, their purpose and how often membership data is submitted. (Limit to three pages)

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Coventry, provides membership information to subcontractors as required per the subcontractors' agreements. In order to implement this transfer of information, we have dedicated testing areas in which we conduct all interface and data feed testing. Coventry's Information Technology (IT) Department and supporting operational units work together to document and test this data. Detailed implementation steps include:

- Conduct a detailed review and comparison of all applicable DPW companion guides to ensure state requirements will be met and any differences amongst the various zones (e.g., Southeast, Southwest, New West, New East) are identified and considered during the implementation process
- Meet with each subcontractor's IT representatives to resolve any questions and/or concerns
- Map data elements to the subcontractor's system fields and make any necessary changes as required by Coventry
- Create a System Change Document detailing the functional/technical requirements of the new process within Coventry
- Obtain business unit approval of the functional requirements
- Build any cross-reference tables and develop code within the development system
- Send small test files to the subcontractor to test any changes and basic formatting
- Develop detailed system testing plans directly with the subcontractor
- Complete the new code and complete unit testing
- After unit testing, move code to test environment for additional system testing by IT analysts against corresponding test plans to ensure that files generate properly
- Develop test plans for End-to-End testing
- Send sequentially larger test files from PW or other entities for testing scenarios



Once IT analysts have successfully completed all necessary system testing, Coventry business units and IT staff work directly with the subcontractor to execute the End-to-End Testing Plans. These tests run through the entire process from file transmission by Coventry, file receipt by the subcontractor, necessary working edits, and final reporting. If, at any point, we detect an error or need to make a necessary adjustment, the process returns to the earlier step until the issue has been completely resolved. Once the End-to-End testing is successfully completed, the business unit provides written approval and the code can be moved into production via our standard Code Move Process. Once in production, we establish an automated process to create and transmit the membership information to the subcontractors.

In order to maintain data integrity, Coventry’s internal control process closely monitors the execution of the batch processes. Production consultants from the Coventry Operations Department oversee all IDX batch processing, including electronic enrollment, claims processing, and encounter data processing and transmission. Operators monitor batch jobs for completion 24 hours a day, 7 days a week. Exceptions are routed to an operator alert console, where the Production Consultant enters them into Coventry’s problem management reporting system using a priority level designation. Mission-critical jobs that are run in batch are manually monitored to ensure both accuracy and completion.

Production batch processes generate log files that track each process. The Production Consultant (PC) logs the job history and any necessary corrective actions. Logs are automatically reviewed using the Tidal Software Job Scheduler. This tool enables production consultants to set up rule-based alerts depending on the contents of the log files. These preset rules look for information such as error and system messages, values of critical variables, and job status. When the criteria in the rules are met, alerts are reported to the operations alert console. Production consultants review logs pertaining to the critical processes. The PC and a Production Shift Lead confirm that both the automated and manually-scheduled jobs run successfully. All activity performed by a PC is recorded via keystroke logging. Figure 26 lists subcontractors that require membership data submission.

**Figure 26: CoventryCares Subcontractors**

Company Name	Address	Scope of Work	Data Freq'y
Block Vision	939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090	Vision	Daily
Clark Resources	321 Front Street Harrisburg, PA 17101	Health Risk Assessment and Welcome Calls	Daily
DentaQuest	465 Medford Street Boston, MA 02129	Dental	Daily
LabCorp	430 S. Spring Street Burlington, NC 27215	Lab	Daily
McKesson 24/7 Nurse Line	5 Country View Road Malvern, PA 19355	Nurse Advice Line	Daily



Company Name	Address	Scope of Work	Data Freq'y
Emdeon Business Services	3055 Lebanon Pike Nashville, TN 37214	Clearinghouse functions	Daily
Medco	Medco Health Solutions 100 Parsons Pond Dr. Franklin Lakes, TN 07417	Pharmacy Vendor	Daily
Quest	3 Giralda Farms Madison, NJ 07940	Lab	Daily

13. Explain your process for maintaining your provider file with detailed information on each provider sufficient to support provider payment and also meet the Department’s reporting and Encounter Data Requirements. Include how you cross-reference your internal provider ID number with the PROMISe provider ID and the provider’s NPI number. (Limit to two pages)

Using IDX, our comprehensive claims processing system, CoventryCares possesses the tools to maintain required provider records to support reporting and claims processing functions. These processes are currently in effect in the Southeast Zone of HealthChoices and will soon be implemented in the Southwest Zone.

In conjunction with these existing and routine processes, CoventryCares has the ability to retain and cross-reference:

- PROMISe provider identification number
- CoventryCares provider identification number
- National Provider Identification (NPI)

This ensures the provider reference is accurate and meets all HealthChoices requirements.

### Maintaining Provider Files

CoventryCares’ providers are maintained within the Coventry Provider Database (CPD). CPD is a centralized database utilized by Provider Relations representatives to maintain participating provider demographics, including but not limited to, Tax ID, location and billing addresses, NPI, PROMISe Provider ID and contractual relationships. Information is transmitted from CPD and loaded into the IDX provider module.

Within the IDX system, each provider and group has an internal unique provider number that identifies the provider’s participating status with CoventryCares. Each provider and group has an NPI number, which is used as the standard unique identifier and primary reference number for providers. IDX has the



capability of storing up to 99 alternate NPI numbers for providers that have applied for and received sub-part NPI numbers. The CoventryCares-specific provider number is used in conjunction with the NPI number to support provider payment, identification and maintenance.

The IDX structure allows for the submission of NPI numbers billed on claims for rendering providers, billing providers, and facilities where services were rendered. A taxonomy code is captured on claims submissions for rendering and billing providers. Each of these numbers is stored within the Provider Module of the IDX system. The IDX structure incorporates provider selection logic in every claim submission by evaluating the CoventryCares provider number, NPI, and Taxonomy Code. Although NPI is the primary reference, the additional examination of the submitted data identifies discrepancies requiring further investigation. This advanced capability ensures accurate provider selection for claims adjudication.

### **Cross-Reference of Provider Identification Numbers**

The PROMISe ID is obtained as part of the contracting and credentialing process. IDX houses 13 characters for the PROMISe ID. The PROMISe ID is stored and maintained in CPD and in the Provider Module in IDX for reporting and reference purposes, including provider directory and encounter reporting. A cross-reference table, incorporating the provider's name, PROMISe ID, NPI number, and CoventryCares provider number is used to extract encounter data from IDX to ensure accurate reporting to DPW, fulfilling the standards defined in the PA HealthChoices Agreement.

Controls have been implemented to prevent providers without a valid PROMISe ID from being contracted. Claims confirmed to have been submitted by a non-participating provider without a valid PROMISe ID are loaded in the IDX system and considered for payment of medically necessary and covered services only with a valid NPI. We recognize the PROMISe ID can be submitted in encounter data when a provider does not have an NPI. In accordance with federal guidelines, CoventryCares is compliant with all NPI requirements. NPI is a mandatory element to reimburse all providers.

Additionally, data stored within CPD and the IDX system is internally audited for discrepancies against provider files received from DPW. Such processes ensure accurate reporting of encounter data for claims submissions from providers enrolled in MA that have a valid PROMISe ID.

CoventryCares is committed to maintain accurate provider files, make appropriate payment to providers, and collect and report accurate encounter data. Processes are continuously monitored, and CoventryCares will work with DPW and/or its designee to ensure PROMISe ID management meets the needs of the Commonwealth.



14. Explain your processes for ensuring providers are enrolled in MA and have a valid PROMISE Provider ID number and NPI. Include how you will monitor your subcontractors to ensure their providers are enrolled in MA and have a valid PROMISE Provider ID number and NPI. (Limit to two pages)

CoventryCares has a proven ability to promptly and accurately maintain provider identification records to prevent providers excluded from the MA program from providing services to our membership and receiving inappropriate reimbursement.

### **Initial Validation**

Validating the PROMISE Provider ID number begins at the time of contracting. All contracted providers must pass credentialing requirements before they are entered into our claims payment system, IDX. The credentialing process includes a review of the U.S. Department of Health and Human Services (US DHHS) Office of the Inspector General (OIG) Web site, exclusion lists, and the PROMISE Web site to ensure all newly-credentialed, as well as re-credentialed, providers participate in the MA program and are free from sanction and debarment actions. CoventryCares will continue to partner with DPW to address provider number discrepancies.

CoventryCares has processes to validate non-contracted providers as well. When claims are received by new non-contracted providers, a validation system is in place to confirm the provider is eligible to service our MA membership. The claim is automatically pended to the Provider Systems Administration Unit (PSA) to match the provider to the PROMISE Web site and record in the provider's records. A list of excluded and sanctioned providers is maintained up-to-date on a monthly basis by the Special Investigation Unit (SIU) for additional cross-referencing.

In accordance with federal guidelines, CoventryCares complies with all National Provider Identifier (NPI) requirements. NPI is a mandatory element to reimburse all providers. The Credentials Verification Center (CVC) will not process an initial credentialing application or a recredentialing application that does not have the required NPI number. Credentialing processors will check the National Plan and Provider Enumeration System (NPPES) website for the practitioner's individual NPI number. If the NPI number cannot be found on the NPPES website, the processors will follow the Exhaustive Efforts policy in order to obtain the information from the provider. If this is not successful, the Provider Relations representative will be asked to intervene.

### **Continuous Monitoring**

Coventry's dedicated Special Investigation Unit (SIU) focuses solely on the identification, review and reporting of potentially abusive or fraudulent providers and billing practices, as well as classifying providers on state and federal excluded provider lists. Our comprehensive, documented practices foster vigilant monitoring of provider sanction status, prevent members from receiving services from excluded providers and deny payment for claims submitted by such providers.

The SIU monitors the US DHHS OIG Web site and exclusions list, as well as other sources to detect excluded providers. Coventry's PSA also downloads this list monthly and executes a proven, automated



procedure to match providers. The PSA uses this information when loading new non-participating providers to IDX.

The SIU takes proactive steps to ensure our health plans do not pay claims submitted by sanctioned or excluded providers. These steps include, at a minimum:

- Reviewing provider files received from DPW.
- Reviewing OIG debarment reports monthly.
- Reviewing state MA and licensure debarment reports monthly to identify contracted providers.
- Flagging sanctioned providers on the CoventryCares Provider Database.
- Placing a Prospective Review Flag on all claims associated with debarred or sanctioned providers. During adjudication, IDX automatically checks the Prospective Review Flag and suspends all claims submitted by a debarred/suspended provider. The SIU reviews these claims prior to payment. The review is intended to detect any claims and deny them appropriately for debarment reasons, or alternately, to suspend them until the SIU can conduct an investigation. Any such claims submitted for services provided to CoventryCares members will be denied. This type of denial cannot be overridden by claims processing staff.
- Transmitting provider debarment information to Provider Relations staff for provider database flagging and investigation. Providers identified as debarred are further flagged by Provider Relations staff as unavailable to accept new patients. Provider Relations immediately identifies members receiving services from sanctioned providers and works with members to transfer them to other appropriate providers, as required by the regulatory action. The transfer process places emphasis on member needs and seamless transition to ensure continuity of services.

### **Subcontractor Monitoring**

CoventryCares oversees subcontractors in accordance with our established vendor management policies and procedures. CoventryCares utilizes our subcontractor agreements as well as regular and frequent interaction between the responsible key personnel and the subcontractor to both identify and address any issues arising from the relationship. This oversight includes monitoring reports regarding claims and provider information. CoventryCares requires each subcontractor to submit periodic performance reports and a quarterly contract compliance report on subcontracted functions. This information is reviewed by our Delegated Vendor Oversight Committee (DVOC) which meets on a monthly basis. The subcontractor submits more frequent and ad hoc reports as required by performance or function.

In accordance with this monitoring process, we require our MA subcontractors to include the Promise ID and NPI within its claims and other mandated reports.



15. What is your plan to ensure that claims timeliness standards are met and that providers are paid timely? (Limit to two pages)

Coventry, the corporate parent of CoventryCares, performs claims processing functions for the Southeast Zone, and will soon perform the functions for the Southwest Zone, and will include the New West and New East Zones at our dedicated Medicaid claims site. CoventryCares operates an effective system that features consistent claims handling procedures, advanced adjudication capabilities and thorough monitoring measures, reducing turnaround time and enhancing provider payment and program experience. CoventryCares will comply with all claims timeliness standards defined in the New West and New East HealthChoices Agreement, and has consistently exceeded the goals defined in the Southeast Agreement.

**Process**

CoventryCares successfully processes claims to meet timeliness standards for various products and state markets using IDX, our claims management system. IDX records the date of claim receipt, real-time claim status history and payment dates. The system is capable of tracking prompt payment standards as specified by each state.

CoventryCares has stringent turnaround requirements to ensure timely processing. Paper claims received by our subcontracted data vendor are required to be marked with the actual date received. Claims are then submitted into IDX within 48 hours of the received date, with no individual claim exceeding 72 hours. Claims are received and transferred to an electronic format using optical character recognition and submitted electronically into IDX twice daily. Electronic claims received through the clearinghouse transfer into IDX within 24 hours. CoventryCares' Southeast Zone averaged a 61.5% electronic submission rate in 2010, and a 69.8% electronic submission rate for 2011.

CoventryCares prides itself in ensuring that claims are paid quickly and meet or exceed established quality requirements. In 2010, CoventryCares' Southeast Zone processed 98% of claims within 15 days of receipt and 99.7% of claims within 30 days of receipt, exceeding the Pennsylvania requirements established in Section VII.D.1 of the New West and New East HealthChoices Agreement. Such quick turnaround time is due to Coventry's commitment to auto-adjudication, system rules that review and process claims without manual intervention. Employee audits, auto-adjudication audits, and focused audits confirm payment accuracy per contract requirements.

Once the adjudication process is complete, the claim is either denied or sent to IDX Accounts Payable for payment. Claims follow a pre-determined weekly check run schedule, with a two-day turnaround time guarantee on paper check generation. During the check run process, the date of issue is printed on the check. CoventryCares is committed to providing timely notifications to providers of claims disposition and encourages providers to utilize electronic remittance advice (ERA) and electronic funds transfer (EFT) transactions. In 2010, there were 163 Southeast Zone EFT payments, totaling \$38,474, and in 2011, there were 2,421 Southeast Zone EFT payments, totaling \$7,404,928.



## Monitoring

CoventryCares employs many checks and balances, allowing for monitoring of current inventory, forecasting future inventory, and directing staff accordingly to meet claims requirements. Management and processors monitor claim age and inventory using an array of historical and real-time data. Daily inventory reports allow for tracking and trending, including quantities of claims received, keyed, suspended, and non-standard correspondence received.

CoventryCares constantly evaluates and augments auto-adjudication and claims processing rules, to improve turnaround time for claims payments as well as ensure the most updated and accurate processing. Updates to system rules are guided through the Operations Change Management Process, complying with all legislation, including the Public Company Accounting Reform and Investor Protection Act (“Sarbanes-Oxley”).

CoventryCares realizes that claims statistics are only as solid as the skills of their processors. Therefore, processors undergo initial and ongoing claims training. Each processor must meet individualized processing goals. Also, performance tracking and trending allows management to identify processors for coaching, focused audits, or corrective action, as necessary.

We are proud of our history of consistently meeting and exceeding claims processing standards. As demonstrated in the Southeast Zone and other implementations, careful planning and diligent execution lead to initial and long-term success. Furthermore, all Medicaid implementations include a business validation process to ensure high quality claims processing—initial and ongoing—while meeting accuracy and timeliness standards.

The chart below depicts various claims statistics for CoventryCares' Southeast Zone, and demonstrates that CoventryCares consistently meets or exceeds claims requirements.

**CoventryCares' Southeast Zone Claim Performance**

	2010	2011
Claims Processed Within 15 Days	98.0%	95.7%
Claims Processed Within 30 Days	99.7%	99.6%
Financial Accuracy	98.5%	99.4%
Percentage of Claims Submitted Electronically	61.5%	69.8%
Auto-Adjudication Rate	67.8%	76.0%
EFT Payments (Numbers)	163	2,421
EFT Payments (Dollars)	\$38,474	\$7,404,928



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### *Provider Network Composition and Network Management*

1. Explain your plan to ensure that your provider network meets the network and access requirements in the draft Agreement. Specifically include:
  - The method you plan to use on an ongoing basis to assess and ensure that network standards outlined in the draft Agreement are maintained for all provider types. Describe your process for continuous improvement in your network over and above contract compliance.
  - Describe how you will ensure that appointment access standards are met when members cannot access care within your provider network and must go to an out-of-network provider?
  - Describe how you will collect and record language needs for those consumers with limited English proficiency and how you will ensure all written notices are language appropriate.
  - Describe how you will educate and coordinate interpreter services with your network providers.

(Limit to six pages)

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CoventryCares has demonstrated that care is best provided when the network reflects and supports the cultural and linguistic needs of the population it serves.

We do not discriminate in any fashion for recruitment and credentialing of providers. Our inclusion of traditional and Allied Health Professionals and emphasis on geographic diversity are intended to ensure members appropriate proximity to providers who can address medical, social, and cultural needs.

We maintain an active license and continuous statewide provider network in all 67 counties in Pennsylvania. CoventryCares will capitalize on this existing network to constitute its network for HealthChoices members in the New West and New East Zones. A mail solicitation to all existing providers will be sent, including a contract amendment for the terms and conditions and reimbursement, of the New West and New East Zones. Supplementing this mailing will be telephonic and in-person recruitment efforts by the Provider Relations team.

We currently contract with 67% of the FQHCs and RHCS located in these zones:

- 23 FQHCs and RHCs in the New West Zone
- 19 Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) in the New East Zone
- 171 FQHCs and RHCS across Pennsylvania

These safety net providers are located in urban, suburban, and rural locations and are critical access points for community-based primary care services.



## Assess and Ensure Network Standards

The Provider Relations team is responsible for oversight of our provider network, which includes efforts to ensure compliance with access standards and monitoring geographic adequacy. Various specialties and provider type will contain different geographic access requirements.

CoventryCares requires PCPs to provide access 24/7 to direct members' health care needs. Our PCPs accomplish this using a variety of methods including but not limited to:

- Extending office hours to evenings and weekends
- After hours call coverage solutions, which include:
  - Covering physician
  - Answering service
  - Direct access to physician

## Continuous Improvement

Provider Relations reviews, monitors and resolves member complaints of provider accessibility, both geographically and hours of operation.

### *Access*

CoventryCares employs a monitoring process to ensure an extensive network of care for its members. CoventryCares complies with all of DPW's Access Standards. In addition to reviewing Geo Access mapping to ensure network access as described in Question 2, we receive information from Member Services, Case Management and network physicians. We use information from all these sources to identify and act on network needs. For example, we continue to expand our network in the Southeast Zone through organic growth and targeted recruitment. Most recently, we added 4 hospitals and 118 physicians with Community Health Systems to the CoventryCares network in Southeast Pennsylvania. This health system also owns and operates several hospitals throughout the New East Zone.

### *Availability*

Primary care providers must provide care or direct access to care 24 hours per day, seven days per week. Audits are conducted to determine that provider after hour telephone lines do not automatically direct members to the emergency department. CoventryCares employs a "secret shopper" program to monitor appointment availability in our physician network. In addition, CoventryCares monitors office hours and after-hours accessibility through postcard surveys; member service complaints and Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction survey.

Member complaints regarding network providers received by Member Service organization are entered into an electronic tracking system called Navigator, which is monitored by the Provider Relations staff. The Provider Relations team reviews these entries and providers not meeting the appropriate standard receive a visit from their Provider Relations Representative to review contractual access standards and needs for improvement.



Upon identification and validation of a provider's failure to meet DPW standards for appointment availability and/or waiting times, our Provider Relations staff educates the provider as to the standards and expectations. All appointment access audit results are reported to our Utilization Management/Quality Improvement (UM/QI) Committee.

### **Out-of-Network Providers**

We have a PCP-driven model of care and Medical Home in which timely access for physician services is critical to managing a member's health care needs. Our primary focus is on presenting a broad and comprehensive network that will minimize the need and usage of out-of-network providers. When members cannot access care within our provider network and must go to an out-of-network provider, we use various methods of outreach to the provider's office, including telephone calls from our Provider Relations and Medical Management teams and personal visits by a Provider Relations representative.

When necessary, CoventryCares enters into Limited Provider Agreements with out-of-network providers specific to a member, to ensure the member has access to necessary providers and the providers have obligated themselves to an agreed upon reimbursement level. We utilized this process in our Southeast HealthChoices region with four ancillary providers: Alere, National Seating and Mobility, Peritech and Vitas Hospice. After agreeing to the Limited Provider Agreement, each of these providers executed a full-service agreement with CoventryCares to serve our Southeast Pennsylvania members.

### **Collecting and Recording Language Needs**

CoventryCares identifies a member's primary language through two methods

- Through the 834 Enrollment File, which automatically feeds into the claims management system, IDX, for immediate use
- Member Services interaction with the member to validate or obtain primary languages

When a member is identified to have limited English proficiency, CoventryCares captures the member's primary language and records the information into the member's permanent record in IDX for future use.

CoventryCares ensures all written notices are available in Spanish, Russian, Vietnamese, Khmer and Chinese (Cantonese and Mandarin). Any time a member requests that a document be translated, CoventryCares employs the services of Avante Language Services, a certified Pennsylvania disadvantaged business to accommodate the member's request.

CoventryCares makes translation services available by telephone and face-to-face, with telephone translation available through Language Line. With over 28 years of experience and translation available in over 190 languages, Language Line is a leader in telephone translation services. Each telephone request is routed according to skills-based routing techniques, ensuring that each member is matched with a translator who speaks the requested language. Face-to-face translation services are available to members for medical appointments, and requests for these services can be made by the provider or the member by calling CoventryCares Member Services.



For our hearing impaired members, we maintain a toll-free TTY/TDD telephone relay function manned by specially-trained representatives. CoventryCares also provides in-person sign language interpretation upon request to CoventryCares Member Services. CoventryCares has identified two Pennsylvania organizations to assist with services for the hearing impaired. They are the Center for Hearing & Deaf Services, Inc., and The Center for Community and Professional Services at The Pennsylvania School for the Deaf. We work with the Associated Services for the Blind and Visually Impaired for access to translation and alternative formatting services. We use local resources whenever possible.

### **Educating Providers on Interpreter Services**

Providers and their office staffs are made aware of Limited English Proficiency (LEP) Low Literacy Proficiency (LLP), and hearing impaired services through our provider representatives, educational forums, Provider Manuals and through our provider web portal, DirectProvider.com. The following is an excerpt from the CoventryCares Provider Manual:

*“...CoventryCares and its Network Providers have an obligation to provide interpreter services to LEP and LLP Members and to make reasonable efforts to accommodate Members with other sensory impairments. Network Providers who are unable to arrange for translation services for an LEP, LLP or sensory impaired Member should contact CoventryCares' Member Services 1-866-903-0748 and a representative will assist in locating a professional interpreter that communicates in the Member's primary language.”*

Provider Relations representatives conduct an initial provider orientation for all newly contracted providers and office staff within the providers' first 30 days of participation in our network. Training includes language services and community resources that have been identified.

Provider and office staff education does not end with the initial orientation or distribution of provider manuals. Routine training continues with, at minimum, an annual provider meeting, quarterly distribution of provider newsletters, annual redistribution of provider manuals and routine provider one-on-one site visits on a periodic basis. In the Winter 2010 edition of CoventryCares Network News, which is sent to all participating physicians, we supplied an article discussing cultural competency and provided resources, such as [thinkculturalhealth.hhs.gov](http://thinkculturalhealth.hhs.gov), to assist physicians on incorporating cultural beliefs, customs, values and language in their health interventions.

During all training sessions, Provider Relations supplies telephone numbers for the CoventryCares Member Services, TTY/TTD, and Special Needs Unit. These options ensure access for all non-English speaking, LEP, LLP or any sensory impaired CoventryCares member.

Additionally, providers are encouraged to use the online provider portal, [www.DirectProvider.com](http://www.DirectProvider.com). Directprovider.com provides comprehensive access to electronic tools and real-time information on members, referrals, policies, criteria, and numerous other resources for our providers.



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2. How will you use Geo Access mapping to ensure network adequacy? (Limit to two pages)

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To ensure access to primary and preventive care, CoventryCares uses GeoAccess technology to identify the distribution of providers by specialty within its service areas. GeoAccess data are run according to contract requirements. The reports fall into two categories: maps and summaries. Both of these reports are utilized in order to better understand the network and to better fulfill the goal of providing CoventryCares members with the best possible access to medical care.

CoventryCares utilizes a variety of maps to plot its members and its providers. The four most common maps are transportation plot maps, provider plot maps, provider radius maps and member maps.

Weekly, Provider Relations and Quality Improvement use these maps to determine deficiencies within the CoventryCares network. Once deficiencies are identified, CoventryCares will utilize and capitalize on the existing plan network that is in place to address any deficiencies. We have Certificate of Authorities and Operating Authorities to operate in all 67 counties in Pennsylvania. Through our existing relationships with providers and hospitals in these counties, CoventryCares will initiate contracting efforts to build out the network for MA where GEO access identifies needs that are not currently being met by the provider network.

Provider accessibility reports by mileage and membership are the most common data tables that are produced. Additionally, our GeoAccess tools give us the capability to plot accessibility by travel time. The reports are generated to determine compliance with the Commonwealth access standards, which would include for example, two Primary care providers within 30 minutes for an urban area and 60 minutes for a rural area. CoventryCares recognizes these standards and will comply with them by producing ad hoc reports, which help to define network needs within the specific geographic areas. For example, these reports include providers speaking specific languages, providers within a given radius of a zip code, and providers who have extended hours.

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3. Explain the policy and procedure utilized to insure your provider directories are accurate and up to date. Please describe how policies are applied to both hard-copy and on-line or electronic versions. (limit to three pages)

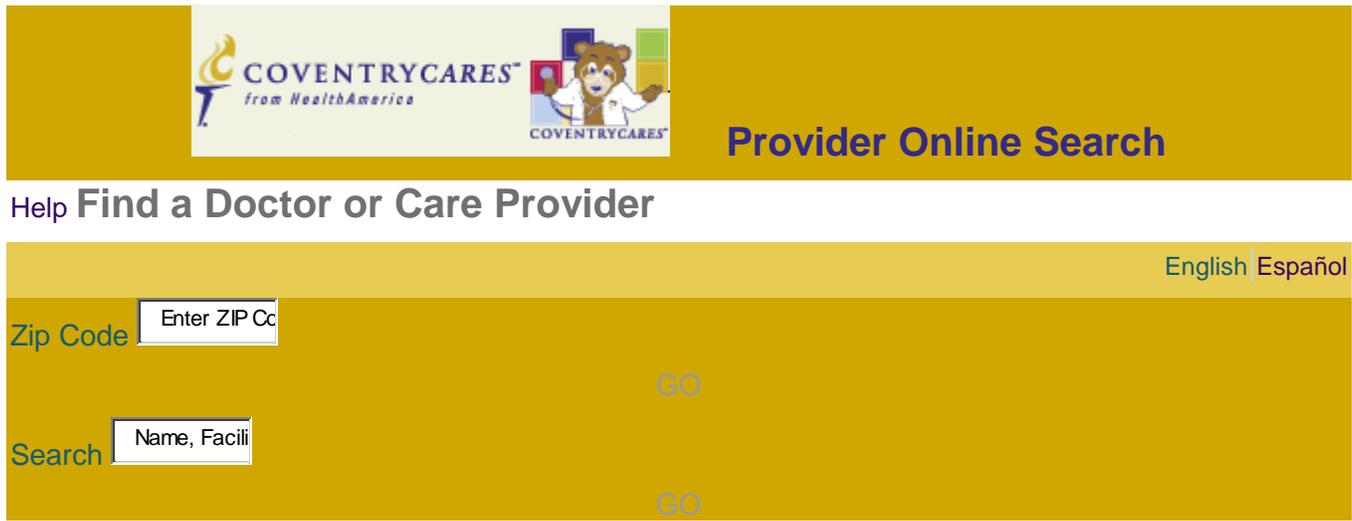
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The CoventryCares Provider Database (CPD) is the data source for all provider directory information. CPD is updated daily for all additions, deletions, and changes to provider or hospital/facility entries. The policy designates that Provider Relations will be responsible for maintaining the integrity of the provider and hospital/facility data that supports the directory.

The hard copy directory is produced according to DPW guidelines on an annual basis. The CoventryCares website ([www.myCoventryCares.com](http://www.myCoventryCares.com)) is updated weekly with all changes and is available to members and providers, where they can request a paper directory at any time. Figure 27 shows an example of the Provider Search Page.



**Figure 27: Sample Provider Search Page**



Show Providers that accept: **CoventryCares**

PROVIDERS	SPECIALTIES	CONDITIONS
Specialists	Family Practice	Diabetes
Hospitals	Obstetrics And Gynecology	Asthma
Ancillaries	Gynecology	Heart Disease (Coronary Artery Disease, Atherosclerosis)
Urgent Care Centers	General Practice	High Cholesterol (Hyperlipidemia)
Allied Health Professionals	Internal Medicine	Acquired Immune Deficiency Syndrome (HIV/AIDS)
All Physicians	Pediatrics	

Provider and hospital/facility initial information is entered into the CPD system and verified during the initial credentialing and re-credentialing process. To ensure that accurate information is included in the provider directory and in member material, the Provider Relations Department is responsible for updating the provider and hospital/facility directory weekly.

Annually, the Provider Information Form will be sent to providers via fax blast in an effort to maintain accurate information. Once the completed Provider Information Form has been returned by the provider, any new/revised information will be updated in CPD.

**Web based Directories**

In addition to the annual outreach to the provider, the Provider Relations department receives demographic updates from providers on a regular basis. Once the update is entered into the CPD system, the change will appear on the Web based directories within 24 hours of the provider information change.



### **Hard Copy Directory**

Annually, a draft copy of the newest Provider Directory is produced for review by the Provider Relations staff. The Provider Relations staff's reviews their assigned areas and submit the necessary corrections to Provider Data Maintenance for updates. At that time, hard copy directories are printed in bulk. Additionally, a real time hard copy document is available for printing on demand when requested by member or Provider.

The provider directory is available at [www.mycoventrycares.com](http://www.mycoventrycares.com). If a member indicates that he does not have access to the Internet or email, the Member Service representative will create the online directory and offer to email it to the member. If the member indicates that he does not have email, the rep will mail a hard copy of the customized directory to the member.





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4. Explain your plan to manage contracted skilled nursing and home health providers to meet members' growing needs for access to home and community based services for medically complex cases. (Limit to two pages)
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### **New West Zone**

CoventryCares will utilize the services of Rx HomeCare (RxHC) to act as our network manager in the New West Zone. RxHC is responsible for contracting, credentialing, serving, and educating the home skilled nursing and home health provider network. CoventryCares holds the underlying contracts for the home health network managed by RxHC. This vendor has extensive experience developing and managing provider networks and coordinating member needs with appropriate home health services/providers.

Quarterly, CoventryCares, in partnership with RxHC, reviews the number of providers by provider type and by county to ensure that provider access standards are met. Should there be a deficiency in the network, research is done on the area for the providers and recruitment process begins. Through the initial credentialing and recredentialing process, we gather and track information regarding ADA accessibility and non-English languages spoken by the providers' staff.

CoventryCares in partnership with RxHC also continuously monitors member complaints. All complaints received, whether they are from our Member Services Provider Relations, Medical Management staff or from other network providers, are quickly addressed. CoventryCares or RxHC, as applicable, contacts the provider for a formal written response as to the resolution of the complaint.

Each complaint received by RxHC is reviewed quarterly at their Credentialing Committee meeting. Up to four member complaints received within a 90 day period require the provider to submit a written response explaining the circumstances. After review by internal QI staff a corrective action plan may be required. Should CoventryCares receive five or more complaints for any reason, for any single provider within a 90-day period RxHC will perform a documented site visit. During the site visit, recommendations for improvement as well as a Corrective Action Plan is developed and its adherence is monitored by RxHC every six months until an approved resolution is reached.

Formal and informal communications between CoventryCares and RxHC is key to the success of our partnership. Additionally, communication between RxHC and their subcontracted providers is essential to keep them informed and educated.





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4. Explain your plan to manage contracted skilled nursing and home health providers to meet members' growing needs for access to home and community based services for medically complex cases. (Limit to two pages)
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### **New East Zone**

In this region, CoventryCares staff is responsible for contracting, credentialing, serving, and educating the home skilled nursing and home health provider network.

Quarterly, CoventryCares staff reviews the number of providers by specialty type and by county to ensure that provider access standards are met. Should there be a deficiency in the network, CoventryCares staff will research the area for additional providers and begin the recruitment process. Through the initial credentialing and recredentialing process, CoventryCares staff gathers and tracks information regarding ADA accessibility and non-English languages spoken by a providers staff.

CoventryCares staff also continuously monitor member complaints. All complaints received, whether they are from our Member Service organization, Provider Relations, Medical Management staff or from other network providers, are quickly addressed. CoventryCares staff contacts the provider for a formal written response as to the resolution of the complaint.

Each complaint received by CoventryCares in the New East Zone is reviewed in detail by the Internal Research Committee, which is composed of CoventryCares employees in our quality management unit. The Internal Research Committee reports its findings to the Quality Improvement / Utilization Management Committee which meets monthly to evaluate any problems and proposed resolution as well as recommends corrective actions, if any. The Quality Improvement / Utilization Management Committee is a combination of CoventryCares medical directors and physicians from various geographies throughout the Commonwealth who also participate in the CoventryCares provider network.





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5. What risk adjustment strategies and/or provider incentives do you employ in PCP contracting to ensure members with complex medical needs have adequate access to primary care and care coordination services? How do you measure and assure that these members have adequate access to care? (Limit to two pages)
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CoventryCares' objective is to identify all members requiring special needs, to assign them to appropriate providers, and to assist them in obtaining any services required. Identifying this population is done through many methods:

- Physician office requests
- Hospital-based concurrent review nurses
- Provider calls to outpatient authorization nurses
- Member calls to our dedicated member service organization
- Data mining of claims payment or authorizations

When a member with complex medical needs is identified, a case manager is assigned to ensure that services are directed to the most appropriate provider. If a member's special needs require that a specialist physician act as the PCP, the member, provider and CoventryCares agree to the plan of care. CoventryCares provides transportation when needed through the MA Transportation Program.

### **Provider Incentives**

CoventryCares contracts with Primary Care Physicians require active cooperation and participation in CoventryCares' care management program including arrangement of necessary medical services for both complex and chronic medical needs. The CoventryCares provider incentive program is a pay-for-performance model based on eight HEDIS measures. The model is focused on appropriate care and screenings to avoid acute or sudden onset of illness. Success is measured by both short-term and long-term utilization results. These measures can extend additional reimbursement to providers for ensuring appropriate care for these medically complex members. In addition to this provider incentive program, CoventryCares provides reimbursement for after hours visits to encourage physicians to remain active in the treatment of their patients as opposed to using Emergency department services. Figure 28 details the HEDIS measures that will be measured quarterly to monitor compliance with obtaining recommended care:

### **Access Measurement**

CoventryCares measures access to providers for members with complex medical needs through the Coventry suite of tools. An example of our suite of tools is The Gaps in Care Report. This report records and reports compliance on a variety of quality measures such as Antidepressant Medication Management, Childhood Upper Respiratory Infection Care and Asthma Management, in addition to the 8 HEDIS measurements listed above. The tool not only uses claim data to identify members with specific medical needs, but also uses the claim data to assign members to a physician, and then measures



the percentage of non-compliant members. Lists of members who are non-compliant are shared with the physician, and through a collaborative effort with the physician, CoventryCares will make outreach to these members to insure the needed care is arranged and delivered. In addition to the CoventryCares Provider Relations staff providing these reports, we will grant physicians access to a secure, HIPAA compliant, internet-based portal to our suite of tools and physicians can access these reports directly.

**Access Assurance**

When CoventryCares identifies gaps in its provider network, whether that is through its normal gap analyses, or through member, provider or staff identification, we develop a plan to recruit providers to fill the need. Our company’s strength is that we currently have existing certificates of authority and licenses to operate that allow us to use these contracts as the foundation of our provider network in the New West and New East Zones.

Figure 28 shows the HEDIS measures used to monitor compliance with obtaining care.

**Figure 28: Quarterly HEDIS® Measures**

Breast Cancer Screening (Ages: 42–69)	<ul style="list-style-type: none"> <li>• Provider must provide member with a script to receive a mammogram.</li> <li>• Evidence of a claim for mammogram will trigger payment to provider.</li> </ul>
Comprehensive Diabetes Measure: Hemoglobin A1C (HbA1c)	<ul style="list-style-type: none"> <li>• Documented Hemoglobin A1c (HbA1c) screening for people with Diabetes.</li> </ul>
Prenatal Care in the first trimester or within 42 days after enrollment	<ul style="list-style-type: none"> <li>• Documented prenatal visit in the first trimester or within 42 days of enrollment.</li> <li>• Claim for prenatal visit to be submitted with appropriate code.</li> </ul>
Frequency of Ongoing prenatal	<ul style="list-style-type: none"> <li>• Documented prenatal visits obtaining 81% of expected visits.</li> <li>• Claim submitted with appropriate code.</li> </ul>
Postpartum Care	<ul style="list-style-type: none"> <li>• Documented post partum care.</li> <li>• Claim submitted with appropriate code.</li> </ul>
Adolescent Well Care Visits (Ages: 12–21)	<ul style="list-style-type: none"> <li>• Documented physical assessment, anticipatory guidance, health education, developmental history, mental assessment, smoking cessation.</li> </ul>
Emergency department Utilization	<ul style="list-style-type: none"> <li>• Provider receives a list of CoventryCares members who frequently visit the ED (4 or more times in a year).</li> <li>• Documentation of a PCP visit within 3 months of the distribution of the ED list and submission of a clinical note documenting a discussion of appropriate ED use and how to access the PCP during and after normal hours.</li> </ul>
Annual Dental Visits (Ages: 2–21)	<ul style="list-style-type: none"> <li>• Documented dental visit.</li> <li>• Submission of a claim with appropriate coding.</li> </ul>



6. How do you monitor and evaluate PCP compliance with availability and scheduling requirements outlined in the draft Agreement? What is your plan to ensure PCP-to-member ratio requirements are maintained throughout the term of the Agreement? (Limit to two pages)

### **Availability and Scheduling Standards**

CoventryCares evaluates and monitors PCP availability and scheduling requirements defined within the CoventryCares HealthChoices Agreement.

### **Monitoring Process**

Provider Relations works closely with the Reporting and Quality Improvement departments to monitor the required access standards by county. Additionally, we monitor the Open/Closed Panel to determine physician availability for new members.

For provider offices, CoventryCares monitors office hours and after-hours accessibility through:

- “Secret Shopper” telephone calls—The Quality Improvement department performs outreach calls to the provider office to inquire about available office hours for appointments.
- Member Access surveys—An outside vendor is used to make telephone outreach calls to the member to administer a survey. The purpose of the survey is to gauge the performance of the provider in regard to appointment availability as defined by the access policy requirement of CoventryCares. Things included are appointment wait times for various types of care, member of provider after hours policy and care, and time required to make appointment by telephone.
- Member Service complaints—Member complaints are recorded in the CoventryCares Navigator tool. These complaints are tracked and trended to determine educational needs of the provider.

### **Ratio Requirements**

CoventryCares ensures that the PCP member-ratio requirement of 1 PCP per 1000 members is met through:

- Evaluating monthly PCP practice eligibility rosters and PCP panel reports
- Identifying practices that are outside of the ratio standards
- Contacting PCPs falling outside of the ratio and notify them of the need to close the panel based on membership



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7. How do you ensure that members have access to medical care for needs that arise after hours and for urgent, non-emergency situations? How do you monitor providers to ensure that follow-up is done with the member and the member's PCP to facilitate transfer of information from the afterhours provider? Describe any incentive programs you have in place to improve access to care by rewarding providers who provide extended and/or after hours care. (Limit to two pages)
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### **Access to Care**

CoventryCares incorporates provisions within our provider contracts that require 24/7 coverage, either direct or through on-call arrangements with other qualified providers. This coverage allows for members in need of urgent or emergency care to seek this coverage through their primary care physician, associate or like provider.

CoventryCares partners with hospitals to add their Urgent and Convenient Care locations into the network for all lines of business. Recent additions include

- Allegheny General Hospital Suburban Campus Urgent Care Center
- Heritage Valley Convenient Care locations
- Butler Hospital FastER Care Center and Kensington Urgent Care

We are currently negotiating with:

- Albert Einstein Medical Center
- Drexel University College of Medicine

Through a National agreement, CoventryCares' membership has access to the Walgreens Take Care Convenient Clinics. This provides 14 facilities in the New West Zone and 6 in the New East Zone.

Our statewide license has afforded us the ability to build a comprehensive network across the state. This network will be the basis from which we build the CoventryCares network.

### **Information Transfer and Monitoring**

MA consumers may go to providers other than their PCP's for after-hours care as well as some daytime acute problems. When this occurs, communication between these entities is integral for high -quality, cost-effective health care. PCPs need to know if their patients encounter medical issues elsewhere requiring follow-up or resulting in a new diagnosis or change in medication. Providers are contractually obligated to share medical information with primary care physicians.

Monitoring after-hours availability is an ongoing responsibility of Provider Relations. CoventryCares plan/goal is to initiate and conduct seminars with Urgent Care Centers and Primary Care Physicians (PCPs) to discuss opportunities to work together to create and improve communications regarding after hours care. In this way, CoventryCares can determine the needs, capabilities, and limitations of the various providers. Through this collaboration, we will use innovative processes to facilitate exchange of information to reach a common goal of high quality, cost-effective outcomes.



## Incentives

We reimburse after-hours visit codes when services are performed at the provider office. This allows for additional and more convenient access for the member, additional reimbursement to responsive providers and avoidance of unnecessary emergent or urgent care visits.

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8. Describe the policies and procedures followed in response to the network termination or loss of a large-scale provider group or health system. Please develop the response taking the following areas into consideration:
- System utilized for identification and notification of members affected by the provider loss;
  - The automated systems and membership supports utilized in assisting affected members with provider transitions;
  - Systems and policies utilized for continuity of care of members experiencing provider transition; and
  - Outcomes experienced in coverage of the membership with existing network resources following the terminations. (Limit to five pages)
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CoventryCares provider/facility Termination Policy ensures that the Pennsylvania Department of Public Welfare(DPW) and all members are notified when a Network Provider (which includes a specialty unit within a Facility) is no longer participating with CoventryCares.

- 30 Day Notice:
  - CoventryCares shall provide members with adequate notification of the termination of a provider/facility from the network
  - The notice shall include provisions of continuity of care, as applicable.
- 60 day Notice:
  - CoventryCares must notify DPW in writing of its intent to terminate a Network Provider and services provided by a Network Provider
  - This notification applies for both terminations initiated by provider/facility or Provider terminations initiated by CoventryCares
- 90 day Notice:
  - The provider/facility must notify CoventryCares of their intent to terminate the agreement based on the terms and conditions of their agreement
  - The notification must be in writing and date stamped upon receipt
  - Such notification will be made as outlined in the contract



If CoventryCares decides to terminate a contract for a non-quality of care reason, CoventryCares shall send the provider/facility written notification of the termination effective date as outlined in the provider or facility agreement.

If CoventryCares terminates the contract of a participating provider for cause, including breach of contract, fraud, criminal activity or posing a danger to an enrollee or the health, safety or welfare of the public as determined by CoventryCares, then CoventryCares has a right for immediate termination and shall send the provider written notification of the immediate termination and the effective date as outlined in the Provider Agreement.

Once the termination effective date has been determined, the Provider Relations Representative will follow the process below:

### **Provider Terminations**

1. Complete the appropriate paperwork to ensure internal databases are updated and CoventryCares Website reflects all updates
2. An internal email via a specific termination notification form is sent to all necessary departments
3. Compile a report from our claims payment system (IDX) to determine the members who have accessed care with the terminating provider over the previous 12 months
4. Identify members with open authorizations
5. Identify providers remaining in the network by provider type and location including travel time and indication if urban or rural area
6. Provide Geo Access reports and maps documenting member access for services to other Providers remaining in the CoventryCares Network

### **Facility Terminations**

1. Complete the appropriate paperwork to ensure internal databases are updated and CoventryCares Website reflects all updates
2. An internal email via a specific termination notification form is sent to all necessary departments
3. Identify members who have received services at the facility within the past 12 months
4. Provide a list of all Providers by Provider type who have admitting privileges only at the terminating facility
5. Provide a list of Providers by Provider type, who are affected by the termination, including admitting privileges they have at other facilities
6. Identify Providers remaining in the network by Provider type and location. including travel time and indicate if Urban or Rural area
7. Provide Geo Access reports and maps documenting members access for services to other facilities remaining in the CoventryCares Network



### **Identification of Members**

1. If the termination is for a Primary Care provider, the Enrollment Department will generate a list of members assigned to that provider.
2. If the termination is for a specialty care provider or facility termination, Financial Reporting will forward a list of members affected by the termination to the Member Service Organization and the Provider Relations representative making the request. The list of members identified are based on claims submitted by the terminating provider or facility over a 12 month period.

### **Notification of Members**

Based on the member list generated, CoventryCares communicates the termination to all affected members at least 30 days prior to the termination date utilizing the appropriate member provider termination letter, as per the CoventryCares Agreement. The CoventryCares Member Services phone number is included in the termination letter so the CoventryCares member knows who to contact if he/she has questions. A copy of the member letter, along with a list of the members who received the letter, is posted to an internal shared drive.

### **Membership Support**

Before the termination letter is sent, internal constituents are apprised of the pending termination. For a Facility termination all departments are given a Frequently Asked Questions (FAQ) Document to assist with questions and to address the members' concerns.

### **Continuity of Care for Members**

The termination letters sent to CoventryCares' members and the internal FAQ address continuity of care situations. CoventryCares' case managers aggressively work the member list utilizing telephonic outreach, e-mail and regular mail, and contact the member so an appropriate transition of care plan can be developed. All affected active members receive a letter outlining the continuity of care provision. Members who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Member is notified of the termination or pending termination of the Provider or for up to sixty (60) days from the date of Provider termination, whichever is greater. This continuation of access is pending CoventryCares medical review and approval in accordance with the Continuity of Care Policy. Should the members choose to seek continuity of care with the terminated Providers, Utilization Management will determine if the member qualifies for continuity. Members in their second or third trimester of pregnancy have access to their terminated Provider through the postpartum period.

### **Outcomes Experienced**

While we have not had any large network terminations in MA, in July 2010, the plan experienced the termination of a large statewide dialysis provider. By implementing all of the following steps in a methodical and organized fashion, we were able to maintain member satisfaction by ensuring network adequacy and a smooth member transition with no disruption in care:



- Generated a geographic access report
- Determined network gaps
- Identified alternative non-participating dialysis providers that could fill the network gaps using the CMS website
- Contacted and recruited non-participating dialysis providers for our network
- Sent notification letters to the affected members
- Sent notification letters to the nephrologists and primary care physicians in our network
- Performed outreach to each dialysis member affected by the termination and a transition of care plan was implemented
- Provided a non-participating authorization, when necessary, to prevent any disruption in care

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### *Transparency Program*

The questions in this section are designed to determine the current and/or potential future ability of each Offeror to design and implement a healthcare transparency program for select populations of Medicaid members. This program would be designed to maximize use by these members of the most cost-effective healthcare settings, locations and providers, while continuing to ensure appropriate access to, and the highest quality of, all medically necessary healthcare services and procedures. In the answer to each question, Offerors must clearly indicate whether and to what extent each program component, function, activity described:

- Is currently in place and operational, or;
- Would have to be designed and implemented at a future date, and how long it would take to do so, and;
- Is or would be either delivered “in-house” by direct employee(s) of the Offeror or by subcontractor(s)
- Could be adapted or expanded to include additional populations and geographic regions

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CoventryCares understands the importance of providing effective tools to close the gap between the limited knowledge available in today’s complex and ever changing health care environment and empowering members to be self-sufficient consumers of health care services. To achieve this goal, CoventryCares is proposing to invest up to \$1 million in a consumer empowerment program.

This investment will be used to align CoventryCares providers and members on an innovative program called “CarePOINTS”. This program will utilize our web-based tool, *My Cost of Care*, and our online provider directory, along with other tools in development. With these tools, our MA members can plan for and manage their health care costs by choosing the most effective, high quality providers and



receiving needed services. CoventryCares is proposing to implement this concept in incremental steps during the term of the contract.

Through this program, members accumulate CarePOINTS for receiving preventive and chronic care services aligned with the Department of Public Welfare's MCO P4P program initiative that include the following services:

- Frequency of Ongoing Prenatal Care
- Prenatal Care First Trimester
- Breast Cancer Screening
- Cervical Cancer Screening
- Annual Dental (ages 2–21)
- Adolescent Well Visits
- Lead Screening

In addition, we will explore avenues on how best to reward members for avoiding emergency department visits for select conditions such as asthma.

CoventryCares will offer members the opportunity to receive points for choosing high quality, cost effective providers including those in our Patient Centered Medical Home. Points would be added to a "CarePOINTS" smart card that would be used for products and services such as co-payments, transportation tokens and babysitting vouchers while attending medical visits..

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1. Describe how you currently use or how you would in the future create and use a tool that includes a graphical interface that allows users to track costs for specific medical procedures across the network of providers. Describe how this tool has been or could be adapted for shared use by Department staff, and whether this tool currently does or will in the future allow the Department to determine the population of providers who will accept a certain payment rate and the associated savings if the Department paid no more than a set payment rate which becomes a defined benefit maximum payment? (Limit to two pages)
- 

CoventryCares believes working collaboratively on transparency initiatives with DPW will enable us to deliver more effective solutions for members that encourage self-sufficiency and personal responsibility when making health purchasing decisions. In the Southeast Zone, CoventryCares has made tools available to help members estimate expenses. Planning, implementation and use of internal and external resources for additional tools would depend on project scope. We are working to develop additional resources which could be expanded to include members in any geographic region.

*My Cost of Care* is a web tool developed by Coventry that gives the average cost for diagnostic procedures, office visits, surgical procedures and inpatient stays based on actual Coventry cost information. Using this tool, health care consumers can plan for and manage health care costs and identify savings opportunities.



For a large commercial client, we currently provide a health care cost-transparency program. Via our web portal, this treatment cost calculator tool enables customers to obtain treatment cost estimates for select medical procedures and conditions. This 2011 pilot program will help us evaluate the tool's ability to improve member use of cost-effective providers in appropriate clinical settings.

This tool gives customers the ability to plan financially for their health care needs while selecting cost effective, quality providers. The online portal uses a real-time interface to obtain current customers, benefit plan, and provider data from the transaction system to formulate various calculations, including estimates for: deductible, co-payment, coinsurance and out-of-network responsibility. Customers can use the results to determine which provider in their selected area meets their needs.

The estimates are based on regional historical claims experience which is updated monthly. The treatment cost calculator provides accurate, real-time estimates of patient liability for a specific provider.

Although the functionality to support payment rate and the associated savings if DPW paid no more than a set payment rate to define benefit maximums is not yet available in existing tools, we will evaluate the ability to offer this information in a future enhancement, provided doing so does not conflict with provisions of our provider agreements.

We are also exploring opportunities to provide cost-transparency solutions for DPW and members that will offer tracking and shopping tools for cost by procedure by provider/network. As we continue to evaluate these tools, CoventryCares will work with DPW to identify and develop cost information to share with members and develop tools DPW can use to determine payment rates and benefit maximums.

- 
2. Describe how you currently or would in the future provide cost transparency information to Medicaid consumers through a call center and over the Internet using a secure web portal. Describe whether and how this call center and/or web portal currently allows or would in the future allow the consumers to shop for required medical services by selecting the most cost-effective healthcare settings, locations and providers, while continuing to ensure appropriate access to high quality, medically necessary healthcare services and procedures. (Limit to two pages)
- 

In the Southeast Zone, CoventryCares provides *My Cost of Care*, a secure, personalized web tool, members can use to choose the most cost-effective health care settings, locations and providers, while ensuring appropriate access to high-quality, medically-necessary health care services and procedures.

Additional resources could be expanded to include members in any geographic region. We use a combination of online tools and one-on-one interaction to help consumers estimate their health care expenses, understand the costs, and evaluate hospitals on quality and cost-efficiency.

### List of resources

- *My Cost of Care*
- Hospital cost and quality comparison
- Call Center



- Message Center—Secure email over the website available allows consumers to ask the CSO questions anytime
- Treatment cost calculator tool described in question 1 (pilot)

### Members Can Estimate Health Expenses with “My Cost of Care”

*My Cost of Care* is a web tool developed by Coventry that gives the average cost for diagnostic procedures, office visits, surgical procedures and inpatient stays based on actual Coventry cost information. Using this tool, health care consumers can plan for and manage health care costs and identify savings opportunities. By logging on the secure member website, My Online Services, they can:

- Compare in-network and out-of-network estimated average costs for certain office visits and hundreds of tests and medical procedures.
- Estimate the annual average cost for the facilities, providers and medicines for treating most health conditions.
- Compare costs for specific brand and generic drugs filled at participating retail drug stores or ordered through CoventryCares mail order program.
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### Cost and Quality Comparison

CoventryCares provides members with access to an online provider directory that enables members to find their “best match” (see Figure 29 provider based on geography, medical condition, age, or gender. Members can search for hospitals based on the quality and cost effectiveness for more than 160 medical conditions. Hospitals are listed in the order of quality of care using an easy-to-understand, five-star rating system.

For each condition, members are able to evaluate a hospital based on:

- Quality of care information
- Cost-efficiency
- Number of patients treated
- Patient safety and health complications during hospital stays.
- 30-day hospital readmission rates for patients.
- Length of stay, preventable readmissions, and



**Figure 29: Online Provider Directory Best Match Sample**



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avoidable days

### CoventryCares' Call Center—One-on-One Interaction

The representatives in CoventryCares' call center are trained to help consumers identify savings opportunities for medical services by guiding them through the provider search. They can use the tools to create a teaching moment and answer questions about cost and a provider's qualifications, and help find a qualified, appropriate and cost-effective network provider.

Future treatment cost calculator will give real-time, provider-specific cost estimates for certain medical procedures.

We work with a commercial customer and external vendor to provide data to support an enhanced decision support tool Described in Question 1. As we continue to evaluate these tools, CoventryCares will partner with DPW to identify and develop requirements to share information with members.

- 
3. Describe any methods and strategies you currently or would in the future employ to encourage Medicaid consumers to utilize the most cost-effective healthcare settings, locations and providers, while continuing to ensure appropriate access to high quality, medically necessary healthcare services and procedures. In particular, describe how you currently or would in the future reward or incent Medicaid consumers who utilize a cost-effective location identified by shopping through the call center or member web portal described above. (Limit to two pages)
- 

CoventryCares will work collaboratively on incentive programs with DPW to encourage members to use cost-effective health care settings, locations and providers while continuing to ensure access to high quality and appropriate health care. Planning, implementation and use of internal or external resources to implement incentives will depend on program requirements. Incentive programs can be expanded to include members in any geographic region.

CoventryCares will promote and support the incentive programs through a suite of analytic tools that measure the quality and efficiency of our participating network. We currently provide members information on high quality, cost-effective health care settings, locations and providers through our online tools and our Member Services Center.

In addition, we have recently launched Primary Care Physician (PCPs) Medical Home Models in Pennsylvania. The goals of PCP Medical Homes is to:

- Improve the quality of care provided to consumers
- Increase access to MCO care coordination and chronic management conditions
- Increase patient satisfaction
- Reward providers for improvements in the quality and efficiency of care rendered



- Promote the principles of evidence-based medicine

CoventryCares will work collaboratively with DPW to promote PCP Medical Homes and incentive programs for members.

We intend to inform MA members about the value these practices offer and provide member incentives for selection of these PCPS. Our goal is to make members aware of the preferred PCP providers and facilities and make the information available via the call center, member portal and program brochures. We will also distribute the information throughout the community and in preferred providers' offices. We are currently developing member incentive programs that could include gift cards, gift packages, health and wellness rewards such as pedometers and exercise equipment.

- 
4. Describe how you currently (or would in the future) perform detailed analysis of claims and/or encounter data, including Medicaid claims data provided by the Department, to generate total average costs for specific medical procedures or tests at various provider locations across the provider network. Describe how you would present and incorporate the results of such analysis both within the shopping tool and as part of the defined benefit maximum tool for use by the Department. (Limit to two pages)
- 

CoventryCares uses the database and reporting systems described in the management information section to analyze claims and encounter data. We will work with DPW to develop shopping and benefit maximum tools. Planning, implementation, and use of internal or external resources would depend on project scope. Results could be expanded to include members in any geographic region.

Our core system, IDX, feeds claim, utilization and enrollment data to the Coventry Data Warehouse (CDW). CDW also integrates third party claim and encounter data, as well as medical management and other data, from a variety of areas, such as DPW's data. The CDW is refreshed on the last day of each month with a snapshot of application system data. The warehouse supports reporting and analysis via multiple data marts to monitor and improve the delivery of services to our members.

Cognos cubes and BI-Query are used for standard and ad-hoc reporting. These technologies give us the flexibility to build detailed reports by both provider and procedure. We have built a comprehensive selection of integrated data marts/cubes and reporting packages supporting clinical claims/encounters, financial, utilization, profiling and other analysis and reporting tools to support the Southeast Zone, and soon, the Southwest Zone.

Coventry has a suite of tools that includes predictive modeling and a clinical rules engine that enable us to mine data and identify high risk members. Coventry utilizes Episode Treatment Groups (ETG) and Episode Risk Groups (ERG) software for predictive modeling capabilities. The ETG software is utilized to stratify past instances of care through data from CDW. ETGs can account for differences in patient severity including variations in patient age, co-morbidities, complicating conditions, and major surgeries. ETGs do this by "tagging" data with a unit of analysis that represents an "episode of care". The ETG software also intelligently tracks and adjusts for changes in a member's health condition during the course of treatment and scores are updated accordingly.



Once the ETG software identifies any conditions a member may have, the ERG software allows us to predict current and future health care usage for individuals and groups by creating individual risk measures that incorporate episodes of care methodology, medical and pharmacy claims data (if available), and demographic variables.

All members that stratify high either due to ERG score or clinical rules are referred to case management for evaluation. All members who score moderate or low will be enrolled in applicable disease management programs. Because data in our system is constantly mined by the clinical rules engine, those enrolled in disease management can be reconsidered for case management should the need arise.

Coventry utilizes its own proprietary clinical rules engine to mine claims and our authorization data nightly. The queries are based on ICD9, CPT, and Rx codes to define disease(s) for referrals to disease and case management programs. Encounter rules to determine risk and program inclusion are integrated into the clinical rules engine (CRE). The CRE queries also trigger Member Reminder and EPSDT reminder mailings for our preventive health initiatives.

In summary, our predictive modeling and clinical rules engine capabilities allow us to:

- Identify future high risk patients for case management/disease management
- Understand the current health status and resource requirements of every member
- Stratify patients for appropriate resource allocation and prioritization
- Match patient needs with appropriate interventions

We believe early recognition and intervention assists with more cost effective treatment by getting the member on the right track early in the disease process. Through this methodology, members are also more satisfied as their road to recovery is shortened.

In addition to the data warehouse, predictive modeling and clinical rules engine, we are evaluating resources currently in place for commercial business to leverage solutions for MA. We are evaluating cost calculator technology, as well as programs offered by vendors such as Optum, to be used to incorporate data into a graphical interface to enhance shopping and benefit maximum tools. The “My Cost of Care” tool reviewed in question 2 is available now to MA members.

Partnering with DPW to assist members in overcoming personal barriers and ultimately to become self-sufficient, smart purchasers of services will improve health outcomes. We believe working collaboratively to share efficiency, quality and cost information with members will enable us to deliver effective results encouraging personal responsibility when making critical health and personal welfare decisions.



5. Describe how your current systems provides and how you use, or how you would in the future create and use, (and how you are or will be able to share the Department) the following:
- Reports that capture consumer program activity/utilization for both the shopping service and defined benefit maximum service, including consumer interactions, incentives delivered and corresponding claim savings attributable to consumers selecting cost-effective locations.
  - Geographic reports that capture total cost by medical procedure, allowing users to understand cost variation across the network and to analyze the impact of maximum allowed reimbursement rates on cost savings?
  - Listings of all in-network providers within specific geographic areas that provide specific medical procedures and the cost for those procedures (or denoting high cost users from low cost users). (Limit to two pages)
- 

CoventryCares will use the database and reporting systems described in the management information section to develop reports to support the shopping and defined benefit maximum tools. We will use reports capturing customer program activity and utilization to develop member outreach and/or incentive programs. Data can also be used to identify opportunities for improvement in contractual negotiations.

Geographic reports including cost by medical procedure and/or provider can be developed using the Coventry Suite of Tools described in question 4. CoventryCares can create a template to obtain the averages of cost and quality results by specific provider, group or affiliation. The frequency of these reports would be agreed upon by CoventryCares and DPW.

A list of network providers within specific geographic areas can also be built as a template report that is filtered by geography and procedure and includes cost and quality. This can be sorted by the efficiency index to denote high-cost users from low-cost users.

Geographic reports by medical procedure and listings by network provider will be considered for a future enhancement, provided doing so does not conflict with provisions of our provider agreements. These reports can be distributed and/or integrated into the “shopping tool,” and can also be used to identify opportunities for cost savings through additional medical management initiatives.

Planning, implementation, and use of internal or external resources for development of additional reports would depend on project scope. Any tools deployed could be expanded to include members in any geographic region.





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## II-5. Financial Condition

The Offeror must submit information about the financial condition of the company in this section. For ease in assembling the proposal, the Offeror should append its financial documentation rather than including it in the main body of the proposal. The Offeror must provide the following information:

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HealthAmerica Pennsylvania, Inc. (HealthAmerica) has multiple lines of business. HealthAmerica d.b.a. CoventryCares is the MA line of business.

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- a. The identity of each entity that owns at least five percent (5%) of the Offeror.
- 

HealthAmerica's Form B "Insurance Holding Company System, 2010 Annual Registration Statement" (**Attachment 19**), filed with the Insurance Department of the Commonwealth of Pennsylvania, HealthAmerica is a wholly owned subsidiary of Coventry Health Care, Inc. (Coventry). Coventry is a publicly traded and regulated entity.

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- b. For the Offeror and for each entity that owns at least five percent (5%) of the Offeror. (The Offeror may also include information for other affiliates as long as they still provide the requested information for each entity that owns at least 5%):
- i.) Audited financial statements for the two (2) most recent fiscal years for which statements are available. The statements must include a balance sheet, statement of revenue and expense, and a statement of cash flow. Statements must include the auditor's opinion and the notes to the financial statements submitted by the auditor to the Offeror. If audited financial statements are not available, explain why and submit unaudited financial statements.
- 

Included as **Attachment 20** and **Attachment 21** are SAP-basis audited financial statements for HealthAmerica for 2010 and 2009, respectively.

As Coventry is not directly regulated by any state insurance department, SAP basis audited financial statements are not prepared for Coventry. **Attachment 22** presents Coventry's 2010 Form 10-K filed with the Securities and Exchange Commission. The Form 10-K includes the most recently audited GAAP basis financial statements for Coventry, including fiscal years 2009 and 2010.



- 
- ii) Unaudited financial statements for the period between the last date covered by the audited statements through the quarter before the submission of the proposal.
- 

**Attachment 23** presents HealthAmerica's 2011Q3 financial statements filed with the Insurance Department of the Commonwealth of Pennsylvania. In order to provide a picture of HealthAmerica's 2011 financial results, we have included as **Attachment 24** HealthAmerica's 2010 Annual Statement filed with the Insurance Department of the Commonwealth of Pennsylvania.

As Coventry is not directly regulated by any state insurance department, quarterly financial statements are not filed with any state insurance departments. **Attachment 22** presents Coventry's 2010 Form 10-K filed with the Securities and Exchange Commission. The Form 10-K includes the most recently audited GAAP basis financial statements for Coventry, including fiscal years 2009 and 2010.

- 
- iii) Documentation about available lines of credit, including maximum credit amount and amount available thirty (30) business days prior to the submission of the proposal.
- 

HealthAmerica does not possess lines of credit.

On July 11, 2007, Coventry executed an Amended and Restated Credit Agreement (the Credit Facility). The Credit Facility provides for a five-year revolving credit facility in the principal amount of \$850 million, with Coventry having the ability to request an increase in the facility amount up to an aggregate principal amount not to exceed \$1.0 billion. Coventry has drawn \$380 million under the Credit Facility, leaving \$470 million undrawn. This Credit Facility is disclosed in the notes to Coventry's 2010 audited financial statements included within Coventry's 2010 Form 10-K (**Attachment 22**).

- 
- iv) The most recent sets of quarterly and annual financial statements filed with the Insurance Department.
- 

**Attachment 23** presents HealthAmerica's 2011Q3 financial statements filed with the Insurance Department of the Commonwealth of Pennsylvania.

As Coventry is not directly regulated by any state insurance department, quarterly financial statements are not filed with any state insurance departments. **Attachment 25** presents Coventry's 2011Q3 Form 10-Q filed with the Securities and Exchange Commission. The Form 10-Q includes the most recent GAAP basis financial statements for Coventry.

- 
- v) State of incorporation.
- 

HealthAmerica and Coventry are incorporated in Pennsylvania and Delaware, respectively.



vi) Type of incorporation, as profit or non-profit.

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Both HealthAmerica and Coventry are for-profit entities.

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vii) Bond rating.

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As HealthAmerica has no external debt, bond ratings are not applicable. The current Coventry bond ratings, updated in 2010, are Baa3 (Stable Outlook) from Moody's, BBB- (Stable Outlook) from Fitch, and BBB- (Stable Outlook) from Standard & Poor.

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viii) A.M. Best rating for life/health.

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The current A.M. Best rating for HealthAmerica is A-, with a Stable Outlook. Coventry does not receive a rating from A.M. Best.

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ix) Standard and Poor rating.

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Other than the Coventry debt rating noted in (vii), Standard and Poor does not provide a separate rating for either HealthAmerica or Coventry.

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x) Weiss rating.

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Weiss does not provide a rating for either HealthAmerica or Coventry.

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xi) The Offeror will provide its Risk Based Capital Ratio for the year filed most recently with the Pennsylvania Insurance Department.

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HealthAmerica's capital and surplus as of December 31, 2010 per the Annual Statement (see **Attachment 24**) filed with the Insurance Department of the Commonwealth of Pennsylvania was \$87.5 million, which represents a Risk Based Capital Ratio of over 5.7:1 or 570%.

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If any information requested is not applicable or not available, provide an explanation. Offerors may submit appropriate documentation to support information provided.

c. Explain how your response provides proof of fiscal soundness.

HealthAmerica is a Commonwealth-licensed HMO that currently possesses a Certificate of Authority and Operating Authority in Pennsylvania, which includes the counties in the New West and New East Zones. HealthAmerica is a participating MA MCO in the HealthChoices Southeast Zone and has been informed that they have passed their Readiness Review for the HealthChoices Southwest Zone. (CoventryCares). **Attachment 26** contains our Certificate of Authority and Operating Authority and **Attachment 27** is the Southeast Zone approval letter. As documented in (f) below, at December 31, 2010, HealthAmerica maintained SAP-basis Equity greater than the highest of the amounts determined by the “Three (3) Part Test.” HealthAmerica’s RBC ratio significantly exceeded 2.0 for 2010 and significantly exceeded 2.0 for each of the five preceding years as follows:

- 2010—5.7 or 570%
- 2009—5.3 or 530%
- 2008—4.9 or 490%
- 2007—6.1 or 610%
- 2006—6.2 or 620%

d. If the Offeror plans to enter into a subcontract at a cost of at least eighty percent of anticipated Agreement revenues received from the Department, and if the subcontract provides for financial risk on the part of the subcontractor, provide items listed in Section II-6.b above, as they relate to the proposed subcontractor.

The only major subcontractors relative to this RFP are between HealthAmerica and its affiliates, and these subcontracts with affiliates do not provide for financial risk on the part of the subcontractor. HealthAmerica’s Form B (Insurance Holding Company System, 2010 Annual Registration Statement, see **Attachment 19**) filed with the Insurance Department of the Commonwealth of Pennsylvania contains a description of management agreements between HealthAmerica and affiliate companies.

e. Identify any proposed subcontractor in which the Offeror has five percent (5%) or more ownership interest.

HealthAmerica has no ownership interest in any of its subcontractors.



f. The Offeror or entity(ies) identified in II.5.a. above must have equity, as of June 30, 2011 or a subsequent date, equal to or greater than \$10 million. An assertion of equity must be supported by a copy of a filing with the Pennsylvania Insurance Department or a balance sheet that is attested to by an independent public accounting firm.

Failure to comply with the equity requirement, or with the requirement to provide documentation satisfactory to the Department, may result in rejection of the proposal. The Department will not permit a selected Offeror to implement a HealthChoices program in the New West and/or the New East Zones unless it has equity, as of the last day of the second quarter prior to the program implementation date, at least equal to \$10 million.

Per the December 31, 2010 Annual Statement (refer to **Attachment 24**) filed with the Pennsylvania Department of Insurance, HealthAmerica posted SAP-basis equity of \$87.5 million, which significantly exceeds the highest amount determined by the “three part test.”

The equity of an entity identified in II.5.a above may not be relied upon to satisfy this requirement.

g. The Offeror shall explain how it will fund development and start up costs, including the source of funds. Provide information and documentation to enable the Department to conclude whether sources have and are committed to providing the expected funds.

HealthAmerica will fund development and start up costs through its excess SAP-basis equity noted in (f), as well as its projected future operating earnings.

h. List any financial interest in proposed subcontractors. Copies of proposed subcontract arrangements are to be included as an appendix. The Department will approve all subcontracts used by the selected Offeror.

As noted in (e), HealthAmerica has no ownership interest in any of the subcontractors. Coventry will support HealthAmerica’s New West and New East Zones HealthChoices operations as we support the HealthChoices Southeast operations, providing corporate oversight, human resources, actuarial, and legal functions. Coventry Management Services, a wholly-owned subsidiary of Coventry, will provide claims processing and member service functions for the Southwest HealthChoices Program.

HealthAmerica has been operating under Management Services Agreements with Coventry and Coventry Management Services since June 1, 1999, and has enjoyed a smooth working relationship. HealthAmerica’s Form B (Insurance Holding Company System, 2010 Annual Registration Statement, refer to **Attachment 19**) filed with the Insurance Department of the Commonwealth of Pennsylvania contains a description of management agreements between HealthAmerica and affiliate companies.





The Offeror will state whether it has changed its independent actuary or independent auditor in the last two years. If it has, it must provide the date and explain why.

---

HealthAmerica has used Ernst and Young, LLC as its independent auditor since 2002.

HealthAmerica selected Milliman, Inc. as an independent actuary for the HealthChoices Southeast Zone for 2011, and will continue to utilize Milliman, Inc., for future independent actuarial functions, including the Southwest Zone and the New West and New East Zones. HealthAmerica's internal actuary is an employee of the organization and thus we did not previously utilize an independent actuary.



## II-6. Objections and Additions to Standard Contract Terms and Conditions

The Offeror will identify which, if any, of the terms and conditions (contained in Appendices A, E and F) it would like to negotiate and what additional terms and conditions the Offeror would like to add to the agreement. The Offeror's failure to make a submission under this paragraph will result in its waiving its right to do so later, but the Department may consider late objections and requests for additions if to do so, in the Department's discretion, would be in the best interest of the Commonwealth. The Department may, in its sole discretion, accept or reject any requested changes to the standard contract terms and conditions. The Offeror shall not request changes to the other provisions of the RFP, nor shall the Offeror request to completely substitute its own terms and conditions for Appendices A, E and F. All terms and conditions must appear in one integrated Agreement.

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CoventryCares has no objections or additions to the terms of the contract.

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The Department will not accept references to the Offeror's, or any other, online guides or online terms and conditions contained in any proposal.

Regardless of any objections set out in its proposal, the Offeror must submit its proposal on the basis of the terms and conditions set out in Appendices A, E and F. The Department will reject any proposal that is conditioned on the negotiation of the terms and conditions.

---

HealthAmerica Pennsylvania, Inc. (HealthAmerica) d.b.a. CoventryCares has reviewed the Draft HealthChoices Agreement (Appendix A), Standard Contract Terms and Conditions for Services (Exhibit D), Grant Terms and Conditions for Services (Appendix E) and DPW Addendum to Standard Contract Terms and Conditions (Appendix F) in the RFP for this proposal and has not identified any objections at this time.





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## **II-8. Domestic Workforce Utilization Certification**

Complete and sign the Domestic Workforce Utilization Certification contained in Appendix L of this RFP. Offerors who seek consideration for this criterion must submit in hardcopy the signed Domestic Workforce Utilization Certification Form in the same sealed envelope with the Technical Submittal.

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Refer to **Attachment 28** for the signed Domestic Workforce Utilization Certificate (Appendix L).





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# SECTION IV: WORK STATEMENT

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### IV-3.A Emergency Preparedness

To support continuity of operations during an emergency, including a pandemic, the Commonwealth needs a strategy for maintaining operations for an extended period of time. One part of this strategy is to ensure that essential contracts that provide critical business services to the Commonwealth have planned for such an emergency and put contingencies in place to provide needed goods and services.

---

Coventry, with our nationwide presence, has developed emergency preparedness plans for all forms of natural disasters as well as a pandemic. Our emergency plans include response strategies for bomb threats, terrorist activity and other conflict scenarios.

---

#### IV-3.A.1. Describe how you anticipate such a crisis will impact your operations.

---

Because of the detail of Coventry's emergency planning and its anticipation of any emergency contingency, any business interruption should be minimal in consideration of the seriousness of the event. Safety of Coventry staff and health plan members is of paramount importance.

Our preparedness includes our members. Whenever possible, our Company will in anticipation of a significant event, educate members, providers and vendors as to precautions inclusive of medication availability and emergency medical care. Coventry will provide members with information on the Red Cross and local and free emergency alerts systems. Through its ongoing Community Outreach Programs, CoventryCares has and will continue to make this information available to our members.



IV-3.2 Describe your emergency response continuity of operations plan. Please attach a copy of your plan, or at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness:

- Employee training (describe your organization’s training plan, and how frequently your plan will be shared with employees).
- Identified essential business functions and key employees (within your organization) necessary to carry them out.
- Contingency plans for:
- How your organization will handle staffing issues when a portion of key employees are incapacitated due to illness.
- How employees in your organization will carry out the essential functions if contagion control measures prevent them from coming to the primary work place.
- How your organization will communicate with staff and suppliers when the primary communications systems are overloaded or otherwise fail, including key contacts, chain of communications (including suppliers) etc.
- How and when your emergency plan will be tested, and if the plan will be tested by a third party.

This response summarizes our emergency response continuity of operations plan. Refer to **Attachment 29** for Business Continuity and Disaster Recovery for Coventry Health Care Inc. (summary).

### **Business Continuity and Disaster Recovery Plan**

The Business Continuity and Disaster Recovery Plan (BCDRP) is a formal written document that ensures a controlled and managed response to an event. The BCDRP identifies the critical people, locations and resources needed to respond to a significant event. The plan also identifies the tasks to be performed by the various teams and the responsibilities of each team member.

By the nature of doing business in today’s business and regulatory environment, changes in Coventry’s operations, priorities and resources are expected. The success and survival of Coventry depends upon our ability to meet obligations and compete successfully under any set of circumstances. This requires that crisis management planning is an integral part of normal business operations: planning, budgeting and expansion. BCDRP requires vigilance that the plans are accurate, tested and ready for implementation at any time.

The BCDRP is a site specific document for Pennsylvania and is an adjunct to the extensive Crisis Management Plan for Pennsylvania.<sup>27</sup> The Crisis Management Plan (CMP) identifies the executive, technical and crisis management personnel who are specially trained for emergency procedures. These

<sup>27</sup> The Crisis Management Plan for Pennsylvania is a confidential proprietary document. It can be made available to the evaluator for review upon request. Because of the proprietary nature of the document, Coventry wishes to limit its distribution outside of the company.



persons along with on-site staff determine the disaster level on a scale of 1 to 4. Thereafter, specific protocols are followed for needed emergency services, evacuations, preservation of data and network accessibility.

The CMP sets forth specific steps for particular types of significant events. The list is comprehensive and includes plans for power outage, telecommunications failure, earthquakes, fire, extreme weather, floods, bomb threats, and armed intruders.

The CMP includes a protocol for a pandemic and relies on the six phase strategy followed by the Center for Disease Control. With the primary objective of containment, Coventry has plans in place for coordinating its efforts with local authorities. The plan is designed to address a pandemic flu as well as more serious conditions.

### **Employee Training**

- All employees of each business unit are educated on Coventry's policies regarding BCDRP, their business unit plans, and their own specific responsibilities.
- Coventry cross-trains key employees to insure coverage of critical operations in the event of a significant event.
- Coventry cross-trains employees on critical functions to ensure there is no business interruption.
- Each business unit staff member is trained annually on how to respond when a disaster occurs. The BCDRP assures individual safety and plan operations are maintained. Also, the BCDRP is accessible on Coventry's internal intranet site for all employees.

### **Essential Business Functions**

- Key business functions include: claims and member services, provider relations, network management, sales and marketing, communications, compliance, health services (utilization management and case management) and pharmacy.
- Key employees: The Senior Manager at each site is responsible for the initiation of the Crisis Communication Process. The Crisis Communication Flowchart defines the activities outlined in the Crisis Management Plan.

### **Contingency Plans**

- Coventry is a statewide organization with key health plan employees located in Eastern Pennsylvania, Central Pennsylvania and Western Pennsylvania. If key employees in one region are incapacitated due to illness, we have the ability to shift work to leadership staff in one of the other regions.
- For essential functions that cannot be performed in Pennsylvania, resources are available throughout many Coventry locations around the country to support calls from members and providers.
- If the employee's primary workplace is affected and employees are prevented from entering the site, a work-at-home contingency plan is implemented. This contingency has been implemented twice in



the last 5 years—once during a major waterline break and second, during the G20 summit in the City of Pittsburgh. During both occurrences, employees worked from home and other nearby Coventry locations for multiple days. Employees had full access to IT systems, files, records, business plans, priorities, and communications to do their work. Both situations were handled flawlessly with no disruption in member or provider services.

### **Communications**

- The BCDRP includes a formal communication plan for all employees, subcontractors and vendors. All home and cell numbers for all employees are maintained as well as all subcontractors and vendor contact information.

### **Testing**

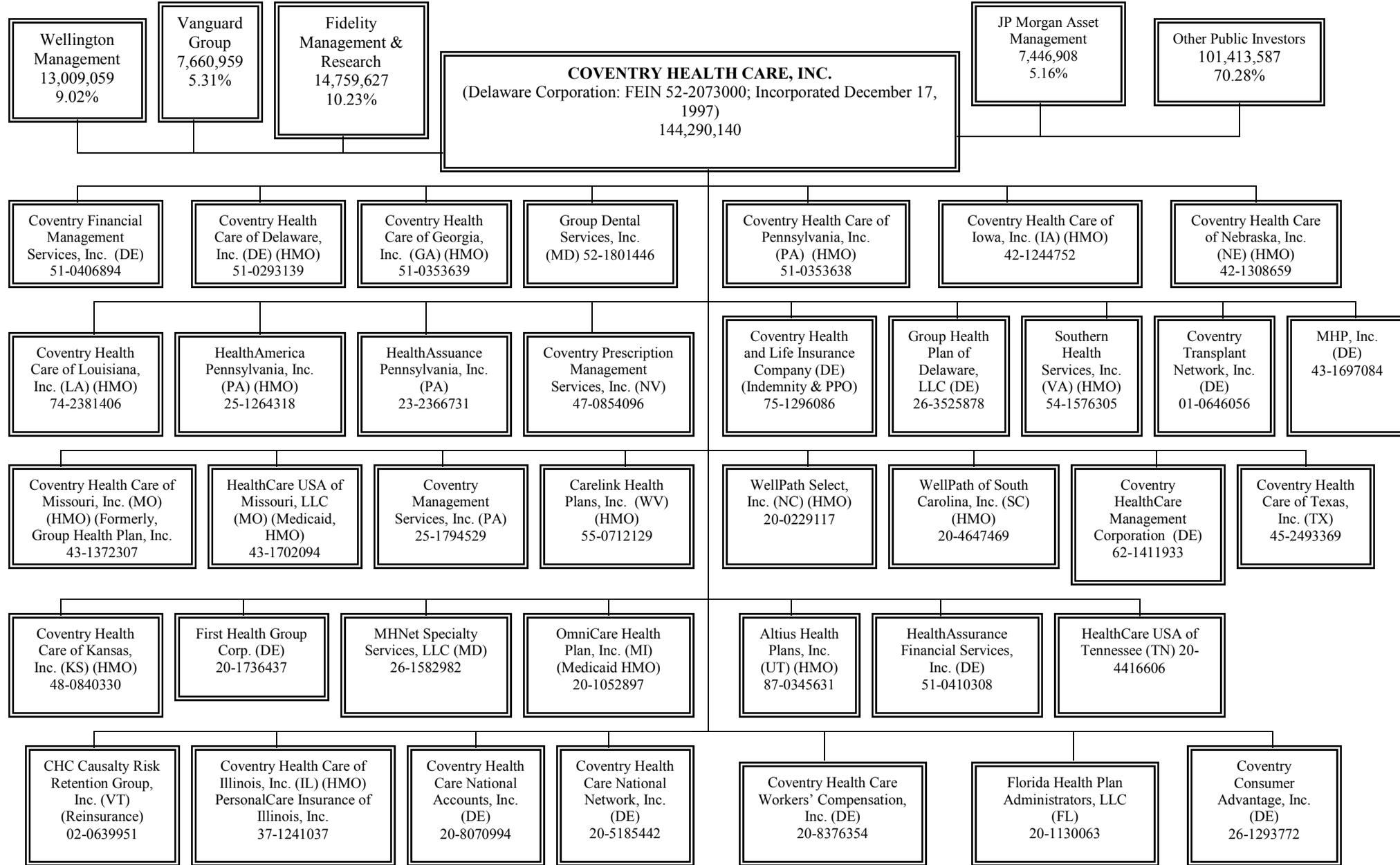
- The Disaster Recovery process for critical applications is completed twice a year by the Coventry Corporate Team. An evaluation of the successes and recommendations for improvements are documented and included in the next testing period.
- Coventry recognizes that the testing of the business continuity plans is important; therefore each location tests their business continuity plan annually as required.

## TECHNICAL SUBMITTAL ATTACHMENTS TABLE OF CONTENTS

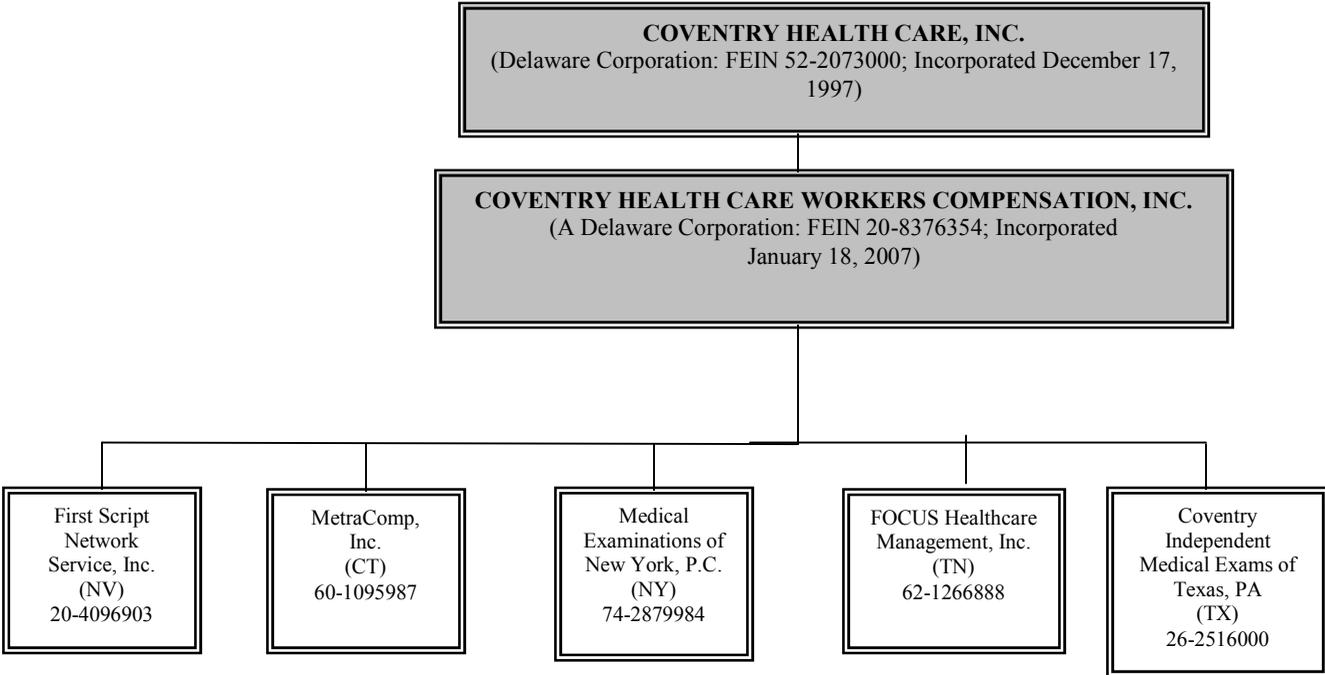
Attachment Number	Attachment Name
1	Corporate Organizational Chart
2	Subcontractor Description Listing
3	Articles of Incorporation
4	Attachment J_ Ownership Structure and Related Information Form (also noted as Appendix J)
5	Board of Directors Listing
6	Appendix G_Managed Care Experience
7	Executive Management Resumes/Job Descriptions
8	Key Administrative Positions Job Descriptions
9	CoventryCares _NW/NE Organizational Chart
10	New West Zone Network Development Work Plan
11	New East Zone Network Development Work Plan
12	New West Zone Operational Work Plan
13	New East Zone Operational Work Plan
14	Appendix K (2)
15	Sample Performance Monitoring Report
16	Monthly, Quarterly, Annual and Ad-Hoc Reports
17	Data Completeness Monitoring Plan
18	DentaQuest Corrective Action Plan 2011
19	2010 Form B
20	2010 HealthAmerica's Audited Financial Statement

<b>Attachment Number</b>	<b>Attachment Name</b>
21	2009 HealthAmerica's Audited Financial Statement
22	Coventry's 2010 Form 10-K
23	HealthAmerica's 2011 3RD QUARTER Statement
24	HealthAmerica's 2010 Annual Statement
25	Coventry's 3 <sup>rd</sup> Q 2011 Form 10-Q
26	HealthAmerica's Certificate of Authority
27	Southeast Zone Approval Letter
28	Appendix L_Domestic Workforce Utilization Certification
29	Business Continuity and Disaster Recovery Plan

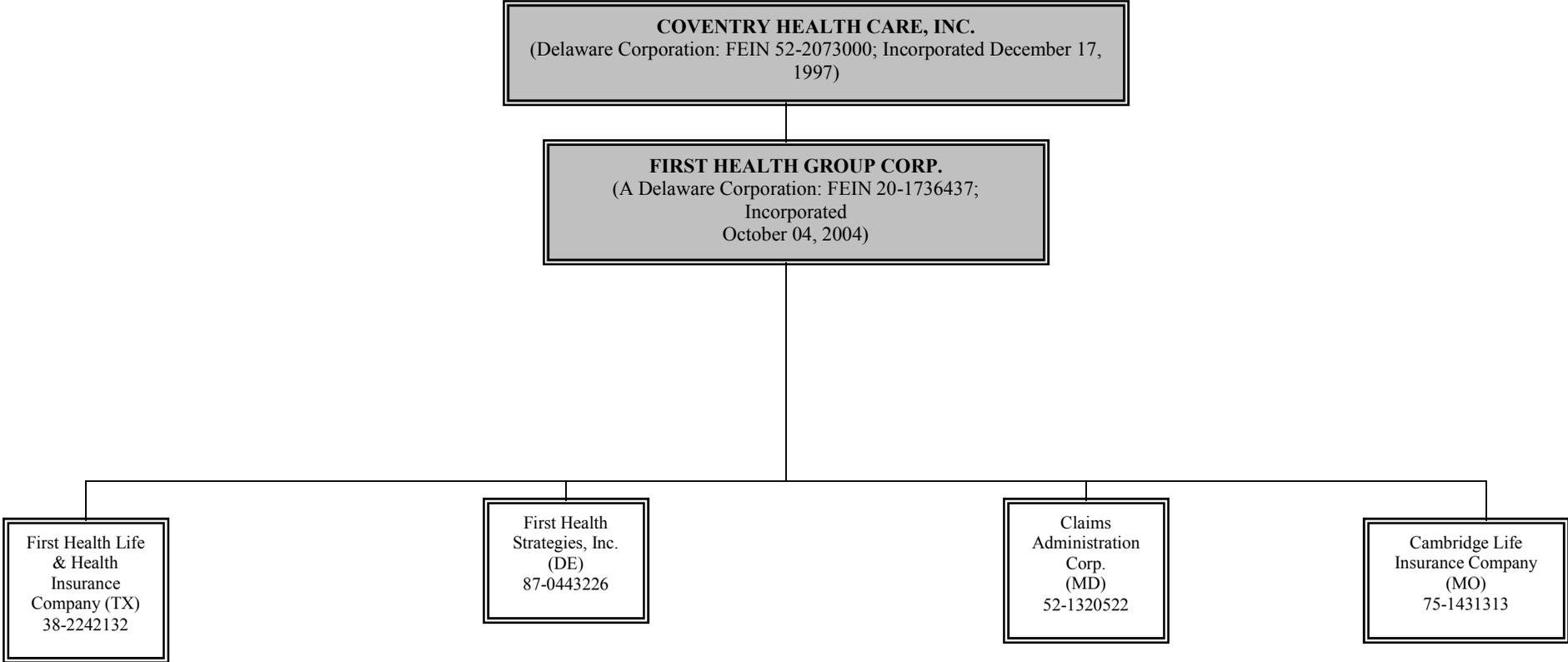
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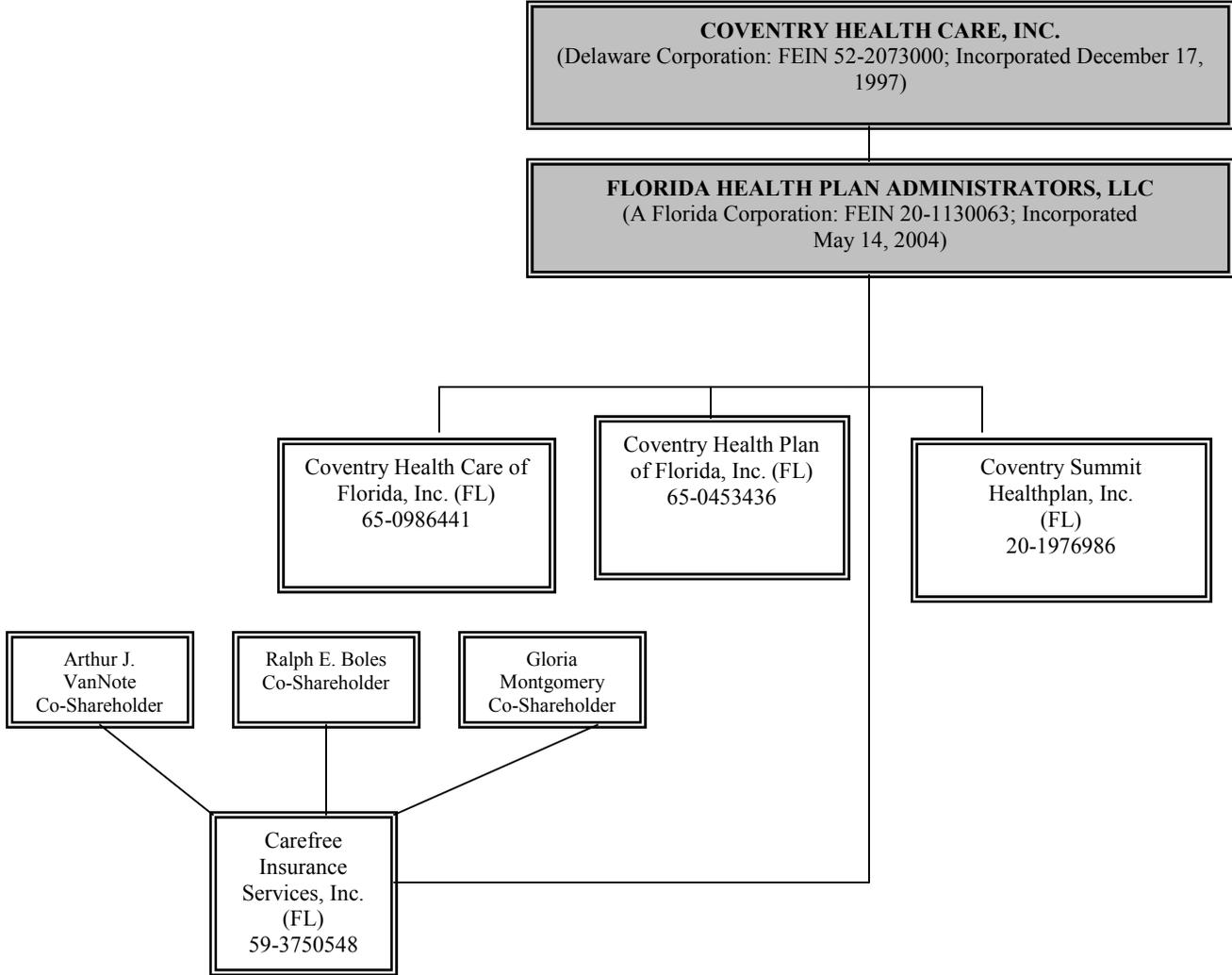
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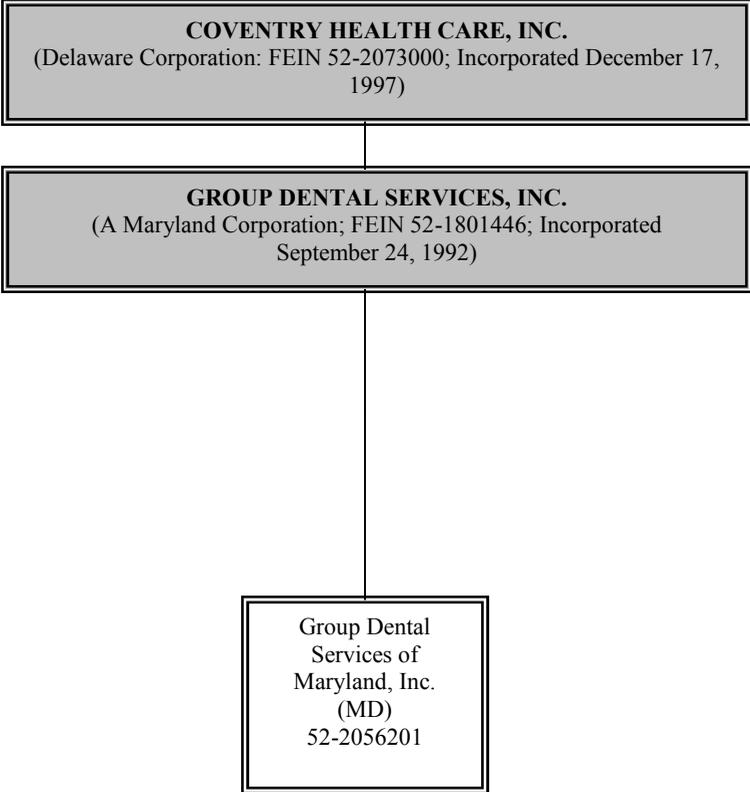
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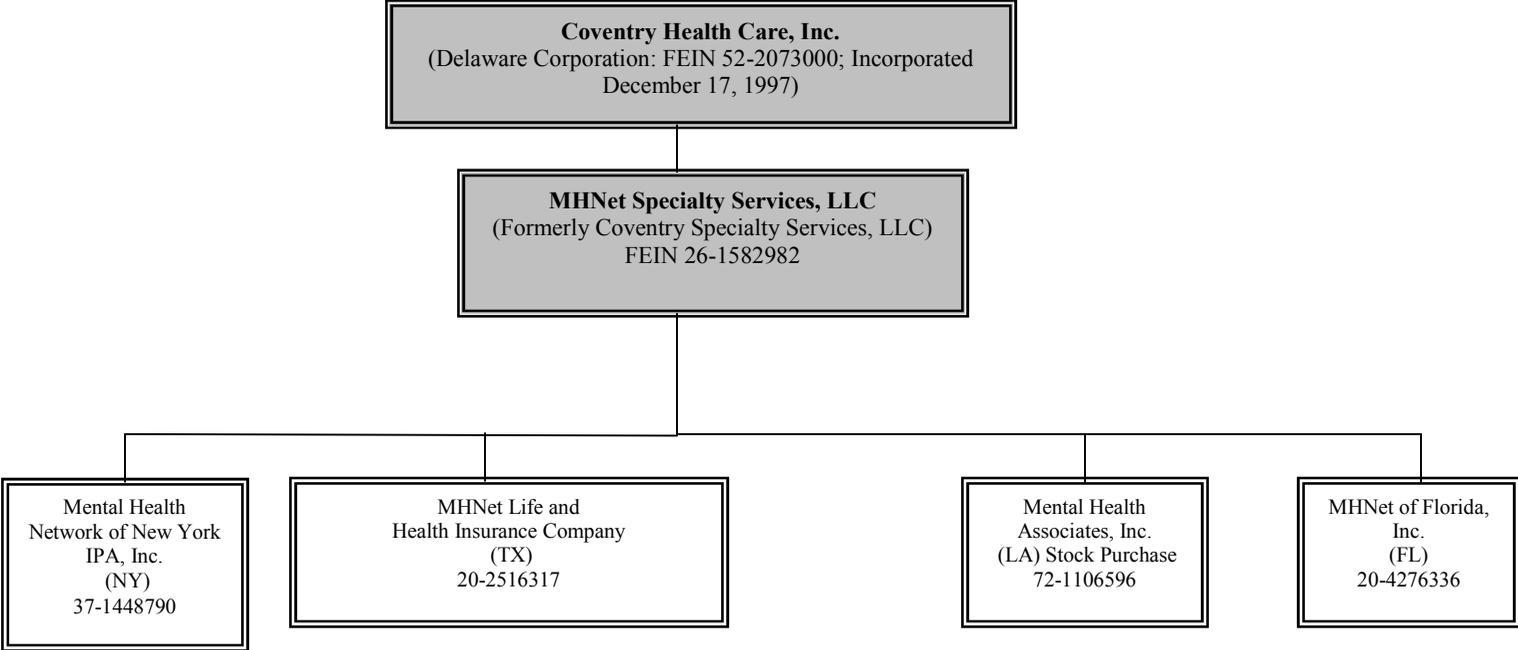
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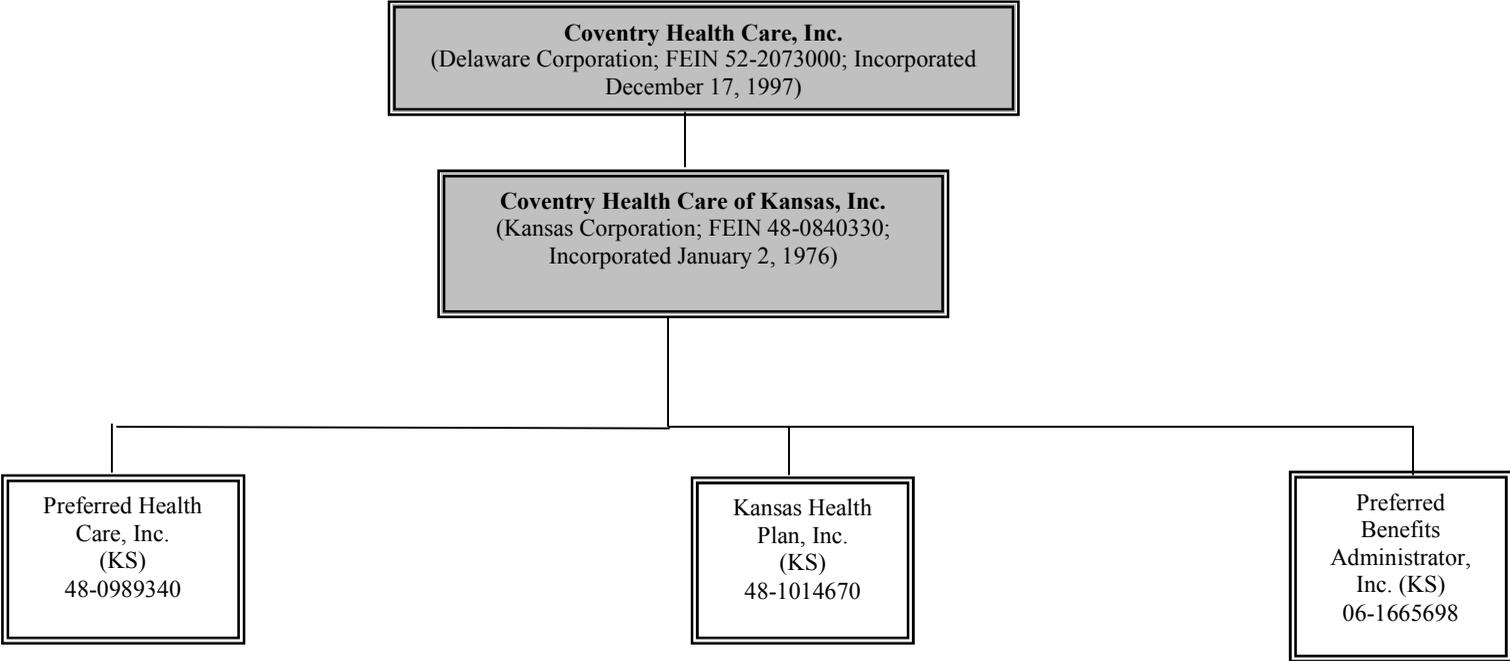
**COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (as of September 30, 2011)**



**COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (as of September 30, 2011)**



**COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (as of September 30, 2011)**



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## Subcontractors Listing

Company Name / Address	Date Founded	Company Size	Ownership	Major Holder
ACS, Inc 1084 South Laurel Road London, KY 40744	1988	47,000	Privately Held	
AIM Healthcare Services, Inc. 1021 Windcross Court Franklin, TN 37067	1995	1,200+	Privately Held	
Arbor Health 381 Riverside Drive Franklin, TN 37064	2002	300+	Privately Held	
Block Vision 120 Fayette Street Suite 700 Baltimore, MD 21201	1990	300+	Privately Held	
Catalyst Technology 2386 Clower St. Suite C-201 Snellville, GA 30078	1998	3,200	Privately Held	
CDR Associates 307 International Circle, Suite 300 Hunt Valley, MD 21030	1989	300+	Privately Held	
ChartPROS Four Tower Bridge 200 Barr Harbour Dr. Suite 400 West Conshohocken, PA 19428	1997	55	Privately Held	
Clark Resources 321 Front Street Harrisburg, PA 17101	2005	15	Privately Held	
Comp Partners, Inc. 4 Park Plaza, Suite 750 Irvine, CA 92614	1998	120	Privately Held	

## Subcontractors Listing

Company Name / Address	Date Founded	Company Size	Ownership	Major Holder
Connolly Healthcare 950 East Paces Ferry Road, Suite 2850 Atlanta, GA 30326	1979	300+	Privately Held	
Coventry Health Care, Inc. Coventry Management Services (subsidiary company) 6705 Rockledge Drive Bethesda, MD 20817	1986	14,000+	Publicly Traded - CVH	Fidelity Management & Research - 10.23% Wellington Management - 9.02% Vanguard Group - 5.31% JP Morgan Asset Management - 5.16%
DentaQuest 465 Medford Street Boston, MA 02129	2001	650	Privately Held	
DSS Research 4150 International Plaza Suite 900 Fort Worth, TX 76109	1990	150	Privately Held	
Emdeon 3055 Lebanon Pike Nashville, TN 37214	1985	3,000	Privately Held	
First Recovery Group 26899 Northwestern Hwy. Southfield, MI 48034	2000	80	Privately Held	
Fiserv 255 Fiserv Drive Brookfield, WI 53045	1984	19,000+	Publicly Traded - FISV	Vanguard Group, Inc. (THE) – 5.64% Price (T.Rowe) Associates Inc – 5.28% FMR LLC – 5.04% State Street Corporation – 4.78% Longview Partners (Guernsey) Ltd – 4.05%

## Subcontractors Listing

Company Name / Address	Date Founded	Company Size	Ownership	Major Holder
HealthDataInsights 7501 Trinity Peak Street, Suite 210 Las Vegas, NV 89128	2006	300+	Privately Held	
Healthcare Data Company, LLC 600 Bent Creek Blvd, Suite 160 Mechanicsburg, PA 17050	1989	300+	Privately Held	
Ingenix 8345 Lenexa Drive, Suite 300 Lenexa, KS 66214	1996	11,000	Privately Held	
LabCorp 430 S. Spring Street Burlington, NC 27215	1995	28,000+	Publicly Traded - LH	Harris Associates L.P. – 8.11% Vanguard Group, Inc. (THE) – 5.43% Price (T.Rowe) Associates Inc – 5.06% Oakmark Equity And Income Fund – 4.98% Wellington Management Company, LLP – 3.84%
Language Line Services 1 Lower Ragsdale Dr. Building 2 Monterey, CA 93940	1984	1,500+	Privately Held	
McKesson Health Solutions 5 Country View Road Malvern, PA 19355	1986	10,000+	Publicly Traded - MCK	Price (T.Rowe) Associates Inc – 8.25% FMR LLC – 6.55% Wellington Management Company, LLP – 6.34% Vanguard Specialized-Health Care Fund – 4.03% Vanguard Group, Inc. (THE) – 4.01%

## Subcontractors Listing

Company Name / Address	Date Founded	Company Size	Ownership	Major Holder
MCMC, LLC 88 Black Falcon Avenue Suite 353 Boston, MA 02210	1992	500	Privately Held	
Medco 100 Parsons Pond Drive Franklin Lakes, NJ 07417	1983	23,000	Publicly Traded - MHS	Capital Research Global Investors – 8.58% State Street Corporation – 4.23% Janus Capital Management, LLC – 4.10% Vanguard Group, Inc. (THE) – 3.97% Growth Fund Of America Inc – 3.13%
Quest Diagnostics 3 Giralda Farms Madison, NJ 07940	1996	42,000	Publicly Traded - DGX	Aberdeen Asset Management PLC – 6.00% Capital World Investors – 5.56% Price (T.Rowe) Associates Inc – 5.30% Wellington Management Company, LLP – 4.42% Harris Associates L.P. – 4.42%
RR Donnelley 111 South Wacker Drive Chicago, IL 60606	1864	55,000+	Publicly Traded - RRD	Capital Research Global Investors – 10.92% Allianz Global Investors Of America L.P. – 9.58% Capital World Investors – 7.11% Income Fund Of America Inc – 7.11% Vanguard Group, Inc. (THE) – 5.49%
The Myers Group 1965 Evergreen Blvd., Suite 100 Duluth, GA 30096	1993	140		

**ACS, Inc. (Affiliated Computer Services)**

1084 South Laurel Rd.  
London, KY 40744

**Founded:** 1988

**Employees:** 47,000

Coventry Health Care, Inc. has outsourced their front end mail room and claims entry operations to ACS, a company headquartered in Dallas, TX. The divisional site supporting the Coventry business is located in London, KY.

ACS provides mailroom sorting, image storage/retrieval and data capture for all Coventry Health Plans. Turnaround time for claim entry into IDX averages 48 hours, with 100% required within 72 hours. Data field accuracy for critical fields is guaranteed to be at least 99.5%.

**Scanning/Imaging/OCR Capabilities**

All images are captured on a Kodak Image Link 9500D scanner. A Batch creator program sends images to the Stored Information Retrieval (SIR) directory, where images are written to the SIR system, the Hard Drive of the SIR server and a corresponding disk on the jukebox. During the first 40 days following the data entry process, there are 3 copies of the image files. After 40 days, the SIR system images are overwritten, but two copies remain (one on the Hard Drive and one on the Jukebox). Images are maintained at ACS for a period of 7 years.

ACS applies OCR/ICR (Optical/intelligent Character Recognition) technology to the data capture process for both HCFA and UB claims. ACS has determined that OCR can be an effective means of reducing data entry costs and improving quality on standardized forms. ACS monitors and adjusts the correct level of OCR dependency to meet the needs of Coventry processing.

**Transmission of Claims to Coventry**

ACS transmits all claim data to Coventry in an EDI 837 file. These files are sent twice a day to Coventry at 11am and 6pm and are loaded into IDX through the same process that Coventry loads our files from WebMD, Gateway and other clearinghouses.

**Retention and Disposal of Claim Documents**

Coventry claims are stored at ACS for a period of 2 months and then shredded.

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**AIM Healthcare Services, Inc. (Recovery Vendor)**

1021 Wind Cross Court  
Franklin, TN 37067

**Founded:** 1995

**Employees:** 1200+

Coventry has contracted with Aim Healthcare Services, Inc. (AIM) to pursue credit balance recoveries. AIM's responsibility is to conduct an on-site audit of the providers' patient accounts for credit balances and request a refund from the provider. Tools used by AIM to identify credit balances include: Provider Credit Balance Report, Aged Trial Balance Report, Unidentified Cash Report, and Accounts Payable Report. A credit balance is a positive balance in a patient's account, created when a payer remits more than the final billed amount. Credit balances exist on the provider books and records as a liability.

AIM Healthcare Services, Inc. provides claims cost management services for government and commercial payors of healthcare benefits in the United States. It provides claims resolution and health care information management services, as well as on-site audits for health insurance companies. The company's services include data mining, coordination of benefits, contract compliance benefits, overpayment resolution, credit balance resolution, reconciliation services, subrogation services, medical bill review, express claim, and prepayment services. It serves hospitals and insurance companies. The company was founded in 1995 and is based in Franklin, Tennessee.

**June 1, 2009** -- Ingenix, a leading health information, technology and consulting company, has acquired AIM Healthcare Services, Inc. and its affiliated companies, Netwerkes and Ingram & Associates. AIM is a leading provider of payment accuracy solutions for health care payer and hospital clients in all 50 states.

Through its universal connectivity platform, INTELLIJET®, its broad network of payer and provider clients, and its on-site teams of highly skilled health care experts, AIM will contribute to existing Ingenix solutions for preventing, detecting and correcting errors throughout the claims lifecycle. AIM's portfolio will also bolster Ingenix's coordination of benefits capabilities, particularly for federal and state government payer clients.

AIM and Ingenix share the goal of helping clients reduce costs by eliminating administrative complexity. The cost of claims inefficiencies to the U.S. health care system is over \$150 billion per year, according to mid-range estimates in a recent review conducted by The Lewin Group.

Ingenix and AIM offer a single source for payment accuracy solutions for health plans and hospitals. Payers and hospitals can more easily identify and reconcile payment inaccuracies, and will no longer need to engage with multiple parties to achieve payment integrity. AIM's ability to connect hospitals and payers as a neutral third party, identify payment errors, and offer corrective solutions enhances transparency and cuts time and cost out of the claims process.

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**Arbor Health**

381 Riverside Drive  
Franklin, TN 37064

**Founded:** 2002

**Employees:** 300+

Coventry has engaged Arbor Health of Tennessee to assist in payment variances and third party recoveries. Arbor's staff, technology and analytics should provide dramatic improvements to the volume and accuracy of errant claims. From Arbor, Coventry expects business solutions that provide transparency and efficiency through the use of Arbor's technology designed specifically to aid payers and providers.

By implementing appropriate data technology solutions Arbor Health will address regulatory requirements for providers and payers to operate with greater transparency, accountability and efficiency. Arbor Health provides real time information that allows prioritizing of resources and reducing errant claims.

Arbor Health seeks to gain clear understanding of the scope and root cause of payment variances by assessing the quality of raw data and scouring claims. Payers and providers, in turn, identify ways to optimize business intelligence. Data analytics solutions can perform reconciliation for all claims, regardless of size. Real time capabilities to review claims, identify those that are errant, flag and document their root cause of errors will drastically diminish payment variances.

Progressive payers and providers using data analytics gain the ability to understand and aggregate disparate claim data. The shift to automated processes for claim payment verification customized reporting and validation allows teams to focus upon specific actions required to eliminate the identified causes.

Arbor Health provides successful and seamless implementation of a data technology solution and will ultimately improve efficiencies that positively impact the revenue cycle.

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**Block Vision**

120 Fayette Street  
Suite 700  
Baltimore, MD 21201

**Founded:** 1990

**Employees:** 300+

Block Vision is CoventryCares vision benefit administrator effective February 1, 2012. Since 1990, Block has been providing quality vision services throughout the United States. Block maintains regional offices in the East, Northeast, South, Southwest and Western states.

Medical Assistance Consumers eligible for benefits from Block Vision will receive an information packet describing available services. CoventryCares members are able to select their eye care provider by logging onto the Block website, [www.blockvision.com](http://www.blockvision.com). Members may also call 800-879-6901 to select a provider, obtain information about their benefit and/or claims or for any assistance.

Block Vision is an established and respected leader in vision benefits management with over 20 years experience. All programs available provide CoventryCares and its Members with unsurpassed administrative support. Block Vision provides all levels of wellness vision and eye health benefits management services, including routine eye examinations, corrective eyewear, primary eye care and comprehensive medical-surgical eye care management. Block Vision manages wellness vision and eye health benefits on behalf of managed care organizations and third-party payers. Block Vision recognized as one of the industry's leading benefits managers of government-sponsored programs (i.e., Medicaid, Medicare Advantage, CHIP).

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## **Catalyst Technology**

2386 Clower St.  
Suite C-201  
Snellville, GA 30078

**Founded:** 1998

**Employees:** 3,200

### **Catalyst Quality Spectrum Insight®**

Catalyst Technologies, a MedAssurant Solution Subsidiary, provides healthcare organizations with cost effective, state-of-the-art solutions for performance measurement and Quality Improvement (QI) reporting. The Company's NCQA Certified Software\* systems produce results for Healthcare Effectiveness Data and Information Set ("HEDIS®"), state specific measures, Pay for Performance ("P4P") measures, internally designed Quality: Improvement ("QI") studies, and Provider Reporting studies.

MedAssurant, Inc. is a leading provider of superior healthcare quality, care management, and financial performance improvement solutions empowered by advanced data analysis, abstraction, and verification systems. Applying a unique combination of nationwide personnel and an advanced technology infrastructure, MedAssurant provides local and national health insurance plans, care delivery networks, employers, pharmaceutical companies, regulatory bodies, and government organizations with powerful, turnkey services addressing disease management, clinical outcomes, quality of care, cost improvement, revenue enhancement, risk adjustment, and healthcare data verification.

At the heart of Catalyst's solution is Quality Spectrum Insight®, a powerful, unified source to report and analyze HEDIS®, state specific measure sets, P4P and internal QI studies. This potent software frees QI staff to take full advantage of graphical flowcharting tools for measure design and produce their own studies without the need for custom programming. The flexibility of Catalyst's solution suite and multi-modal delivery method enables both national and regional managed care organizations to effectively and efficiently perform, oversee, and comprehensively manage their QI measurement and reporting processes.

\*NCQA Certified through HEDIS 2010

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**CDR Associates**

307 International Circle, Suite 300  
Hunt Valley, MD 21030

**Founded:** 1989

**Employees:** 300+

CDR Associates, LLC is a CPA based healthcare financial consulting firm founded in 1989 to assist health insurers in the identification and recovery of claims overpayment. CDR has established itself as the industry leader by completing thousands of onsite audits annually on behalf of Commercial Payers as well as State Medicaid agencies across the country.

The firm also assists hospitals nationwide in creating efficiencies to reduce their credit balances. Through the use of proprietary software, CDR has assisted providers in resolving credit balance accounts.

The firm has its corporate headquarters located near Baltimore, Maryland and maintains satellite offices throughout the country. CDR continues to be managed by its original founders, who are CPAs with over 50 years of combined experience in health care finance.

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## **ChartPROS**

Four Tower Bridge  
200 Barr Harbour Dr., Suite 400  
West Conshohocken, PA 19428

**Founded:** 1997

**Employees:** 55

### **About PalmQuest- DBA ChartPROS**

PalmQuest (CP) is a leading source for healthcare providers seeking effective quality management solutions. Their proven methodologies and proprietary web-based tools have been recognized by several top health care companies as the driving force in their ability to reduce the cost of care per member. They assure compliance with NCQA, JCAHO, CMS and federal and state regulatory requirements. In the State of Pennsylvania, PalmQuest, Inc. operates as ChartPROS and is a certified women owned business.

Offices on both coasts enable PalmQuest (CP) to offer a comprehensive set of capabilities and personalized, attentive customer service across the nation. PalmQuest partners with clients to identify and implement procedural advancements that promote notable results throughout your network of facilities. PalmQuest is dedicated to providing our clients with the most efficient and reliable health care monitoring procedures on the market today.

### **Our Services**

PalmQuest provides organizations with reliable solutions that are time-efficient, streamlined, and simplified to compliment any health plan's internal resources and current processes.

### **Site Visits and Medical Record Review**

PalmQuest assesses and promotes medical record keeping standards that demonstrate a health plan's commitment to quality patient care, organizational accountability, continuity of care; and patient confidentiality. Partnering with providers and multiple health plans enables PalmQuest to complete necessary reviews in the most effective way possible.

### **HEDIS® Data Collection and Reporting**

The Health Plan Employer Data Information Set (HEDIS) is the most widely used set of clinical measures used in the managed care industry today. They have been conducting HEDIS medical records reviews since 1998.

### **Delegated Oversight**

PalmQuest offers auditing services to assist organizations in meeting their oversight responsibilities when credentialing is delegated to a hospital, IPA or medical group. This assists organizations with monitoring the compliance of delegated vendors with NCQA, State and Federal guidelines.

### **Credentialing and Re-credentialing Programs**

PalmQuest assesses designs and implements credentialing program documents, policies and procedures.

### **Custom Chart Review Projects**

PalmQuest employs proprietary, flexible data collection tools tailored to meet client specific needs for Clinical Practice, Preventive Health and Quality Improvement Studies.

**Clark Resources**

321 Front Street  
Harrisburg, PA 17101

**Founded:** 2005

**Employees:** 15

**Integrity**

To be innovative in Clark's approaches, to provide cost-effective solutions to their clients, and to be an invaluable resource to providing the best professional practices in consulting services.

**Excellence**

In building strong, mutually beneficial relationships with team, communities and clients, they are committed to sharing their successes with the people who help make it possible. They believe in communicating with clients, understanding their needs and thinking, enabling and supporting them in delivering the best solution.

**Commitment**

It is people that enable others to realize their full potential. Clark values integrity and honesty. They value passion for their client's organization and team. They are willing to on big or small challenges and see them through. They value accountability for commitments, results and quality to our clients.

Clark Resources partners with HealthAmerica, CoventryCares, which is a new Medicaid Program that launched April 1, 2010. Clark Resources provides welcome calls for new members, health risk assessments and an after hours call center.

**MBE/WBE Diversity**

Clark-Resources-believes-access-through-diversity:-Exceptional performance is driven by exceptional people and we reach goals by having all people, all ideas, all together in joint motion. Understanding the diverse needs of our clients makes us more successful. Using the diverse talents within our company makes us more effective.

Clark Resources has established a firm foundation for which diversity creates a culture that positively impacts their clients and employees alike. They are dedicated to diversity and are dedicated to people. They believe that when diverse individuals are allowed to maximize their own potential, everyone wins.

Diversity forms the cornerstone for their values and is a top to bottom commitment connecting every client and every community where they provide services. Clark Resources takes exceptional pride in the fact that they are demonstrating that diversity not only works, but rather it is the power behind success.

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**Comp Partners, Inc.**

4 Park Plaza, Suite 750  
Irvine, CA 92614

**Founded:** 1998

**Employees:** 120

Partner with employers, the medical community and payers to get injured employees the best possible care in the shortest amount of time gets injured employees back to work sooner.

CompPartners' portfolio of services is based on this simple yet powerful philosophy. They have proven it works time and time again since our company was founded, in 1998. They have established a solid reputation for excellent service and quality results. Services provide customers with peace of mind and lower overall costs.

It is quality you can measure.

Now CompPartners has expanded beyond workers' compensation into group health and other insurance services all with the same goal: Excellent service to customers.

**Services Include:**

Medical Provider Networks (MPN) -California Only  
Health Care Organizations (HCO) - California Only  
Utilization Review Services  
Medical and Disability Case Management Services  
Physician Peer Review Services  
Workers' Compensation PPO Networks  
Medical Bill Review Services  
First Notice of Injury Reporting Services  
A Workers' Compensation Pharmacy PPO Network  
Medicare's Secondary Payor Act  
Independent Review (IRO)

**Physician Peer Review**

CompPartners' Physician Review Network enables:

- Employers
- Insurance Carriers/Third Party Administrators
- Managed Care/Medical Bill Review Firms
- To not only satisfy this statutory requirement, but as the first Workers' Compensation Peer Review Network
- To be certified on a national basis by URAC, we afford substantial support and added medical expertise to our partners/clients on a national basis.

**Focused Peer Reviews and Physician-to-Physician Services Include:**

- Medical Determinations
- Medical/Disability Status Clarifications
- Causation Analysis
- Alternative Therapeutic Interventions
- Detailed Chart Reviews

**Connolly Healthcare**

950 East Paces Ferry Road, Suite 2850  
Atlanta, GA 30326

**Founded:** 1979

**Employees:** 300+

Connolly Healthcare will serve CoventryCares in the HealthChoices program by improving compliance and risk management through recovery audits.

Building on decades of experience in accounts payable recovery auditing, Connolly's services have naturally evolved over the years to span the entire Source-to-Settle continuum. Connolly's expertise, rooted in transactional auditing, uniquely allows them to analyze millions of individual transactions and review contract structure, language, and intent from a "bottom up" perspective.

Connolly applies the lessons from these audits to help identify and close value gaps, mitigate risk, recover overpayments, improve supplier sourcing, prevent future leakage, and improve internal processes and controls. This comprehensive and integrated set of audit and associated advisory services helps Connolly deliver value to their clients in the following major value categories:

- Cash Recovery
- Leakage Prevention
- Compliance Improvement and Assurance
- Contract Risk Management

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**Coventry Health Care, Inc.**  
**Coventry Management Services** (subsidiary company)  
6705 Rockledge Drive  
Bethesda, MD 20817

**Founded:** 1986

**Employees:** 14,000+

Coventry's roots can be traced back to November 21, 1986, the date the company's predecessor company, Coventry Corporation, was incorporated. Coventry Health Care, Inc. became a public company in 1991, and is currently listed on the NYSE with ticker symbol "CVH".

Since the company's inception, the building blocks of "The Coventry Model" have remained financial discipline and service excellence. The company's senior management team has long understood those two objectives need not be mutually exclusive.

As an organization, our long-term success depends on the ability to translate our commitment to affordable and accessible health care into real change. We look to four principles to guide us as we strive to provide exceptional value for members, employers, and providers: Everyone at Coventry is uncompromising in their commitment to ensure that all our customers have an easy, simple, and productive experience - whether enrolling as a new member, refilling a prescription, or filing a claim.

We pay fanatical attention to operational excellence, continually refining the advanced platforms and processes that are essential to what we do: delivering a growing range of services in the most efficient, cost-effective way possible to an ever-larger number of people.

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**DentaQuest**  
465 Medford Street  
Boston, MA 02129

**Founded:** 2001

**Employees:** 650

DentaQuest is the CoventryCares dental benefit administrator. DentaQuest is the nation's leading administrator of government dental programs committed to bringing high quality dental care to all members. By providing innovative dental benefits programs, improving efficiency and effectiveness of care, and working with communities and others to change the perception of oral health, DentaQuest makes a difference.

Over 14 million people across the country are enrolled in the DentaQuest dental programs and the company is improving oral health in 24 states and the District of Columbia. DentaQuest Ventures, Inc. is one of the largest dental benefit service companies in the country with more than eight and one half million members. Headquartered in Boston, DentaQuest employs 650 people nationwide. DentaQuest's subsidiary, DentaQuest Mid-Atlantic, located in Calverton, MD, offers a full spectrum of commercial dental plans, including indemnity, PPO, managed care, dual-option, and voluntary plans throughout Maryland and the District of Columbia. The company's Doral Dental USA subsidiary, located in Mequon, WI, is one of the largest multi-state administrators of government dental programs in the US.

DentaQuest Customer Service can be reached by calling 888-307-6561 or on the web at [www.DentaQuest.com](http://www.DentaQuest.com). Customer Service is available from 8 AM to 6 PM EST Monday through Friday.

Participating DentaQuest Providers may access member eligibility information through DentaQuest's Interactive Voice Response (IVR) by simply calling the DentaQuest General Provider Line at 800-341-8478 and press 1 for eligibility or accessing the Providers only section of the DentaQuest website. By utilizing either system, providers can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

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## **DSS Research**

4150 International Plaza  
Suite 900  
Fort Worth, TX 76109

**Founded:** 1990

**Employees:** 150

DSS Research is a full-service marketing research firm with an emphasis on full-service. The client work is supported by robust infrastructure, including people, specially developed processes, and user-friendly technology solutions. DSS Research handles all aspects of all projects in-house. This gives them unparalleled control and confidential information stays confidential.

DSS offers the full range of research solutions to health care organizations. No matter what type of data collection, target respondents, or survey instruments needed, DSS has the experience to handle any job.

Resources include:

- **Technological Advantage.** Employees at DSS work in a networked, Internet accessible mode, with the appropriate software tools necessary to do the jobs efficiently and effectively. Internal IT professionals maintain the networks and software and do custom programming of proprietary tools. The Internet capabilities are supported by multiple web servers and a dedicated database server. The IT staff is experienced in the development and implementation of Internet applications.
- **On-Site Telephone Interviewing Center.**-Telephone interviewing center, includes 80 interviewing stations fully equipped with our proprietary DSS Live® and iCATI™ systems. In the last 12 months, DSS conducted over 300,000 telephone surveys.
- **Mail Processing Center.** In order to speed workflow, the mail processing center increased its size to over 2,500 square feet of space. An experienced staff and automated equipment provide the capacity to process up to 40,000 outgoing and 20,000 incoming mail pieces per day. Advanced Optical Character Recognition (OCR) technology is used to process and capture data from incoming questionnaires efficiently and accurately. In the last 12 months, mail processing center handled some 2.0 million mail survey pieces.
- **Proprietary Survey Management System.** The survey management system provides the real-time information that project managers and the entire project team use to stay on top of every facet of the project. Project information is live and continually updated to reflect actual project progress and any changes in project specifications that occur.
- **Superior analysis and reporting.** The analytical services team has developed and tested a standard reporting package which includes an insightful executive summary, a highly

graphical display of results by each question and a full set of cross tabulations with statistical testing. All tools that allow at-a-glance views of focused needs.

### **HEDIS® CAHPS® and HOS Certifications**

At DSS, the quality and experience are backed up by numerous certifications. They are one of only four firms in the country certified by NCQA to conduct both the HEDIS®/CAHPS® surveys and the Medicare Health Outcomes Survey (HOS), and have been since 1998. They are certified to conduct 400 CAHPS® 4.0H and CAHPS® PPO surveys.

All of the staff, resources (software, computer hardware, mailing systems, telephone interviewing system, etc.) and processes are rigorously reviewed each year by NCQA in connection with HEDIS® and Medicare Health Outcomes Survey certifications. The review process involves a complete verification of systems and procedures to ensure DSS meets or exceed the standards.

**Emdeon**

3055 Lebanon Pike  
Nashville, TN 37214

**Founded:** 1985

**Employees:** 3,000

Emdeon is a leading provider of revenue and payment cycle management solutions, connecting payers, providers and patients in the U.S. healthcare system. Their product and service offerings integrate and automate key business and administrative functions of payer and provider customers throughout the patient encounter, including precare patient eligibility and benefits verification, claims management and adjudication, payment distribution, payment posting and denial management and patient billing and payment collection. With a comprehensive suite of products and services, which are designed to easily integrate with existing technology infrastructures, customers are able to improve efficiency, reduce costs, increase cash flow and more efficiently manage the complex revenue and payment cycle process. Emdeon believes their solutions are critical to payers and providers as they continue to face increasing financial and administrative pressures.

Emdeon's services are delivered primarily through recurring, transaction-based processes that leverage our revenue and payment cycle network, the single largest financial and administrative information exchange in the U.S. healthcare system. In 2008, they processed a total of 4.0 billion healthcare-related transactions, including approximately one out of every two commercial healthcare claims delivered electronically in the United States. Emdeon has developed a network of payers and providers over 25 years and connect to virtually' all private and government payers, claim submitting providers and pharmacies, making it extremely difficult, expensive and time-consuming for competitors to replicate their market position.

Emdeon's solutions drive consistent automated workflows and information exchanges that support key financial and administrative processes. Their market leadership is demonstrated by the long tenure of payer and provider relationships, which for their 50 largest customers in 2008 average 12 years as of June 2009. Emdeon serves as a central point of communication and data aggregation for their customers. Their network captures the most comprehensive and timely sources of U.S. healthcare information, including approximately 25 terabytes of historical claim data to which we add an average of 125 million rows of data daily. Unlike many other data sources, Emdeon's network provides access to data generated at, or close to, the point of care. Emdeon has connections to more payers, providers and vendors than any other healthcare business in the marketplace. Emdeon understands how to deliver solutions that best impact the flow of information for all parties to increase efficiency and maximize profitability. By connecting information intelligently and making key administrative processes easier, Emdeon simplifies the business of healthcare for everyone.

**Emdeon's network encompasses:**

- 340,000 providers
- 1,200 government and commercial payers
- 5,000 hospitals
- 81,000 dentists
- 60,000 pharmacies
- 600 vendor partners

**First Recovery Group**

26899 Northwestern Hwy.  
Southfield, MI 48034

**Founded:** 2000

**Employees:** 80

Coventry has contracted with First Recovery Group to handle Third Party Liability matters. First Recovery Group is responsible to investigate member files for:

- Automobile Liability
- Homeowners' Liability (premises accidents)
- Workers' Compensation
- No Fault Medical Coverage
- Medical Malpractice
- Product Liability
- Services Liability
- Commercial Premises Liability
- Occupational Diseases

First Recovery Group identifies potential subrogation recoveries through an automated process that evaluates claims data to target those which may be accident related or where another party is responsible for payment. This includes but is not limited to coverage workers' compensation, disability related medical coverage. Multiple factors are evaluated such as diagnostic codes and claim history. Once the investigation is complete, the data is reviewed and the next step in the recovery process is commenced.

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**Fiserv**

255 Fiserv Drive  
Brookfield, WI 53045

**Founded:** 1984

**Employees:** 19,000+

Fiserv provides a variety of support and document services for CoventryCares including delivery of member ID cards, benefit summaries, provider directories, or letters. Fiserv's DocuCentrix services can produce materials, personalize them including but not limited to plan and provider information and compile them into one, integrated booklet.

Fiserv is able to promptly deliver each member ID card, letter, directory or DocuCentrix booklet as each is created as it is entered into the system. There's no need for an inventory of preprinted card stock, envelopes or letterhead. This virtually eliminates costly delays because there is no lead-time needed to order materials.

Enter new member data, message content and special handling requests through Fiserv's Web Client Control Center (WC3)® web portal and the system will:

- Customize each component of a communication, by recipient
- Manage as many versions as needed: multiple networks, languages, benefits and package sizes
- Proof images of the cards and materials online before they are delivered
- Track mail dates and the delivery status of materials online

Fiserv formerly known as "Personix" has a long standing relationship with Coventry including services for its Medical Assistance Members.

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**HealthDataInsights**

7501 Trinity Peak Street, Suite 210  
Las Vegas, NV 89128

**Founded:** 2006

**Employees:** 300+

HealthDataInsights (HDI) is the industry leader in healthcare claims integrity: fraud, waste, abuse, errors and improper payment identification and recoupment solutions. Our customers include the public sector (the Centers for Medicare and Medicaid Services), and the private sector, including a number of the largest commercial payors in the United States.

HealthDataInsights is a technology-enabled healthcare services company that specializes in the identification and recoupment of claim overpayments to providers (hospitals, physicians, DME and other specialty providers.) The company, on behalf of its clients, employs sophisticated, proprietary software tools and database queries to retrospectively analyze 100% of a payor's claims data. HDI currently reviews annually more than \$300 billion in paid claims. The company's technology—which is deployed retrospectively (post-adjudication, post payment) —empowers a full review of all claims paid.

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**HealthcareData Company, LLC**  
600 Bent Creek Blvd, Suite 160  
Mechanicsburg, PA 17050

**Founded:** 1989

**Employees:** 300+

## **Overview**

HealthcareData Company, LLC is a data and research services company serving the health care community.

Experience working in a variety of settings – including inpatient and outpatient acute care, physician office practice, managed care, indemnity insurance, emergency medicine, trauma systems, long-term care, mental health, rehabilitative care, pharmaceuticals, delivery systems and behavioral health.

Mission is to contribute to the well-being of others through data and research services. Strive to make a difference.

Data work is both objective and credible; as an independent firm, they come without “baggage” and produce no output until data integrity has been established. They are dependable. Being able to rely on them with data is essential; the confidentiality statements and HIPAA agreements they sign carry with them a solemn obligation that they take seriously.

Analyses include clear statements of findings, interpretations of their meaning and recommendations for action. This insight is provided in addition to giving reports generally supplemented with informative tables and graphs.

## **History**

The company was founded in 1989 by Dr. Ted Ackroyd as Healthcare Research Affiliates, Inc. (HRA) to provide and interpret data used to guide health care policymaking, planning and management.

Over the years, HRA has used profiling in a variety of different applications. In addition, a number of other data and research services projects have been undertaken and continue to be offered, including:

- conducting an extensive number of HEDIS audits;
- producing standardized (HEDIS) performance reports for managed care companies;
- working with state governments to assess the care given to their beneficiaries;
- developing and administering a variety of surveys;
- conducting immunization registry, emergency medicine and trauma studies for governmental agencies and others;

- assisting employers in their managed care insurance initiatives;
- matching databases that lack shared identifiers using probabilistic linkage software;
- producing a variety of educational programs on getting, giving and using data;
- creating and applying sophisticated "what if" data models;
- conducting numerous data-based strategic planning endeavors;
- developing a variety of customized software packages for individual clients;
- designing and managing numerous special research projects;
- developing behavioral health data programs for county governments;
- conducting special research studies with major universities; and
- providing data and research services support to pharmaceutical companies, long-term care organizations, and organizations facing legislative and regulatory initiatives.

In late 1994, HRA formed a partnership with J. P. Morgan Capital Corporation, which provided significant financial resources to help the partnership develop, in part, extensive and complex data analysis services. Dr. Ackroyd was the CEO of the partnership.

The firms in the partnership were purchased in 1997 by a publicly traded (NASDAQ) health care technology company, of which we operated as the Healthcare Research and Analysis (HRA) Division. In December 1999, the office and its entire staff converted to a freestanding corporate entity, HealthcareData Company (HDC).

**Ingenix**

8345 Lenexa Drive, Suite 300  
Lenexa, KS 66214

**Founded:** 1996

**Employees:** 11,000

**History**

Ingenix has built industry-leading health care consulting capabilities through organic growth and acquisition. Over the past decade, Ingenix Consulting has acquired several top consulting firms, including:

- Reden & Anders - a premier actuarial, management and clinical consulting firm (February 1998)
- The Lewin Group - a preeminent health policy and research organization (June 2007)
- Healthia Consulting - a highly-ranked provider-focused IT strategy, system implementation and optimization consulting firm (September 2007)
- Global Works Systems, Inc. - trusted provider-focused software and services health care IT firm (November 2008)

Together, as Ingenix Consulting, they are able to connect the dots between each firm's individual areas of health care expertise-acting as a more informed, more insightful partner for clients. This big picture view lets them make a real difference in health care.

Today, Ingenix continues to grow in the global market while maintaining an exclusive focus on improving the effectiveness and quality of health care delivery. Parent company, Ingenix, a wholly-owned subsidiary of United Health Group, is a global health information technology organization making significant investments in analytic tools and methodologies to measure and model clinical and financial performance. Ingenix Consulting is privy to the Ingenix health data repository, which houses 14 years of longitudinal, fully-integrated medical, pharmacy and lab data for more than 157 million lives.

Getting valuable information to the right place at the right time requires a unique set of strengths.

Ingenix is built to deliver the information and technology needs that are unique to health care:

- Gather information and apply analytics to make it useful
- Create secure, interoperable networks that enable the exchange of information among communities
- Understand how those in health care actually do their work, so information can be seamlessly introduced into the flow of their everyday activities

Ingenix Consulting, an Ingenix company, is a premier, data-driven health care consulting organization. More than 1,000 experienced consultants work with hospitals, physicians, health plans, government agencies, and pharmaceutical companies. No other consulting firm operates on this scale with an exclusive health and human services focus.

For Coventry Health Care, Inc., Ingenix provides website capability for members patients to select the best doctor using Best Match search technology.

**LabCorp**  
430 S. Spring Street  
Burlington, NC 27215

**Founded:** 1995

**Employees:** 28,000+

In 1995, National Health Laboratories and Roche Biomedical Laboratories merged to become one of the largest clinical lab provider in the world. Recognized for innovation, quality, and customer convenience, LabCorp delivers timely, accurate results for improved patient care. LabCorp has served Coventry's Medical Assistance Members and will continue to serve these members as HealthChoices expands into the Southwest, New West and New East Zones.

LabCorp operates a sophisticated laboratory network, with corporate headquarters in Burlington, NC, and over 28,000 employees worldwide. LabCorp's 220,000 clients include physician offices, hospitals, managed care organizations, and biotechnology and pharmaceutical companies.

LabCorp performs more than one million tests on approximately 400,000 samples each day. LabCorp is a pioneer in applying advances in medicine and science to laboratory testing, with more than 35 years of experience in serving physicians and their patients. LabCorp's expertise is rooted in their dedication to provide physicians with timely, high-quality laboratory tests and services that help them provide improved patient care. In addition, LabCorp is committed to assisting in the development and delivery of new laboratory tests that provide enhanced accuracy and additional clinical information. This experience makes LabCorp an ideal provider of services to Coventry and its Medical Assistance Members

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**Language Line Services**

1 Lower Ragsdale Dr.  
Building 2  
Monterey, CA 93940

**Founded:** 1984 for Government Programs

**Employees:** 1,500+

Language Line Services eliminates language barriers and simplifies communication with customers, employees and business partners.

For local, state and federal government entities, Language Line Services provides a vital link between limited English speaking constituents and the critical services they need. By offering skilled interpreters and a technologically advanced global network to connect them, Language Line Services helps clients expand their reach and comply with state and federal rules and regulations.

Language Line Services offers interpretation and translation services through an internationally distributed team of expert interpreters based throughout the U.S., Canada, Latin America and the U.K. The terms “interpretation” and “translation” are distinct. “Interpretation” refers to the spoken word whereas “translation” relates to the written word.

By utilizing fully redundant telecommunications and database systems, Language Line Services ensures complete continuity of services for clients and provides rapid response time for critically needed services.

Language Line Translation Services provides interpreters for more than 190 languages, 24 hours a day, 7 days a week with a staff of over 1,500 and has been providing these services to government programs since 1984.

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**McKesson Health Solutions**

5 Country View Road  
Malvern, PA 19355

**Founded:** 1986

**Operational with Coventry:** June 2007

**Employees:** 10,000+

McKesson Health Solutions, our Nurse Advice Line, provides clinical triage services. If the member has a certain problem or symptom such as a backache, has questions regarding a medication, the nurse advice line can provide health information. For those phone calls related to a symptom (such as back and muscle pain, sore throat, cuts, fever, cold and viruses), the nurse asks the member series of questions base on standardized algorithm about the problem. These algorithms are developed by McKesson clinicians and reviewed by a committee of practicing physicians that McKesson utilizes. Nurses use these algorithms to determine end-point advice for our members. Based on the answers to the questions in the algorithms, the nurse can help the member decide if the member needs to go to the hospital, urgent care facility, or to their doctor or if the member can care for him or herself or family member at home. The nurse line does not have benefit information.

If the result of the nurse's questions indicates that the member should go to the emergency room or urgent care center, the member is responsible for his or her action and for knowing the provider network including mental health providers.

Additionally McKesson can recommend members as candidates for case management or disease management according to medical criteria.

The Call Center is staffed seven (7) days a week, twenty-four (24) hours a day, including holidays.

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**MCMC, LLC**

88 Black Falcon Avenue

Suite 353

Boston, MA 02210

**Founded:** 1992

**Employees:** 500

MCMC, LLC provides managed care services. Its services include independent peer review, independent medical exams, medical bill review, telephone case management, first report of injury, and hospital bill audits. The company also provides ScheduleLink+, a medical bill review software; WebOPUS; a Web-based case management software system; and mcmc.connection, a HIPAA compliant Web portal, which allows clients to create and submit independent medical review referrals and to retrieve completed electronic case reports through the Internet. It offers its services to group health, workers' compensation, disability, and auto and general liability insurers, as well as TPAs, PBMs, self-insured employers, labor unions, law firms, and state funds government agencies. MCMC, LLC was formerly known as Medical Care Management Corp. The company was founded in 1992 and is based in Boston, Massachusetts.

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**Medco**

100 Parsons Pond Drive  
Franklin Lakes, NJ 07417

**Founded:** 1983

**Employees:** 23,000

Medco is a leading pharmacy benefit manager (PBM), with the nation's largest mail order pharmacy operations. Through advanced pharmacy, Medco improves the health and lowers the total cost of care for clients and their members. Medco has served CoventryCares in the Southeast and will continue to serve Coventry Cares Members when the Southwest begins its HealthChoices Program.

Medco makes pharmacy care better for people with chronic conditions and who need medications on an ongoing basis. Medco has specialist pharmacists trained in specific chronic conditions. Each specialist is trained in the medications used to treat those specific chronic conditions. If a safety concern arises with a member's medication, Medco specialists will work with the member and his or her doctor to help avoid potentially harmful drug interactions. They can even help the member save on medications.

Medco offers total cost solutions that help to lower prescription drug costs and total healthcare costs. This is accomplished through pharmacy benefit modeling, drug trend management, and Medicare solutions. Medco engages members and assists them in making better decisions through innovative personalized member engagement programs. Size and scale allow Medco to provide customized, responsive service through its dedicated Client Service teams and seamless pharmacy operations. In providing a mail order business that helps reduce medication costs for members, Medco can provide greater safety and convenience to CoventryCares members.

Medco encourages the right behavior by working with doctors to prescribe medications on a plan's approved list of medications, also known as a "formulary," and the use of clinically appropriate generic drugs through our generic education and substitution programs. Medco's specialist pharmacists work with the member's physician to help prevent harmful drug interactions, and they cross-check the member's current medications with his/her health history and available lab work to help him/her stay safe. In addition, Medco specialists let the member's doctor's office know how their prescription plan program works so the doctor can also save the member money. Medco's specialist pharmacists help in the treatment of your members' specific chronic conditions.

Drug utilization reviews and innovative pediatric and senior drug review programs help ensure member safety.

**INTENTIONALLY LEFT BLANK**

**Quest Diagnostics**  
3 Giralda Farms  
Madison, NJ 07940

**Founded:** 1996

**Employees:** 42,000

Quest is the world's leading provider of diagnostic testing services, information and services that individuals and doctors need to make better healthcare decisions. Quest's services range from routine blood tests such as cholesterol, Pap testing and white blood cell counts to sophisticated cancer testing as well as gene-based and molecular testing. Quest performs medical tests that aid in the diagnosis or detection of diseases, measure the progress or recovery from a disease or confirm that an individual is free from disease.

Quest maintains facilities in all states facilitating patient access and faster dissemination of testing results.

Quest has served CoventryCares' Medical Assistance members since 2010. Quest's experience with Coventry's members and its understanding the regulatory and reporting requirements of the HealthChoices Program allows Quest to effectively and efficiently deliver services.

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**RR Donnelley**

111 South Wacker Drive  
Chicago, IL 60606

Founded: 1864

Employees: 58,700

RR Donnelley is a global provider of integrated communications. Founded more than 146 years ago, the company works collaboratively with more than 60,000 customers worldwide to develop custom communications solutions that reduce costs, enhance ROI and ensure compliance. Drawing on a range of proprietary and commercially available digital and conventional technologies deployed across four continents, the company employs a suite of leading Internet based capabilities and other resources to provide premedia, printing, logistics and business process outsourcing services to leading clients in virtually every private and public sector.

For Coventry Cares, RR Donnelley produces and mails the member kits.

- President & Chief Executive Officer: Thomas J. Quinlan, **III**
- 2010 sales in millions: \$10,600
- Employees: Approximately 58,700 employees worldwide
- Locations: Manufacturing operations in North America, Latin America, Asia and Europe
- Year founded: 1864

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## **The Myers Group**

1965 Evergreen Blvd., Suite 100  
Duluth, GA 30096

**Founded:** 1993

**Employees:** 140

The Myers Group conducts comprehensive survey research to give healthcare organizations the knowledge they need to continually improve and compete in today's market.

As a leader in healthcare research, The Myers Group offers a full line of survey products and services. Healthcare organizations throughout the nation rely on The Myers Group for dependable survey administration, inbound and outbound dialing services, data collection, and insightful analysis.

The Myers Group works with some of the largest and top MCO performers in the nation. The team approach and ongoing consultation provide clients with a personal level of service. The Myers Group provide valid and reliable results in an easy-to-understand format, helping companies identify areas of focus for quality improvement and customer/member satisfaction.

As a member of the Council for American Survey Research Organizations (CASRO), The Myers Group adheres to the CASRO Code of Standards and Ethics for survey research. CASRO's Code of Standards and Ethics is a rigorous, internationally-cited set of standards recognized as the benchmark for the research industry.

### **History**

The Myers Group was founded in 1993 based on a vision to serve the healthcare community and to help improve the quality of patient care. A.C. Myers, III, The Myers Group Founder and CEO, realized the need for valid survey research within the healthcare market. He also felt there needed to be standards of quality in place to reliably obtain and measure patient experiences and satisfaction levels.

The Myers Group currently employs approximately 140 employees, including full-time survey professionals and highly skilled telephone interviewers. Due to continued growth and increased service offerings, The Myers Group has enlarged their facilities and will conduct all healthcare service operations from their new 33,000-square-foot corporate headquarters in Duluth, Georgia.

### **Services**

The Myers Group has consistently built upon advanced survey knowledge and expertise by expanding and enhancing our services. An extensive line of survey research to measure member/patient satisfaction, provider satisfaction, provider access, case/disease management program effectiveness, behavioral health outcomes, and many other components critical to quality healthcare is offered.

The Myers Group is an NCQA-certified survey vendor for the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS®) and the Medicare Health Outcomes Survey (HOS). They are a CMS-approved Medicare CAHPS survey vendor. In addition to CAHPS, HOS, and other CAHPS Family of Surveys, The Myers Group continually evaluates HEDIS® NCQA standards and guidelines to further develop our product lines in support of many of the standards.

**Survey Research Products .**

- CAHPS® 4.0H Survey
- Medicare CAHPS
- Medicare Health Outcomes Survey (HOS)
- Experience of Care and Health Outcomes (ECHO) Survey for Behavioral Health
- Member Satisfaction Survey
- CAHPS Clinician & Group Survey / Member Experience with Physician Survey
- New Member Understanding and Satisfaction Survey(s)

# Commonwealth of Pennsylvania



December 8, 1988

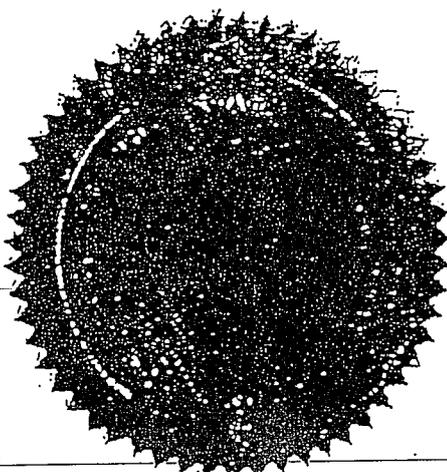
To All to Whom These Presents Shall Come: Greeting:

I DO HEREBY CERTIFY, That from an examination of the indices and corporate records of this department, it appears that on June 11, 1984, a Certificate of Incorporation was issued to a Pennsylvania corporation entitled

'Penn Group Health Plan, Inc.' now  
"HEALTHAMERICA PENNSYLVANIA, INC."

I DO FURTHER CERTIFY, That no proceedings in dissolution adversely affecting the corporate existence of the foregoing have subsequently been filed.

WHEREFORE, it appears that this corporation remains a presently subsisting corporation as of the date hereof.



IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the Commonwealth to be affixed, the day and year above written.

*Jane J. Boyd*

Secretary of the Commonwealth

20



COMMONWEALTH OF PENNSYLVANIA  
INSURANCE DEPARTMENT

HARRISBURG, PA 17120  
TELEPHONE (717) 787-1879

84381753

May 29, 1984



A. Bruce Bowden, Esq.  
Buchanan-Ingersoll  
600 Grant Street - 57th Floor  
Pittsburgh, PA 15219

Dear Mr. Bowden:

Thank you for your letter of April 30, 1984. We have taken into consideration the position set forth in your letter, and we concur that, solely for the purposes of conversion, Penn Group Health Plan, Inc. (PGHP) may take such actions as provided for in the Not-For-Profit Code. The conversion will not affect the Insurance Department's jurisdiction to regulate all applicable aspects of PGHP's operations.

You will need to submit a copy of the Plan of Conversion Agreement and all relevant documents for this Department's review and approval. Once the conversion is completed, please return the original Certificate of Authority issued by this Department to PGHP. As a courtesy, you may want to contact the Health Department. We would appreciate copies of any correspondence between PGHP and the Health Department.

Very truly yours,

David L. Greene, CFE  
Assistant to the Deputy  
Insurance Commissioner  
Bureau of Licenses

DLG/cb

Commonwealth of Pennsylvania  
Department of State

84381754

269781



CERTIFICATE OF INCORPORATION

Office of the Secretary of the Commonwealth

To All to Whom These Presents Shall Come, Greeting:

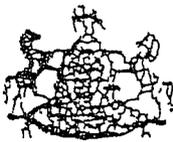
Whereas, Under the provisions of the Laws of the Commonwealth, the Secretary of the Commonwealth is authorized and required to issue a "Certificate of Incorporation" evidencing the incorporation of an entity.

Whereas, The stipulations and conditions of the Law have been fully complied with by

PENN GROUP HEALTH PLAN, INC.

Therefore, Know Ye, That subject to the Constitution of this Commonwealth, and under the authority of the Laws thereof, I do by these presents, which I have caused to be sealed with the Great Seal of the Commonwealth, declare and certify the creation, erection and incorporation of the above in deed and in law by the name chosen hereinbefore specified.

Such corporation shall have and enjoy and shall be subject to all the powers, duties, requirements, and restrictions, specified and enjoined in and by the applicable laws of this Commonwealth.



Given under my Hand and the Great Seal of the Commonwealth,  
at the City of Harrisburg, this 11th day  
of June 5:00 p.m. in the year of our  
Lord one thousand nine hundred and eighty four  
and of the Commonwealth the two hundred and eighth.

*William L. Davis*

Secretary of the Commonwealth

*P*

APPLICANT'S ACCOUNT NO. \_\_\_\_\_

84391473

DSCB BCL-903 (Rev. 6-77)

Filing fee: \$28 plus \$28  
for each party corporation  
in excess of two  
AMS-9  
Articles of Merger—  
Business Corporation

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
CORPORATION BUREAU

17th day of  
June, A.D. 1984.  
COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
*Spencer L. Davis*  
SECRETARY OF THE COMMONWEALTH

269781

In compliance with the requirements of section 9021 of the Business Corporation Law, act of May 5, 1933 (P. L. 364) (15 P. S. § 1903), the undersigned corporations, desiring to effect a merger, hereby certify that:

1. The name of the corporation surviving the merger is:  
Penn Group Health Plan, Inc. (PGHP)

2. (Check and complete one of the following).

The surviving corporation is a domestic corporation and the location of its registered office in this Commonwealth is (the Department of State is hereby authorized to correct the following statement to conform to the records of the Department)

Five Gateway Center, Sixth Floor, 60 Boulevard of the Allies  
Pittsburgh Pennsylvania 15222

The surviving corporation is a foreign corporation incorporated under the laws of \_\_\_\_\_ and the location of its office registered with such domiciliary jurisdiction is:

3. The name and the location of the registered office of each other domestic business corporation and qualified foreign business corporation which is a party to the plan of merger are as follows.

HealthAmerica Management Corporation of Pennsylvania (HMC)  
with its registered office at C/O C.T. Corporation System,  
Oliver Building, Mellon Square, Pittsburgh, Pennsylvania 15222.

①

84391474

4. (Check, and if appropriate, complete one of the following)

The plan of merger shall be effective upon filing the Articles of Merger in the Department of State

The plan of merger shall be effective on \_\_\_\_\_ (DATE) \_\_\_\_\_ (HOUR)

5. The manner in which the plan of merger was adopted by each domestic corporation is as follows:

NAME OF CORPORATION \_\_\_\_\_ MANNER OF ADOPTION \_\_\_\_\_

Penn Group Health Plan, Inc.

Approved the Plan of Merger by consent in writing, setting forth the action so taken, signed by all of the shareholders entitled to vote thereon, and filed with the Secretary of the Corporation.

HealthAmerica Management Corporation of Pennsylvania

Approved the Plan of Merger by consent in writing, setting forth the action so taken, signed by all of the shareholders of the corporation entitled to vote thereon, and filed with the Secretary of the Corporation.

RECEIVED  
MAY 24 1977  
DEPT. OF STATE

6. (Strike out this paragraph if no foreign corporation is party to the merger.)

7. The plan of merger is set forth in Exhibit A, attached hereto and made a part hereof.

8. (Strike out this paragraph if the surviving corporation is a domestic corporation.)

84391475

IN TESTIMONY WHEREOF, each undersigned corporation has caused these Articles of Merger to be signed by a duly authorized officer and its corporate seal, duly attested by another such officer, to be hereunto affixed this 23RD day of MAY 1984.

PENN. GROUP HEALTH PLAN, INC.  
(NAME OF CORPORATION)

By

James Stigler  
(SIGNATURE)  
CHAIRMAN  
(TITLE PRESIDENT, VICE PRESIDENT, ETC.)

Attest:

Ruth Dexter  
(SIGNATURE)  
SECRETARY  
(TITLE SECRETARY, ASSISTANT SECRETARY, ETC.)

(CORPORATE SEAL)

HEALTHAMERICA MANAGEMENT CORPORATION OF PENNSYLVANIA  
(NAME OF CORPORATION)

By

James P. Zimmerman  
(SIGNATURE)  
VICE PRESIDENT  
(TITLE PRESIDENT, VICE PRESIDENT, ETC.)

Attest:

Anthony J. Bugd  
(SIGNATURE)  
ASSISTANT SECRETARY  
(TITLE SECRETARY, ASSISTANT SECRETARY, ETC.)

(CORPORATE SEAL)

*Q*

84391476

AGREEMENT AND PLAN OF MERGER

AGREEMENT AND PLAN OF MERGER between PENN GROUP HEALTH PLAN, INC. (herein called "PGHP") and HEALTHAMERICA MANAGEMENT CORPORATION OF PENNSYLVANIA (herein called "HMC").

RECITALS:

PGHP is a business corporation organized and existing under the laws of the Commonwealth of Pennsylvania, with its registered office at Five Gateway Center, Sixth Floor, 80 Boulevard of the Allies, Pittsburgh, Pennsylvania 15222, having been recently converted from a non-profit corporation to a business corporation pursuant to Sections 7951 through 7956 of the Pennsylvania Nonprofit Corporation Law of 1972.

HMC is a business corporation organized and existing under the laws of the Commonwealth of Pennsylvania, with its registered office at C/O C.T. Corporation System, Oliver Building, Mellon Square, Pittsburgh, Pennsylvania 15222.

PGHP and HMC are both wholly-owned subsidiaries of HealthAmerica Corporation, a Delaware corporation.

The Board of Directors of both PGHP and HMC have determined that a merger between PGHP and HMC is desirable and in the best interests of their respective corporations. The Boards of Directors of PGHP and HMC have approved this Agreement and Plan of Merger (herein the "Plan") by resolutions duly adopted by each. HealthAmerica Corporation, by a duly adopted resolution, approved the Plan.

NOW, THEREFORE, PGHP and HMC, in consideration of the premises and mutual provisions herein contained, intending to be legally bound, and in accordance with the provisions of Sections 801 through 909 of the Business Corporation Law of the Commonwealth of Pennsylvania, hereby agree that the Agreement and Plan of Merger shall be as follows:

2

84391477

FIRST: The Merger shall become effective at 5:00 p.m., prevailing time, upon the date of the filing of the Articles of Merger in the Department of State of the Commonwealth of Pennsylvania (herein called the "Effective Date").

SECOND: On the Effective Date, HMC shall be merged with and into PGHP which shall be the surviving corporation and PGHP shall merge HMC into itself. The corporate existence of PGHP shall continue unaffected and unimpaired by the Merger and as the surviving corporation it shall continue to be governed by the laws of the Commonwealth of Pennsylvania.

THIRD: On the Effective Date, the separate existence of HMC shall cease, and all the property, real, personal and mixed of HMC, and all debts due on whatever account to HMC, including subscriptions to shares and other choses in action, shall be vested in PGHP, without further act or deed. PGHP shall thenceforth be responsible for all the liabilities and obligations of HMC, and all rights of creditors and all liens upon any property of HMC shall be preserved unimpaired.

FOURTH: The Articles of Incorporation of PGHP as in effect immediately prior to the Effective Date shall be the Articles of Incorporation of PGHP, the surviving corporation.

FIFTH: The Merger shall effect no change in any of the shares of PGHP stock and none of its shares shall be converted as a result of the Merger. Each share of HMC stock outstanding on the Effective Date shall, by virtue of the Merger and without any action on the part of the holder thereof, be converted into and exchanged for 1 share of PGHP Common Stock.

84391478

SIXTH: The Board of Directors of PGHP on and following the Effective Date shall be the Board of Directors of PGHP immediately prior to the Merger plus Messrs. Philip H. Brodesen, Jr., John E. Gillmor and James P. Zimmerman.

WITNESS the due execution hereof this 23<sup>RD</sup> day of MAY, 1984.

ATTEST:

PENN GROUP HEALTH PLAN, INC.

*Keith Decker*  
(Corporate Seal)

By *James P. Zimmerman*

ATTEST:

HEALTHAMERICA MANAGEMENT CORPORATION  
OF PENNSYLVANIA

*Anthony J. Byzel*  
(Corporate Seal)

By *James P. Zimmerman*

②

85160017

Filed this MAR 1 day of 1985  
Commonwealth of Pennsylvania  
Department of State  
*William E. Davis*  
Secretary of the Commonwealth

ICART'S ACCT NO.  
B: BCL-806 (Rev. 8-72)  
Filing Fee: \$10  
18-2  
Articles of  
Amendment—  
Domestic Business Corporation

(Line for numbering)  
269731  
COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
CORPORATION BUREAU

(Box for Certification)

In compliance with the requirements of section 806 of the Business Corporation Law, act of May 5, 1933 (P. L. 364) (15 P. S. §1806), the undersigned corporation, desiring to amend its Articles, does hereby certify that:

1. The name of the corporation is:  
Penn Group Health Plan INC.

2. The location of its registered office in this Commonwealth is (the Department of State is hereby authorized to correct the following statement to conform to the records of the Department).  
40 CT Corporation System Oliver Bldg. Mellon Square  
Pittsburgh Pennsylvania 15022  
CITY STATE ZIP CODE

The statute by or under which it was incorporated is:  
Pennsylvania Business Corporation Law, act of May 5, 1933 (P.L. 364)

1. The date of its incorporation is: 6-11-84

3. (Check, and if appropriate, complete one of the following).  
 The meeting of the shareholders of the corporation at which the amendment was adopted was held at the time and place and pursuant to the kind and period of notice herein stated.

Time The \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.  
Place \_\_\_\_\_  
Kind and period of notice \_\_\_\_\_

The amendment was adopted by a consent in writing, setting forth the action so taken, signed by all of the shareholders entitled to vote thereon and filed with the Secretary of the corporation.

6. At the time of the action of shareholders:  
(a) The total number of shares outstanding was:  
5 common

(b) The number of shares entitled to vote was:  
5

85160018

7. In the action taken by the shareholders:

(a) The number of shares voted in favor of the amendment was:

5

(b) The number of shares voted against the amendment was:

0

8. The amendment adopted by the shareholders, set forth in full, is as follows:

(1) The Name of the corporation is:

HealthAmerica Corporation of Pennsylvania

IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer and its corporate seal, duly attested by another such officer, to be hereunto affixed this 11st day of January 1985

Attest:  
Ruth Drescher  
Ruth Drescher  
Secretary  
(TITLE SECRETARY ASSISTANT SECRETARY ETC)

By James P. Zimmerman  
James P. Zimmerman  
President  
(TITLE PRESIDENT VICE PRESIDENT ETC)

CORPORATE SEAL

INSTRUCTIONS FOR COMPLETION OF FORM

- A. Any necessary copies of Form DSCB 17.2 (Consent to Appropriation of Name) or Form DSCB 17.3 (Consent to Use of Similar Name) shall accompany Articles of Amendment effecting a change of name.
- B. Any necessary governmental approvals shall accompany this form.
- C. Where action is taken by partial written consent pursuant to the Articles, the second alternate of Paragraph 5 should be modified accordingly.
- D. If the shares of any class were entitled to vote as a class, the number of shares of each class so entitled and the number of shares of all other classes entitled to vote should be set forth in Paragraph 6(b).
- E. If the shares of any class were entitled to vote as a class, the number of shares of such class and the number of shares of all other classes voted for and against such amendment respectively should be set forth in Paragraphs 7(a) and 7(b).
- F. BC<sup>1</sup>, §807 (13 P. S. §1807) requires that the corporation shall advertise its intention to file or the filing of Articles of Amendment. Proofs of publication of such advertising should not be delivered to the Department, but should be filed with the minutes of the corporation.

Filing Fee None

85160010

Consent to Use of  
Similar Name

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
CORPORATION BUREAU

#968218

Pursuant to 19 Pa. Code §17.3 (relating to use of a deceptively similar name) the undersigned corporation, desiring to consent to the use by another corporation of a name which is deceptively similar to its name, does hereby certify that:

1. The name of the corporation executing this Consent to Use of Similar Name is:

HealthAmerica Corporation of Harrisburg

2. The address of the registered office of the corporation is (the Department of State is hereby authorized to correct the following statement to conform to the records of the Department):

CT Corporation System  
(NUMBER)

123 S. Broad Street

Philadelphia  
(CITY)

Pennsylvania 19109  
(ZIP CODE)

3. The date of its incorporation is:

9-12-83

4. The statute under which it was incorporated is:

BCA 5/5/33

5. The corporation(s) entitled to the benefit of this Consent to Use of Similar Name is (are):

HealthAmerica Corporation of Pennsylvania

HealthAmerica Corporation of Philadelphia

6. A check in this box:  indicates that the corporation executing this Consent to Use of Similar Name is the parent or prime affiliate of a group of corporations using the same name with geographic or other designations, and that such corporation is authorized to and does hereby act on behalf of all such affiliated corporations, including the following (see 19 Pa. Code §17.3(c)(7)):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

G

85160011

IN TESTIMONY WHEREOF, the undersigned corporation has caused this consent to be signed by a duly authorized officer and its corporate seal, duly attested by another such officer, to be hereunto affixed, this 1 day of March, 1985.

HealthAmerica Corporation of Harrisburg  
(NAME OF CORPORATION)

Philip N. Bredeesen  
(SIGNATURE)

By:

PHILIP N. BREDEESEN  
President

(TITLE PRESIDENT VICE PRESIDENT, ETC.)

Attest:

John E. Gillior  
(SIGNATURE)

JOHN E. GILLIOR

Secretary

(TITLE SECRETARY ASSISTANT SECRETARY, ETC.)

(CORPORATE SEAL)

INSTRUCTIONS FOR COMPLETING FORM:

- A. Where this form is executed by an unincorporated body which has registered its name pursuant to statute (see 19 Pa. Code §17.101 et seq.) the language of the form should be modified accordingly, and a seal need be affixed only where the unincorporated body has adopted a seal.

DEPT OF STATE  
MAR 1 12 03 PM '85

(Handwritten mark)

ARTICLES OF INCORPORATION

PLEASE INDICATE (CHECK ONE) TYPE CORPORATION:

- DOMESTIC BUSINESS CORPORATION
- DOMESTIC BUSINESS CORPORATION A CLOSE CORPORATION - COMPLETE BACK
- DOMESTIC PROFESSIONAL CORPORATION ENTER BOARD LICENSE NO.

FEE  
\$75.00

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE - CORPORATION BUREAU  
308 NORTH OFFICE BUILDING, HARRISBURG, PA 17120

010 NAME OF CORPORATION (MUST CONTAIN A CORPORATE INDICATOR UNLESS EXEMPT UNDER 15 P.S. 2903 B)  
Penn Group Health Plan, Inc.

011 ADDRESS OF REGISTERED OFFICE IN PENNSYLVANIA (P.O. BOX NUMBER NOT ACCEPTABLE)  
123 South Broad Street, c/o C T Corporation System

012 CITY Philadelphia      013 COUNTY (5) Philadelphia      015 STATE Pennsylvania      054 ZIP CODE 19109

050 EXPLAIN THE PURPOSE OR PURPOSES OF THE CORPORATION

To engage in any lawful act or activity for which corporations may be organized under the Pennsylvania Business Corporation Law.

(ATTACH 8 1/2 x 11 SHEET IF NECESSARY)

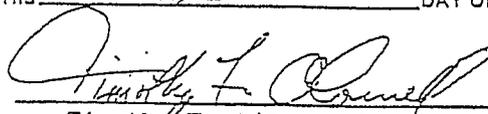
The Aggregate Number of Shares, Classes of Shares and Par Value of Shares Which the Corporation Shall have Authority to Issue:

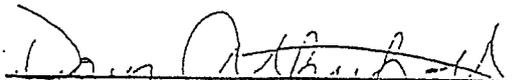
040 Number and Class of Shares 1,000 Common	041 Stated Par Value Per Share If Any \$1.00	042 Total Authorized Capital \$1,000.00	043 Term of Existence Perpetual
--	---	--	------------------------------------

Name and Address of Each Incorporator, and the Number and Class of Shares Subscribed to by each Incorporator

060 Name	061, 062 063, 064 Address (Street, City, State, Zip Code)	Number & Class of Shares
Timothy F. O'Connell	123 S. Broad St., Philadelphia, PA 19109	One (1) Common
Dawn Atherholt	123 S. Broad St., Philadelphia, PA 19109	One (1) Common
(ATTACH 8 1/2 x 11 SHEET IF NECESSARY)		

IN TESTIMONY WHEREOF, THE INCORPORATOR(S) HAS (HAVE) SIGNED AND SEALED THE ARTICLES OF INCORPORATION THIS 15th DAY OF February 1985.

  
Timothy F. O'Connell

  
Dawn Atherholt

- FOR OFFICE USE ONLY -

030 FILED MAR 21 1985	002 CODE	003 REV BOX	SEQUENTIAL NO. 76790	100 MICROFILM NUMBER 85241579	
	REVIEWED BY	004 SIC	AMOUNT \$ 75	001 CORPORATION NUMBER 86/661	
William L. Davis Secretary of the Commonwealth Department of State Commonwealth of Pennsylvania (PA. - 1343 - 2/23/82)	DATE APPROVED	CERTIFY TO <input checked="" type="checkbox"/> REV. <input checked="" type="checkbox"/> L & I <input type="checkbox"/> OTHER	INPUT BY [Signature]	LOG IN	LOG IN (REFILE)
	DATE REJECTED		VERIFIED BY	LOG OUT	LOG OUT (REFILE)
	MAILED BY DATE				



Plan Group Health Plan, Inc.

85241580

EXHIBIT

85241580

Paragraph 1. The directors may make, alter, amend and repeal the by-laws subject to the power of the shareholders to change such action.

6

6

6

CORPORATION BUREAU  
 DEPARTMENT OF STATE  
 308 NORTH OFFICE BUILDING  
 HARRISBURG, PENNSYLVANIA 17120

FILING FEE Corporation \$40.00  
 Individual \$25.00  
 Check Enclosed  
 Charge Account # \_\_\_\_\_

7. In compliance with the requirements of Section 311 of Act 1982-295 (54 Pa. C.S. §311), this undersigned entity(ies) desiring to carry on or conduct a business in this Commonwealth under an assumed or fictitious name, style or designation, does (do) hereby certify that:

1. Fictitious Name: Penn Group Health Plan

2. Address of the principal place of business: (including street and number)  
Five Gateway Center, Pittsburgh, Pa. 15222 (02)

3. Brief statement of the character or nature of the business:  
Health Maintenance Organization

4. Individual or individuals interested in the business: (name and address)

(NAME)	(NUMBER)	(STREET)	(CITY)	(STATE)	(ZIP CODE)

5. Entity other than an individual interested in the business:

(NAME)	(FORM OF ENTITY)	ORGANIZING JURISDICTION	ADDRESS IN JURIS.	REGISTERED OFFICE (if any)
<u>HealthAmerica Corporation of Pennsylvania</u>			<u>Five Gateway Center Pittsburgh, Pa. 15222</u>	<u>CT Corp. Systems Oliver Bldg, Mellon Sq. Bldg PA 15222</u>

6. I am familiar with the provisions of Section 332 of the Fictitious Names Act and understand that filing under the Act does not create any exclusive or other right to the fictitious name.

Agent, if any, authorized to execute amendments, withdrawals, or cancellations.

TIMONY WHEREOF, the undersigned have caused this registration to be executed this 21<sup>st</sup> day of MARCH, 19 85.

Individual \_\_\_\_\_

Individual \_\_\_\_\_

Corporate Seal \_\_\_\_\_

Both Desher  
 Secretary or Assistant Secretary

Corporate Seal \_\_\_\_\_

Secretary or Assistant Secretary

Secretary or Assistant Secretary

James P. Zimmerman  
 Individual

Individual \_\_\_\_\_

HealthAmerica Corporation of Pennsylvania  
 Name of Corporation

James P. Zimmerman, President  
 President or Vice President

Name of Corporation \_\_\_\_\_

President or Vice President \_\_\_\_\_

330 FILED MAR 21 1985

- FOR OFFICE USE ONLY -

002 CODE	003 REV BOX	SEQUENTIAL NO. 76789	100 ARCHIVAL NUMBER 85241578
REVIEWED BY	004 SICC	AMOUNT	001 CORPORATION NUMBER 859067
DATE APPROVED		\$ 40	
DATE REJECTED	CERTIFY TO	INPUT BY aw 3/25	LOG IN LOG IN (REFILE)
MAILED BY DATE	<input checked="" type="checkbox"/> L & I <input type="checkbox"/> OTHER	VERIFIED BY 3-26	LOG OUT LOG OUT (REFILE)

William R. Davis

APPLICANT'S ACCT NO.

Form BCL-806 (Rev. 8-72)

Filing Fee: \$40  
AB-2

Articles of  
Amendment—  
Domestic Business Corporation

(Line for numbering)

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
CORPORATION BUREAU

Filed this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_.

Commonwealth of Pennsylvania  
Department of State

Secretary of the Commonwealth

(Box for Certification)

In compliance with the requirements of section 806 of the Business Corporation Law, act of May 5, 1933 (P. L. 364) (15 P. S. §1806), the undersigned corporation, desiring to amend its Articles, does hereby certify that:

1. The name of the corporation is:

PENN GROUP HEALTH PLAN, INC.

2. The location of its registered office in this Commonwealth is (the Department of State is hereby authorized to correct the following statement to conform to the records of the Department):

123 South Broad St., C/O C T Corporation System

(NUMBER)

(STREET)

Philadelphia

Pennsylvania

19109

(CITY)

(ZIP CODE)

3. The statute by or under which it was incorporated is:

Pennsylvania Business Corporation Law

4. The date of its incorporation is: April 19, 1974

5. (Check, and if appropriate, complete one of the following):

The meeting of the shareholders of the corporation at which the amendment was adopted was held at the time and place and pursuant to the kind and period of notice herein stated.

Time: The \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_.

Place: \_\_\_\_\_

Kind and period of notice \_\_\_\_\_

The amendment was adopted by a consent in writing, setting forth the action so taken, signed by all of the shareholders entitled to vote thereon and filed with the Secretary of the corporation.

6. At the time of the action of shareholders:

(a) The total number of shares outstanding was:

(b) The number of shares entitled to vote was:

22

7. In the action taken by the shareholders:

(a) The number of shares voted in favor of the amendment was:

\_\_\_\_\_

(b) The number of shares voted against the amendment was:

\_\_\_\_\_

8. The amendment adopted by the shareholders, set forth in full, is as follows:

The name of the corporation is changed to read as follows:

HealthAmerica Corporation of Pennsylvania

IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer and its corporate seal, duly attested by another such officer, to be hereunto affixed this \_\_\_\_\_ day of \_\_\_\_\_ 19 85.

Attest:

PENN GROUP HEALTH PLAN, INC.  
(NAME OF CORPORATION)

\_\_\_\_\_  
(SIGNATURE)

By: \_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(TITLE: SECRETARY, ASSISTANT SECRETARY, ETC.)

\_\_\_\_\_  
(TITLE: PRESIDENT, VICE PRESIDENT, ETC.)

(CORPORATE SEAL)

INSTRUCTIONS FOR COMPLETION OF FORM

- A. Any necessary copies of Form DSCB:17.2 (Consent to Appropriation of Name) or Form DSCB:17.3 (Consent to Use of Similar Name) shall accompany Articles of Amendment effecting a change of name.
- B. Any necessary governmental approvals shall accompany this form.
- C. Where action is taken by partial written consent pursuant to the Articles, the second alternate of Paragraph 5 should be modified accordingly.
- D. If the shares of any class were entitled to vote as a class, the number of shares of each class so entitled and the number of shares of all other classes entitled to vote should be set forth in Paragraph 6(b).
- E. If the shares of any class were entitled to vote as a class, the number of shares of such class and the number of shares of all other classes voted for and against such amendment respectively should be set forth in Paragraphs 7(a) and 7(b).
- F. BCL §807 (15 P. S. §1807) requires that the corporation shall advertise its intention to file or the filing of Articles of Amendment. Proofs of publication of such advertising should not be delivered to the Department, but should be filed with the minutes of the corporation.



# Commonwealth of Pennsylvania



Department of State

To All to Whom These Presents Shall Come, Greeting:

Whereas, In and by Article VIII of the Business Corporation Law, approved the fifth day of May, Anno Domini one thousand nine hundred and thirty-three, P. L. 364, as amended, the Department of State is authorized and required to issue a

## CERTIFICATE OF AMENDMENT

evidencing the amendment of the Articles of Incorporation of a business corporation organized under or subject to the provisions of that Law, and

Whereas, The stipulations and conditions of that Law pertaining to the amendment of Articles of Incorporation have been fully complied with by

HEALTHAMERICA CORPORATION OF PENNSYLVANIA  
name changed to:  
MAXICARE/HEALTHAMERICA PENNSYLVANIA, INC.

Therefore, Know Ye, That subject to the Constitution of this Commonwealth and under the authority of the Business Corporation Law, I do by these presents, which I have caused to be sealed with the Great Seal of the Commonwealth, extend the rights and powers of the corporation named above, in accordance with the terms and provisions of the Articles of Amendment presented by it to the Department of State, with full power and authority to use and enjoy such rights and powers, subject to all the provisions and restrictions of the Business Corporation Law and all other applicable laws of this Commonwealth.

Given under my Hand and the Great Seal of the Commonwealth, at the City of Harrisburg, this 22nd day of December in the year of our Lord one thousand nine hundred and eighty six and of the Commonwealth the two hundred eleventh.

Secretary of the Commonwealth

cay

DSCB: BCL-806 (Rev. 8-72)

Filing Fee: \$40  
AB-2

Articles of  
Amendment—  
Domestic Business Corporation

8705 501

(Line for numbering)

269781

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
CORPORATION BUREAU

Filed this \_\_\_\_\_ day of \_\_\_\_\_  
DEC 22 1986, 19 \_\_\_\_\_

Commonwealth of Pennsylvania  
Department of State

*Robert W. Gleason, Jr.*  
Secretary of the Commonwealth

(Box for Certification)

In compliance with the requirements of section 806 of the Business Corporation Law, act of May 5, 1933 (P.L. 364. S. §1806), the undersigned corporation, desiring to amend its Articles, does hereby certify that:

1. The name of the corporation is:

HealthAmerica Corporation of Pennsylvania

2. The location of its registered office in this Commonwealth is (the Department of State is hereby authorized to correct the following statement to conform to the records of the Department):

CT Corporation System Oliver Bldg, Mellon Square

(NUMBER)

(STREET)

Pittsburgh

Pennsylvania

(CITY)

(ZIP CODE)

3. The statute by or under which it was incorporated is:

Pennsylvania Business Corporation Law, Act of May 5, 1933 (P.L. 364)

4. The date of its incorporation is: 6-11-84

5. (Check; and if appropriate, complete one of the following):

The meeting of the shareholders of the corporation at which the amendment was adopted was held at the time and place and pursuant to the kind and period of notice herein stated.

Time: The \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_

Place: \_\_\_\_\_

Kind and period of notice \_\_\_\_\_

The amendment was adopted by a consent in writing, setting forth the action so taken, signed by all of the shareholders entitled to vote thereon and filed with the Secretary of the corporation.

6. At the time of the action of shareholders:

(a) The total number of shares outstanding was:

5 (Five)

*(Handwritten mark)*

7. In the action taken by the shareholders:

(a) The number of shares voted in favor of the amendment was:

5 (Five)

(b) The number of shares voted against the amendment was:

0 (Zero)

8. The amendment adopted by the shareholders, set forth in full, is as follows:

(1) The Name of the Corporation is:

Maxicare/HealthAmerica Pennsylvania, Inc.

IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer and its corporate seal, duly attested by another such officer, to be hereunto affixed this 18 day of December, 1986

Attest:

*Alan R.*  
\_\_\_\_\_  
(SIGNATURE)

Secretary  
(TITLE: SECRETARY, ASSISTANT SECRETARY, ETC.)

(CORPORATE SEAL)

HealthAmerica Corporation of Pennsylvania  
(NAME OF CORPORATION)

*[Signature]*  
\_\_\_\_\_  
(SIGNATURE)

By: \_\_\_\_\_  
(SIGNATURE)

President  
(TITLE: PRESIDENT, VICE PRESIDENT, ETC.)

INSTRUCTIONS FOR COMPLETION OF FORM

- A. Any necessary copies of Form DSCB: 17.2 (Consent to Appropriation of Name) or Form DSCB: 17.3 (Consent to Use of Similar Name) shall accompany Articles of Amendment effecting a change of name.
- B. Any necessary governmental approvals shall accompany this form.
- C. Where action is taken by partial written consent pursuant to the Articles, the second alternate of Paragraph 5 should be modified accordingly.
- D. If the shares of any class were entitled to vote as a class, the number of shares of each class so entitled and the number of shares of all other classes entitled to vote should be set forth in Paragraph 6(b).
- E. If the shares of any class were entitled to vote as a class, the number of shares of such class and the number of shares of all other classes voted for and against such amendment respectively should be set forth in Paragraphs 7(a) and 7(b).
- F. BCLG 807 (15 P. S. §1807) requires that the corporation shall advertise its intention to file or the filing of Articles of Amendment. Proofs of publication of such advertising should not be delivered to the Department, but should be filed with the minutes of the corporation.

ARTICLES OF AMENDMENT

OF

HEALTHAMERICA CORPORATION OF PENNSYLVANIA

In compliance with the requirements of section 806 of the Business Corporation Law act of May 5, 1933 (P.L. 364) (15 P.S. 1806) the undersigned corporation, desiring to amend its Articles, does hereby certify that:

1. The location of the registered office is c/o CT Corporation System, Oliver Building Mellon Square, Pittsburgh, Pennsylvania 15022
2. The Corporation was incorporated under the Pennsylvania Business Corporation law, as amended on June 11, 1984.
3. The amendment to the Articles of Incorporation was adopted by means of a written Consent of Sole Shareholder dated November 3, 1986.
4. The Corporation has five shares of common stock outstanding. Five shares voted in favor of the amendment and zero shares voted against the amendment.
5. The amendment to the Articles of Incorporation as adopted by the shareholder is as follows:

(1) The name of the corporation is:

Maxicare/HealthAmerica Pennsylvania, Inc.

(2)

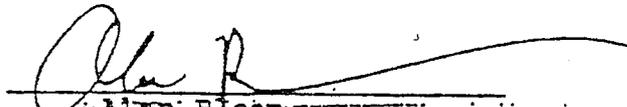
IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer and its corporate seal, duly attested by another such officer, to be hereunto affixed, this 18 day of December, 1986.

HEALTHAMERICA CORPORATION  
OF PENNSYLVANIA



\_\_\_\_\_  
Pamela Anderson  
President

ATTEST:

  
\_\_\_\_\_  
Alan Bloom  
Secretary

CORPORATE SEAL



Applicant's Account No. \_\_\_\_\_

DSCB-8CL-204 (Rev. 8-72)

Filing Fee: \$75  
A18-7

80-70 760  
/19602

Articles of  
Incorporation--  
Domestic Business Corporation

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
CORPORATION BUREAU

Filed this 24th day of  
November, A.D. 1980

Commonwealth of Pennsylvania  
Department of State

*William L. Davis*

Secretary of the Commonwealth slg

In compliance with the requirements of section 294 of the Business Corporation Law, act of May 5, 1933 (P. L. 364) (15 P. S. §1204) the undersigned, desiring to be incorporated as a business corporation, hereby certifies (certify) that:

1. The name of the corporation is:

HEALTHPLANS MANAGEMENT CORPORATION OF PENNSYLVANIA

2. The location and post office address of the initial registered office of the corporation in this Commonwealth is:

<u>Five</u> (NUMBER)	<u>Gateway Center</u> (STREET)	
<u>Pittsburgh</u> (CITY)	<u>Pennsylvania</u>	<u>15222</u> (ZIP CODE)

3. The corporation is incorporated under the Business Corporation Law of the Commonwealth of Pennsylvania for the following purpose or purposes:

The Corporation shall have unlimited power to engage in and to do any lawful act concerning any or all lawful business for which corporations may be incorporated under the Pennsylvania Business Corporation Law, as amended.

4. The term for which the corporation is to exist is: Perpetual

5. The aggregate number of shares which the corporation shall have authority to issue is:

Five Shares of Common Stock of the par value of \$1.00.



6. The name(s) and post office address(es) of each incorporator(s) and the number and class of shares subscribed by such incorporator(s) is (are):

NAME	ADDRESS (Including street and number, if any)	NUMBER AND CLASS OF SHARES
Ellen Fenstermacher	57th Floor - 600 Grant St. Pittsburgh, PA 15219	1 share, Common

IN TESTIMONY WHEREOF, the incorporator(s) has (have) signed and sealed these Articles of Incorporation this 21st day of November, 19 80.

\_\_\_\_\_ (SEAL) *Ellen Fenstermacher* (SEAL)  
 \_\_\_\_\_ (SEAL)

INSTRUCTIONS FOR COMPLETION OF FORM:

- A. For general instructions relating to the incorporation of business corporations see 19 Pa. Code Ch. 35 (relating to business corporations generally). These instructions relate to such matters as corporate name, stated purposes, term of existence, authorized share structure and related authority of the board of directors, inclusion of names of first directors in the Articles of incorporation, optional provisions on cumulative voting for election of directors, etc.
- B. One or more corporations or natural persons of full age may incorporate a business corporation.
- C. Optional provisions required or authorized by law may be added as Paragraphs 7, 8, 9 ... etc.
- D. The following shall accompany this form:
  - (1) Three copies of Form DSCB:BCL-206 (Registry Statement Domestic or Foreign Business Corporation).
  - ~~(2) Any necessary copies of Form DSCB:17-2 (Consent to Appropriation of Name) or Form DSCB:17-3 (Consent to Use of Similar Name).~~
  - (3) Any necessary governmental approvals.
- E. BCL §205 (15 Pa. S. §1205) requires that the incorporators shall advertise their intention to file or the corporation shall advertise the filing of articles of incorporation. Proofs of publication of such advertising should not be delivered to the Department, but should be filed with the minutes of the corporation.

768218

CONSENT TO USE OF SIMILAR NAME

Pursuant to Section 202 of the Pennsylvania Business Corporation Law (relating to the use of a similar name) the undersigned corporation, desiring to consent to the use by another corporation of a name which is similar to its name, does hereby certify that:

1. The name of the corporation executing this Consent to Use of Similar Name is HealthAmerica Corporation of Harrisburg (the "Corporation").

2. The address of the registered office of the Corporation is (the Department of State is hereby authorized to correct the following statement to conform to the record of Department) 123 South Broad Street, Philadelphia, Pennsylvania 19109.

3. The date of its incorporation is September 12, 1983.

4. The statute under which it is incorporated is the Pennsylvania Business Corporation Law.

5. The corporation entitled to the benefit of this Consent of Use of Similar Name is HealthAmerica Pennsylvania, Inc.

IN TESTIMONY WHEREOF, the undersigned corporation has caused this Consent to be signed and attested by duly authorized officers this 16th day of November, 1988.

HEALTHAMERICA CORPORATION  
OF HARRISBURG

By: Alvin B.  
Secretary

ATTEST:

HEALTHAMERICA CORPORATION  
OF HARRISBURG

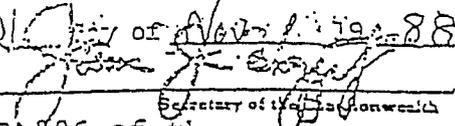
By: [Signature]  
Assistant Secretary

[Handwritten mark]

## ARTICLES OF AMENDMENT

MAXICARE/HEALTHAMERICA PENNSYLVANIA, INC.

Filed in the Department of State on

the 21<sup>st</sup> day of November 1988  
Secretary of the Commonwealth

In compliance with the requirements of section 806 of the Business Corporation Law, act of May 5, 1933 (P.L. 364. S. §1806), the undersigned corporation, desiring to amend its Articles, does hereby certify that:

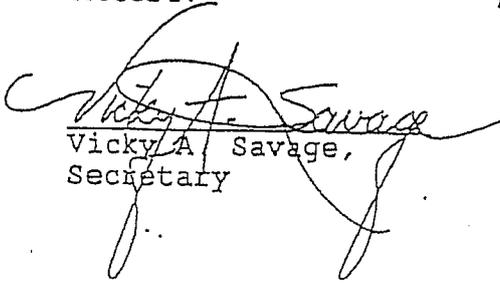
1. The name of the corporation is Maxicare/HealthAmerica Pennsylvania, Inc.
2. The location of its registered office in this Commonwealth is (the Department of State is hereby authorized to correct the following statement to conform to the records of the Department) CT Corporation System, Oliver Bldg., Mellon Square, Pittsburgh, Pennsylvania 15022.
3. The statute by or under which it was incorporated is the Pennsylvania Business Corporation Law, Act of May 5, 1933 (P.L. 364).
4. The date of its incorporation is June 11, 1984.
5. The amendment was adopted by a consent in writing, setting forth the action so taken, signed by all of the shareholders entitled to vote thereon and filed with the Secretary of the corporation.
6. At the time of the action of shareholders, the total number of shares outstanding was five, and the number of shares entitled to vote was five.
7. In the action taken by the shareholders, the number of shares voted in favor of the amendment was five. No shares were voted against the amendment.
8. The amendment adopted by the shareholders, set forth in full, is as follows:
  - (1) The Name of the Corporation is:  
HealthAmerica Pennsylvania, Inc.



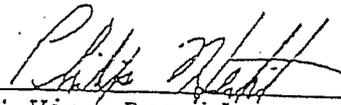
IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer and its corporate seal, duly attested by another such officer, to be hereunto affixed this 19th day of October, 1988.

Attest:

Maxicare/HealthAmerica Pennsylvania, Inc.

  
Vicky A. Savage,  
Secretary

(Corporate Seal)

By:   
Title: Vice President

8889 623  
Commonwealth of Pennsylvania



Department of State

To All to Whom These Presents Shall Come, Greeting:

Whereas, In and by Article VIII of the Business Corporation Law, approved the fifth day of May, Anno Domini one thousand nine hundred and thirty-three, P. L. 364, as amended, the Department of State is authorized and required to issue a

CERTIFICATE OF AMENDMENT

evidencing the amendment of the Articles of Incorporation of a business corporation organized under or subject to the provisions of that Law, and

Whereas, The stipulations and conditions of that Law pertaining to the amendment of Articles of Incorporation have been fully complied with by

MAXICARE/HEALTHAMERICA PENNSYLVANIA, INC.  
name changed to  
HEALTHAMERICA PENNSYLVANIA, INC.

Therefore, Know Ye, That subject to the Constitution of this Commonwealth and under the authority of the Business Corporation Law, I do by these presents, which I have caused to be sealed with the Great Seal of the Commonwealth, extend the rights and powers of the corporation named above, in accordance with the terms and provisions of the Articles of Amendment presented by it to the Department of State, with full power and authority to use and enjoy such rights and powers, subject to all the provisions and restrictions of the Business Corporation Law and all other applicable laws of this Commonwealth.

Given under my Hand and the Great Seal of the Commonwealth, at the City of Harrisburg, this 21st day of November in the year of our Lord one thousand nine hundred and eighty-eight and of the Commonwealth the two hundred thirteenth.

A handwritten signature in cursive script, appearing to read "James J. Hoyt".

Secretary of the Commonwealth

*Bylaws*

2

AMENDED BYLAWS  
OF  
HEALTHAMERICA PENNSYLVANIA, INC.

ARTICLE I - GENERAL

1.01. Name. The name of the corporation shall be HealthAmerica Pennsylvania, Inc.

1.02. Purposes. The corporation is organized to maintain and operate a prepaid group health plan; to solicit and enter into contracts with persons to become subscribers in a prepaid group health plan (hereinafter called "Subscribers"); to provide medical and hospital care to persons who become Subscribers of such prepaid group health plan; to own and operate facilities in which such care is provided; to contract with and employ medical practitioners, hospitals and others for the provision of such care (hereinafter called "Providers"); to provide facilities for the conduct of medical research; to conduct programs of health education and preventative medicine; to provide services to Subscribers of a nature similar to the foregoing and not inconsistent with the other purposes stated therein.

1.03. Offices. The offices of the corporation shall be established by the Board of Directors.

1.04. Other Offices. The corporation also may have offices at such other places, both within and without the Commonwealth of Pennsylvania, as the Board of Directors may from time to time decide are necessary or proper for the business of the corporation.

ARTICLE II - SHAREHOLDERS

2.01. Place of Meetings. All meetings of the shareholders for any purpose shall be held at such time and place, within or without the Commonwealth of Pennsylvania, as designated for that purpose by the Board of Directors in the notice of the meeting or in a duly executed waiver of notice thereof.

2.02. Annual Meetings. ~~Annual meetings of the shareholders shall be held at a time and on a day during the month of December to be selected by the Board of Directors. At each such annual meeting, the shareholders shall elect a Board of Directors and transact such other business as properly may be brought before the meeting.~~

2.03. Special Meetings. Special meetings of the shareholders may be called for any purpose at any time by the Chairman of the Board of Directors, the Chief Executive Officer,

the Board of Directors, or the holders of not less than ten percent (10%) of all the shares entitled to vote at the meeting.

2.04. Notice of Meetings. Written notice stating the place, day and hour of the meeting and, in case of a special meeting, the purpose for which the meeting is called, shall be delivered not less than ten days before the date of the meeting, either personally or by mail.

2.05. Quorum of Shareholders. The holders of a majority of the shares issued and outstanding and entitled to vote at such meeting, present in person or represented by proxy, shall constitute a quorum for the transaction of business at all meetings of the shareholders.

2.06. Action by Shareholders. When a quorum is present at any meeting, the vote of the holders of a majority of the shares having voting power, present in person or represented by proxy, shall decide any question brought before such meeting.

2.07. Action by Unanimous Written Consent. Any action required or permitted by statute to be taken at a meeting of the shareholders, may be taken without a meeting if a consent in writing, setting forth the action so taken, shall be signed by all of the shareholders entitled to vote with respect to the subject matter thereof and such consent shall have the same force and effect as a unanimous vote of the shareholders. Any such signed consent, or a copy thereof, shall be placed in the minute book of the corporation by the Secretary of the corporation.

### ARTICLE III - DIRECTORS

3.01. Powers of Directors. The business and affairs of the corporation shall be managed by its Board of Directors, which may exercise all powers of the corporation and do all lawful acts and things as are not by statute or by the Articles of Incorporation or by these Bylaws directed or required to be exercised or done by the shareholders.

3.02. Number and Qualification. The number of directors, which shall constitute the Board of Directors, shall be not less than three (3) nor more than fifteen (15) as the Board shall from time to time determine. Directors need not be shareholders of the corporation or residents of the Commonwealth of Pennsylvania. The directors shall be elected at the annual meeting of the shareholders and each director elected shall serve until his successor shall have been elected and qualified. At least one-third of the members of the Board of Directors shall be Subscribers, who shall be elected among a panel of individuals nominated by the Subscriber Nominating Committees. At least one Subscriber member from each of the Harrisburg and Pittsburgh state approved service areas shall be elected to and shall serve on the Board of Directors at all times. If disqualification, death, disabilities or resignations at any time reduce the number of qualified and able Directors to less than a quorum of the Board as then established, the size of the Board shall be automatically reduced, without need of Board action, to the number of Directors then qualified and able to serve, but never below three, whichever is greater. No decrease shall have the effect of shortening the term of any incumbent Director.

3.03. Ex-Officio Members of the Board. If the Chief Executive Officer and the President are not otherwise elected members of the Board, the Chief Executive Officer and the President shall serve ex-officio as members of the Board of Directors. If the Medical Director is not otherwise an elected member of the Board, the Medical Director shall serve ex-officio as a member of the Board of Directors.

3.04. Classes of Board Members. The members of the Board of Directors shall be divided into three classes, each class consisting of one-third of the Board. The Subscriber members of the Board of Directors shall be evenly distributed among the classes to the extent practicable. In the first year that classes of Directors are elected, the Shareholders shall designate the class to which each Director belongs. The first class shall serve until the next following annual meeting; the a second class until the second following annual meeting; and the third class until the third following annual meeting.

An honorary directorship may be bestowed upon retiring Board members whose counsel is deemed valuable to the Board and upon other distinguished individuals as determined by the Board. An Honorary Board Member shall have the right to attend and shall serve at the pleasure of the Board of Directors. Honorary Directors may be appointed and removed at any time upon a vote of a simple majority of those Board members attending any regularly scheduled Board meeting.

3.05. Filling Vacancies. Any vacancy occurring on the Board of Directors by reason of death, resignation, or removal may be filled by the affirmative vote of a majority of the remaining directors, although less than a quorum of the Board of Directors. A director elected to fill a vacancy shall be elected for the unexpired term of his predecessor in office. Any directorship to be filled by reason of an increase in the number of directors may be filled by election at a regular meeting or a special meeting of the Board of Directors called for that purpose, except for vacancies occurring among Subscriber members of the Board. Any vacancy occurring among Subscriber members of the Board of Directors shall be filled by a vote of the shareholders from a slate of nominees in the same manner as provided in Section 3.02 of these Bylaws regarding election of the Subscriber members.

3.06. Resignation of Directors. Any director may resign from his office at any time by delivering his written resignation to the Secretary, and such resignation shall be effective immediately upon delivery to the Secretary.

3.07. Removal of Directors. Any director may be removed with or without cause at any special or annual meeting of shareholders.

3.08. Place of Meetings. Regular or special meetings of the Board of Directors may be held either within or without the Commonwealth of Pennsylvania. A majority of the meetings of the Board of Directors held during each year shall be held within the geographic boundaries of the Commonwealth of Pennsylvania.

3.09. Chairman of the Board. The Chairman of the Board of Directors, if one be elected by the Board of Directors, shall preside at all meetings of the Board of Directors and shall have such other powers and duties as may from time to time be prescribed by the Board of Directors, upon written direction given to such Chairman pursuant to resolution duly adopted by the Board of Directors.

3.10. Regular Meetings. Regular meetings of the Board of Directors may be held without notice at such time and place as shall from time to time be determined by the Board of Directors. The Board of Directors shall meet at least annually. At such meetings, the Board shall ensure that management of the corporation reports on management's progress in carrying out the policies of the Board and discusses management's recommendations for changes in policy.

3.11. Special Meetings. Special meetings of the Board of Directors may be called by the Chairman of the Board of Directors or the Chief Executive Officer and shall be called by the Secretary on the written request of two (2) directors. Notice of any special meeting of the Board of Directors shall be given to each director at least three (3) days before the date of the meeting.

3.12. Quorum of Directors. At all meetings of the Board of Directors, a majority of the directors shall constitute a quorum for the transaction of business and the act of a majority of the directors present at any meeting at which there is a quorum shall be the act of the Board of Directors. If a quorum shall not be present at any meeting of the directors, the directors present thereat may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

3.13. Committees. The Board of Directors, by resolution passed by a majority of the entire Board of Directors, may from time to time designate members of the Board of Directors to constitute committees, including an executive committee, which shall in each case consist of such number of directors, not less than two (2), and shall have and may exercise such powers as the Board of Directors may determine and specify in the respective resolutions appointing them. A majority of all the members of any such committee may determine its action and fix the time and place of any meeting, unless the Board of Directors shall otherwise direct. Except for the Subscriber Nominating Committee, the Board of Directors shall have power at any time to change the number and the members of any such committee, to fill vacancies and to discharge any such committee.

3.14. Grievance Committee. The Chairman shall appoint a Grievance Committee which may consist of Board members or such other persons as the Board may designate for the purpose of hearing grievances, complaints and suggestions from Subscribers regarding the services provided by the corporation. The Grievance Committee shall regularly report such matters to the Board of Directors.

3.15. Subscriber Nominating Committee. The Board of Directors, by resolution passed by a majority of the entire Board of Directors, shall establish one or more Subscriber Nominating Committees. Each Subscriber Nominating Committee shall consist of five members, a majority of whom shall be Subscribers. No Subscriber members of the Subscriber Nominating Committee shall be officers, directors, or employees of the corporation. The Subscriber Nominating Committee shall nominate persons to serve as Subscriber members of the Board of Directors. Vacancies among Subscriber members of the Subscriber Nominating Committee shall be chosen by the Board of Directors. The initial members of the Subscriber Nominating Committee shall be the following named persons: Ruth Drescher, M.S.W., Walter V. Leon, Jr., Robert Mathias, Ph.D., Lee Hoskins, and Anthony Mastro.

3.16. Action by Unanimous Written Consent. Any Action required or permitted to be taken at a meeting of the Board of Directors or of any committee may be

taken without a meeting if a consent in writing, setting forth the actions so taken, is signed by all the members of the Board of Directors or such committee, as the case may be.

3.17. Compensation of Directors. The directors may be paid their expenses, if any, of attending each meeting of the Board of Directors, but shall not be paid for attending meetings of the Board of Directors or otherwise compensated for serving as a director. No such payment shall preclude any director from serving the corporation in any other capacity and receiving compensation therefor. Members of the executive committee or of special standing committees may, by resolution of the Board of Directors, be allowed like compensation for attending committee meetings.

3.18. Conflicts of Interest. Board Members having a direct interest in any matter under consideration by the Board shall disqualify themselves from taking part in the consideration of such matter.

3.19. Minutes of Meetings. The Board of Directors shall keep regular minutes of its proceedings and such minutes shall be placed in the minute book of the corporation. Committees of the Board of Directors shall maintain a separate record of the minutes of their proceedings.

#### ARTICLE IV - NOTICES AND MEETINGS

4.01. Method of Giving Notice. Any notice to directors or shareholders shall be in writing and shall be delivered personally or mailed to the directors or shareholders at their respective addresses appearing on the books of the corporation. Notice by mail shall be deposited in the United States mail, postage prepaid.

4.02. Waiver of Notice. Any notice required to be given may be subject to a waiver thereof in writing signed by the person or persons entitled to receive such notice, whether before or after the time stated therein, and such waiver shall be deemed equivalent to the giving of such notice in a timely manner. Any such signed waiver of notice, or a signed copy thereof, shall be placed in the minute book of the corporation. Attendance of such persons at any meeting shall constitute a waiver of notice of such meetings, except where the persons attend for the express purpose of objecting that the meeting is not lawfully convened.

4.03. Telephone Meetings. Subject to the requirements of the Pennsylvania Business Corporation Law, as amended, or these Bylaws for notice of meetings, shareholders, members of the Board of Directors, or members of any committee designated by such Board of Directors, may participate in and hold a meeting of such shareholders, Board of Directors, or committee by means of a conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and participation in a meeting pursuant to this Section 4.03 shall constitute presence in person at such meeting.

ARTICLE V - OFFICERS

5.01. Qualifications. The officers of the corporation need not be shareholders of the corporation or residents of the Commonwealth of Pennsylvania. The Board of Directors shall elect a President, one or more Vice Presidents, a Treasurer and a Secretary and such other officers, including a Chairman of the Board of Directors, Chief Executive Officer and assistant officers as the Board of Directors may deem desirable to have to conduct the affairs of the corporation. Any two (2) or more offices may be held by the same person, except that the offices of President and Secretary may not be held by the same person.

5.02. Compensation of Officers. The salaries of all officers of the corporation shall be fixed by the Board of Directors. The Board of Directors shall have the power to enter into contracts for the employment and compensation of officers on such terms as the Board of Directors deems advisable. No officer shall be disqualified from receiving a salary or other compensation by reason of the fact that he is also a director of the corporation.

5.03. Term and Vacancies. The officers of the corporation shall hold office until their successors are elected or appointed and qualified, or until their death, resignation, or removal from office. Any vacancy occurring in any office of the corporation by death, resignation, removal, or otherwise, may be filled by the Board of Directors.

5.04. Removal of Officers. Any officer elected or appointed by the Board of Directors may be removed at any time by the Board of Directors.

5.05. General Authority of Officers. The Board of Directors, except as otherwise provided in these Bylaws, may authorize any officer to enter into any contract or execute and deliver any instrument in the name of and on behalf of the corporation, and such authority may be general or confined to specific instances. Unless so authorized, no officer, agent or employee shall have any power or authority to bind the corporation by any contract or engagement or to pledge its credit or to render it liable pecuniarily for any purpose or in any amount.

5.06. Duties of Chief Executive Officer. The Chief Executive Officer shall have general and active management and control of the business and affairs of the corporation, and shall see that all orders and resolutions of the Board of Directors are carried into effect. The Chief Executive Officer shall call regular and special meetings of the shareholders and directors in accordance with law and these Bylaws and, in the absence of the Chairman of the Board, shall preside at such meetings. The Chief Executive Officer shall appoint, discharge and fix the compensation of officers, agents and employees other than those appointed by the Board of Directors. The Chief Executive Officer shall perform such other duties as may be prescribed from time to time by the Board of Directors and shall ensure that the Board of Directors receives such information from the other officers and management of the corporation as the Board of Directors shall deem necessary.

5.07. Duties of President. The President unless otherwise determined by the Board of Directors, shall, in the absence or disability of the Chief Executive Officer, perform the duties and have the authority and exercise the powers of the Chief Executive

Officer. The President shall perform such other duties and have such other authority and powers as the Board of Directors may from time to time prescribe.

5.08. Duties of Vice Presidents. The Vice Presidents, in the order of their seniority, unless otherwise determined by the Board of Directors, shall, in the absence or disability of the Chief Executive Officer and the President, perform the duties and have the authority and exercise the powers of the Chief Executive Officer. They shall perform such other duties and have such other authority and powers as the Board of Directors may from time to time prescribe, or as the Chief Executive Officer may from time to time delegate.

5.09. Duties of Secretary. The Secretary shall attend all meetings of the Board of Directors and of the shareholders and record all business transacted at such meetings in a minute book to be kept for that purpose and shall perform like duties for the standing committees when required. The Secretary shall give, or cause to be given, notice of all meetings of the shareholders and special meetings of the Board of Directors, and shall perform such other duties as may be prescribed by the Board of Directors, or Chief Executive Officer, under whose supervision the Secretary shall be. The Secretary shall take and keep custody of the seal of the corporation and, when authorized by the Board of Directors, shall affix the same to any instrument requiring it and, when so affixed, it shall be attested by the signature of the Secretary or by the signature of an assistant Secretary or of the Treasurer.

5.10. Duties of Assistant Secretaries. The assistant secretaries, in the order of their seniority, unless otherwise determined by the Board of Directors, shall, in the absence or disability of the Secretary, perform the duties and have the authority and exercise the powers of the Secretary. They shall perform such other duties and have such powers as the Board of Directors may from time to time prescribe or as the Chief Executive Officer or Secretary from time to time may delegate.

5.11. Duties of Treasurer. The Treasurer shall have the custody of the corporation's funds and securities, shall keep full and accurate accounts and records of receipts, disbursements and other transactions in books belonging to the corporation and shall deposit all funds and other valuable effects in the name and to the credit of the corporation in such depositories as may be designated by the Board of Directors. The Treasurer shall disburse funds of the corporation as may be ordered by the Board of Directors, taking proper vouchers for such disbursements, and shall render to the Chief Executive Officer and the Board of Directors at the regular meetings of the Board, or whenever they may require it, an account of all the Treasurer's transactions as Treasurer and of the financial condition of the corporation. The Treasurer shall perform such other duties and have such other authority as the Board of Directors may from time to time prescribe, or as the Chief Executive Officer may from time to time delegate.

5.12. Duties of Assistant Treasurers. The assistant treasurers, in the order of their seniority, unless otherwise determined by the Board of Directors, shall, in the absence or disability of the Treasurer, perform the duties and have the authority and exercise the powers of the Treasurer. They shall perform such other duties and have such other powers as the Board of Directors may from time to time prescribe or as the Chief Executive Officer or Treasurer may from time to time delegate.

5.13. Execution of Instruments. All documents, instruments or writings of any nature shall be signed, executed, verified, acknowledged and delivered by such

officer or officers or such agent or agents of the corporation and in such manner as the Board of Directors from time to time may determine. All notes, drafts, acceptances, checks, endorsements, and all evidences of indebtedness of the corporation whatsoever, shall be signed by such officer or officers or such agent or agents of the corporation and in such manner as the Board of Directors from time to time may determine. Endorsements for deposit to the credit of the corporation in any of its duly authorized depositories shall be made in such manner as the Board of Directors may from time to time determine.

#### ARTICLE VI - CERTIFICATES AND SHAREHOLDERS

6.01. Forms of Certificates. Certificates shall be delivered representing all shares of stock in the corporation to which shareholders are entitled. Certificates for shares of the stock of the corporation shall be in such form as shall be required by law and as shall be approved by the Board of Directors. Every certificate for shares issued by the corporation must be signed by the Chief Executive Officer, the President, or a Vice President, and the Secretary, or an assistant Secretary. Such certificates shall bear a legend or legends in the form and containing the restrictions required to be stated thereon by the Pennsylvania Business Corporation Law, other provisions of law, the Articles of Incorporation or these Bylaws. Certificates shall be consecutively numbered and shall be entered into the books of the corporation as they are issued. Each certificate shall state on the face thereof the holder's name, the number and class of shares, the par value of such shares, and other such matters as may be required by law, the Articles of Incorporation or these Bylaws.

6.02. Transfer of Shares. Shares of stock shall be transferable only on the books of the Corporation by the holder thereof in person or by such holder's duly authorized attorney. Upon surrender to the corporation or its transfer agent of a certificate representing shares properly endorsed or accompanied by proper evidence of succession, assignment or authority to transfer, the corporation or its transfer agent shall issue a new certificate to the person entitled thereto, cancel the old certificate and record the transaction upon its books.

6.03. Record Ownership Conclusive. The corporation shall be entitled to treat the holder of record of any share or shares of stock in the corporation as the holder in fact thereof and, accordingly, shall not be bound to recognize any equitable or other claim to or interest in such share or shares on the part of any person, whether or not it has express or other notice thereof, except as otherwise provided by law or by any stock purchase and redemption agreement to which the stock may be subject, if such agreement has been formally executed or accepted by the corporation.

#### ARTICLE VII - OTHER PROVISIONS

7.01. Dividends. Dividends may be declared by the Board of Directors at any regular or special meeting and may be paid in cash, in property, or in shares of capital stock of the corporation, subject to the provisions of the Articles of Incorporation and to the laws of the Commonwealth of Pennsylvania. The declaration and payment of dividends shall be at the discretion of the Board of Directors.

7.02. Records. The corporation shall keep correct and complete books and records of account and shall keep minutes of the proceedings of its shareholders and Board of Directors, and shall keep at its registered office or principal place of business, or at the office of its transfer agent or registrar, a record of its shareholders, giving the names and addresses of all shareholders and the number and class of the shares held by each.

7.03. Fiscal Year. The fiscal year of the corporation shall be fixed by resolution of the Board of Directors.

7.04. Seal. The corporation's seal shall be in such form as may be prescribed by the Board of Directors. The seal may be used by causing it or a facsimile thereof to be impressed or affixed or in any manner reproduced.

7.05. Indemnification for Directors, Officers, and Employees. The Board of Directors may, and to the extent required by law shall, authorize the corporation to pay expenses incurred by, or to satisfy a judgment or fine rendered or levied against present or former directors, officers, or employees of this corporation as provided by the Pennsylvania Business Corporation Law, as amended.

#### ARTICLE VIII - AMENDMENT AND CONSTRUCTION

8.01. Amendment. The power to alter, amend, or repeal the Bylaws or adopt new Bylaws shall be vested in the Directors.

AMENDMENT NO. 1 TO THE BY-LAWS OF

HEALTHAMERICA PENNSYLVANIA, INC.

1. The first sentence of Section 2.02 of Article II is deleted and the following sentence is inserted in its place:

"Annual meeting of the shareholders shall be held on the first Wednesday of December of each year."

2. The second sentence of Section 3.10 of Article III is deleted and the following sentence is inserted in its place:

"The first meeting of each newly elected Board of Directors shall be held, without call or notice, immediately following and at the same place as the annual meeting of Shareholders."

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AMENDMENT NO. 2 TO THE BY-LAWS OF  
HEALTHAMERICA PENNSYLVANIA, INC.

Section 3.17 of Article III is deleted in its entirety and the following section is inserted in its place:

"13. Compensation of Outside Directors. By resolution of the Board of Directors, the Outside Directors, as defined below, may be paid their expenses, if any, for attending each meeting of the Board of Directors and may be paid either a fixed sum for attending each meeting or a stated salary for serving as an Outside Director. Outside Directors who are members of the executive committee or of special or standing committees of the Board may, by resolution of the Board of Directors, be allowed like compensation for attending committee meetings. "Outside Directors" means a person who is a member of the Board of Directors who is not an officer or employee of (i) the Company, (ii) any shareholder of the Company, or (iii) any Company controlling, controlled by or under common control with the Company or any such shareholder."

The first sentence of Section 2.02 of Article II is deleted and the following sentence is inserted in its place:

"2.02. Annual Meetings. Annual meeting of the shareholders shall be held during the first quarter of each year on a date designated by the Chairman of the Board of Directors of the Corporation."

and that all other provisions of the Bylaws of the Corporation remain in full force and effect.

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*Trademark Sublicense Agreement Between  
Penn Group Corporation,  
Coventry Corporation and HealthAmerica  
Pennsylvania, Inc.*

CONFIDENTIAL

TRADEMARK SUBLICENSE AGREEMENT

This Agreement effective the thirty-first day of December, 1992, by and between PENN GROUP CORPORATION, a Delaware corporation (hereinafter called "Sublicensor") and a subsidiary of COVENTRY CORPORATION (hereinafter called "Coventry"), and HEALTHAMERICA PENNSYLVANIA, INC., a Pennsylvania corporation and a subsidiary of Coventry (hereinafter called "Sublicensee").

WITNESSETH:

WHEREAS, Sublicensor, Sublicensee, Maxicare Health Plans, Inc. ("MHP"), and Coventry, are parties to a License Agreement of even date as clarified by Amendment No. 1 dated January 1, 1993 (the "License Agreement"), a copy of which is attached hereto and marked "Exhibit A," under which MHP grants to Coventry an exclusive license (the "License"), to use the service mark "HEALTHAMERICA" (the "Mark"), under certain conditions set forth in the License Agreement; and

WHEREAS, Coventry has the right under the License Agreement to grant sublicenses to sublicensees under the License to its subsidiaries and affiliates, and such sublicensees have the further right to grant sublicenses to subsidiaries or affiliates of Coventry; and

*[Handwritten mark]*

WHEREAS, Coventry has granted a sublicense to Sublicensor to use the Mark under certain conditions set forth in a Trademark Sublicense Agreement of even date (the "Coventry Sublicense"), a copy of which is attached hereto and marked "Exhibit C;" and

WHEREAS, Sublicensor wishes to grant to Sublicensee, and Sublicensee wishes to acquire from Sublicensor, a sublicense, under the License and the Coventry Sublicense, to use the Mark.

NOW, THEREFORE, in consideration of the premises and mutual covenants, and intending to be legally bound hereby, the parties agree as follows:

1. Grant of License

Sublicensor grants to Sublicensee a sublicense, under the Coventry Sublicense, to use the Mark, along with the goodwill of Sublicensor associated therewith, said sublicense to be geographically limited to the Commonwealth of Pennsylvania only, in connection with providing, managing, or administering health care services, and Sublicensee accepts the limited sublicense granted herein subject to the following terms and conditions. Sublicensee shall have the right further to sublicense the Mark for use only by subsidiaries and affiliates of Sublicensor in accordance with the terms of this Agreement.

2. Payment for License

As consideration for the sublicense granted hereunder, Sublicensee shall pay to Sublicensor (i) upon execution of this Agreement a one-time fee of ten million, forty one thousand (\$ 10,041,000.00) Dollars, and (ii) during each month during the term of this Agreement a sum equal to a fixed percentage of the gross premium revenue generated by Sublicensee during the month. Gross premium revenue shall be calculated in the same manner as it is calculated for reporting in Sublicensee's Annual Statement as filed with the Office of Prepaid Health Care of the Commonwealth of Pennsylvania (the "Annual Statement"). The percentage for 1993 shall be 5%. The percentage shall be negotiated by Sublicensor and Sublicensee for each succeeding year. In the event that the cumulative payments made by Sublicensee to Sublicensor during a year would cause the statutory net income of Sublicensee, as reported in the Annual Statement, to fall below 1% of its gross premium revenue at the end of the year, the total payment due Sublicensor for the year shall be adjusted to cause Sublicensee's statutory net income to be 1% of its gross premium revenue for that year. If Sublicensee's payments to Sublicensor during the year exceed the adjusted total payment, Sublicensor shall credit the excess against royalties due for the following year.

CONFIDENTIAL

3. Quality Standards

The parties hereby agree that so long as Sublicensee is in good standing with and maintains its licensure as a manager, administrator or provider of health care services with the Departments of Insurance and/or Health which regulate such entities, Sublicensee shall be presumed to be in compliance with the quality standards set by Sublicensor.

4. Quality Maintenance

Sublicensee agrees to cooperate with Sublicensor in facilitating Sublicensor's control of such standards to permit reasonable inspection of the operation of Sublicensee pursuant to this Agreement upon 48 hours prior written notice, and to supply Sublicensor with specimens of use of the Mark upon request. Sublicensee shall comply with all applicable laws and regulations and obtain all appropriate government approvals pertaining to the sale, distribution and advertising of services covered by this Agreement.

5. Infringement Proceedings

Sublicensee agrees to notify Sublicensor of any unauthorized use of the Mark by others promptly as it comes to Sublicensee's attention. Sublicensee shall have no right to

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11. Severability

In the event that any provision(s) of this Agreement is held invalid or unenforceable for any reason by a Court of competent jurisdiction, such provision(s) or part thereof shall be considered separate from the remaining provision(s) of this Agreement, which shall remain in full force and effect.

12. Disclaimer of Agency

This Agreement shall not be deemed to create any relationship of agency, joint-venture or partnership between Sublicensor or Sublicensee.

13. Entire Agreement

This Agreement constitutes the entire agreement between the parties relating to the subject matter hereof. There are no understandings, representations or warranties of any kind except as expressly set forth herein. No amendment to this Agreement shall be valid, unless in writing and signed by the parties thereto.

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CONFIDENTIAL

14. Counterparts

This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which shall constitute together one and the same agreement.

15. Board Approval

This Agreement shall become effective upon approval or ratification by the Board of Directors of Sublicensee.

IN WITNESS WHEREOF, the parties hereto, intending to be legally bound, have caused this Agreement to be executed as of the day and year first above written.

PENN GROUP CORPORATION  
a Delaware corporation

HEALTHAMERICA PENNSYLVANIA, INC.  
a Pennsylvania corporation

By: Richard H. Jones

By: Richard P. Horn

Print Name: Richard H. Jones

Print Name: Richard P. Horn



12/15/10

Tim G.

*State Approval for Business Name*

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8889 623  
Commonwealth of Pennsylvania



Department of State

To All to Whom These Presents Shall Come, Greeting:

WHEREAS, In and by Article VIII of the Business Corporation Law, approved the fifth day of May, Anno Domini one thousand nine hundred and thirty-three, P. L. 364, as amended, the Department of State is authorized and required to issue a

CERTIFICATE OF AMENDMENT

evidencing the amendment of the Articles of Incorporation of a business corporation organized under or subject to the provisions of that Law, and

WHEREAS, The stipulations and conditions of that Law pertaining to the amendment of Articles of Incorporation have been fully complied with by

MAXICARE/HEALTHAMERICA PENNSYLVANIA, INC.  
name changed to  
HEALTHAMERICA PENNSYLVANIA, INC.

Therefore, Know Ye, That subject to the Constitution of this Commonwealth and under the authority of the Business Corporation Law, I do by these presents, which I have caused to be sealed with the Great Seal of the Commonwealth, extend the rights and powers of the corporation named above, in accordance with the terms and provisions of the Articles of Amendment presented by it to the Department of State, with full power and authority to use and enjoy such rights and powers, subject to all the provisions and restrictions of the Business Corporation Law and all other applicable laws of this Commonwealth.

Given under my Hand and the Great Seal of the Commonwealth, at the City of Harrisburg, this 21st day of November in the year of our Lord one thousand nine hundred and eighty-eight and of the Commonwealth the two hundred thirteenth.

Handwritten signature of James J. Hoyt in cursive script.

Secretary of the Commonwealth



## ARTICLES OF AMENDMENT

MAXICARE/HEALTHAMERICA PENNSYLVANIA, INC.

Filed in the Department of State of  
 the State of Pennsylvania 1988  
 \_\_\_\_\_  
 Secretary of the Commonwealth

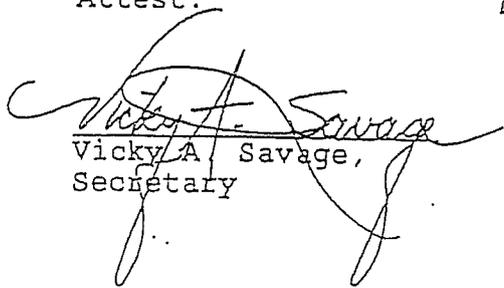
In compliance with the requirements of section 806 of the Business Corporation Law, act of May 5, 1933 (P.L. 364. S. §1806), the undersigned corporation, desiring to amend its Articles, does hereby certify that:

1. The name of the corporation is Maxicare/HealthAmerica Pennsylvania, Inc.
2. The location of its registered office in this Commonwealth is (the Department of State is hereby authorized to correct the following statement to conform to the records of the Department) CT Corporation System, Oliver Bldg., Mellon Square, Pittsburgh, Pennsylvania 15022.
3. The statute by or under which it was incorporated is the Pennsylvania Business Corporation Law, Act of May 5, 1933 (P.L. 364).
4. The date of its incorporation is June 11, 1984.
5. The amendment was adopted by a consent in writing, setting forth the action so taken, signed by all of the shareholders entitled to vote thereon and filed with the Secretary of the corporation.
6. At the time of the action of shareholders, the total number of shares outstanding was five, and the number of shares entitled to vote was five.
7. In the action taken by the shareholders, the number of shares voted in favor of the amendment was five. No shares were voted against the amendment.
8. The amendment adopted by the shareholders, set forth in full, is as follows:
  - (1) The Name of the Corporation is:  
 HealthAmerica Pennsylvania, Inc.

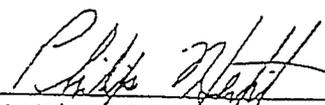
IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer and its corporate seal, duly attested by another such officer, to be hereunto affixed this 19th day of October, 1988.

Attest:

Maxicare/HealthAmerica Pennsylvania, Inc.

  
Vicky A. Savage,  
Secretary

(Corporate Seal)

By:   
Title: Vice President

CONSENT TO USE OF SIMILAR NAME

768218

Pursuant to Section 202 of the Pennsylvania Business Corporation Law (relating to the use of a similar name) the undersigned corporation, desiring to consent to the use by another corporation of a name which is similar to its name, does hereby certify that:

1. The name of the corporation executing this Consent to Use of Similar Name is HealthAmerica Corporation of Harrisburg (the "Corporation").

2. The address of the registered office of the Corporation is (the Department of State is hereby authorized to correct the following statement to conform to the record of Department) 123 South Broad Street, Philadelphia, Pennsylvania 19109.

3. The date of its incorporation is September 12, 1983.

4. The statute under which it is incorporated is the Pennsylvania Business Corporation Law.

5. The corporation entitled to the benefit of this Consent of Use of Similar Name is HealthAmerica Pennsylvania, Inc.

IN TESTIMONY WHEREOF, the undersigned corporation has caused this Consent to be signed and attested by duly authorized officers this 16th day of November, 1988.

HEALTHAMERICA CORPORATION  
OF HARRISBURG

By: Alvin B.  
Secretary

ATTEST:

HEALTHAMERICA CORPORATION  
OF HARRISBURG

By: [Signature]  
Assistant Secretary

*Articles of Incorporation and Amendments*

10

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF STATE

CORPORATION BUREAU

ARTICLES OF INCORPORATION

In compliance with the Nonprofit Corporation Law of 1972, approved November 15, 1972, Act No. 271, the undersigned, all of whom are of full age, desiring to form a nonprofit corporation, do hereby certify as follows:

ARTICLE I

Name of Corporation

The name of the corporation is PENN GROUP HEALTH PLAN, INC.

ARTICLE II

Address

The location and post office address of the initial registered office of the corporation shall be Penn Group Health Plan, Inc., IBM Building, Pittsburgh, Pennsylvania 15222.

ARTICLE III

Purposes

The corporation is organized exclusively for charitable, educational and scientific purposes as defined and limited by Section 501(c)(3) of the Internal Revenue Code of 1954 (or the corresponding

provision of any future United States Internal Revenue Law), including the following purposes: To maintain and operate a prepaid group health plan, as described in the Voluntary Nonprofit Health Service Act of 1972, approved December 29, 1972, Act No. 364; to solicit and enter into contracts with persons to become subscribers in a prepaid group health plan; to provide medical and hospital care to persons who become subscribers of such prepaid group health plan; to own and operate facilities in which such care is provided; to contract with and employ medical practitioners, hospitals and others for the provision of such care; to provide facilities for the conduct of medical research; to conduct programs of health education and preventive medicine; to provide other services to subscribers of a nature similar to the foregoing and not inconsistent with the other purposes stated herein.

No directors, officers or subscribers of the corporation shall receive any pecuniary gain or profit, incidental or otherwise, from its activities, except that the corporation shall be authorized to pay reasonable compensation for services rendered and to make payments in furtherance of the purposes set forth above in this Article III. No substantial part of the activities of the corporation shall be the carrying on of propoganda or otherwise attempting to influence legislation, and the corporation shall not participate in or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office. The corporation shall not carry on any

activity not permitted to be carried on either by a corporation exempt from Federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law) or by a corporation contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law).

The corporation shall provide or arrange for the aforementioned services in the following counties of Pennsylvania: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington and Westmoreland.

#### ARTICLE IV

##### Nonprofit Nature

The corporation does not contemplate nor shall it receive pecuniary gain or profit, incidental or otherwise, to its officers, directors, or subscribers.

#### ARTICLE V

##### Term

The corporation is to have perpetual existence.

ARTICLE VI

Incorporators

The names and addresses of the incorporators and interim members of the board of directors (pending election of the board of directors) as prescribed by Section 7 of the aforementioned Voluntary Nonprofit Health Service Act of 1972) are as follows:

Kenneth J. Raynes  
97 Burdine Ave.  
Pittsburgh, Pa. 15227

Saul F. Shapira  
5533 Aylesboro Ave.  
Pittsburgh, Pa. 15217

William B. Miklos  
100 Wallace Circle  
Aliquippa, Pa. 15001

Eli S. Egert  
5435 Claybourne St.  
Pittsburgh, Pa. 15232

ARTICLE VII

No stock

The corporation is organized on a nonstock basis.

ARTICLE VIII

Dissolution

At such time as the corporation may be dissolved, the assets of the corporation shall be distributed and applied with the primary goal of providing a continuation of services to subscribers of the nature described in their contracts with the corporation. In the event of dissolution the board of directors shall, after



Articles approved on the            day of            , A.D. 1973.

\_\_\_\_\_  
Secretary of Health

Articles approved on the            day of            , A.D. 1973.

\_\_\_\_\_  
Secretary of the Commonwealth

SECRET

(

8358 312  
719602  
Commonwealth of Pennsylvania



Department of State

To All to Whom These Presents Shall Come, Greeting:

Whereas, In and by Article VIII of the Business Corporation Law, approved the fifth day of May, Anno Domini one thousand nine hundred and thirty-three, P. L. 364, as amended, the Department of State is authorized and required to issue a

CERTIFICATE OF AMENDMENT

evidencing the amendment of the Articles of Incorporation of a business corporation organized under or subject to the provisions of that Law, and

Whereas, The stipulations and conditions of that Law pertaining to the amendment of Articles of Incorporation have been fully complied with by

HEALTHPLANS MANAGEMENT CORPORATION OF PENNSYLVANIA

name changed to

HEALTHAMERICA MANAGEMENT CORPORATION OF PENNSYLVANIA

Therefore, Know Ye, That subject to the Constitution of this Commonwealth and under the authority of the Business Corporation Law, I do by these presents, which I have caused to be sealed with the Great Seal of the Commonwealth, extend the rights and powers of the corporation named above, in accordance with the terms and provisions of the Articles of Amendment presented by it to the Department of State, with full power and authority to use and enjoy such rights and powers, subject to all the provisions and restrictions of the Business Corporation Law and all other applicable laws of this Commonwealth.

Given under my Hand and the Great Seal of the Commonwealth, at the City of Harrisburg, this 27th day of September in the year of our Lord one thousand nine hundred and eighty-three and of the Commonwealth the two hundred and eighth.

*William L. Davis*

Secretary of the Commonwealth

8358 311

Filed this 27th day of September, 1983  
Commonwealth of Pennsylvania  
Department of State

*William L. Davis*

Secretary of the Commonwealth

719602

pjd

ARTICLES OF AMENDMENT

FOR

HEALTHPLANS MANAGEMENT CORPORATION OF PENNSYLVANIA

In compliance with the requirements of section 806 of the Business Corporation Law act of May 5, 1933 (P.L. 364)(15P.S. 1806) the undersigned corporation, desiring to amend its Articles, does hereby certify that:

1. The name of the registered office is C T Corporation System and its address is Oliver Building, Mellon Square, Pittsburgh, Pennsylvania 15222.

2. The Corporation was incorporated under the Pennsylvania Business Corporation law, as amended, on November 24, 1980.

3. The amendment to the Articles of Incorporation was adopted by means of a written Consent of Sole Shareholder dated September 1, 1983.

4. The Corporation has five shares of common stock outstanding. Five shares voted in favor of the amendment and zero shares voted against the amendment.

5. The amendment to the Articles of Incorporation as adopted by the shareholder is as follows:

(1) The name of the corporation is:

HealthAmerica Management Corporation of Pennsylvania

IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer and its corporate seal, duly attested by another such officer, to be hereunto affixed, this 15<sup>th</sup> day of September, 1983.

HEALTHPLANS MANAGEMENT CORPORATION  
OF PENNSYLVANIA

*Philip N. Bredesen*

Philip N. Bredesen  
President

ATTEST:

*Roger W. Legare*  
\_\_\_\_\_  
Roger W. Legare  
Secretary

CORPORATE SEAL

①

84391479  
70791  
Commonwealth of Pennsylvania



Department of State

To All to Whom These Presents Shall Come, Greeting:

Whereas, Under the terms of the Business Corporation Law, approved May 5, 1933, P. L. 364, as amended, the Department of State is authorized and required to issue a

CERTIFICATE OF MERGER

evidencing the merger of one or more corporations into one of such corporations under the provisions of that law; and

Whereas, The stipulations and conditions of that law relating to the merger of such corporations have been fully complied with by HEALTHAMERICA MANAGEMENT CORPORATION OF PENNSYLVANIA and PENN GROUP HEALTH PLAN, INC.

Therefore, Know Ye, That subject to the Constitution of this Commonwealth and under the authority of the Business Corporation Law, approved May 5, 1933, P. L. 364, as amended, I DO BY THESE PRESENTS, which I have caused to be sealed with the Great Seal of the Commonwealth, merge the above named HEALTHAMERICA MANAGEMENT CORPORATION OF PENNSYLVANIA into and with PENN GROUP HEALTH PLAN, INC., the surviving corporation,

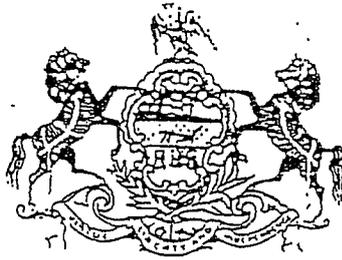
which shall continue to be invested with and have and enjoy all the powers, privileges and franchises incident to a domestic business corporation, and be subject to all the duties, requirements and restrictions specified and enjoined in and by the Business Corporation Law and all other applicable laws of this Commonwealth.

Given under my Hand and the Great Seal of the Commonwealth, at the City of Harrisburg, this 14th day of June in the year of our Lord one thousand nine hundred and eighty-four and of the Commonwealth the two hundred and eighth.

*William L. Davis*

Secretary of the Commonwealth

# Commonwealth of Pennsylvania



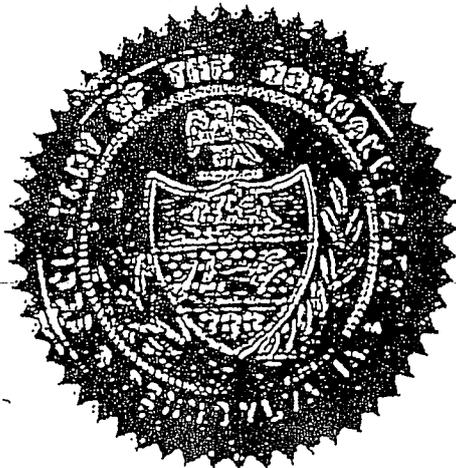
August 9, 1984

To All to Whom These Presents Shall Come: Greeting:

IN RE: "PENN GROUP HEALTH PLAN, INC."

I, WILLIAM R. DAVIS, Secretary of the Commonwealth of the Commonwealth of Pennsylvania do hereby certify that the foregoing and annexed is a true and correct photocopy of Articles of Conversion and all Amendments and Certificate

which appear of record in this Department.



IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the seal of the Secretary's Office to be affixed, the day and year above written.

*William R. Davis*  
Secretary of the Commonwealth

APPLICANT'S ACCT. NO. 84381749

FORM 104 11th May of  
 June 14 84  
 COMMONWEALTH OF PENNSYLVANIA  
 DEPARTMENT OF STATE  
*William C. Davis*  
 SECRETARY OF THE COMMONWEALTH

DSCB 15-7953 (Rev. 11-72)

269781

(LINE FOR NUMBERING)

Filing Fee \$75  
CDB-71

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
CORPORATION BUREAU

Article of Conversion  
Business and  
Nonprofit Corporations

(BOX FOR CERTIFICATION) vod

In compliance with the requirements of 15 Pa. S. §7953 (relating to articles of conversion) the undersigned domestic corporation, desiring to effect a conversion, does hereby certify:

1. The name of the converting corporation is:

Penn Group Health Plan, Inc.

2. The address of its registered office in this Commonwealth is (the Department of State is hereby authorized to correct the following statement to conform to the records of the Department):

Five Gateway Center, Sixth Floor, 60 Boulevard of the Allies

Pittsburgh

Pennsylvania

15222

3. The statute by or under which it was incorporated is:

Nonprofit Corporation Law of 1972, approved November 15, 1972, Act No. 271

4. The date of its incorporation is: April 9, 1974

5. (Check, and if appropriate, complete one of the following):

- The plan of conversion shall be effective upon filing these Articles of Conversion in the Department of State ~~or upon the approval of the Conversion by the Pennsylvania Departments of Health and Insurance whichever is the later date.~~
- The plan of conversion shall be effective on \_\_\_\_\_ at \_\_\_\_\_

6. (Check one of the following):

- The plan of conversion was adopted by the members of a nonprofit corporation pursuant to 15 Pa. S. §§7924(a) and 7952(b).
- The plan of conversion was adopted by the board of directors of a nonprofit corporation pursuant to 15 Pa. S. §§7924(b) and 7952(b).
- The plan of conversion was adopted by the shareholders of a business corporation pursuant to Article IX of the Business Corporation Law and 15 Pa. S. §7952(b) and (c).

7. The plan of conversion is set forth in Exhibit A attached hereto and made a part hereof.

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DSCG 15-1953 (Rev. 11-77)-2

IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Conversion to be signed by a duly authorized officer and its corporate seal, duly attested by another such officer, to be hereunto affixed this 23RD day of MAY, 1984.

PENN GROUP HEALTH PLAN, INC.

(NAME OF CORPORATION)

By:

James Puglisi  
(SIGNATURE)

CHAIRMAN

(OFFICE PRESIDENT VICE PRESIDENT, ETC.)

Attest:

Ruth Dexter  
(SIGNATURE)

SECRETARY

(TITLE SECRETARY ASSISTANT SECRETARY, ETC.)

(CORPORATE SEAL)

INSTRUCTIONS FOR COMPLETION OF FORM.

Any necessary governmental approvals shall accompany this form.

If the action of a nonprofit corporation was authorized by a body other than the board of directors or members Paragraph 6 should be modified accordingly.

①

84381751

PLAN OF CONVERSION  
OF  
PENN GROUP HEALTH PLAN, INC.

Pursuant to the provisions of Sections 7951 through 7956 of the Pennsylvania Nonprofit Corporation Law of 1972, the Plan of Conversion shall be as follows:

FIRST: The Conversion shall become effective at 5:00 p.m., prevailing time, upon the date of the later (a) the filing of Articles of Conversion in the Department of State of the Commonwealth of Pennsylvania, or (b) the approval of the Conversion by the Pennsylvania Departments of Health and Insurance (herein called the "Effective Date").

SECOND: On the Effective Date, Penn Group Health Plan, Inc. shall cease operating as a Nonprofit Corporation in accordance with the Pennsylvania Nonprofit Corporation Law, and thereafter shall operate as a Pennsylvania Business Corporation in accordance with the Pennsylvania Business Corporation Law of 1933.

THIRD: On and following the Effective Date, Penn Group Health Plan, Inc. shall remain liable for all existing obligations, public and private, taxes due the Commonwealth or any other taxing authority for periods prior to the effective date of the conversion, and, as such business corporation, it shall continue to be entitled to all assets theretofore pertaining to it as a nonprofit corporation.

FOURTH: On the Effective Date, HealthAmerica Corporation, a Delaware corporation, shall be entitled to all the shares in Penn Group Health Plan, Inc., and the proper officers of Penn Group Health Plan, Inc. shall be authorized, upon payment by HealthAmerica Corporation of a sum equal to \$1.00 for each share desired to be purchased, to issue and deliver to HealthAmerica Corporation, a share certificate evidencing the number of shares purchased.

FIFTH: The Articles of Incorporation of Penn Group Health Plan, Inc. shall be amended and restated to read as follows:

1. The name of the Corporation is Penn Group Health Plan, Inc.
2. The location and post office address of the registered office of the Corporation in this Commonwealth is Five Gateway Center, Sixth Floor, 60 Boulevard of the Allies, Pittsburgh, Pennsylvania 15222.

94391752

3. The Corporation is incorporated under the Pennsylvania Business Corporation Law, Act of May 5, 1933, P.L. 364 (15 P.S. 1001, et seq.), and shall have unlimited power to engage in any lawful activity for which a business corporation may be incorporated under this Act. Such purposes shall include, but not be limited to, the following:
- (a) to maintain and operate a health maintenance organization;
  - (b) to solicit and enter into contracts with persons who become subscribers in such health maintenance organization;
  - (c) to provide medical and hospital care to persons who become subscribers in such health maintenance organization;
  - (d) to own and operate facilities in which such care is provided;
  - (e) to contract with and employ medical practitioners, hospitals and others for the provision of such care;
  - (f) to provide facilities for the conduct of medical research;
  - (g) to conduct programs of health education and preventive medicine;
  - (h) to provide other services to subscribers of a nature similar to the foregoing and not inconsistent with the other purposes stated herein.
4. The term for which the corporation is to exist is perpetual.
5. The aggregate number of shares which the corporation shall have authority to issue is five (5) shares of common stock of the par value of \$1.00 per share."

SIXTH: The Board of Directors of Penn Group Health Plan, Inc. on and following the Effective Date shall be the same as the Board of Directors immediately prior to the Effective Date.

SEVENTH: The officers of Penn Group Health Plan, Inc. on and following the Effective Date shall be those same persons who served as officers immediately prior to the Effective Date.

WITNESS the due execution hereof this Monday of May, 1984.

ATTEST:

PENN GROUP HEALTH PLAN, INC.

Robert D. ...

By William P. Zimmerman

Corporate Seal



## ATTACHMENT J

### OWNERSHIP STRUCTURE AND RELATED INFORMATION

The Offeror must include, at a minimum, the following:

1. Narrative explanation of its ownership structure.

*An explanation of ownership is available in **Attachment 22**, Form 10-K for Coventry Health Care, Inc. for the year ended 12/31/2010. The information begins on page 4 under Item 1: Business, General. A Coventry Health Care, Inc. organizational chart is available in **Attachment 23**, the 2011 3rd quarter Statutory filing starting on page 15.*

2. A description of any anticipated merger and the impact on ownership structure.

*At this time, there is no anticipated merger.*

3. A copy of any executed merger agreement.

*Not Applicable.*

4. A copy of the Articles of Incorporation.

*Refer to **Attachment 3***

5. All related organizational documents.

*Refer to **Attachment 5** for the listing of the Board of Directors and to **Attachment 19**, Form B filing.*

6. A copy of any guaranty agreement.

*Not Applicable.*

7. Copy of contractual or other arrangements with any affiliate (including Parent or other affiliates) to which Offeror is bound and/or which imposes fees on Offeror to affiliate.

*Refer to **Attachment 19**, Form B filing.*

8. Breakdown of financial statement amounts due to and from Offeror's affiliates.

*Refer to **Attachment 23**, the 2011 3<sup>rd</sup> Quarter Statutory Filing Notes to Financial Statements on page 10.1.*

9. Copies and explanations of any payments made to Offeror's affiliates.

*Refer to **Attachment 19**, Form B filing.*

10. Narrative of any trust arrangement.

*Not Applicable*

11. Disclosure of prior suspensions or debarment by state or federal or any other government involving the proposer or any affiliate.

*Not Applicable*

12. Narrative on any pending lawsuits or investigations involving the Offeror or any affiliate.

*Refer to **Attachment 25**, Form 10-Q for Coventry Health Care, Inc. for the period ending 9/30/2011, starting on page 9 under the heading Legal Proceedings.*

13. Information which identifies any parent corporation ownerships and relationship status (direct or indirect).

*Refer to **Attachment 22**, Form 10-K for Coventry Health Care, Inc. for the year ended 12/31/2010. The information is on page 4 under Item 1: Business, General. Additional details are available in **Attachment 19**, Form B filing.*

14. Amounts on first quarter filing with the Department of Labor.

*Not Applicable.*

15. Information on intermediary subsidiary which hold Offeror's stock (indirect only).

*There is no intermediary subsidiary which holds Offeror's stock.*

16. Statement on whether any affiliates will be a subcontractor.

*HealthAmerica Pennsylvania, Inc. will utilize Coventry Health Care, Inc. as a subcontractor for certain services. Refer to **Attachment 19**, Form B filing.*

17. Identification of the affiliate(s) receiving management fees and copies of any such contractual arrangements.

*Refer to **Attachment 19**, Form B filing.*

## HEALTHAMERICA BOARD OF DIRECTORS

Timothy E. Nolan  
Robert Mathias, Ph.D.  
Douglas B. Templeton  
Ronald M. Robinson  
John Wallendjack, M.D.  
Frank E. Weaver

## HEALTHAMERICA OFFICERS

<u>Name</u>	<u>Title</u>
David W. Fields	President and Chief Executive Officer
Mary Lou Osborne	Executive Vice President- WPA
N. Timothy Guarneschelli	Vice President & Secretary
John Joseph Ruhlmann	Vice President, Finance
Shirley Ann Roquemore Smith	Assistant Secretary
Evelyn N. Pendleton	Treasurer & Chief Financial Officer
Michael L. Regis	Chief Actuary
Dane Kreiss	Corporate Controller
Melinda Lee Tuozzo	Assistant Treasurer

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**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

**TO BE COMPLETED BY THE OFFEROR**

**The Offeror must complete a separate APPENDIX G for each state where the Offeror has contracted with a state agency to provide managed care services since January 2006.**

**State:** Florida

**Name of Health Plan in This State\*:** Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc.

The name of the health plan as it appears on the contract with the state agency. If this is a different name than that being used by the Offeror for this Pennsylvania RFP, the Offeror must explain the corporate relationship between these two entities in the Additional Explanation section of this Appendix G. The Offeror must be able to document that both entities are under the control of the same corporate family.

**Name of Offeror:** HealthAmerica Pennsylvania, Inc. d.b.a CoventryCares

**Name of Individual Completing This Appendix G:**

Denise Gallagher

**Does the Offeror have experience since January 2006?** If the Offeror has experience since January 2006 where they were the primary party who contracted with a state agency to provide managed care services, then the Offeror is to check “Yes” and complete the remainder of this Appendix G. If the Offeror was not the primary contractor and/or the Offeror is unable to document that they were covered under the same corporate umbrella as the health plan for which they are claiming experience in this other state, the Offeror is to check “No” and is not to complete the remainder of this Appendix G.

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.	<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b> <i>Regular Medicaid: Sept 2006-Aug 2009; FL Healthy Kids and LTC: Oct. 2007-Sept 2008</i>	<b>CONTRACT YEAR 2008-2009</b> <i>Regular Medicaid: Sept 2006-Aug 2009; FL Healthy Kids and LTC: Oct. 2008-Sept 2009</i>	<b>CONTRACT YEAR 2009-2010</b> <i>Regular Medicaid: Sept. 2009-Aug 2012 FL Healthy Kids and LTC: Oct. 2009-Sept 2010</i>	
<b>PRIMARY CONTRACTOR</b>  Place an "x" in the box if the Offeror is/was the primary contractor. Primary Contractor is defined as there being a direct contractual relationship between the Offeror and the state agency, and the Offeror must be the party held accountable by the state agency for meeting the provisions of the contract.	YES <input type="checkbox"/>  NO <input checked="" type="checkbox"/>  <i>Coventry did not acquired the Florida health plans until Sept. 2007.</i>	YES <input checked="" type="checkbox"/>  NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/>  NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/>  NO <input type="checkbox"/>	
<b>POPULATION</b>  Place an "x" in this box for each population group included in the contract between the Offeror and the state agency. If the Offeror places an "x" next to "OTHER", the Offeror is to provide clarification under the Additional Explanation section of this Appendix G.  TANF = Temporary Aid to Needy Families  ABD = Aged, Blind and Disabled	TANF		X	X	X
	AGED, BLIND, DISABLED		X	X	X
	OTHER*		X	X	X

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.		<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
<b>SERVICES</b> Place an "x" in the one box that describes the services the Offeror was contracted to provide. "Full Benefits with Exceptions*" refers only to those situations where an entire component of the benefit package was excluded or carved out and provided entirely by another entity or not at all. So long as the Offeror was responsible for providing at least some coverage for a particular service, even if another entity provided a larger overall proportion of this coverage, this would fall under "Full Benefits" (e.g., the Offeror was only required to cover up to 30 days in a long term care facility for their members and any additionally needed long term care coverage was provided through the state's traditional Medicaid program). If the Offeror places an "x" next to any Services option marked with an asterisk, the Offeror is to provide clarification.	Full Medicaid Benefits				
	Full Medicaid Benefits with Exceptions*		X	X	X
	Behavioral Health Only				

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b>	<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.				

**Additional Explanation:**

If you checked any of the boxes under headings with an (\*), provide clarification below:

**Name of Health Plan:**

Beginning in September 2007, the entities now named Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc. are wholly-owned subsidiaries of Coventry Health Care, Inc. HealthAmerica Pennsylvania, Inc. d.b.a. CoventryCares is also a wholly-owned subsidiary of Coventry health care, Inc. Please refer to the attached Schedule Y documents from HealthAmerica Pennsylvania, Inc.'s financial Q3 2011 Quarterly Statement

**Population:**

The Florida health plans have contracts for the separate CHIP and Long Term Care programs.

**Services:**

For Medicaid, dental services and transportation services were optional services for health plans to cover during the specified time period. The Florida health plans opted not to cover those services; however, limited adult dental services (cleanings/fillings and/or extractions) were covered as "expanded services."

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

**TO BE COMPLETED BY THE OFFEROR**

**The Offeror must complete a separate APPENDIX G for each state where the Offeror has contracted with a state agency to provide managed care services since January 2006.**

**State:** Maryland

**Name of Health Plan in This State\*:** Coventry Health Care of Delaware, Inc.

The name of the health plan as it appears on the contract with the state agency. If this is a different name than that being used by the Offeror for this Pennsylvania RFP, the Offeror must explain the corporate relationship between these two entities in the Additional Explanation section of this Appendix G. The Offeror must be able to document that both entities are under the control of the same corporate family.

**Name of Offeror:** HealthAmerica Pennsylvania, Inc. d.b.a CoventryCares

**Name of Individual Completing This Appendix G:**

Denise Gallagher

**Does the Offeror have experience since January 2006?** If the Offeror has experience since January 2006 where they were the primary party who contracted with a state agency to provide managed care services, then the Offeror is to check “Yes” and complete the remainder of this Appendix G. If the Offeror was not the primary contractor and/or the Offeror is unable to document that they were covered under the same corporate umbrella as the health plan for which they are claiming experience in this other state, the Offeror is to check “No” and is not to complete the remainder of this Appendix G.

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.	<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>	
	Jan. 2006 - Dec. 2006	Jan. 2007 - Dec. 2007	Jan. 2008 - Dec. 2008	Jan. 2009 - Dec. 2009	
<b>PRIMARY CONTRACTOR</b>  Place an "x" in the box if the Offeror is/was the primary contractor. Primary Contractor is defined as there being a direct contractual relationship between the Offeror and the state agency, and the Offeror must be the party held accountable by the state agency for meeting the provisions of the contract.	YES <input checked="" type="checkbox"/>  NO <input type="checkbox"/>				
<b>POPULATION</b>  Place an "x" in this box for each population group included in the contract between the Offeror and the state agency. If the Offeror places an "x" next to "OTHER", the Offeror is to provide clarification under the Additional Explanation section of this Appendix G.  TANF = Temporary Aid to Needy Families  ABD = Aged, Blind and Disabled	TANF	X	X	X	X
	AGED, BLIND, DISABLED	X	X	X	X
	OTHER*	X	X	X	X

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.		<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
<p><b>SERVICES</b> Place an "x" in the one box that describes the services the Offeror was contracted to provide. "Full Benefits with Exceptions*" refers only to those situations where an entire component of the benefit package was excluded or carved out and provided entirely by another entity or not at all. So long as the Offeror was responsible for providing at least some coverage for a particular service, even if another entity provided a larger overall proportion of this coverage, this would fall under "Full Benefits" (e.g., the Offeror was only required to cover up to 30 days in a long term care facility for their members and any additionally needed long term care coverage was provided through the state's traditional Medicaid program). If the Offeror places an "x" next to any Services option marked with an asterisk, the Offeror is to provide clarification.</p>	Full Medicaid Benefits				
	Full Medicaid Benefits with Exceptions*	X	X	X	X
	Behavioral Health Only				

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.	<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
---	------------------------------------	------------------------------------	------------------------------------	------------------------------------

**Additional Explanation:**

If you checked any of the boxes under headings with an (\*), provide clarification below:

**Name of Health Plan:**

Coventry Health Care of Delaware, Inc. and HealthAmerica Pennsylvania, Inc. are both wholly-owned subsidiaries of Coventry Health Care, Inc. Please refer to the attached Schedule Y from HealthAmerica Pennsylvania, Inc.'s financial 2011 Q3 Quarterly Statement.

**Population:**

The other population is CHIP.

**Services:**

For the specified time periods, there were no major carve-out services. As of July 2009, dental services were carved out for all populations (previously, they were covered for children and pregnant women).

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

**TO BE COMPLETED BY THE OFFEROR**

**The Offeror must complete a separate APPENDIX G for each state where the Offeror has contracted with a state agency to provide managed care services since January 2006.**

**State:** Michigan

**Name of Health Plan in This State\*:** OmniCare Health Plan, Inc.

The name of the health plan as it appears on the contract with the state agency. If this is a different name than that being used by the Offeror for this Pennsylvania RFP, the Offeror must explain the corporate relationship between these two entities in the Additional Explanation section of this Appendix G. The Offeror must be able to document that both entities are under the control of the same corporate family.

**Name of Offeror:** HealthAmerica Pennsylvania, Inc. d.b.a CoventryCares

**Name of Individual Completing This Appendix G:**

Denise Gallagher

**Does the Offeror have experience since January 2006?** If the Offeror has experience since January 2006 where they were the primary party who contracted with a state agency to provide managed care services, then the Offeror is to check "Yes" and complete the remainder of this Appendix G. If the Offeror was not the primary contractor and/or the Offeror is unable to document that they were covered under the same corporate umbrella as the health plan for which they are claiming experience in this other state, the Offeror is to check "No" and is not to complete the remainder of this Appendix G.

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.	<b>CONTRACT YEAR 2006-2007</b>  Oct. 2006 - Sept. 2007	<b>CONTRACT YEAR 2007-2008</b>  Oct. 2007 - Sept. 2008	<b>CONTRACT YEAR 2008-2009</b>  Oct. 2008 - Sept. 2009	<b>CONTRACT YEAR 2009-2010</b>  Oct. 2009 - Sept. 2010	
<b>PRIMARY CONTRACTOR</b>  Place an "x" in the box if the Offeror is/was the primary contractor. Primary Contractor is defined as there being a direct contractual relationship between the Offeror and the state agency, and the Offeror must be the party held accountable by the state agency for meeting the provisions of the contract.	YES <input checked="" type="checkbox"/>  NO <input type="checkbox"/>				
<b>POPULATION</b>  Place an "x" in this box for each population group included in the contract between the Offeror and the state agency. If the Offeror places an "x" next to "OTHER", the Offeror is to provide clarification under the Additional Explanation section of this Appendix G.  TANF = Temporary Aid to Needy Families  ABD = Aged, Blind and Disabled	TANF	X	X	X	X
	AGED, BLIND, DISABLED	X	X	X	X
	OTHER*				

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.		<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
<p><b>SERVICES</b> Place an "x" in the one box that describes the services the Offeror was contracted to provide. "Full Benefits with Exceptions*" refers only to those situations where an entire component of the benefit package was excluded or carved out and provided entirely by another entity or not at all. So long as the Offeror was responsible for providing at least some coverage for a particular service, even if another entity provided a larger overall proportion of this coverage, this would fall under "Full Benefits" (e.g., the Offeror was only required to cover up to 30 days in a long term care facility for their members and any additionally needed long term care coverage was provided through the state's traditional Medicaid program). If the Offeror places an "x" next to any Services option marked with an asterisk, the Offeror is to provide clarification.</p>	Full Medicaid Benefits				
	Full Medicaid Benefits with Exceptions*	X	X	X	X
	Behavioral Health Only				

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b>	<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.				

**Additional Explanation:**

If you checked any of the boxes under headings with an (\*), provide clarification below:

**Name of Health Plan:**

OmniCare Health Plan, Inc. and HealthAmerica Pennsylvania, Inc. are both wholly-owned subsidiaries of Coventry Health Care, Inc. Please refer to the attached Schedule Y from HealthAmerica Pennsylvania, Inc.'s financial 2011 Q3 Quarterly Statement.

**Population:**

**Services:**

For the specified time periods, major carve-out services included dental services and long term care facility services.

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

**TO BE COMPLETED BY THE OFFEROR**

**The Offeror must complete a separate APPENDIX G for each state where the Offeror has contracted with a state agency to provide managed care services since January 2006.**

**State:** Missouri

**Name of Health Plan in This State\*:** HealthCare USA of Missouri, LLC

The name of the health plan as it appears on the contract with the state agency. If this is a different name than that being used by the Offeror for this Pennsylvania RFP, the Offeror must explain the corporate relationship between these two entities in the Additional Explanation section of this Appendix G. The Offeror must be able to document that both entities are under the control of the same corporate family.

**Name of Offeror:** HealthAmerica Pennsylvania, Inc. d.b.a CoventryCares

**Name of Individual Completing This Appendix G:**

Denise Gallagher

**Does the Offeror have experience since January 2006?** If the Offeror has experience since January 2006 where they were the primary party who contracted with a state agency to provide managed care services, then the Offeror is to check “Yes” and complete the remainder of this Appendix G. If the Offeror was not the primary contractor and/or the Offeror is unable to document that they were covered under the same corporate umbrella as the health plan for which they are claiming experience in this other state, the Offeror is to check “No” and is not to complete the remainder of this Appendix G.

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.	<b>CONTRACT YEAR 2006-2007</b> Jan. 2006 - June 2006; July 2006 - June 2007	<b>CONTRACT YEAR 2007-2008</b> July 2007 - June 2008	<b>CONTRACT YEAR 2008-2009</b> July 2008 - June 2009	<b>CONTRACT YEAR 2009-2010</b> July 2009 - June 2010	
<b>PRIMARY CONTRACTOR</b>  Place an "x" in the box if the Offeror is/was the primary contractor. Primary Contractor is defined as there being a direct contractual relationship between the Offeror and the state agency, and the Offeror must be the party held accountable by the state agency for meeting the provisions of the contract.	YES <input checked="" type="checkbox"/>  NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/>  NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/>  NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/>  NO <input type="checkbox"/>	
<b>POPULATION</b>  Place an "x" in this box for each population group included in the contract between the Offeror and the state agency. If the Offeror places an "x" next to "OTHER", the Offeror is to provide clarification under the Additional Explanation section of this Appendix G.  TANF = Temporary Aid to Needy Families  ABD = Aged, Blind and Disabled	TANF	X	X	X	X
	AGED, BLIND, DISABLED				
	OTHER*	X	X	X	X

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.		<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
<p><b>SERVICES</b> Place an "x" in the one box that describes the services the Offeror was contracted to provide. "Full Benefits with Exceptions*" refers only to those situations where an entire component of the benefit package was excluded or carved out and provided entirely by another entity or not at all. So long as the Offeror was responsible for providing at least some coverage for a particular service, even if another entity provided a larger overall proportion of this coverage, this would fall under "Full Benefits" (e.g., the Offeror was only required to cover up to 30 days in a long term care facility for their members and any additionally needed long term care coverage was provided through the state's traditional Medicaid program). If the Offeror places an "x" next to any Services option marked with an asterisk, the Offeror is to provide clarification.</p>	Full Medicaid Benefits				
	Full Medicaid Benefits with Exceptions*	X	X	X	X
	Behavioral Health Only				

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b>	<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.				

**Additional Explanation:**

If you checked any of the boxes under headings with an (\*), provide clarification below:

**Name of Health Plan:**

HealthCare USA of Missouri, LLC and HealthAmerica Pennsylvania, Inc. are both wholly-owned subsidiaries of Coventry Health Care, Inc. Please refer to the attached Schedule Y from HealthAmerica Pennsylvania, Inc.'s financial Q3 2011 Quarterly Statement.

**Population:**

The other population is CHIP.

**Services:**

For the specified time periods, major carve-out services included long term care facilities. As of October 2009, pharmacy services were carved-out.

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

**TO BE COMPLETED BY THE OFFEROR**

**The Offeror must complete a separate APPENDIX G for each state where the Offeror has contracted with a state agency to provide managed care services since January 2006.**

**State:** Virginia

**Name of Health Plan in This State\*:** Southern Health - CareNet

The name of the health plan as it appears on the contract with the state agency. If this is a different name than that being used by the Offeror for this Pennsylvania RFP, the Offeror must explain the corporate relationship between these two entities in the Additional Explanation section of this Appendix G. The Offeror must be able to document that both entities are under the control of the same corporate family.

**Name of Offeror:** HealthAmerica Pennsylvania, Inc. d.b.a CoventryCares

**Name of Individual Completing This Appendix G:**

Denise Gallagher

**Does the Offeror have experience since January 2006?** If the Offeror has experience since January 2006 where they were the primary party who contracted with a state agency to provide managed care services, then the Offeror is to check "Yes" and complete the remainder of this Appendix G. If the Offeror was not the primary contractor and/or the Offeror is unable to document that they were covered under the same corporate umbrella as the health plan for which they are claiming experience in this other state, the Offeror is to check "No" and is not to complete the remainder of this Appendix G.

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.	<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>	
	July 2006 - June 2007	July 2007 - June 2008	July 2008 - June 2009	July 2009 - June 2010	
<b>PRIMARY CONTRACTOR</b>  Place an "x" in the box if the Offeror is/was the primary contractor. Primary Contractor is defined as there being a direct contractual relationship between the Offeror and the state agency, and the Offeror must be the party held accountable by the state agency for meeting the provisions of the contract.	YES <input checked="" type="checkbox"/>  NO <input type="checkbox"/>				
<b>POPULATION</b>  Place an "x" in this box for each population group included in the contract between the Offeror and the state agency. If the Offeror places an "x" next to "OTHER", the Offeror is to provide clarification under the Additional Explanation section of this Appendix G.  TANF = Temporary Aid to Needy Families  ABD = Aged, Blind and Disabled	TANF	X	X	X	X
	AGED, BLIND, DISABLED	X	X	X	X
	OTHER*	X	X	X	X

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.		<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
<p><b>SERVICES</b> Place an "x" in the one box that describes the services the Offeror was contracted to provide. "Full Benefits with Exceptions*" refers only to those situations where an entire component of the benefit package was excluded or carved out and provided entirely by another entity or not at all. So long as the Offeror was responsible for providing at least some coverage for a particular service, even if another entity provided a larger overall proportion of this coverage, this would fall under "Full Benefits" (e.g., the Offeror was only required to cover up to 30 days in a long term care facility for their members and any additionally needed long term care coverage was provided through the state's traditional Medicaid program). If the Offeror places an "x" next to any Services option marked with an asterisk, the Offeror is to provide clarification.</p>	Full Medicaid Benefits				
	Full Medicaid Benefits with Exceptions*	X	X	X	X
	Behavioral Health Only				

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b>	<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.				

**Additional Explanation:**

If you checked any of the boxes under headings with an (\*), provide clarification below:

**Name of Health Plan:**

For Southern Health - CareNet, CareNet is the Medicaid product that is part of Southern Health Services, Inc., and both Southern Health Services, Inc. and HealthAmerica Pennsylvania, Inc. are wholly-owned subsidiaries of Coventry Health Care, Inc. Please refer to the attached Schedule Y from HealthAmerica Pennsylvania, Inc.'s financial Q3 2010 Quarterly Statement.

**Population:**

The other population is CHIP, which is called FAMIS in Virginia.

**Services:**

Major carve-out services include dental services and long term care facility services.

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

**TO BE COMPLETED BY THE OFFEROR**

**The Offeror must complete a separate APPENDIX G for each state where the Offeror has contracted with a state agency to provide managed care services since January 2006.**

**State:** West Virginia

**Name of Health Plan in This State\*:** Carelink Health Plans

The name of the health plan as it appears on the contract with the state agency. If this is a different name than that being used by the Offeror for this Pennsylvania RFP, the Offeror must explain the corporate relationship between these two entities in the Additional Explanation section of this Appendix G. The Offeror must be able to document that both entities are under the control of the same corporate family.

**Name of Offeror:** HealthAmerica Pennsylvania, Inc. d.b.a CoventryCares

**Name of Individual Completing This Appendix G:**

Denise Gallagher

**Does the Offeror have experience since January 2006?** If the Offeror has experience since January 2006 where they were the primary party who contracted with a state agency to provide managed care services, then the Offeror is to check "Yes" and complete the remainder of this Appendix G. If the Offeror was not the primary contractor and/or the Offeror is unable to document that they were covered under the same corporate umbrella as the health plan for which they are claiming experience in this other state, the Offeror is to check "No" and is not to complete the remainder of this Appendix G.

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<b>PRIMARY CONTRACTOR</b>  Place an "x" in the box if the Offeror is/was the primary contractor. Primary Contractor is defined as there being a direct contractual relationship between the Offeror and the state agency, and the Offeror must be the party held accountable by the state agency for meeting the provisions of the contract.	YES <input checked="" type="checkbox"/>  NO <input type="checkbox"/>				
<b>POPULATION</b>  Place an "x" in this box for each population group included in the contract between the Offeror and the state agency. If the Offeror places an "x" next to "OTHER", the Offeror is to provide clarification under the Additional Explanation section of this Appendix G.  TANF = Temporary Aid to Needy Families  ABD = Aged, Blind and Disabled	TANF	X	X	X	X
	AGED, BLIND, DISABLED				
	OTHER*				

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b> Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.		<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
<p><b>SERVICES</b> Place an "x" in the one box that describes the services the Offeror was contracted to provide. "Full Benefits with Exceptions*" refers only to those situations where an entire component of the benefit package was excluded or carved out and provided entirely by another entity or not at all. So long as the Offeror was responsible for providing at least some coverage for a particular service, even if another entity provided a larger overall proportion of this coverage, this would fall under "Full Benefits" (e.g., the Offeror was only required to cover up to 30 days in a long term care facility for their members and any additionally needed long term care coverage was provided through the state's traditional Medicaid program). If the Offeror places an "x" next to any Services option marked with an asterisk, the Offeror is to provide clarification.</p>	Full Medicaid Benefits	X	X	X	X
	Full Medicaid Benefits with Exceptions*				
	Behavioral Health Only				

**APPENDIX G  
OFFEROR'S MANAGED CARE EXPERIENCE**

<b>CONTRACT YEAR</b>	<b>CONTRACT YEAR 2006-2007</b>	<b>CONTRACT YEAR 2007-2008</b>	<b>CONTRACT YEAR 2008-2009</b>	<b>CONTRACT YEAR 2009-2010</b>
Enter the dates (month and year of each contract's duration under the corresponding Contract Year as determined by the start and end date of that contract.				

**Additional Explanation:**

If you checked any of the boxes under headings with an (\*), provide clarification below:

**Name of Health Plan:**

Carelink Health plans and HealthAmerica Pennsylvania, Inc. are both wholly-owned subsidiaries of Coventry Health Care, Inc. Please refer to the attached Schedule Y from HealthAmerica Pennsylvania, Inc.'s financial Q3 2011 Quarterly Statement.

**Population:**

**Services:**

Major carve-out services for these time periods were behavioral health, children's dental, non-emergency transportation and outpatient pharmacy.

## II-3 Personnel - Executive Management List

**Resumes and Job Descriptions are provided for the following:**

Employee's Name	RFP Job Title	Job Description Title
David W. Fields	Chief Executive Officer	Chief Executive Officer
Mary L. Osborne	Chief Operating Officer	Chief Operating Officer
Evelyn N. Pendleton	Chief Financial Officer	Chief Financial Officer
Robert S. Mirsky	Chief Medical Officer	SVP, Chief Medical Officer
Heather R. Gross	Pharmacy Director	Clinical Regional Pharmacy Director
Denise Gallagher	HealthChoices Program Manager	Vice President / General Manager - Medicaid
Sherry Thornton	Chief Information Officer	Dir, Applications Development

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# DAVID W. FIELDS

PRESIDENT AND CEO, HEALTHAMERICA

## EXPERIENCE

HEALTHAMERICA, INC. Pittsburgh, Pennsylvania 08/2011 - Present

### President and CEO

Responsible for all Pennsylvania statewide health plan operations consisting of a wide range of health benefits solutions for Commercial, Medicare Advantage, Medicaid and Individual subscribers. Also has authority over the entire CoventryCares operation, including contract management, financial management, quality management, utilization management, marketing, data management, compliance, recipient services and provider utilization. Directs all departments in the development, implementation and maintenance of policies and procedures to ensure compliance with State, Federal and regulatory requirements.

Executive Director – Western Pennsylvania 08/2010 – 08/2011

Responsible for Sales, Account Management, Provider Relations and Contracting for Commercial, Medicare, Individual and Medicaid products in Western Pennsylvania.

cvx ADVISORS Chicago, IL 11/2008 – 08/2010

### Managing Director

Advising diverse businesses; not-for-profit and for-profit organizations, political campaigns, and evaluating personal investment opportunities.

HEALTHMARKETS, INC. Dallas, TX 10/2007 - 09/2008

### President and Chief Operating Officer

HealthMarkets is a \$1.5B revenue Company serving 600,000 members through 2,000 employees, operating in 44 states. The Company distributes its products solely through a captive distribution channel of 5,000 agents. It has been privately held by Blackstone (52%), Goldman Sachs (25%), and DLJ (10%), the Private Equity ("PE") owners since April, 2006. The remaining ownership is held by management and the captive agents which subjects the Company to SEC reporting and disclosures.

WELLPOINT, INC Chicago, IL 1997- 2007

President and CEO (UniCare and HealthLink – Chicago) 2004- 2007

Serving 2.4M members and managing revenue of \$2.5B, 2,300 Associates, administrative budgets exceeding \$300M and Operating Gain exceeding \$100M. Responsibilities: Led integration of two entities, and develop a comprehensive non-Blue growth strategy for WellPoint. Charged with introducing rental network strategy to Midwest Blue states, and identifying acquisition targets.

UniCare is the sole 50 state insurance license in WellPoint with core operations in Texas, Illinois, Mid-Atlantic and Massachusetts markets. UniCare offers Individual, Group and Specialty fully insured and ASO products. HealthLink is a non-risk bearing rental network serving self insured employers, TPA's and insurance carriers in Missouri, Illinois and the Mid-Atlantic markets.

- Reset strategy, develop a credible story for the Brand, recruit new Team to implement strategy and build a motivated and functioning management Team.
- Combined disparate Operations areas under one Leader, developed and resourced a Compliance area, engaged in concerted efforts to minimize Litigation risk.
- Engaged in significant product development activities; strategically with Student Health and Limited Benefits policies, innovative Internet products for youth market, and products for small employer market.

- Implemented Full Circle Health, a sales story for integrated utilization management, disease management, advanced care management and the business structure behind it.
- Introduced multi-cultural marketing efforts for Hispanic and African American (Stepping Stone) communities, including support for UniverSoul Circus and the Million Pound Challenge.

**Vice President/General Manager Blue Cross Blue Shield of Georgia** Atlanta, GA 2001- 2004  
 Profit and loss responsibility for Individual, Small Group and Senior products following WellPoint acquisition and reorganization of Georgia Blue. Business encompassed 325K members, \$600M in revenue and 700 Associates. Responsibilities included Sales, Product Development, Account Management, Claims, Member Services, Enrollment and Billing.

- Doubled membership to 600+K, revenue to \$1.2B and Operating Gain to \$200M. Market share increased to over 70% in Individual and 60% in Small Group. Accomplished through strategic expansion of distribution channel for Individual, innovative products for all 3 markets and a focus on earning customer's business.
- In 2003-2004, took on responsibility for Product Development, Broker Services and Licensing, Contract Administration for all Georgia Business Units
- For 2003-2004 planning cycle, Three Year Plan and Annual plan, led WellPoint-wide Strategic Assessment for the Small Group markets across all Business Units. Resulted in development of company-wide GM Council to collaboratively set strategy and allocate resources among Blue plans.
- Began multi-cultural market efforts (Stepping Stone) and initiated outreach to African American business community on behalf of BCBSGA.

**Regional Vice President, Blue Cross Blue Shield of Georgia** Savannah, GA 1997 - 2001  
 Profit and loss responsibility for Individual and Group business in southeast GA, Sales, Account Management and Provider Contracting and Relations. Additionally, served as CEO of Community Health Partnership; a partnership jointly owned and governed by BCBSGA, St. Joseph/Candler Health System, Primary Care IPA and Specialty Care IPA. Primary responsibility was to make the Partnership function as intended; collect capital deficits from partners, negotiate market-competitive contracts, and grow the business. Achieved financial and membership targets each year, collected capital contributions and amicably dissolved the Partnership in 2000. Also charged with similar responsibilities for Macon Region and Partnership. Renegotiated provider contracts and engaged in significant financial turn around of the Region while growing membership and revenue. Dissolved Partnership. Also made responsible for Albany Region based upon previous success.

<b>Humana, Inc.</b>		
Executive Director-Kansas/Missouri	Kansas City, MO	1990-1997
Assoc. Executive Director-Kentucky	Louisville, KY	1987-1990
Corporate Finance	Louisville, KY	1986-1987
<b>Coopers &amp; Lybrand CPA's</b>	Louisville, KY	1982-1986

<b>EDUCATION</b>
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University of Louisville, Louisville, Kentucky – Bachelors in Commerce  
 University of Kentucky – pursuing business degree  
 Duke University (Fuqua School of Business) – Executive Education  
 Harvard (School of Public Health) – Executive Education

# MARY LOUISE OSBORNE

CHIEF OPERATING OFFICER, HEALTHAMERICA

## EXPERIENCE

HEALTHAMERICA PENNSYLVANIA, INC.	Pittsburgh, PA	2002-Present
Chief Operating Officer		08/2010-Present
Regional President		04/2008-08/2010
Executive Vice President		11/2002-04/2008
Chief Operating Officer		8/2010 to present
<ul style="list-style-type: none"><li>• Statewide responsibility for CoventryCares Pennsylvania Health Choices Operation</li><li>• Direct accountability for CoventryCares, including sales and marketing, health services, compliance, communications, provider relations and network management</li><li>• Statewide accountability for Medicare Advantage and Individual business Operations</li><li>• Sales growth has increased 20% year over year in both Medicare Advantage and Individual Business</li><li>• Statewide oversight for utilization management, product development and Operations.</li><li>• Achievement of two consecutive 3-year NCQA Excellent Accreditations; 2010 U.S. News/NCQA "America's Best Health Insurance Plans", ranked HealthAmerica's commercial plans 14th out of 227 plans and the Medicare Advantage plans 28th out of 183 plans nationwide</li><li>• 2010, HealthAmerica exceeded 50,000 subscribers in all product lines, a new all-time sales record</li></ul>		
AETNA	Pittsburgh PA and Alpharetta, GA	1986-2002
General Manager, Aetna, Southeast Region		05/1999-10/2002
<ul style="list-style-type: none"><li>• Managed the profit and loss for the Southeast Region Select Business Segment: Georgia, Mississippi, Alabama, Louisiana, Florida, North and South Carolina, Tennessee and Arkansas</li><li>• Participated in the development, implementation and execution of action plans to build cost effective networks, reduced medical costs through patient and practice management, achieved targeted medical loss ratios and improved access and quality for members</li><li>• Monitored sales strategies and financial results in the Southeast Region</li><li>• Developed sales and financial plans in order to meet targeted profit margins and increase shareholder value. Developed and executed corrective action plans for under-performing markets</li><li>• Achieved membership targets through sales training, plan sponsor and broker strategies, and cross-selling of all product lines</li><li>• Worked cross-functionally with all departments in support of organization goals</li><li>• Participated in development and execution of underwriting and pricing strategies to yield financial results</li><li>• Chaired Quality Oversight Committee, actively participated in the Quality Management program. <i>Georgia received Excellent Accreditation on August 15, 2001 from the National Committee for Quality Assurance</i></li></ul>		
General Manager, Aetna U.S. Healthcare, Pittsburgh		02/1996-05/1999
<ul style="list-style-type: none"><li>• Selected as Talented Leader by President</li><li>• Nominated to participate on High Potential Leadership Team</li></ul>		
Account Executive-District Manager, U.S. Healthcare		07/1986-02/1996
<ul style="list-style-type: none"><li>• Consistently exceeded performance expectations</li><li>• U.S. Healthcare Record Breaking Sales Successes</li></ul>		

## EDUCATION

Duquesne University -Bachelor of Arts, Journalism Major, Communications Minor

## CERTIFICATIONS/LICENSURES

Pennsylvania Health and Life Insurance License  
Ohio Health and Life Insurance License

## COMMUNITY/VOLUNTEER EXPERIENCE

- HealthAmerica's United Way of Allegheny County Campaign
- Georgia Leadership Council
- Georgia HMO Managed Care Association
- North Fulton County Chamber of Commerce Board of Director

## REFERENCES

Available upon request

# EVELYN N. PENDLETON, ASA, MAAA

CHIEF FINANCIAL OFFICER, HEALTHAMERICA.

Respected Health Care Finance executive with proven results-driven track record and strong work ethic. Effective in reorganizing, streamlining and strengthening financial operations and revenue to maximize performance and profitability. Respond to operational and financial challenges with confidence, determination and focus. Verified strengths include:

- Forecasting, Reporting & Analysis
- Strategic Planning & Execution
- Respected Leadership
- Medical Pricing and Reserving
- Budget Development & Management
- Staff Building, Coaching and Mentoring
- Cost-Avoidance & Reduction
- Productivity/Efficiency Improvement

## EXPERIENCE

HEALTHAMERICA	Harrisburg, PA	1999- Present
Chief Financial Officer		2007 - Present
<ul style="list-style-type: none"><li>• Responsible for the financial operations and analysis of \$1.6 billion health plan. Products include Medicare, Commercial, Individual and Medicaid.</li><li>• Navigated Actuarial, Underwriting and Finance changes to increase the Plan Level total profits by 30%.</li><li>• Restructured Medicare Revenue Enhancement team to increase Medicare premium an additional \$10 million.</li><li>• Added CFO responsibilities for a \$300 million health plan in 2009. New health plan has beaten plan goals by more than 50% since 2009. Regionalized both health plan operations and cut staff in half.</li><li>• Developed network and pricing strategies for expansion of Medicaid product. These strategies have produced profitable growth for this new Medicaid line.</li><li>• Turned around Medicare profitability and sales with changes in product, medical management and pricing.</li></ul>		
Chief Actuary		2007 - 2008
<ul style="list-style-type: none"><li>• Responsible for pricing and reserving Medicare, Commercial and Individual products.</li><li>• Through pricing, underwriting and product changes, improved Commercial MLR by 3% and Medicare MLR by 7%.</li></ul>		
Vice President of Finance/Director of Finance		2004 - 2007
<ul style="list-style-type: none"><li>• Developed the budget, forecasting and analysis for \$1.5 billion health plan.</li><li>• Initiated numerous policies and employee optimization initiatives that resulted in overall SG&amp;A dollars less than budget for 2006.</li><li>• Automated member kit process that resulted in \$250,000 of cost savings.</li><li>• Part of the overall management team assigned to large employer accounts, which required frequent client interactions, presentations and visits with senior leadership.</li></ul>		
Director of Actuarial Services, Pricing		1999 - 2005
<ul style="list-style-type: none"><li>• Developed pricing discipline for all commercial products that resulted in the organization exceeding budgeted profit targets every year from 2000 through 2005.</li><li>• Directed statewide small group underwriting of group sizes 2 to 99 for 2002 and 2003. During this period, the team sold over 120,000 new members.</li><li>• Large case actuarial and underwriting consultant for 40,000 member client; including presenting financial results and recommending plan design changes and customized utilization programs.</li><li>• Championed the development of an internet rating tool that reduced small group underwriting staff from twelve employees to four.</li><li>• Established a collaborative working relationship with the Pennsylvania Department of Insurance.</li></ul>		



# ROBERT S. MIRSKY, MD, MMM, FAAFP

CHIEF MEDICAL OFFICER, HEALTH AMERICA

## EXPERIENCE

HEALTHAMERICA OF PENNSYLVANIA, INC.

Pittsburgh, PA

3/09 - PRESENT

### Chief Medical Officer

- Ensures that the company delivers quality health care and services to our members and grows profitably.
- Responsible for strategic medical affairs issues including developing physician networks, maintaining physician relationships, and recruiting physicians and physician groups.
- Responsible for establishing and implementing standards and policies to ensure the highest quality of the medical care is provided to patients.
- Responsible for the strategic direction of the Pharmacy Operations, Utilization Management and Quality Assurance functional areas.

GATEWAY HEALTH PLAN

Pittsburgh, PA

06/07 – 03/09

### Vice President & Chief Medical Officer (6/21/07-Present)

- Responsible for strategic direction and operational effectiveness of Medical Management
- Responsible for clinical oversight of Care/Case Management, Quality Improvement, Credentialing and Pharmacy
- Responsible for overseeing coordination and activities of the GHP Medical Directors and Physician Advisors
- Serves as a senior Plan official when dealing with physician and Member clinical and contractual problems.
- Works closely with all divisions and departments within the corporate structure to develop overall medical policy and clinical coordination.
- Collaborates with the Vice President of Health Services to develop and implement effective Utilization Management, Case Management, Disease Management and Preventive Services.

BLUECROSS BLUESHEILD OF FLORIDA (BCBSF)

Jacksonville/Tampa, FL

01/01- 06/07

### Senior Medical Director Professional Programs (10/05-Present)

- Statewide leadership for Professional Programs in support of key deliverables outlined below
- Management of five regional medical directors (PPMD's) and support staff
- Oversight of 2 million dollar operational budget
- Continued accountability for strategy and clinical components of BCBSF Pay for Performance (Recognizing Physician Excellence/RPE) Program

TENET HEALTHSYSTEM, FLORIDA REGION (THSF) Fort Lauderdale, FL

03/98 – 01/01

### Chief Medical Officer, Tenet Network Management (TNM)

- Direct oversight of HMO delegated Utilization Management for over 4,500 Medicare, 4,000 Medicaid and 24,000 commercial risk lives on behalf of 11 hospitals and over 1,600 physicians associated with Palm Medical Group, IPA, North Shore and Hialeah PHO's (a \$60 million budget). These lives are members of a 50% provider (Dimension PHO) owned HMO (Neighborhood Health Partnership).
- Selection, development and implementation of physician profiling systems at the HMO

- Coordination and Oversight: IPA Utilization Management and Credentialing Committees, IPA Local Operating Committees, IPA Board and Executive Committee, PHO Boards and Committees
- Development of actuarially based risk sharing models and utilization reports

## EDUCATION

Tulane University School of Public Health, New Orleans, Louisiana - *Master Medical Management.*

SUNY Downstate, Brooklyn, New York - *Doctorate of Medicine cum laude.*

University of Michigan, Ann Arbor, Michigan - *Bachelor of Science with distinction; Major in Psychology.*

## CERTIFICATIONS/LICENSURES

Board Certification

Family Practice, 1989 (recertified 1995, 2002)

## REFERENCES

Available upon request.

## HEATHER R. GROSS, PHARM.D.

CLINICAL REGIONAL PHARMACY DIRECTOR, COVENTRY HEALTH CARE, INC.

### EXPERIENCE

COVENTRY HEALTH CARE, INC. Harrisburg, PA April 2005 – Present

Clinical Regional Pharmacy Director 03/2010 - Present

Primary responsibility for the day-to-day operations and administration of HealthAmerica's Managed Medicaid product, CoventryCares. Develop new strategies, tactics and programs to further develop excellence in the delivery of optimal cost effective medical and prescription drug coverage. Evaluate Prior Authorization and Formulary Exception requests for medical necessity and make recommendations for coverage to Medical Director for members. Implement and enforce compliance with corporate coverage policies and formulary. Assure compliance with Department of Public Welfare policies and procedures related to managed Medicaid pharmacy services. Query pharmacy claims data to evaluate utilization trends, conduct appropriate prescribing analysis, and evaluate market share. Support all reporting requirements to DPW and the plan related to pharmacy benefit utilization and operation. Collaborate with Coventry Health Care, Inc. Pharmacy team in the development and maintenance of the prescription drug formulary. Serve as Medicaid Pharmacy Team lead for all Coventry Health Care, Inc. Managed Medicaid plans on Corporate and National initiatives. Evaluate and develop national coverage policy and guidelines for specialty pharmaceuticals. Disseminate coverage policies to internal stakeholders. Survey biotechnology pipelines in anticipation of new product approvals. Participate in biweekly Pharmacy Subcommittee and monthly Pharmacy Director meetings. Evaluate new pharmaceuticals and biotechnology for formulary review/coverage criteria. Report on new drug approvals to Medical Directors, Health Services and Pharmacy Management Departments on regular basis. Review patient medication history for enrolled in case management to improve appropriate utilization and identify medication non-compliance. Facilitate the development of a student training site at HealthAmerica plan location. Assist in the development, implementation and execution of new clinical programs to continually improve the health and welfare of the plans membership.

Clinical Pharmacy Specialist 4/2005 - 3/2010

Develop new strategies, tactics and programs to further develop excellence in member satisfaction while delivery optimal cost effective medical and prescription drug coverage. Evaluate Prior Authorization and Formulary Exception requests for medical necessity and make recommendations for coverage to Medical Director for members with commercial and Medicare benefits. Implement and enforce compliance with corporate coverage policies and formulary. Query pharmacy claims data to evaluate utilization trends, conduct appropriate prescribing analysis, and evaluate market share. Collaborate with Coventry Health Care, Inc. Pharmacy team in the development and maintenance of the prescription drug formulary. Evaluate and develop national coverage policy and guidelines for specialty pharmaceuticals. Disseminate coverage policies to internal stakeholders. Survey biotechnology pipelines in anticipation of new product approvals. Participate in biweekly Pharmacy Director's Subcommittee meetings. Evaluate new pharmaceuticals and biotechnology for formulary review/coverage criteria. Report on new drug approvals to Medical Directors, Health Services and Pharmacy Management Departments on regular basis. Review patient medication history for Medicare members enrolled in case management to improve appropriate utilization and identify medication non-compliance. Facilitate the development of a student training site at HealthAmerica plan location. Assist in the development, implementation and execution of new clinical programs to continually improve the health and welfare of the plans membership.

Clinical Coordinator, Pharmacy Services - Holy Spirit Hospital Camp Hill, PA 2001- 2005

Directed development, implementation and maintenance of clinical pharmacy services to provide care to the department's customers. Facilitated the transition of department from traditional centralized distributive practice model to total pharmacy care practice model. Coordinated activities that permitted existing distributive pharmacists to train and evolve into clinical pharmacists. Directed the development and assessment of professional staff competency assessments. Provided clinical consultation and clarification to practitioners. Suggested appropriate, cost-effective therapeutic alternatives. Facilitated the

development and implementation of treatment guidelines, protocols, formulary changes and critical pathways. Worked cooperatively with numerous hospital departments to ensure safe, cost-effective quality patient care. Implemented new clinical programs. Assisted the Operations Coordinator with the design and function of the departmental staffing patterns. Developed vision statement for the Department of Pharmacy Services and designed programs aimed at meeting *ASHP Health-System Pharmacy 2015 Initiative* goals for pharmacy practice. Demonstrated leadership role in medication safety and patient safety initiatives. System administrator for Medmarx database and medication misadventure team leader. Developed and maintained departmental policy and procedures. Assisted in assuring compliance with state, federal and Joint Commission standards. Oversight of Doctor of Pharmacy students on clinical experiential rotations from multiple schools of pharmacy. Provided accurate and timely drug information. Published the pharmacy newsletter for hospital distribution.

Drug Information and Clinical Pharmacist, Tucson Medical Center	Tucson, AZ	2000- 2001
Staff Pharmacist, Saint Francis Hospital	Pittsburgh, PA	1999 –1999
Retail Pharmacist, Somerset Drug Company	Somerset, PA	1998- 1999

#### EDUCATION

Tucson Medical Center, Tucson, AZ - ASHP Pharmacy Practice Resident  
Duquesne University (Mylan School of Pharmacy), Pittsburgh, PA - Doctor of Pharmacy  
Duquesne University (Mylan School of Pharmacy), Pittsburgh, PA - Bachelor of Science, Pharmacy

#### CERTIFICATIONS/LICENSURES

Pennsylvania pharmacy license, RP-044453-L

#### PROFESSIONAL ASSOCIATIONS

American College of Clinical Pharmacy  
Academy of Managed Care Pharmacy

#### REFERENCES

Available upon request

# DENISE GALLAGHER

VICE PRESIDENT / GENERAL MANAGER - MEDICAID, HEALTHAMERICA

## EXPERIENCE

**HEALTHAMERICA, INC.** King of Prussia, Pennsylvania 10/2011- Present  
VP/General Manager, Medicaid

Principal oversight of HealthChoices/CoventryCares Medical Assistance Managed Care Plan. Ensures compliance with applicable state, federal and regulatory requirements through the development, implementation and maintenance of departmental policies and procedures.

**COVENTRY HEALTH CARE, INC.** Bethesda, MD 08/2011 – 10/2011  
Vice President, Government Programs

Work as part of a national team to facilitate new product development and implementation. Focus on areas of dual eligibles, foster care, and guardianship initiatives.

**COMPLETE HEALTH SOLUTIONS** Nationwide 2007 - 2011  
Independent Health Care Consultant

Healthcare consulting; providing evaluation of business opportunities, development and implementation of successful strategies, executive level mentoring and cross-operational management; primary focus on government programs including Medicaid, ABD(aged/blind/disabled), Special Needs Plans, Medicare, Long Term Care, Health Care Reform, Senior Villages and uninsured populations. Public, private and non-profit product development and contracting.

**FIDELIS SENIORCARE** Schaumburg, Illinois 2006-2007  
Senior Vice President Corporate Sales, Marketing & Provider Contracting  
Acting CEO-President Texas

Directed national sales and marketing strategies, local Plan operations, sales, enrollment, provider contracting and serving. Directed, and implemented top-line strategies for newly formed, multi-state Medicare Advantage – Special Needs Plans, focused on long-term care institutionalized membership. Developed revenue streams through collaborations with assisted living, nursing homes and continuum of care communities. Increased growth efficiencies. Evaluated current staff. Hired and trained all field sales personnel. Responsible for corporate relationships at state and federal levels, business development, and contracts. Revenue generation, top-line change agent in two established markets. Directed and managed all enrollment and provider contracting staff. Responsible for the third and most successful revenue market at Fidelis. Generated 80% of all membership and P&L responsibility in this privately held venture backed company.

**SENIOR WHOLE HEALTH** Cambridge, Massachusetts 2003-2006  
Founder, Managing Partner & Chief Marketing Officer

Recognized opportunity and secured venture capital backing to develop a unique, for profit, comprehensive coordinated health plan to provide and expand the provisions of Medicaid and Medicare to low income seniors. Senior Whole Health was a federal demonstration project. Developed clinical model and provider contract strategy using innovation to attract traditional and nontraditional providers. Coordinated and supervised the creation of all marketing materials and sales activities. Created brand identity and market entry strategy.

**AMERIGROUP**  
Vice President

Virginia Beach, Virginia

2000 - 2003

Initially hired as Associate Vice President, directed sales, marketing and advertising operations for a multi-cultural focused national corporation exceeding two billion dollars in revenue and over 800,000+ covered lives. Annual corporate sales and revenue projections exceeded by second quarter in first year of joining the company. Responsible areas include administration of a multi-million dollar budget for corporate headquarters and multi-state plan locations during both pre and post-IPO stages of growth. Global oversight and direction for restructuring corporate centralization, including budget development and sales growth strategies. Integration of cross-organizational department disciplines and partnership opportunities on the national and local level. Development of standardized sales and productivity reporting to senior level decision makers.

**AMERICHoice**  
Vice President

New York, New York

1998 - 2000

Directed sales, marketing, customer service, member service, network development, contracting, provider relations and facilities. Oversaw all areas for the Northeast Region's two HMO's in New York and New Jersey, representing 130,000 members. Designed and implemented restructure to streamline processes and met corporate goals. Analyzed market. Initiated successful strategies that generated member growth for the first time since initial operations. Planned new customer and contracted vendor-driven strategies. Introduced effective checks and balances to monitor market strategies. Developed and implemented network rightsizing of this multi-million dollar corporation. P&L responsibility. Board Committees - Chair Service Quality Improvement Committee, Member of Professional Affairs and Quality Improvement Committee.

Consultant to CEO, Boston Healthnet Plan (Americhoice)                      Boston, Massachusetts                      1998-1999

Marketing Director, Neighborhood Health Plan of Massachusetts/Rhode Island                      1991-1997

Director of External Relations, Department Of Public Welfare                      Boston, Massachusetts                      1988-1990

Special Markets Coordinator, Healthway Medical Plan                      Brockton, Massachusetts                      1987-1988

**EDUCATION**

Center for Creative Leadership, Greensboro, North Carolina - Leadership Development  
Gala International, Barcelona, Spain - Conversational Spanish  
North Adams State College, North Adams, Massachusetts - Bachelor of Arts/Sociology

**REFERENCES**

Available upon request

# SHERRY THORNTON

DIRECTOR, APPLICATIONS DEVELOPMENT (CHIEF INFORMATION OFFICER), COVENTRY HEALTH CARE, INC.

## EXPERIENCE

**COVENTRY HEALTH CARE, INC.** Bethesda, MD 2009 - Present  
*A national Managed Care Company with more than 4.5 million members as of October 2011 in all 50 states with 2010 revenues of \$11.5 billion.*

Director, Applications Development, Coventry Health Care, Inc., St. Louis, MO 2009 - Present  
Responsible for planning, directing and controlling the resources and efforts of MIS teams to accomplish large Medicaid project implementations and support IT operational needs for Medicaid health plans within the corporation.

- Developed budget processes and procedures to align and prioritize business objectives within limited resource parameters.
- Led large-scale IT implementation for Pennsylvania Medicaid business awarded in 2009, including readiness reviews with State Medicaid agency.
- Provides leadership to team members to accomplish goals and objectives.
- Ensures compliance with federal and state laws, regulations, and standards related to health information and coding principles.

**CENTENE CORPORATION** St. Louis, MO 2006- 2009  
*Centene Corporation is a multi-line healthcare enterprise that provides programs and related services to individuals receiving benefits under Medicaid, including the Children's Health Insurance Program (CHIP), as well as Aged, Blind, or Disabled (ABD), Foster Care, Long-Term Care and Medicare (Special Needs Plans).*

Director Encounter Business Operations, Centene Corporation St. Louis, MO 2007-2009  
Responsible for ensuring timely and accurate submission of encounter data from health plans and subcontractors to State Medicaid agencies while ensuring compliance with all federal and state laws.

- Established processes and dashboards to ensure accuracy and timeliness of encounters output and deliverables; achieving greater than 90% first time encounter acceptance for all Medicaid health plans.
- Represented corporation in client interaction during the development of new business opportunities.
- Reported operational progress, financial, issue and risk status to senior management and all business partners.
- Developed a strong team through mentoring, training and effective organizational development practices.

IT Manager/EDI, Centene Corporation St. Louis, MO 2006-2007  
Responsible for project delivery and daily operations activities for electronic data interchange (EDI) function within corporation. Managed a team of 31 application programmers and business analysts that developed and implemented health care transactions for Medicaid and behavioral health lines of business.

- Established processes and procedures to improve efficiency of EDI transactions for 11 health plans coast-to-coast.
- Ensured compliance with HIPAA and Sarbanes Oxley rules and mandates
- Adopted ANSI X12 transaction standards to process claims, eligibility, claims status, electronic remits, paper claims and claims encounter reporting to various providers and state partners.

**BLUECROSS BLUESHIELD OF MISSOURI** St. Louis, MO 2000 - 2006  
*Leading regional health and medical insurance provider to commercial clients in Missouri and Illinois.*

Senior Project Manager, BlueCross and BlueShield of Missouri St. Louis, MO 2000 -2006  
Managed a team of 10 application programmers responsible for analysis, design, construction, documentation, test scripts and deployment of new EDI solutions: 270/271, 276/277, 278, 820, 834, 835, and 837.

- Created an EDI solution using HIPAA-mandated federal regulations.

- Collaborated with cross-functional departments (Data Warehouse, QA Testing, Systems Support, Business Groups, Network Administration) to develop optimal solutions.
- Recommended software purchases to executive management and served on committees including ANSI X12 Organization, HIPAA Regulations, Federal Employee HIPAA Workgroup and Trizetto Software Workgroup.
- Responsible for yearly budget planning and day-to-day EDI operations.

Network Administrator, Southwestern Illinois College	Red Bud, IL	2000
Consultant/EDI Programmer/Analyst (Sterling Commerce), IBS Consulting	Dublin, OH	2000
Consultant/EDI Programmer/Analyst, Data Management Consultants, Inc.	St. Louis, MO	1999
Consultant/Documentation Specialist, Cap Gemini America	St. Louis, MO	1998-1999
Business Analyst/EDI Coordinator, Cap Gemini America	St. Louis, MO	1998
Assistant to the Quality Manager, Cap Gemini America	St. Louis, MO	1997-1998
Computer Lab Supervisor/Network Administrator, Marissa Junior Senior High School	Marissa, IL	1995-1997
Accounts Receivable Manager, Famous-Barr Credit	St. Louis, MO	1992-1993
Personal Services Supervisor, Mercantile Card Services	St. Louis, MO	1989-1992

#### EDUCATION

University of Phoenix, Phoenix, AZ - Bachelor of Science/Management  
Southern Illinois University, Edwardsville, IL - Management Information Systems  
Belleville Area College, Belleville, IL - Associate of Science Accounting

#### CERTIFICATIONS/LICENSURES

Not Applicable

#### COMMUNITY/VOLUNTEER EXPERIENCE

Not Applicable

#### REFERENCES

Available upon request

## COVENTRY HEALTHCARE JOB PROFILE

Last Updated: 06/30/11

<b>TITLE</b>	Chief Executive Officer 3 (Sector)	<b>JOB CODE</b>	903131
<b>JOB FUNCTION</b>	Executive -- Executive	<b>FLSA STATUS</b>	Exempt

### GENERAL SUMMARY

Functional head with overall responsibility for all field operations including profit and loss of single or multiple business units with a total membership of 250K+ members or \$500M or more in total annual revenue. Responsible for all long-range planning and ensuring the effectiveness and quality services provided meet corporate short and long-term objectives and regulatory body requirements.

### ESSENTIAL RESPONSIBILITIES

- Ensures that assigned functional area delivers quality services to our members and clients and grows profitably.
- Responsible for the overall financial performance of assigned area.
- Directs all departments in the development, implementation and maintenance of policies and procedures to ensure compliance with State, Federal and regulatory requirements.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including, employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Performs other duties as assigned.

### JOB SPECIFICATIONS

- Bachelor's degree of equivalent experience. Master's degree preferred.
- Significant experience (10+ years) of progressively responsible management positions.
- Strong independent decision making ability
- Demonstrated expert process and project management ability.
- Strong analytical, organizational and communication skills.
- Proven strategic visionary ability.
- Ability to work with all levels of management and in a team environment.

**DISCLAIMER:** The above statements are intended to describe the general nature and level of work being performed by individuals assigned to this position. They are not intended to be construed as an exhaustive list of responsibilities, duties and skills required of personnel so.

## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 02/19/08

<b>TITLE</b>	Chief Operating Officer 3 (Sector)	<b>JOB CODE</b>	902101
<b>JOB FUNCTION</b>	Executive - Operations	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Top operations job with oversight of single or multiple business units with a total membership of 250K+ members or \$500M or more in total annual revenue. Responsible for the day-to-day operation of the assigned business unit(s). Ensures compliance with applicable State, Federal and regulatory regulations through the development, implementation and maintenance of departmental policies and procedures in coordination with Coventry's Legal Department.

### **ESSENTIAL RESPONSIBILITIES**

- Directs managers and directors of specific functional areas as assigned (including but not limited to Operations, Provider Relations, Network Development, Utilization Management, Quality Improvement, Disease State Management, Pharmacy Operations, Mailroom and Administrative/Facilities Management).
- Coordinates and monitors functional integration of these areas in cooperation with corporate departments to achieve planned business results.
- Oversees and directs activity in the key areas of contracts and communications.
- Ensures compliance with applicable state, federal and regulatory bodies as required in coordination with Coventry's Legal Department.
- Directs all departments in the development, implementation and maintenance of policies and procedures to ensure compliance with the State, Federal and regulatory requirements.
- Responsible for the coordination and direction of State audits by DOI and DHR to include market conduct and compliance audits.
- Monitors budget in assigned function areas and takes corrective action.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including, employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Performs other duties as required.

### **JOB SPECIFICATIONS**

- Bachelor's degree of equivalent experience. Master's degree preferred.
- Significant experience (10+ years) of progressively responsible management positions.
- Strong independent decision making ability
- Demonstrated expert process and project management ability.
- Strong analytical, organizational and communication skills.
- Proven strategic visionary ability.
- Ability to work with all levels of management and in a team environment.

**DISCLAIMER:** The above statements are intended to describe the general nature and level of work being performed by individuals assigned to this position. They are not intended to be construed as an exhaustive list of responsibilities, duties and skills required of personnel so classified.

## COVENTRY HEALTHCARE JOB PROFILE

Last Updated: 04/24/09

<b>TITLE</b>	Chief Financial Officer 3 (Sector)	<b>JOB CODE</b>	906121
<b>JOB FUNCTION</b>	Executive - Finance	<b>FLSA STATUS</b>	Exempt

### GENERAL SUMMARY

Top financial job with oversight of single or multiple business units with a total membership of 250K+ members or \$500M or more in total annual revenue. Responsible for formulating financial policy and plans and for providing overall direction for the accounting, internal and external reporting, budgeting, underwriting, and financial planning functions. Ensures that financial transactions, policies and procedures meet corporate short and long-term objectives, and regulatory body requirements.

### ESSENTIAL RESPONSIBILITIES

- Responsible for developing and overseeing the financial and operating functions within an assigned functional area including financial policy and plans, accounting, internal and external reporting, budgeting, and financial planning functions.
- Develops and implements the financial policies and procedures that safeguard and ensure the stability of the company.
- Oversees the analysis and presentation of periodic financial statements.
- Coordinates departmental requirements for the annual audit as well as those conducted by government or regulatory agencies.
- Participates in meetings and task force groups which seek to improve the operations of the company with the objective to provide a financial perspective and analysis of the issues.
- Oversees the preparation, distribution and presentation of ad-hoc financial analysis and reports at the request of management.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Performs other duties as required.

### JOB SPECIFICATIONS

- Bachelor's degree or equivalent experience. Master's degree preferred.
- Significant experience (usually 10+ years) in the financial field analyzing company performance.
- Experience in health plan field operations.
- Familiarity with legal and tax issues associated with financial operations.
- Proficient in a variety of software, data base applications and mainframe financial systems.
- Strong ability to identify problem areas, evaluate possible solutions, implement the appropriate solution and monitor the results.
- Strong organization, coordination, negotiation and communication skills with outside professionals including legal and investment banking.

**DISCLAIMER:** The above statements are intended to describe the general nature and level of work being performed by individuals assigned to this position. They are not intended to be construed as an exhaustive list of responsibilities, duties and skills required of personnel so classified.

## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 09/09/09

<b>TITLE</b>	SVP, Chief Medical Officer (Corp)	<b>JOB CODE</b>	910101
<b>JOB FUNCTION</b>	Executive – Medical Management	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Highest level of management responsible for overseeing the medical policies, medical service delivery and quality care for all health plan members.

### **ESSENTIAL RESPONSIBILITIES**

- Ø Ensures that the company delivers quality health care and services to our members and grows profitably.
- Ø Responsible for strategic medical affairs issues including developing physician networks, maintaining physician relationships, and recruiting physicians and physician groups.
- Ø Responsible for establishing and implementing standards and policies to ensure the highest quality of the medical care is provided to patients.
- Ø Responsible for the strategic direction of the Pharmacy Operations, Utilization Management and Quality Assurance functional areas.
- Ø Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including, employment, termination, performance reviews, salary reviews, and disciplinary actions.

### **JOB SPECIFICATIONS**

- Ø Active, unrestricted license to practice medicine required.
- Ø Board certification by a specialty board approved by the American Board of Medical Specialties or Advisory Board of Osteopathic Specialists required.
- Ø Significant experience (10+ years) in progressively responsible management positions.
- Ø Proven strategic visionary ability.
- Ø Strong independent decision making ability.
- Ø Proven negotiation skills.
- Ø Strong analytical, organization and communication skills.
- Ø Ability to work with all levels of management and in a team environment.

**DISCLAIMER:** The above statements are intended to describe the general nature and level of work being performed by individuals assigned to this position. They are not intended to be construed as an exhaustive list of responsibilities, duties and skills required of personnel so classified.

## COVENTRY HEALTH CARE JOB PROFILE

Last Updated: 08/30/10

<b>TITLE</b>	Regional Director, Pharmacy ( <b>Pharmacy. Director</b> )	<b>JOB CODE</b>	760131
<b>JOB FUNCTION</b>	Pharmacy - Operations	<b>FLSA STATUS</b>	Exempt

### GENERAL SUMMARY

Coordinates and oversees functions for both internal and external pharmacy operations. Provides supervision to the in-house staff pharmacists. Responds to informational requests concerning drugs and pharmacy programs.

### ESSENTIAL RESPONSIBILITIES

- Provides pharmaceutical education and guidance to physicians, nurses, and other health care professionals.
- Analyzes the drug program, assesses pharmacy benefits, and provides expertise to health plan and customers concerning benefit design questions.
- Reports on and evaluates drug use and/or cost. Responsible for identifying and developing creative approaches to reduce pharmaceutical costs.
- Acts as liaison to third party administrators and contracted pharmacies.
- Conducts, reviews, and analyzes drug therapy utilization. Uses this data in company contracts for negotiations and/or rebates.
- Supports regional and national Pharmacy and Therapeutic Committee function.
- Attends health plan quality meetings. Performs Quality Assurance functions.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including, employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Performs other duties as required.

### JOB SPECIFICATIONS

- Bachelor's degree from accredited school of pharmacy.
- PharmD from accredited school of pharmacy. Board certification and residency preferred.
- Current unrestricted state licensure required.
- Previous (3 years) management experience required.

**DISCLAIMER:** The above statements are intended to describe the general nature and level of work being performed by individuals assigned to this position. They are not intended to be construed as an exhaustive list of responsibilities, duties and skills required of personnel so classified.

## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 08/12/08

<b>TITLE</b>	VP, General Manager (Medicare/Medicaid) <b>(HC Program Manager)</b>	<b>JOB CODE</b>	902131
<b>JOB FUNCTION</b>	Marketing - Government Programs	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Top operations job with oversight for Medicare and/or Medicaid within a single or multiple site health plan. Responsible for the development and execution of the annual operating plan, including profit and loss accountability. Provides day-to-day oversight for operation of the Medicare/Medicaid health plan including Sales, Marketing, Provider Relations, Network Development, Utilization Management and Quality. Ensures compliance with applicable state, federal and regulatory requirements through the development, implementation and maintenance of departmental policies and procedures in coordination with the Medicare/Medicaid Compliance and Legal Departments.

### **ESSENTIAL RESPONSIBILITIES**

- Responsible for the overall financial performance of the Medicare and/or Medicaid plans within the market.
- Directs managers and/or directors of specific functional areas as assigned. Functional areas may include operations, sales, marketing, provider relations, network development, utilization management, and/or quality improvement. Coordinates and monitors functional integration of these areas in cooperation with corporate departments to achieve planned business results.
- Oversees and directs activity in the key areas of contracts and communications.
- Directs all departments in the development, implementation and maintenance of policies and procedures to ensure compliance with the State and Federal regulatory requirements.
- Responsible for the plan performance related to all required Federal audits.
- Responsible for the management and organization of plan activities at the health plan.
- Monitors budget in assigned function areas and takes corrective action.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including, employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Performs other duties as required.

### **JOB SPECIFICATIONS**

- Bachelor's degree or equivalent experience. Master's degree preferred.
- Significant (10+ years) management experience required.
- Previous health plan experience preferred.

**DISCLAIMER:** The above statements are intended to describe the general nature and level of work being performed by individuals assigned to this position. They are not intended to be construed as an exhaustive list of responsibilities, duties and skills required of personnel so classified.

## COVENTRY HEALTHCARE JOB PROFILE

### (Chief Information Officer)

Last Updated: 06/13/08

<b>TITLE</b>	Director, Applications Development	<b>JOB CODE</b>	420111
<b>JOB FUNCTION</b>	IT – Applications Development	<b>FLSA STATUS</b>	Exempt

#### GENERAL SUMMARY

Oversees, directs, and plans the operational and administrative activities of multiple applications development project teams. Accountable for successful delivery of all assigned projects, releases and application production support. Partners with business leaders to understand direction and identify technology solutions to meet current and future business needs. Ensures workforce has the skills and competencies to meet current and future business needs. Key contributor in defining organization vision, strategies and direction. Provides the leadership necessary to drive change and successfully execute against organization's strategy.

#### ESSENTIAL RESPONSIBILITIES

- Ø Directs multiple project teams which are responsible for all phases of the system development and implementation process including analysis, design, development, testing and ongoing support for the client area application systems in an environment of diverse development platforms, computing environments (e.g., host based, distributed systems, client server), software, hardware, technology, tools, etc.
- Ø Responsible for responding to production system issues to meet business critical service level agreements.
- Ø Develops proactive business relationships/partnerships to implement solutions for tactical and strategic business direction.
- Ø Proactively monitors system risk to ensure production stability.
- Ø Drives continuous improvement in all IT processes and procedures.
- Ø Coordinates activities with managers.
- Ø Oversees the activities of multiple teams. Assigns resources to the various projects and directs their activities.
- Ø Provides leadership in developing, implementing and maintaining departmental processes, identifying and resolving departmental issues, and directing, guiding and supporting the staff in the performance of their responsibilities.
- Ø Develops and manages the department budget. Manages the budget and controls expenses while meeting service requirements.
- Ø Recruits, develops, and motivates staff. Initiates and communicates a variety of staffing actions including, employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Ø Performs other duties as required.

#### JOB SPECIFICATIONS

- Ø Bachelor's degree or equivalent experience.
- Ø Previous (7-10 years) experience in systems analysis and application program development.
- Ø Previous (5-7 years) management experience required.
- Ø Extensive knowledge of the system development life cycle and system and application program development technology alternatives.
- Ø Excellent leadership, critical thinking and analysis, verbal and written communication skills..
- Ø Ability to communicate effectively with clients and other IT staff at all levels.
- Ø Understanding of health care business and care delivery processes preferred.

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## II-3 Personnel – Key Administrative Positions List

**Job Descriptions are provided for the following positions:**

RFP Job Title	Job Description Title	Employee's Name
Quality Management Coordinator	Director, Quality Management	Elaina Wickas
Utilization Management Coordinator	Director, Health Services	Mary Trafican
FT Special Needs Unit Coordinator	Manager, Special Needs	Gina Balakoff
FT Government Liaison	Regulatory Compliance Analyst	Joan Gaughan
Maternal Health/EPSTD Coordinator	Health Education Coordinator	Emily Perkins
Member Services Manager and Claims Administrator	Manager, Service Operations	Suzanne Wilson
Provider Services Manager	Director, Provider Relations	Kathy Kalcevich
Complaint, Grievance and Department Fair Hearing Coordinator	Manager, Appeals	Kevin O'Brien
Contract Compliance Officer	Director, Regulatory Compliance	Bernard Lapine
Other Key Personnel:	Director, Human Resources	Regina Wheat

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## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 06/27/08

<b>TITLE</b>	Manager, Quality Improvement <b>(Quality Management Coord.)</b>	<b>JOB CODE</b>	710141
<b>JOB FUNCTION</b>	Medical Management - Quality	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Manages the Quality Improvement activities for a business, including one or more of the following; provider relations, health services, customer service, and/or credentialing. May be responsible for supervising the grievance activities for the business and ensuring compliance with state regulations and national accrediting body requirements.

### **ESSENTIAL RESPONSIBILITIES**

- Responsible for compliance with state and federal quality regulations. Ensures all quality improvement activities are conducted according to regulatory guidelines and principles.
- Oversees the maintenance of accurate documentation of all quality improvement activities, i.e., surveys, audits, peer reviews, etc.
- Prepares the agenda and manages the activities of the Quality Improvement Committee, in conjunction with Medical Affairs.
- Develops new quality improvement activities within the assigned business to improve the quality of care and service in the most efficient manner.
- Oversees the annual Medical Record Documentation/Preventive Services clinical study.
- Ensures all departments including credentialing, provider relations, health services, and customer service collect and report quality improvement information to the Quality Improvement Committee, including the monitoring and evaluation of indicators.
- Directs data collection for HEDIS measures. Identifies opportunities for improvement based on HEDIS results.
- Remains current with new developments in the field of quality improvement.
- May be responsible for the direct supervision of the appeals staff and for ensuring compliance with State law regarding the handling of appeals.
- May oversee the disease management and preventive health programs for the business unit.
- Provides input into department budget. Controls department expenses while meeting service requirements.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Performs other duties as required.

### **JOB SPECIFICATIONS**

- Bachelor's degree or equivalent experience. Master's degree preferred.
- Previous (3-5 years) clinical or health education experience required.
- Previous (2+ years) quality improvement experience required.
- Certified Professional in Health Quality (CPHQ) preferred.
- Previous supervisory or project lead experience required.
- Excellent organizational, analytical, and problem solving skills.

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## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 04/15/10

<b>TITLE</b>	Director, Health Services <b>(Utilization Management Coord.)</b>	<b>JOB CODE</b>	725121
<b>JOB FUNCTION</b>	Medical Management – Health Services	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Provides coordination, supervision, and direction for the utilization management functions of the health plan.

### **ESSENTIAL RESPONSIBILITIES**

- Develops, directs, and supervises the implementation of all departmental policies and procedures, goals and objectives.
- Oversees pre-authorization, concurrent review and case management programs.
- Assures staffing levels and staff competencies are appropriate to accomplish departmental duties and responsibilities productively and efficiently.
- Maintains working knowledge and communication of legislature, consortiums, and impending insurance law changes that may potentially affect utilization trends, practices, and standards at the plan or corporate level.
- Provides direction for the development of screening criteria, protocols, and benefit interpretations.
- Coordinates and participate in provider orientation/development/maintenance activities specific to utilization management.
- Assists in the identification and reporting of potential quality improvement issues. Responsible for assuring these issues are reported to the Quality Improvement Department.
- Participates in the budgetary process at the plan level, including preparation of a departmental budget and monitoring for adherence.
- Performs other duties as required.

### **JOB SPECIFICATIONS**

- Registered Nurse with an active state RN license.
- Bachelor's degree or equivalent experience.
- Significant experience (usually 7+ years) in utilization management.
- Significant experience (usually 5+ years) clinical experience.
- Previous experience (usually 3+ years) managerial experience.

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## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 10/04/10

<b>TITLE</b>	Manager, Special Needs <b>(FT Special Needs Unit Coord.)</b>	<b>JOB CODE</b>	728191
<b>JOB FUNCTION</b>	Medical Management – Social Services	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Responsible for the management, coordination, and implementation of appropriate access to care and services for members with special needs, based on referrals from within or outside of the health plan. Implements and maintains procedures to support the Special Needs Unit. Oversees the coordination of physical health and behavioral health in conjunction with the appropriate behavioral health organizations.

### **ESSENTIAL RESPONSIBILITIES**

- Implements and maintains accurate and up-to-date policies and procedures that support state regulatory requirements related to the operation of the Special Needs Unit and the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- Serves as liaison with appropriate state agencies. Participates in state directed meetings and/or in-services to provide care and coordination of care for the special needs population.
- Represents the health plan and actively participates in state consumer advocacy and required state committee meetings.
- Manages the Special Needs Unit and hotline, ensuring that staff is coordinating access to care and services appropriate to the member's condition or circumstance, addressing psycho-social and economic needs. Ensures resolution of open issues is reached.
- Implements revisions to policies and procedures to ensure benefits are administered appropriately and regulatory changes are followed as directed by state agencies.
- Completes regulatory reporting requirements; submits reports to appropriate state agencies. Prepares and distributes internal reports relating to, but not limited to, productivity and barrier analysis.
- Monitors staff calls and performs quality audits. Analyzes audits and statistical reports; makes recommendations for process improvements. Provides training to staff when appropriate.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including employment, termination, performance reviews, salary reviews and disciplinary actions.
- Performs other duties as assigned.

### **JOB SPECIFICATIONS**

- Master's degree in Social Work required.
- Complies with all state requirements in the state where job duties are performed.
- Previous experience (5-7 years) working with special needs populations.
- Previous (1-3 years) supervisory experience required.
- Knowledge of regulations and statutes impacting the Medicaid managed care environment.
- Strong written and verbal communication skills.
- Ability to use standard corporate software packages and corporate applications (i.e., Microsoft Excel, Word, PowerPoint).

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## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 08/20/08

<b>TITLE</b>	Regulatory Compliance Analyst <b>(FT Government Liaison)</b>	<b>JOB CODE</b>	732141
<b>JOB FUNCTION</b>	Regulatory – Regulatory	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Collaborates with Compliance Department and Coventry counsel to assure compliance with state and federal legislative and regulatory requirements. Monitors internal implementation plans, conducts internal audits, and provides training on topics including, but not limited to Health Insurance Portability and Accountability Act (HIPAA) and Anti-Fraud. Maintains an awareness of proposed legislation and regulations and analyzes the potential effects to the Company.

### **ESSENTIAL RESPONSIBILITIES**

- Maintains an awareness of trends, developments and governmental regulations in health care and managed health care organizations.
- Analyzes and interprets existing and proposed legislation and regulations and determines their effects to the Company.
- Drafts responses to proposed laws and regulations and serves as a resource to staff for review and implementation of benefit and policy statements.
- Prepares, drafts, and files plan certificates of coverage and any other information required by the federal and state agencies.
- May assist in developing risk assessments to identify required audit areas and audit frequency.
- May conduct internal audits to assess compliance with company policies, state and federal laws and regulations.
- May conduct external on-site audits to assess compliance with Administrative Services Provider Contract (ASPC) and Third Party Administrator (TPA) laws and regulations.
- May develop audit reports to identify areas of noncompliance, propose recommendations and obtain responses and corrective action plans from the head of the functional area.
- May monitor the implementation of state and federal laws and regulations. Conducts appropriate reviews to ensure policies and procedures comply with enacted laws and regulations.
- May conduct training regarding company policies and procedures. Provides training on security of personal health information (PHI), Anti-Fraud, HIPAA requirements, and other compliance related topics.
- Performs other duties as required.

### **JOB SPECIFICATIONS**

- Bachelor's degree or equivalent experience.
- Previous (3-5 years) insurance and HMO regulatory compliance.
- Previous experience with internal auditing functions.
- Excellent organizational and interpersonal skills.
- Strong analytical and problem solving skills.
- Demonstrated verbal and written communication skills.
- Proficient with standard PC applications.

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## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 05/27/11

<b>TITLE</b>	Health Education Coordinator <b>(Maternal Health/ EPSDT Coord.)</b>	<b>JOB CODE</b>	780141
<b>JOB FUNCTION</b>	Medical Management – Health Education	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Provides a comprehensive curriculum of health education and wellness programs to members, employees, and/or providers to promote and support healthy lifestyles. Serves as a liaison with internal departments, participating integrated delivery systems, and community resources to implement educational programs.

### **ESSENTIAL RESPONSIBILITIES**

- Assesses health and wellness education needs of the members, employees, and/or providers. Develops, implements, and presents health education programs and materials to provide for these needs. Monitors the programs to ensure they meet company standards and expectations.
- Identifies resources for health education programs. Coordinates referrals to outside programs. Arranges classes for members. Publicizes and promotes health education offerings.
- Facilitates health education activities for health promotion, quality improvement, accreditation, and related functions.
- Assists internal departments with the development and implementation of their health education programs.
- Assists with community relations programs to raise the company's profile as a positive corporate presence.
- Develops and implements a health education database and reporting system.
- Develops and implements a course payment process. Periodically audits the process to ensure payments are recorded in an accurate and timely manner.
- Monitors the health education budget to ensure expenses are controlled while meeting service requirements.
- Performs other duties as required.

### **JOB SPECIFICATIONS**

- Bachelor's degree or equivalent experience.
- Previous (1-3 years) experience in health education/wellness programs. Expertise in related disciplines such as dietary management or nutrition desired.
- Previous program management and evaluation experience required.
- Basic knowledge of disease and illness prevention and health promotion.
- Demonstrated presentation, interpersonal, and written communication skills required.
- Must be able to work independently.
- Proficient with standard corporate software packages (i.e., Word, Excel, Access).
- Regular local travel may be required.

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## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 06/17/11

<b>TITLE</b>	Manager, Service Operations <b>(Member Services Mgr and Claims Administrator)</b>	<b>JOB CODE</b>	545161
<b>JOB FUNCTION</b>	Operations – Customer Service	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY:**

Responsible for the management, coordination and implementation of a broad range of projects and programs in direct support of the service center management team as well as the day-to-day management of service or business units to meet or exceed customer service requirements and business objectives.

### **ESSENTIAL RESPONSIBILITIES:**

- Assumes responsibility for programs and projects, at the direction of the service center management team, through the analysis, implementation and evaluation phases. May directly manage/coordinate such projects after implementation or may delegate that responsibility to other persons as appropriate. Performs data analysis and develops summaries and/or recommendations on programs and projects for the service center management team.
- Builds and administers a business plan to meet or exceed goals.
- Coordinates resources (financial, capital, human, etc.) to ensure that programs and projects have sufficient means to meet/exceed expectations.
- Analyzes daily, weekly, and monthly statistical reports and makes appropriate recommendations/forecasts regarding call volume and staff schedules. Provides accurate and pertinent data to Director/Vice President for use in strategic and tactical planning.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Resolves member, provider, and staff complaints, issues, and concerns. Serves as the focal point for all issues relative to the team's customers; fosters collaborative relationships with internal and external customers.
- Provides input into the development of the service center budget; manages the budget and controls expense while meeting operations, financial and service requirements.
- Rewards employees based on the development and utilization of required skills and competencies that contribute to the achievement of business objectives.
- Maintains a positive work environment and structure that supports self-directed teams and optimizes the experience, skills, knowledge and capability of the team.
- Performs other duties as required.

### **JOB SPECIFICATIONS**

- Bachelor's degree or equivalent experience.
- Significant experience in health care (usually 6-7 years) with management responsibility. Experience in managing cross-functional, self-directed teams preferred.
- Management of inbound customer service call centers preferred.
- Knowledge of queuing theories, work force scheduling, and telecommunications.
- Demonstrated leadership and motivation skills.
- Ability to initiate and drive change; demonstrated results-driven approach.
- Demonstrated process and project management ability.
- Ability to develop and implement service strategies for internal and external customers.

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## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 08/11/08

<b>TITLE</b>	Director, Provider Relations <b>(Provider Services Manager)</b>	<b>JOB CODE</b>	750121
<b>JOB FUNCTION</b>	Network Development - Provider Relations	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Responsible for Physician administrative and operational aspects of Provider Relations, including primary care physician (PCP), specialist (SCP) and allied health practitioner contracting, education and day-to-day provider services for assigned geographic region.

### **ESSENTIAL RESPONSIBILITIES**

- Assesses, develops and organizes physician network for HMO/PPO/POS networks.
- Reviews and facilitates contracting of interested providers whose services match a need for Plan access/expansion, often working with Marketing to ensure this.
- Provides oversight of physician contracting for service area.
- Responsible for physician retention; initial and ongoing provider servicing and provider compliance to Plan policy. Collaborates with other departments within the organization to ensure key provider reimbursement methodologies and provisions are administratively supported.
- Develops and implements provider education and Provider Information Fairs in support of continuing provider service relationships and contract compliance.
- May be responsible for the creation and revision of the Provider Office Manual. Prepares articles for the physician newsletter.
- Assists in information gathering for Plan audits by NCQA, DOH, CMS (formerly HCFA) including oversight of provider office site surveys required for credentialing and re-credentialing.
- Interacts with the CSO, Contract Management and other departments in resolving Provider Billing Issues.
- Assures that initial provider office orientation as well as scheduled and unscheduled visits are periodically conducted by assigned representatives.
- May lead interdepartmental teams to implement large and/or complex provider contracts accurately.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including, employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Performs other duties as required.

### **JOB SPECIFICATIONS**

- Bachelor's degree or equivalent experience.
- Significant experience (usually 7+ years) in managed care.
- Extensive knowledge of provider contracting and provider office practices.
- Substantial knowledge of managed care and direction.
- Strong communication, negotiation and presentation skills.
- Ability to lead professionals and manage through influence and cooperation.

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## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 08/19/08

<b>TITLE</b>	Manager, Appeals <b>(Complaint, Grievance and Dept Fair Hearing Coord.)</b>	<b>JOB CODE</b>	720111
<b>JOB FUNCTION</b>	Medical Management - Appeals	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Responsible for managing the appeals and grievance activities of a staff. Ensures compliance with all State and Federal regulations and national accrediting body requirements.

### **ESSENTIAL RESPONSIBILITIES**

- Responsible for the direct management of an appeals staff.
- Responsible for compliance with State and Federal laws regarding the handling of appeals. Ensures compliance with national accrediting body standards regarding grievances.
- Ensures compliance with the applicable accreditation agency's standard section regarding member rights and responsibilities.
- Produces all appeals and grievance reports. Researches customer information including applicable medical records in response to difficult inquiries, including authorizations, payments, denials, and coordination of benefits.
- Assesses, investigates, and resolves difficult issues to achieve customer and member satisfaction when possible. Receives all legal correspondence that is not directed to any specific individual.
- Manages all complaints and inquiries for the Department of Insurance, legislators and elected officials.
- May write and review policies to ensure compliance with all regulatory and applicable accreditation agency's requirements.
- May work in conjunction with Legal Department to ensure all legal issues are addressed regarding appeals.
- May oversee regulatory audits.
- May identify, analyze, report, and insure implementation of all new and revised CMS and other applicable compliance requirements related to quality improvement and new CMS coverage.
- May ensure compliance and quality improvement through periodic oversight reviews of critical plan processes. May assist in the development, implementation, and evaluation of quality improvement plans.
- May develop and maintain quality improvement policies and procedures required by Federal contracts, statutes and regulations. May review processes for continued improvement and efficiencies.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including employment, termination, performance reviews, salary reviews, and disciplinary actions
- Performs other duties as required.

### **JOB SPECIFICATIONS**

- Bachelor's degree or equivalent experience.
- Licensed Registered Nurse preferred.
- Previous (1-3 years) supervisory or project lead experience preferred.
- Previous (1 – 2 years) direct customer service experience preferred.
- Experience in processing and working with all types of products including HMO, PPO, CCPPO and Indemnity under both fully insured and self-funded arrangements.
- Expert knowledge of medical terminology required.
- Knowledge of product specific regulations.
- Ability to train employees on all products, procedures, and systems.

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## **COVENTRY HEALTH CARE JOB PROFILE**

Last Updated: 08/08/08

<b>TITLE</b>	Director, Regulatory Compliance <b>(Contract Compliance Officer)</b>	<b>JOB CODE</b>	360181
<b>JOB FUNCTION</b>	Regulatory -- Regulatory	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Oversees department, health plan, or assigned region to ensure compliance with state and federal laws and regulations. May act as primary liaison with CMS, the Department of Insurance, and/or the Department of Labor. Provides summaries of new legislation and develops plans for compliance.

### **ESSENTIAL RESPONSIBILITIES**

- Responsible for overall regulatory compliance for department, health plan or assigned region.
- Oversees process for changes to standard forms, marketing materials, advertising and contracts, including, but not limited to, Evidences of Coverage, Schedules of Benefits, enrollment forms, provider contracts, and group applications. Creates new documents as needed. Files new and revised documents for Department of Insurance and CMS.
- Implements tracking mechanism for all issues outstanding with state and federal regulatory entities.
- Tracks legislative issues and regulatory changes and analyzes impact on the department, health plan or assigned region. Coordinates with state trade associations and other industry groups. Develops new procedures required as the result of newly effective regulatory requirements or changes to existing health plan policies.
- Responsible for all regulatory filings for governmental programs with department, health plan, or assigned region.
- Oversees Market Conduct process and CMS biannual monitoring visits, including pre-exam/visit preparation, actual exams/visits, mock exams/visits, responses to draft audit reports, and follow-up issues raised by regulators with respect to the department, health plan, or region. Ensures recommended changes are implemented.
- Oversees process for market service area expansion for commercial, Medicare and/or Medicaid products.
- All of the above duties will be undertaken in close coordination with Coventry counsel and corporate governmental affairs personnel.
- May be responsible for special account contractual compliance/reporting.
- May develop and deliver compliance training to local compliance staff.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Performs other duties as required.

### **JOB SPECIFICATIONS**

- Bachelor's degree or equivalent experience. Master's degree preferred.
- Minimum of 7-10 years of insurance and HMO laws and rules compliance experience.
- Prior QI experience a plus.
- Management experience required.
- Excellent organizational, managerial and analytical skills required.
- Excellent communication skills.
- Proficient with PC applications.
- Demonstrated leadership and team building skills.

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## COVENTRY HEALTH CARE JOB PROFILE

Last Updated: 09/28/09

<b>TITLE</b>	Director, Human Resources	<b>JOB CODE</b>	815151
<b>JOB FUNCTION</b>	Human Resources - Generalist	<b>FLSA STATUS</b>	Exempt

### GENERAL SUMMARY

Provides human resources services for a large/medium sized region of over 300 employees. Serves as a resource for management concerning human resource issues.

### ESSENTIAL RESPONSIBILITIES

- Assists with the development and implementation of strategic and tactical human resource plans designed to reinforce business success (profitable growth) and the desired culture (ownership) of the organization.
- Implements and administers all human resource policies, staffing, organization development, compensation and benefits, performance management and training and learning programs. Evaluates program effectiveness, making recommendations for program revisions.
- Performs all duties related to employee relations. Coordinates with corporate counsel on any litigation involving employee issues.
- Participates in education, communication, implementation and training for all compensation and benefit programs.
- Guides supervisors and managers in the application of the corrective action and grievance process.
- Assesses training and development needs within assigned departments and develops recommendations to meet those needs. Coordinates and/or delivers training programs individually or as part of training team.
- Explains the salary determination process to supervisors and managers to effectively allocate dollars based on individual and organizational performance.
- Oversees the annual salary determination and incentive pay process.
- Manages training and organizational development functions. Directs and participates in the development and implementation of training programs including but not limited to new employee orientation, supervisory training, staff skill development and others.
- Partners with HR community to facilitate management and employee understanding of Coventry's total compensation system. Educates, mentors, and trains all Human Resource's staff on compensation and performance management practices.
- Responsible for the recruitment, selection and staffing function ensuring department needs and all legal requirements are met. Assists HR staff and hiring supervisors in the employment process by developing and implementing effective recruitment and retention techniques.
- Ensures HRMS and PeopleSoft data integrity.
- Participates in company-wide Human Resource projects, taking project lead or other roles as assigned.
- Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Performs other duties as required.

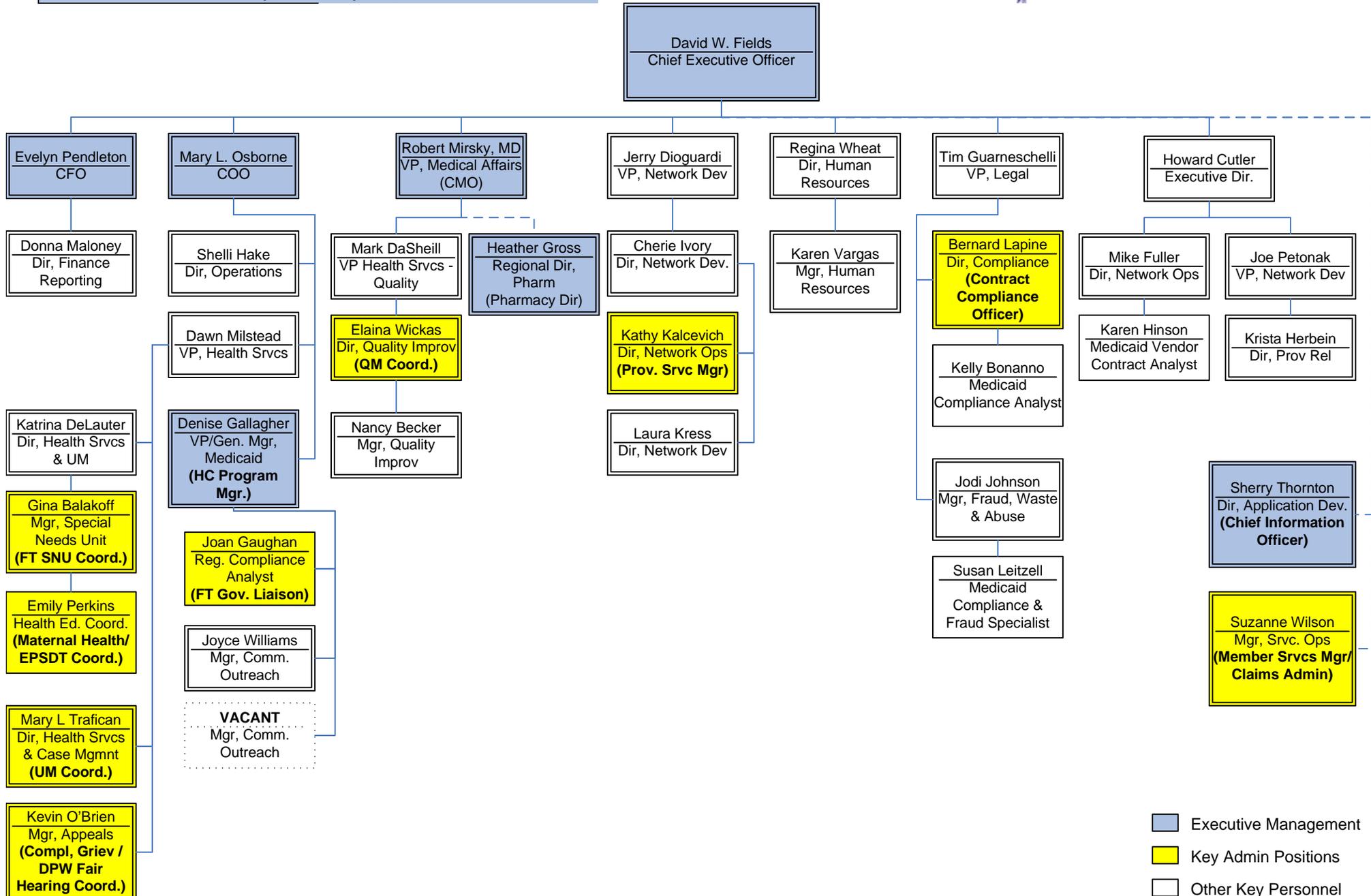
### JOB SPECIFICATIONS

- Bachelor's degree or equivalent experience. Master's degree preferred.
- PHR or SPHR certifications preferred.
- Previous (6-8 years) progressively responsible experience as a professional HR generalist or related position.
- Proven strong technical ability with software used by department.
- Analytical and project management skills.
- Consulting and leadership skills; innovative and flexible. Effective communication and presentation skills.

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# CoventryCares – Organizational Chart New East and New West Regions

Thursday, January 12, 2012



- Executive Management
- Key Admin Positions
- Other Key Personnel

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**CoventryCares Network Development Work Plan  
New West Zone**

<b>Task</b>	<b>Responsible Department</b>	<b>Implementation Time Frame</b>	<b>Target Completion Date</b>	<b>Status (Open/Closed)</b>	<b>Comments</b>
<b><u>Provider Identification</u></b>					
Obtain comprehensive provider listing to include all contracted providers and the data elements required from DPW	Network Operations	1/2/12 - 1/13/12	1/13/2012		
Identify which counties are included in NW Zone efforts	Network Development	1/2/12 - 1/6/12	1/6/2012		
Sort Phase 1 physician and ancillary providers to exclude those affiliated w/ a Health System Agreement	Network Operations	1/16/12 - 1/31/12	1/31/2012		
Identify competitor Hospital network in all NW Zone counties	Network Development	1/9/12 - 1/13/12	1/13/2012		
<b><u>Provider Mailing/Notification</u></b>					
Create/obtain mailing labels	Provider Relations	1/2/12 - 1/13/12	1/13/2012		
Update SW cover letter for mailing of NW amendments	Network Development	1/9/12 - 1/13/12	1/13/2012		
Update SW FAQ for NW	Provider Relations	1/9/12 - 1/20/12	1/20/2012		
First mailing of physician amendments for docs not affiliated w/ PHO or large negotiated group	Provider Relations	1/13/12 - 1/20/12	1/20/2012		
First mailing of ancillary amendments (excluding therapy, anesthesia, ambulance and ASC providers)	Provider Relations	1/20/12 - 2/3/12	2/3/2012		

**CoventryCares Network Development Work Plan  
New West Zone**

<b>Task</b>	<b>Responsible Department</b>	<b>Implementation Time Frame</b>	<b>Target Completion Date</b>	<b>Status (Open/Closed)</b>	<b>Comments</b>
Mail all hospital amendments	Network Development	1/13/12 - 1/20/12	1/20/2012		
Mail asc/therapy amendments	Provider Relations	1/20/12 - 2/3/12	2/3/2012		
Mail ambulance/anesthesia amendments	Provider Relations	1/20/12 - 2/3/12	2/3/2012		
Second mailing of physician amendments for docs not affiliated w/ PHO or large negotiated group	Provider Relations	2/17/12 - 2/24/12	2/24/2012		
Second mailing of ancillary amendments (excluding therapy, anesthesia, ambulance and ASC providers)	Provider Relations	2/17/12 - 2/24/12	2/24/2012		
Follow-up on second mailing to physicians/ancillaries	Provider Relations & Network Development	3/2/12 - 3/9/12	3/9/2012		
Make phone contact with all Phase 1 hospitals and schedule face to face meeting as necessary	Network Development	1/30/12 - 2/3/12	2/3/2012		
Draft cover letter for returning signed contracts	Network Development	4/2/12 - 4/6/12	4/6/2012		
Provide Customer Service Operations copies of the notification and mailings	Network Operations	1/20/12 - 2/29/12	2/29/2012		

**CoventryCares Network Development Work Plan  
New West Zone**

Task	Responsible Department	Implementation Time Frame	Target Completion Date	Status (Open/Closed)	Comments
<b><u>Data Collection/Recording</u></b>					
Copy, scan and return amendments already received	Network Development & Provider Relations	2/1/12 - 5/31/12	5/31/2012		
Enter required data into data base	Network Operations	2/1/12 - 5/31/12	5/31/2012		
Produce open/closed practice reports	Network Operations	2/1/12 - 5/1/12	5/1/2012		
Track "no thanks" responses	Network Operations	2/1/12 - 5/1/12	5/1/2012		
Obtain Geoaccess maps	Network Operations	2/1/12 - 5/1/12	5/1/2012		
Compile required signature pages	Network Development	2/1/12 - 5/1/12	5/1/2012		
Update internal systems (e.g. IDX, CPD) with DPW information	Network Operations	2/1/12 - 5/31/12	5/31/2012		
List contracting status by provider type for all counties on a shared drive	Network Operations	2/1/12 - 5/31/12	5/31/2012		
Member benefit - co-pay amount, need for PCP system set up.	Benefits	2/1/12 - 5/15/12	5/15/2012		

**CoventryCares Network Development Work Plan  
New West Zone**

<b>Task</b>	<b>Responsible Department</b>	<b>Implementation Time Frame</b>	<b>Target Completion Date</b>	<b>Status (Open/Closed)</b>	<b>Comments</b>
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**CoventryCares Network Development Work Plan  
New East Zone**

Task	Responsible Department	Implementation Time Frame	Target Completion Date	Status (Open/Closed)	Comments
<b>Provider Identification</b>					
Obtain comprehensive provider listing to include all contracted providers and the data elements required from DPW	Network Operations	1/2/12 - 1/13/12	1/13/2012		
Identify which counties are included in NE Zone efforts	Network Development	1/2/12 - 1/6/12	1/6/2012		
Sort Phase 1 physician and ancillary providers to exclude those affiliated w/ a Health System Agreement	Network Operations	1/2/12 - 1/12/12	1/12/2012		
Identify competitor Hospital network in all NE Zone counties	Network Development	1/9/12 - 1/13/12	1/13/2012		
<b>Provider Mailing/Notification</b>					
Create/obtain mailing labels	Provider Relations	1/2/12 - 1/31/12	1/31/2012		
Update SW cover letter for mailing of NE amendments	Network Development	1/9/12 - 1/13/12	1/13/2012		
Update SW FAQ for NE	Provider Relations	1/9/12 - 1/20/12	1/20/2012		
First mailing of physician amendments for docs not affiliated w/ PHO or large negotiated group	Provider Relations	2/1/12 - 2/15/12	2/15/2012		
First mailing of ancillary amendments (excluding therapy, anesthesia, ambulance and ASC providers)	Provider Relations	2/1/12 - 2/15/12	2/15/2012		
Mail all hospital amendments	Network Development	2/15/12 - 2/29/12	3/1/2012		

**CoventryCares Network Development Work Plan  
New East Zone**

<b>Task</b>	<b>Responsible Department</b>	<b>Implementation Time Frame</b>	<b>Target Completion Date</b>	<b>Status (Open/Closed)</b>	<b>Comments</b>
Mail asc/therapy amendments	Provider Relations	2/15/12 - 2/29/12	2/29/2012		
Mail ambulance/anesthesia amendments	Provider Relations	2/15/12 - 2/29/12	2/29/2012		
Second mailing of physician amendments for docs not affiliated w/ PHO or large negotiated group	Provider Relations	4/1/12 - 4/15/12	4/15/2012		
Second mailing of ancillary amendments (excluding therapy, anesthesia, ambulance and ASC providers)	Provider Relations	4/1/12 - 4/15/12	4/15/2012		
Follow-up on second mailing to physicians/ancillaries	Provider Relations & Network Development	5/15/12 - 5/31/12	5/31/2012		
Make phone contact with all Phase 1 hospitals and schedule face to face meeting as necessary	Network Development	3/1/12 - 3/31/12	3/31/2012		
Draft cover letter for returning signed contracts	Network Development	5/1/12 - 5/8/12	5/8/2012		
Provide Customer Service Operations copies of the notification and mailings	Network Operations	2/15/12 - 5/31/12	5/31/2012		

**CoventryCares Network Development Work Plan  
New East Zone**

Task	Responsible Department	Implementation Time Frame	Target Completion Date	Status (Open/Closed)	Comments
<b>Data Collection/Recording</b>					
Copy, scan and return amendments already received	Network Development & Provider Relations	2/28/12 - 12/31/12	12/31/2012		
Enter required data into data base	Network Operations	3/1/12 - 12/31/12	12/31/2012		
Produce open/closed practice reports	Network Operations	3/1/12 - 12/1/12	12/1/2012		
Track "no thanks" responses	Network Operations	3/1/12 - 12/1/12	12/1/2012		
Obtain Geoaccess maps	Network Operations	9/1/12 - 12/1/12	12/1/2012		
Compile required signature pages	Network Development	3/1/12 - 12/1/12	12/1/2012		
Update internal systems (e.g. IDX, CPD) with DPW information	Network Operations	3/1/12 - 12/31/12	12/31/2012		
List contracting status by provider type for all counties on a shared drive	Network Operations	3/1/12 - 12/31/12	12/31/2012		
Member benefit - co-pay amount, need for PCP system set up.	Benefits	3/1/12 - 12/15/12	12/15/2012		

**CoventryCares Network Development Work Plan  
New East Zone**

<b>Task</b>	<b>Responsible Department</b>	<b>Implementation Time Frame</b>	<b>Target Completion Date</b>	<b>Status (Open/Closed)</b>	<b>Comments</b>
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CoventryCares from HealthAmerica  
 Operations Implementation Plan  
 Member Effective Date Target 9/1/2012

DAYS LEFT TIL GO  
 LIVE...  
 233

IDX PLATFORM: **MEDMGR**  
 HMO: **701**

EL Code:  
 EL Name:  
 Mnemonic:  
 GL Entity:  
 AP Entity:

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
1.0	<b>Enrollment</b>							
	Schedule Module Meeting		Michelle Truitt			3/20/2012		
	Set up enrollment location in MEDEDI (Dict 40)		Dane Kreiss			3/20/2012		
	Set up enrollment location in Production		Dane Kreiss			3/20/2012		
	Set up carrier code in EDI		Michelle Truitt			3/20/2012		
	Set up carrier code in Production		Michelle Truitt			3/20/2012		
	Set up Plan Type A in EDI		Lisa Ussia			3/20/2012		
	Set up Plan Type A in Production		Lisa Ussia			3/20/2012		
	PA Medicaid default FSC in EDI		Michelle Truitt			3/20/2012		
	PA Medicaid default FSC in Production		Michelle Truitt			3/20/2012		
	Define and document all Alert processes & Lock Ins		HS/Enrollment/CSO/ S.Kirkpatrick			3/20/2012		
	834 File Upload Process		Michelle Truitt			3/20/2012		
	Test 834 file		Michelle Truitt			3/20/2012		
	Weekly files		Michelle Truitt			3/20/2012		
	Define and document PCP Autoassignment letter creation process		Michelle Truitt			3/20/2012		
	Establish business rules and scope with EA&T		Michelle Truitt			3/20/2012		
	PCP auto assignment logic		Michelle Truitt			3/20/2012		
	Set up group structure		Michelle Truitt			4/15/2012		
	Set up billing process for Finance to run financial reconciliation		Michelle Truitt/Finance			4/15/2012		
	Define and document Newborn Process		Michelle Truitt			4/15/2012		
	Define and document Returned Mail and Kits		Michelle Truitt			4/15/2012		
	Vendor Eligibility Extracts		Sherry Thornton			4/15/2012		
	Involuntary Disenrollment process		Kelly Bonanno			4/15/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
2.0	<b>ID Cards/Kits</b>							
	ID card template for approval		Sue Melnychuk/Health Plan			4/15/2012		
	ID card queue created - extracts to ID Card/Kit Vendors		S.Thornton			6/15/2012		
3.0	<b>Front End Operations - Paper</b>							
	Request PO Box		B. Moore			4/15/2012		
	Create mailroom sorting document					4/15/2012		
	Review doc attach table		B. Moore			4/15/2012		
	Non-standards/Rejects Process		B. Moore			4/15/2012		
	Provide estimated claim receipts for PA Medicaid		D. St.John			4/15/2012		
	Define returned mail process		B. Moore			4/15/2012		
	Set up reject letter for ACS		B. Moore			4/15/2012		
4.0	<b>Front End Operations - EDI</b>							
	Fatal Edit Documentation		G. Wilson-Dorsey			4/15/2012		
	Request Payor ID #		B. Moore			4/15/2012		
	Verify member matching logic with new Medicaid ID field		B. Moore			4/15/2012		
	Review POS/TOB table		B. Moore/ D.St.John			4/15/2012		
	Ensure FEO documentation is available on Essentials		G. Wilson-Dorsey			4/15/2012		
	Document newborn process		B. Moore			4/15/2012		
	Mom & Baby billed on same claim		D. St.John			4/15/2012		
	PEARL Billing Areas		B. Moore			4/15/2012		
	Non-par billing provider selection (Skip par check)		G. Wilson-Dorsey			4/15/2012		
5.0	<b>PSA</b>							
	Schedule Module Meeting		Lara Griffin			4/31/2012		
	Add Plan Type to CPD		Lara Griffin			4/28/2012		
	Enable the HAPA Medicaid product in CPD		Lara Griffin			5/1/2012		
	PROMISE ID set up		S.Thornton			3/20/2012		
	Load providers		Lara Griffin			3/30/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Set up affiliation		Kim Graham			3/20/2012		
	Set up fee class		Kim Graham			3/15/2012		
	Vaccines For Children (VFC) Payment Set Up		Kim Graham			3/15/2012		
	DRGs		Kim Graham			3/15/2012		
	DRG Calculator					3/15/2012		
	Submit FSIFs, CARFs, build facility contracts		Kim Graham			3/15/2012		
	Determine PEARL Providers		Kim Graham			3/15/2012		
	Determine modifier table		Kim Graham			3/15/2012		
	Set up Rev/CPT table		Kim Graham			3/15/2012		
	Define provider selection process		Kim Graham			3/15/2012		
	Develop workflows to address contract issues		Kim Graham			3/15/2012		
	Non-Standard Contract Review Process		Kim Graham			3/15/2012		
6.0	<b>Benefits</b>							
	Schedule Module Meeting		Lisa Ussia					
	Review member handbook		Lisa Ussia /Rachel Malsch			3/15/2012		
	Review and set up BRD for plan		Lisa Ussia /Rachel Malsch			3/20/2012		
	Determine number of benefit plans required		Lisa Ussia /Rachel Malsch			3/20/2012		
	Review authorization documents, determine codes, locations that require authorization		Lisa Ussia /Rachel Malsch			3/20/2012		
	Build plan header		Lisa Ussia /Rachel Malsch			3/20/2012		
	Update D2535		Lisa Ussia /Rachel Malsch			4/1/2012		
	Add plan to D683		Lisa Ussia /Rachel Malsch			4/1/2012		
	Build Benefit Plans in EDI		Lisa Ussia /Rachel Malsch			4/1/2012		
	Test Core Benefit Plan		D. St.John			5/1/2012		
	Test Addtl Benefit Plan(s)		D. St.John,			5/1/2012		
	Receive business and CSO Approvals (Core plan)		D. St.John/Health Plan			5/7/2012		
	Build Authorization Rules in EDI		Lisa Ussia / Jenny Richner			5/1/2012		
	Test Authorization Rules		D. St.John			5/1/2012		
	Receive business and CSO Approvals		D.St.John/ Health Plan			5/1/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Benefit limitation notifications - IDX set up		D. St.John/ D.Milstead/H. Gross			4/1/2012		
	Determine if riders will be required to support Transportation and Block Vision benefits		Lisa Ussia/S.Thornton			4/1/2012		
	Communicate IDX Plan Numbers to Distribution		Lisa Ussia / Rachel Malsch			3/20/2012		
	NDC Dictionary 3225/3226 set up		Lisa Ussia			3/1/2012		
7.0	<b>Claims</b>							
	Establish Rule Banks		Kelly Veatch / Nicole Huber / D. St.John			6/1/2012		
	Establish Night Job Rules		Kelly Veatch / Nicole Huber / D. St.John			6/1/2012		
	Review and revise duplicate/potential duplicate logic		Kelly Veatch / Nicole Huber / D. St.John			3/1/2012		
	Build claims queues		D. St.John			3/1/2012		
	Establish timely filing parameters		D. St.John			6/1/2012		
	Define interest parameters		Kelly Veatch / Finance			6/1/2012		
	Obtain copy of Provider Manual		D. St.John			4/1/2012		
	Reporting		D. St.John			6/1/2012		
	State required reports		D. St.John			6/1/2012		
	Build standard internal operations reports		D. St.John			6/1/2012		
	Encounter reporting requirements		D. Maloney			6/1/2012		
	Establish team with EAS/Claims Quality		D. St.John			4/1/2012		
8.0	<b>Member Service</b>							
	Determine staffing needs		D. St.John			3/1/2012		
	Establish transition and hire dates		D. St.John			5/1/2012		
	Develop training plan		D. St.John			5/1/2012		
	Establish phone opening date		D. St.John			4/1/2012		
	Create initial talking points for member service		D. St.John			4/21/2012		
	Establish hours of operations		D. St.John			4/1/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Establish TDD Line		D. St.John			5/1/2012		
	Establish 800#		D. St.John			5/1/2012		
	Check capability of zip code selection to route calls		D. St. John			5/1/2012		
	Identify and build skill sets		D. St.John			6/1/2012		
	Build scripts for IVR/Call Tree		D. St.John			6/1/2012		
	Build call routing to support 24 hour hotline		D. St.John			6/1/2012		
	Pre-enrollment script recorded and programmed		D. St.John			6/1/2012		
	Updated script recorded and programmed		D. St.John			6/1/2012		
	On hold messaging/night messages		D. St.John			6/1/2012		
	24 hour member hotline		Joan Gaughn			4/30/2012		
	Identify vendor/execute contract		Joan Gaughn			4/30/2012		
	Formalized disaster Plan for vendor		Joan Gaughn			3/1/2012		
	Provide training materials, call expectations to vendor		Joan Gaughn/ D. St.John			3/1/2012		
	Add to Language Line		D. St.John					
	Establish fax number		D. St.John					
	Build symposium/add staff to skill sets		D. St.John			2/1/2012		
	Build CS Reports		D. St.John			2/1/2012		
	Add staff to Verint		D. St.John			3/15/2012		
	Check supervisor and team assignments in system		D. St.John			3/15/2012		
	Obtain PR Territory List		D. St.John			6/1/2012		
	Schedule Module Meeting - Navigator		T. Habbershon			4/1/2012		
	Identify/build Navigator Work Queues		D. St.John/Tracy Habbershon			6/1/2012		
	A480 Clinical Notification Set up		D. St.John/Tracy Habbershon			3/1/2012		
	Nav Reporting		D. St.John					
	Build standard internal operations reports		D. St.John			5/15/2012		
	Identify required state/plan reports		D. St.John			5/15/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Obtain schedule of communications		D. St.John/ Kendall Marcocci			5/15/12012		
	Develop ID card sticker program		D. St.John					
	Obtain copies of printed materials/stationary		D. St.John			2/1/2012		
	Complaints & Grievance Process		D. St.John/Kevin O'Brien			6/1/2012		
	Submission timelines/requirements		D. St.John/Kevin O'Brien			6/1/2012		
	Turn-around times - expectations		D. St.John/Kevin O'Brien			6/1/2012		
	Identify process to handle Quality of Care/Quality of Service		D. St.John/Kevin O'Brien			6/1/2012		
	Build Navigator Complaint/Grievance work queues		D. St.John/Kevin O'Brien			6/1/2012		
	Letter templates		D. St.John/Kevin O'Brien			6/1/2012		
	Reporting Requirements		D. St.John/Kevin O'Brien			6/1/2012		
	Navigator PCR		D. St.John			6/1/2012		
	Appeals Process		Kevin O'Brien			6/1/2012		
	Essentials Procedure		D. St.John			6/1/2012		
	Submission timelines/requirements		Kevin O'Brien			6/1/2012		
	Turn-around times - expectations		Kevin O'Brien			6/1/2012		
	Build Navigator Appeal work queues		D. St.John/Kevin O'Brien			6/1/2012		
	Reporting Requirements		D. St.John/Kevin O'Brien			6/1/2012		
	Develop appeal backer language and DOL code		Kevin O'Brien / Bernard Lapine			4/15/2012		
	Develop communications to providers		Kendall Marcocci			3/15/2012		
	Develop communications to members		Kendall Marcocci			6/15/2012		
	Develop communication for community organizations		Joyce Williams			3/30/2012		
3.0	<b>Essentials Development</b>							
	Submit logo to have site built		D. St.John			6/1/2012		
	Establish content review process		D. St.John			6/1/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Build claims processing manual in essentials		D. St.John			6/1/2012		
	COB/FSC Assignment		D. St.John			6/1/2012		
	Sterilization		D. St.John			6/1/2012		
	Immunization		D. St.John			6/1/2012		
	Maternity		D. St.John			6/1/2012		
	ER		D. St.John			6/1/2012		
	Transplant		D. St.John			6/1/2012		
	Provider Letters		D. St.John			6/1/2012		
	Build Member Service Handbook in essentials		D. St.John			6/1/2012		
	PCP Change		D. St.John			6/1/2012		
	Transition of Care		D. St.John			6/1/42012		
	Sticker Survey		D. St.John			6/1/2012		
	Address Change		D. St.John			6/1/2012		
	COB		D. St.John			6/1/2012		
	<b>Process Control and Improvement</b>							
	Schedule Module Meeting							
	Provide required information to PC&I to set up RA		Kellene Parthemore / Colleen Hummel / Pam Shay			4/1/2012		
	Set up AP Entity in Print Vendor Dict		Pam Shay / Finance			6/1/2012		
	Provide Tax ID number of new plan		Pam Shay			6/1/2012		
	Physical Address of new plan		Pam Shay			6/1/2012		
	RA Footer Message determined (if any)		Pam Shay			6/1/2012		
	Plan refund address		Pam Shay			6/1/2012		
	Plan return address		Pam Shay			6/1/2012		
	Undeliverable mail address		Pam Shay			6/1/2012		
	Any backers for RA (i.e. negative remit)		Pam Shay			6/1/2012		
	Check run dates		Pam Shay			6/1/2012		
	Dynamic message (if any)		Pam Shay			6/1/2012		
	List of providers that never should receive (missing vendor)		Pam Shay			6/1/2012		
	Contact names (CSO Claims, Finance, PR) for implementation		Pam Shay			6/1/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Provide required information to PC&I to set up EOB (if applicable)		Kellene Parthemore / Colleen Hummel / Pam Shay			6/1/2012		
	Flag dispositions codes to trigger EOBs		D. St.John / PC&I			6/1/2012		
	DOL messages required		Bernard Lapine			6/1/2012		
	Link DOL message to appropriate backer		Pam Shay			6/1/2012		
	Determine EOB frequency		Bernard Lapine			6/1/2012		
	Define and establish denial notice requirement					6/1/2012		
	Design and Test EOBs / RA s /Appeal Insert		PC & I / Bernard Lapine / D.Hannon			6/1/2012		
4.0	<b>Medical Payment</b>							
	Schedule Module Meeting		Mike Clemons (Janene Hill)			03/23/12		
	Verisk/BHI/PCI setup (Bloodhound/Physician Claim Insight)		Mike Clemons (Janene Hill)			03/01/12		
	Testing Verisk/BHI/PCI		Mike Clemons (Janene Hill)			03/01/12		
	iHT setup (iHealth Technologies editing)		Mike Clemons (Janene Hill)			03/01/12		
	Testing iHT		Mike Clemons (Janene Hill)			02/01/12		
	Log tickets for set up		Mike Clemons (Janene Hill)			03/01/12		
	Activate plan in Dictionaries		Mike Clemons (Janene Hill)			03/01/12		
	Plan Specific Edits (Assistant Surgeon, MPR, etc.)		Mike Clemons (Janene Hill)			03/01/12		
	Excluded Providers (consider BHI, iHT, HDR)		Mike Clemons (Janene Hill)			04/01/12		
	Define and document process for vendor editing Disputes		Mike Clemons (Janene Hill)			04/01/12		
	Coventry High Dollar Process		Mike Clemons (Janene Hill)			05/01/12		
	Define claim types requiring MedPmt review (ER LOC, ER Prudent Lay, Unlisted Codes, etc...)		Mike Clemons (Janene Hill)			04/01/12		
	Ensure Med Payment documentation is available on Essentials		Mike Clemons (Janene Hill)			04/01/12		
5.0	<b>Recovery/Recovery Ops</b>							
	Schedule Module Meeting					4/1/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Define recovery parameters for PA		Leigh Cupelli			5/1/2012		
	Exclusions		Leigh Cupelli			5/1/2012		
	Letter set up/Approval		Leigh Cupelli / Tracy Habberson / D. St.John			5/1/2012		
	Subrogation		Leigh Cupelli			5/1/2012		
	Define method of recovery for state (offset vs. notification)		Leigh Cupelli			5/1/2012		
	State required reporting on recovery activity (i.e. COB)		Leigh Cupelli			5/1/2012		
	Set up Vendor extracts for Recovery		S. Thornton			5/1/2012		
	Recovery Vendor selection (FirstRecovery.Group, HMS)		E.Pendleton, L.			5/1/2012		
	Obtain Finance contact names for Ops		Kim Wilkinson / Dane Kreiss			5/15/2012		
	Lock Box Set Up: Address		Dane Kreiss			5/15/2012		
	Notify ACS that they will receive HAPA MA information		Kim Wilkinson			5/15/2012		
	Make sure recovery checks address appears on Remittance		Kim Wilkinson			5/15/2012		
	Navigator Set work queue set up:		Kim Wilkinson			5/15/2012		
	Recovery Team Queue for High \$ Review		Kim Wilkinson			5/15/2012		
	Recovery staff access IDX		Kim Wilkinson / Tina Blakley/ Theresa McMaster			5/15/2012		
	Recovery staff access Navigator		Kim Wilkinson / Tina Blakley/ Theresa McMaster			5/15/2012		
	<b>Finance :</b>					5/15/2012		
	Obtain Finance contact names for Ops		Kim Wilkinson/Tina Blakley / Theresa McMaster/ Finance			5/15/2012		
	Finance notify Recovery Ops when post-prior to the check run.		Kim Wilkinson/Tina Blakley / Theresa McMaster/ Finance			5/15/2012		
	Hand Check Process-Review/approval		Kim Wilkinson/Tina Blakley / Theresa McMaster/ Finance			5/15/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Net Refund Process-Review		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			5/15/2012		
	Review Stop Pay Process with CSO, Treasury and/or Finance		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			5/15/2012		
	Misdirects		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			5/15/2012		
	Mailing of voids		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			5/15/2012		
	Plan Tax ID #		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			5/15/2012		
	Capatation		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			5/15/2012		
	Finance access to Check & Proj Database		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			5/15/2012		
	Train Finance on Coventry Check and Project Database		Kim Wilkinson/Leigh Cupelli			5/15/2012		
	<b>CSO:</b>					5/15/2012		
	Review Stop Pay Process with CSO, Treasury and/or Finance - Comercial & Medicare		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			5/15/2012		
	CSO access to project database		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			5/15/2012		
	Train CSO on Coventry Project Database		Kim Wilkinson/Leigh Cupelli			5/15/2012		
6.0	<b>CSO Reporting</b>							
	Add Team/Staff to Non-Production Database		D. St.John/ Kozminski			3/1/2012		
	Build Pend Database		D. St.John/ Kozminski			4/1/2012		
	Add SWPA Medicaid to Government Programs Flash		Kozminski			3/15/2012		
	Add SWPA Medicaid to current standard reports		Kozminski			3/15/2012		
	State reporting requirements		D. St.John/ Kozminski			3/15/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
6.0	<b>SIU</b>							
	Define SIU process		Jodi Johnson			4/15/2012		
	Member letter review verification process		Jodi Johnson			4/15/2012		
	Member letter review recipient recipient					4/15/2012		
13.0	<b>Contracting Provider Relations</b>							
	Finalization of PCP capitation age/sex composites (Finance/Network Affairs)		E.Pendleton/J.Dioguardi			4/1/2012		
	Load of PCP demographic information (individual/group relations) and testing (Network Affairs/PSA)		J.Dioguardi/L.Griffin			4/15/2012		
	PCP capitation set-up and testing					4/15/2012		
	Production of provider directory		J.Dioguardi			7/15/2012		
	Geo-access weekly		J.Dioguardi			3/15/2012		
	Contract Strategy		J.Dioguardi/D.Fields			2/1/2012		
	Provider visits & education		J.Dioguardi/D.Fields/MLO			3/1/2012		
	Provider Blitz		J.Dioguardi			4/15/2012		
	Provider conference		J.Dioguardi			6/15/2012		
14.0	<b>Finance</b>							
	Load of finalized PCP capitation composites (Finance)					6/1/2012		
	Hospital financial competitive analysis		E. Pendleton			6/1/2012		
15.0	<b>Marketing</b>							
	Establish Marketing Plan (Radio, Print)		J.Williams			5/1/2012		
	Identify local papers/radio stations		J.Williams			4/15/2012		
	Bus advertisements		K. Marcocci			1/1/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Identify community leaders		J.Williams			4/15/2012		
	Identify community organizations		J.Williams			4/15/2012		
	Identify events from Sept 2012 - July 2012		J.Williams			2/1/2012		
	Feet on the Street campaign		J.Williams			1/1/6 - 3/31/6		
	Identify Spokesperson		J.Williams			6/1/2012		
	Set meetings with key leaders to introduce CC		J.Williams			4/1/2012		
	Place materials in key organizations		J.Williams			2/1/2012		
	Conduct focus group(s)		J.Williams			5/1/2012		
	Community leader conference		J.Williams			2/1/2012		
16.0	<b>Contracts</b>							
	Secure agreement w/mental health carriers		J. Gaughan/Bernard			5/1/2012		
	Establish contract with MBE/WBE		J. Gaughan			5/1/2012		
	Establish contracts with Children & youth agencies		B. Lapine			5/1/2012		
	Contract with fitness centers		J. Gaughan			5/1/2012		
	Vision/Dental Contracts		K. Hinson			5/1/2012		
17.0	<b>Clark Resources Phone set up for new 800?</b>		Joan Gaughan					
	Clark Resources Training					7/1/2012		
18.0	<b>Staffing</b>							
	Marketing Staff		MLO/D. Gallagher			6/1/2012		
	CSO Staff		J. Coppadage			6/1/2012		
	Special Needs		D.Milstead			6/1/2012		

CoventryCares from HealthAmerica  
 Operations Implementation Plan  
 Member Effective Date Target 3/1/2013

DAYS LEFT TIL GO  
 LIVE...  
 414  
 IDX PLATFORM: MEDMGR  
 HMO: 701

EL Code:  
 EL Name:  
 Mnemonic:  
 GL Entity:  
 AP Entity:

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
1.0	<b>Enrollment</b>							
	Schedule Module Meeting		Michelle Truitt					
	Set up enrollment location in MEDEDI (Dict 100)		Dane Kreiss			8/20/2012		
	Set up enrollment location in Production		Dane Kreiss			8/20/2012		
	Set up carrier code in EDI		Michelle Truitt			8/20/2012		
	Set up carrier code in Production		Michelle Truitt			8/20/2012		
	Set up Plan Type A in EDI		Lisa Ussia			8/20/2012		
	Set up Plan Type A in Production		Lisa Ussia			8/20/2012		
	PA Medicaid default FSC in EDI		Michelle Truitt			8/20/2012		
	PA Medicaid default FSC in Production		Michelle Truitt			8/20/2012		
	Define and document all Alert processes & Lock Ins		HS/Enrollment/CSO/ S.Kirkpatrick			8/20/2012		
	834 File Upload Process		Michelle Truitt			8/20/2012		
	Test 834 file		Michelle Truitt			8/20/2012		
	Weekly files		Michelle Truitt			8/20/2012		
	Define and document PCP Autoassignment letter creation process		Michelle Truitt			8/20/2012		
	Establish business rules and scope with EA&T		Michelle Truitt			8/20/2012		
	PCP auto assignment logic		Michelle Truitt			8/20/2012		
	Set up group structure		Michelle Truitt			9/15/2012		
	Set up billing process for Finance to run financial reconciliation		Michelle Truitt/Finance			9/15/2012		
	Define and document Newborn Process		Michelle Truitt			9/15/2012		
	Define and document Returned Mail and Kits		Michelle Truitt			9/15/2012		
	Vendor Eligibility Extracts		Sherry Thornton			9/15/2012		
	Involuntary Disenrollment process		Kelly Bonanno			9/15/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
2.0	<b>ID Cards/Kits</b>							
	ID card template for approval		Sue Melnychuk/Health Plan			8/20/2012		
	ID card queue created - extracts to ID Card/Kit Vendors		S.Thornton			8/20/2012		
3.0	<b>Front End Operations - Paper</b>							
	Request PO Box		B. Moore			11/15/2012		
	Create mailroom sorting document					11/15/2012		
	Review doc attach table		B. Moore			11/15/2012		
	Non-standards/Rejects Process		B. Moore			11/15/2012		
	Provide estimated claim receipts for PA Medicaid		D. St.John			11/15/2012		
	Define returned mail process		B. Moore			11/15/2012		
	Set up reject letter for ACS		B. Moore			11/15/2012		
4.0	<b>Front End Operations - EDI</b>							
	Fatal Edit Documentation		G. Wilson-Dorsey			11/15/2012		
	Request Payor ID #		B. Moore			11/15/2012		
	Verify member matching logic with new Medicaid ID field		B. Moore			11/15/2012		
	Review POS/TOB table		B. Moore/ D.St.John			11/15/2012		
	Ensure FEO documentation is available on Essentials		G. Wilson-Dorsey			11/15/2012		
	Document newborn process		B. Moore			11/15/2012		
	Mom & Baby billed on same claim		D. St.John			11/15/2012		
	PEARL Billing Areas		B. Moore			11/15/2012		
	Non-par billing provider selection (Skip par check)		G. Wilson-Dorsey			11/15/2012		
5.0	<b>PSA</b>							
	Schedule Module Meeting		Lara Griffin			9/30/2012		
	Add Plan Type to CPD		Lara Griffin	benefit plan load to prod on 10/27/11		9/28/2012		
	Enable the HAPA Medicaid product in CPD		Lara Griffin			9/30/2012		
	PROMISE ID set up		S.Thornton			8/20/2012		
	Load providers		Lara Griffin			2/20/2013		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Set up affiliation		Kim Graham			8/20/2012		
	Set up fee class		Kim Graham			8/15/2012		
	Vaccines For Children (VFC) Payment Set Up		Kim Graham			8/15/2012		
	DRGs		Kim Graham			8/15/2012		
	DRG Calculator					8/15/2012		
	Submit FSIFs, CARFs, build facility contracts		Kim Graham			8/15/2012		
	Determine PEARL Providers		Kim Graham			8/15/2012		
	Determine modifier table		Kim Graham			8/15/2012		
	Set up Rev/CPT table		Kim Graham			8/15/2012		
	Define provider selection process		Kim Graham			8/15/2012		
	Develop workflows to address contract issues		Kim Graham			8/15/2012		
	Non-Standard Contract Review Process		Kim Graham			8/15/2012		
6.0	<b>Benefits</b>							
	Schedule Module Meeting		Lisa Ussia			6/15/2012		
	Review member handbook		Lisa Ussia /Rachel Malsch			8/15/2012		
	Review and set up BRD for plan		Lisa Ussia /Rachel Malsch			8/20/2012		
	Determine number of benefit plans required		Lisa Ussia /Rachel Malsch			8/20/2012		
	Review authorization documents, determine codes, locations that require authorization		Lisa Ussia /Rachel Malsch			8/20/2012		
	Build plan header		Lisa Ussia /Rachel Malsch			8/20/2012		
	Update D2535		Lisa Ussia /Rachel Malsch			9/1/2012		
	Add plan to D689		Lisa Ussia /Rachel Malsch			9/1/2012		
	Build Benefit Plans in EDI		Lisa Ussia /Rachel Malsch			9/1/2012		
	Test Core Benefit Plan		D. St.John			10/1/2012		
	Test Addtl Benefit Plan(s)		D. St.John,			10/1/2012		
	Receive business and CSO Approvals (Core plan)		D. St.John/Health Plan			10/7/2012		
	Build Authorization Rules in EDI		Lisa Ussia / Jenny Richner			10/1/2012		
	Test Authorization Rules		D. St.John			10/1/2012		
	Receive business and CSO Approvals		D.St.John/ Health Plan			10/1/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Benefit limitation notifications - IDX set up		D. St.John/ D.Milstead/H. Gross			9/1/2012		
	Determine if riders will be required to support Transportation and Block Vision benefits		Lisa Ussia/S.Thornton			9/1/2012		
	Communicate IDX Plan Numbers to Distribution		Lisa Ussia / Rachel Malsch			8/20/2012		
	NDC Dictionary 9225/9226 set up		Lisa Ussia			8/20/2012		
7.0	<b>Claims</b>							
	Establish Rule Banks		Kelly Veatch / Nicole Huber / D. St.John			11/1/2012		
	Establish Night Job Rules		Kelly Veatch / Nicole Huber / D. St.John			11/1/2012		
	Review and revise duplicate/potential duplicate logic		Kelly Veatch / Nicole Huber / D. St.John			11/1/2012		
	Build claims queues		D. St.John			2/1/2013		
	Establish timely filing parameters		D. St.John			11/1/2012		
	Define interest parameters		Kelly Veatch / Finance			11/1/2012		
	Obtain copy of Provider Manual		D. St.John			9/1/2012		
	Reporting		D. St.John			11/1/2012		
	State required reports		D. St.John			11/1/2012		
	Build standard internal operations reports		D. St.John			11/1/2012		
	Encounter reporting		D. Maloney			11/1/2012		
	Establish team with EAS/Claims Quality		D. St.John			11/1/2012		
8.0	<b>Member Service</b>							
	Determine staffing needs		D. St.John			11/1/2012		
	Establish transition and hire dates		D. St.John			10/1/2012		
	Develop training plan		D. St.John			1/1/2012		
	Establish phone opening date		D. St.John			9/1/2012		
	Create initial talking points for member service		D. St.John			10/21/2011		
	Establish hours of operations		D. St.John			10/1/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Establish TDD Line		D. St.John			10/1/2012		
	Establish 800#		D. St.John/ D. Croce			10/1/2012		
	Check capability of zip code selection to route calls		D. Croce			10/1/2012		
	Identify and build skill sets		D. St.John			11/1/2012		
	Build scripts for IVR/Call Tree		D. St.John			11/1/2012		
	Build call routing to support 24 hour hotline		D. St.John			11/1/2012		
	Pre-enrollment script recorded and programmed		D. St.John			11/1/2012		
	Updated script recorded and programmed		D. St.John			11/1/2012		
	On hold messaging/night messages		D. St.John			11/1/2012		
	24 hour member hotline		Joan Gaughn			9/30/2012		
	Identify vendor/execute contract		Joan Gaughn			9/30/2012		
	Formalized disaster Plan for vendor		Joan Gaughn			9/30/3011		
	Provide training materials, call expectations to vendor		Joan Gaughn/ D. St.John			2/1/2013		
	Add to Language Line		D. St.John			1/1/2013		
	Establish fax number		D. St.John			1/1/2013		
	Build symposium/add staff to skill sets		D. St.John			1/1/2013		
	Build CS Reports		D. St.John			1/1/2013		
	Add staff to Verint		D. St.John			2/15/2013		
	Check supervisor and team assignments in system		D. St.John			2/15/2013		
	Obtain PR Territory List		D. St.John			11/1/2012		
	Schedule Module Meeting - Navigator		T. Habbershon			9/1/2012		
	Identify/build Navigator Work Queues		D. St.John/Tracy Habbershon			11/1/2012		
	A480 Clinical Notification Set up		D. St.John/Tracy Habbershon			2/1/2013		
	Nav Reporting		D. St.John			10/15/2012		
	Build standard internal operations reports		D. St.John			10/15/2012		
	Identify required state/plan reports		D. St.John			10/15/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Obtain schedule of communications		D. St.John/ Kendall Marcocci			1/1/2013		
	Develop ID card sticker program		D. St.John			1/1/2013		
	Obtain copies of printed materials/stationary		D. St.John			1/1/2013		
	Complaints & Grievance Process		D. St.John/Kevin O'Brien			1/1/2013		
	Submission timelines/requirements		D. St.John/Kevin O'Brien			1/1/2013		
	Turn-around times - expectations		D. St.John/Kevin O'Brien			1/1/2013		
	Identify process to handle Quality of Care/Quality of Service		D. St.John/Kevin O'Brien			1/1/2013		
	Build Navigator Complaint/Grievance work queues		D. St.John/Kevin O'Brien			1/1/2013		
	Letter templates		D. St.John/Kevin O'Brien			1/1/2013		
	Reporting Requirements		D. St.John/Kevin O'Brien			1/1/2013		
	Navigator PCR		D. St.John			1/1/2013		
	Appeals Process		Kevin O'Brien			1/1/2013		
	Essentials Procedure		D. St.John			1/1/2013		
	Submission timelines/requirements		Kevin O'Brien			1/1/2013		
	Turn-around times - expectations		Kevin O'Brien			1/1/2013		
	Build Navigator Appeal work queues		D. St.John/Kevin O'Brien			11/1/2012		
	Reporting Requirements		D. St.John/Kevin O'Brien			1/1/2013		
	Develop appeal backer language and DOL code		Kevin O'Brien / Bernard Lapine			9/15/2012		
	Develop communications to providers		Kendall Marcocci			8/15/2012		
	Develop communications to members		Kendall Marcocci			11/15/2012		
	Develop communication for community organizations		Joyce Williams			8/30/2012		
9.0	<b>Essentials Development</b>							
	Submit logo to have site built		D. St.John			1/1/2013		
	Establish content review process		D. St.John			1/1/2013		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Build claims processing manual in essentials		D. St.John			1/1/2013		
	COB/FSC Assignment		D. St.John			1/1/2013		
	Sterilization		D. St.John			1/1/2013		
	Immunization		D. St.John			1/1/2013		
	Maternity		D. St.John			1/1/2013		
	ER		D. St.John			1/1/2013		
	Transplant		D. St.John			1/1/2013		
	Provider Letters		D. St.John			1/1/2013		
	Build Member Service Handbook in essentials		D. St.John			1/1/2013		
	PCP Change		D. St.John			1/1/2013		
	Transition of Care		D. St.John			1/1/2013		
	Sticker Survey		D. St.John			1/1/2013		
	Address Change		D. St.John			1/1/2013		
	COB		D. St.John			1/1/2013		
	<b>Process Control and Improvement</b>							
	Schedule Module Meeting							
	Provide required information to PC&I to set up RA		Kellene Parthemore / Colleen Hummel / Pam Shay			1/1/2013		
	Set up AP Entity in Print Vendor Dict		Pam Shay / Finance			1/1/2013		
	Provide Tax ID number of new plan		Pam Shay			1/1/2013		
	Physical Address of new plan		Pam Shay			1/1/2013		
	RA Footer Message determined (if any)		Pam Shay			1/1/2013		
	Plan refund address		Pam Shay			1/1/2013		
	Plan return address		Pam Shay			1/1/2013		
	Undeliverable mail address		Pam Shay			1/1/2013		
	Any backers for RA (i.e. negative remit)		Pam Shay			1/1/2013		
	Check run dates		Pam Shay			1/1/2013		
	Dynamic message (if any)		Pam Shay			1/1/2013		
	List of providers that never should receive (missing vendor)		Pam Shay			1/1/2013		
	Contact names (CSO Claims, Finance, PR) for		Pam Shay			1/1/2013		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Provide required information to PC&I to set up EOB (if applicable)		Kellene Parthemore / Colleen Hummel / Pam Shay			1/1/2013		
	Flag dispositions codes to trigger EOBs		D. St.John / PC&I			1/1/2013		
	DOL messages required		Bernard Lapine			1/1/2013		
	Link DOL message to appropriate backer		Pam Shay			1/1/2013		
	Determine EOB frequency		Bernard Lapine			1/1/2013		
	Define and establish denial notice requirement					1/1/2013		
	Design and Test EOBs / RA s /Appeal Insert		PC & I / Bernard Lapine / D.Hannon			1/1/2013		
10.0	<b>Medical Payment</b>							
	Schedule Module Meeting		Mike Clemons (Janene Hill)			09/23/11		
	Verisk/BHI/PCI setup (Bloodhound/Physician Claim Insight)		Mike Clemons (Janene Hill)			02/01/13		
	Testing Verisk/BHI/PCI		Mike Clemons (Janene Hill)			02/01/13		
	iHT setup (iHealth Technologies editing)		Mike Clemons (Janene Hill)			02/01/13		
	Testing iHT		Mike Clemons (Janene Hill)			01/01/13		
	Log tickets for set up		Mike Clemons (Janene Hill)			01/01/13		
	Activate plan in Dictionaries		Mike Clemons (Janene Hill)			01/01/13		
	Plan Specific Edits (Assistant Surgeon, MPR, etc.)		Mike Clemons (Janene Hill)			02/01/13		
	Excluded Providers (consider BHI, iHT, HDR)		Mike Clemons (Janene Hill)			09/01/12		
	Define and document process for vendor editing Disputes		Mike Clemons (Janene Hill)			09/01/12		
	Coventry High Dollar Process		Mike Clemons (Janene Hill)			10/01/12		
	Define claim types requiring MedPmt review (ER LOC, ER Prudent Lay, Unlisted Codes, etc...)		Mike Clemons (Janene Hill)			09/01/12		
	Ensure Med Payment documentation is available on Essentials		Mike Clemons (Janene Hill)			09/01/12		
11.0	<b>Recovery/Recovery Ops</b>							
	Schedule Module Meeting							

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Define recovery parameters for PA		Leigh Cupelli			10/1/2012		
	Exclusions		Leigh Cupelli			10/1/2012		
	Letter set up/Approval		Leigh Cupelli / Tracy Habberson / D. St.John			10/1/2012		
	Subrogation		Leigh Cupelli			10/1/2012		
	Define method of recovery for state (offset vs. notification)		Leigh Cupelli			10/1/2012		
	State required reporting on recovery activity (i.e. COB)		Leigh Cupelli			10/1/2012		
	Set up Vendor extracts for Recovery		S. Thornton			10/1/2012		
	Recovery Vendor selection (FirstRecoveryGroup, HMS)		E.Pendleton, L.			10/1/2012		
	Obtain Finance contact names for Ops		Kim Wilkinson / Dane Kreiss			10/1/2012		
	Lock Box Set Up: Address		Dane Kreiss			10/1/2012		
	Notify ACS that they will receive HAPA MA information		Kim Wilkinson			10/1/2012		
	Make sure recovery checks address appears on Remittance		Kim Wilkinson			10/15/2012		
	Navigator Set work queue set up:		Kim Wilkinson			10/1/2012		
	Recovery Team Queue for High \$ Review		Kim Wilkinson			10/1/2012		
	Recovery staff access IDX		Kim Wilkinson / Tina Blakley/ Theresa McMaster			10/1/2012		
	Recovery staff access Navigator		Kim Wilkinson / Tina Blakley/ Theresa McMaster			10/1/2012		
	<b>Finance :</b>					10/1/2012		
	Obtain Finance contact names for Ops		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		
	Finance notify Recovery Ops when post-prior to the check run.		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		
	Hand Check Process- Review/approval		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Net Refund Process-Review		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		
	Review Stop Pay Process with CSO, Treasury and/or Finance		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		
	Misdirects		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		
	Mailing of voids		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		
	Plan Tax ID #		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		
	Capatation		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		
	Finance access to Check & Proj Database		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		
	Train Finance on Coventry Check and Project Database		Kim Wilkinson/Leigh Cupelli			10/1/2012		
	<b>CSO:</b>					10/1/2012		
	Review Stop Pay Process with CSO, Treasury and/or Finance - Comercial & Medicare		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		
	CSO access to project database		Kim Wilkinson /Tina Blakley / Theresa McMaster/ Finance			10/1/2012		
	Train CSO on Coventry Project Database		Kim Wilkinson/Leigh Cupelli			10/1/2012		
						10/1/2012		
12.0	<b>CSO Reporting</b>							
	Add Team/Staff to Non-Production Database		D. St.John/ Kozminski			10/1/2012		
	Build Pend Database		D. St.John/ Kozminski			10/1/2012		
	Add SWPA Medicaid to Government Programs Flash		Kozminski			10/1/2012		
	Add SWPA Medicaid to current standard reports		Kozminski			10/1/2012		
	State reporting requirements		D. St.John/ Kozminski			10/1/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
12.0	<b>SIU</b>							
	Define SIU process		Jodi Johnson			9/15/2012		
	Member letter review verification process		Jodi Johnson			9/15/2012		
	Member letter review recipient					9/15/2012		
13.0	<b>Contracting Provider Relations</b>							
	Finalization of PCP capitation age/sex composites (Finance/Network Affairs)		E.Pendleton/J.Dioguardi			9/1/2012		
	Load of PCP demographic information (individual/group relations) and testing (Network Affairs/PSA)		J.Dioguardi/L.Griffin			9/15/2012		
	PCP capitation set-up and testing					9/15/2012		
	Production of provider directory		J.Dioguardi			9/15/2012		
	Geo-access weekly		J.Dioguardi			9/1/2012		
	Contract Strategy		J.Dioguardi/D.Fields			9/1/2012		
	Provider visits & education		J.Dioguardi/D.Fields/MLO/D.Croce			8/1/2012		
	Provider Blitz		J.Dioguardi			9/15/2012		
	Provider conference		J.Dioguardi			1/15/2013		
14.0	<b>Finance</b>							
	Load of finalized PCP capitation composites (Finance)					11/1/2012		
	Hospital financial competitive analysis		E. Pendleton			11/1/2012		
15.0	<b>Marketing</b>							
	Establish Marketing Plan (Radio, Print)		D. Croce/J. Williams			10/1/2012		
	Identify local papers/radio stations		J. Williams			9/15/2012		
	Bus advertisements		K. Marcocci			1/1/2012		

Task #	Task Name	Comments	Responsible	Dependencies	Deadline to satisfy dependencies	Expected Completion	Actual Completion	Status
	Identify community leaders		J.Williams			9/15/2012		
	Identify community organizations		J.Williams			9/15/2012		
	Identify events from Sept 2011 - July 2012		J.Williams			1/1/2013		
	Feet on the Street campaign		J.Williams			12/1/2012 - 2/28/2012		
	Identify Spokesperson		J.Williams			9/15/2012		
	Set meetings with key leaders to introduce CC		D. Croce/J.Williams			7/15/2012		
	Place materials in key organizations		J.Williams			1/1/2013		
	Conduct focus group(s)		J.Williams			10/1/2012		
	Community leader conference		J.Williams			1/1/2013		
16.0	<b>Contracts</b>							
	Secure agreement w/mental health carriers		J. Gaughan/Bernard			10/1/2012		
	Establish contract with MBE/WBE		J. Gaughan			10/1/2012		
	Establish contracts with Children & youth agencies		B. Lapine			10/1/2012		
	Contract with fitness centers		J. Gaughan			10/1/2012		
	Vision/Dental Contracts		K. Hinson			9/30/2012		
17.0	<b>Clark Resources Phone set up for new 800?</b>		Joan Gaughan			9/15/2012		
	Clark Resources training							
18.0	Staffing							
	Marketing staff		D.Croce/J.Williams/MLO			1/1/2013		
	CSO staff		J. Coppadage			1/1/2013		
	Special Needs		D.Milstead			1/1/2013		

**APPENDIX K (2)**  
**HEDIS® REPORTING FORM**

This Appendix is for Offerors currently participating in the HealthChoices Program who began participating in the HealthChoices Program effective 4/1/2010 and for Offerors who operate as a Commercial HMO in Pennsylvania. These Offerors must provide 2009 and 2010 HEDIS® rates for the HEDIS® performance measures displayed in this Appendix for their Pennsylvania Commercial HMO.

	<b>HEDIS PERFORMANCE MEASURES</b>	<b>2009 Commercial HEDIS® Rate</b>	<b>2010 Commercial HEDIS® Rate</b>
<b>1</b>	<b>Controlling High Blood Pressure</b>	<b>78.93%</b>	<b>76.92%</b>
<b>2</b>	<b>Comprehensive Diabetes Care: HbA1c Poorly Controlled</b>	<b>13.44%</b>	<b>13.44%</b>
<b>3</b>	<b>Comprehensive Diabetes Care: LDL Control &lt;100</b>	<b>66.67%</b>	<b>67.66%</b>
<b>4</b>	<b>Prenatal Care in the First Trimester</b>	<b>97.78%</b>	<b>98.13%</b>
<b>5</b>	<b>Frequency of Ongoing Prenatal Care: &gt;81 Percent of the Expected Number of Prenatal Care Visits</b>	<b>N/A</b>	<b>N/A</b>
<b>6</b>	<b>Breast Cancer Screening (Ages 42-69 years)</b>	<b>71.54%</b>	<b>71.30%</b>
<b>7</b>	<b>Cervical Cancer Screening (Ages 24-64 years)</b>	<b>75.62%</b>	<b>73.74%</b>
<b>8</b>	<b>Cholesterol Management in Patients with Cardiovascular Conditions: LDL-C Controlled &lt;100</b>	<b>81.55%</b>	<b>81.55%</b>
<b>9</b>	<b>Annual Dental Visits (Ages 2-21 years)</b>	<b>N/A</b>	<b>N/A</b>
<b>10</b>	<b>Well-Child Visits in the First 15 Months of Life</b>	<b>85.25%</b>	<b>95.33%</b>
<b>11</b>	<b>Well-Care Visits in the Third, Fourth, Fifth and Sixth Years of Life</b>	<b>78.04%</b>	<b>83.55%</b>
<b>12</b>	<b>Adolescent Well-Care Visits</b>	<b>50.13%</b>	<b>54.41%</b>
<b>13</b>	<b>Lead Screening in Children</b>	<b>N/A</b>	<b>N/A</b>
<b>14</b>	<b>Emergency Department Utilization</b>	<b>191.50/1,000 Member years</b>	<b>196.16/1,000 Member years</b>

**INTENTIONALLY LEFT BLANK**

CoventryCares Delegated Vendor Oversight Committee (DVOC) Monthly Statistical Reporting Matrix

	January	February	March	April	May	June	July	August	September	October	November	December
<b>Davis Vision</b>												
<b>Clean Claims</b>												
# Received												
# Adj 30 days												
# Adj 31-45 days												
# Adj 46-90 days												
# Adj > 90 days												
# Rejected												
# Not Adjudicated												
<b>Service Stats</b>												
Total Calls												
% in VRU												
# Transferred												
Abandon rate												
% ans in 30 sec.												
<b>Provider Appeals</b>												
First Level												
Second Level												
<b>Provider Services</b>												
Authorizations Issued												
PSR ASA												
Abandon %												
<b>NIA</b>												
<b>Claims</b>												
# Paid Claims												
% Paid												
Paid Avg Days												
# Denied												
% Denied												
Denied Avg Days												
Total Claims												
Total Avg Days												
<b>Call Center Activity</b>												
# incoming calls												
# calls answered												
# abandoned												
# answered within threshold												
? Adding this to quarterly reports template vs. having total #s here and discuss any details												



CoventryCares Delegated Vendor Oversight Committee (DVOC) Monthly Statistical Reporting Matrix

	January	February	March	April	May	June	July	August	September	October	November	December
Complaints												
# Member Complaints												
# Provider Complaints												
Provider Hotline Inquiries												
MA Child Calls												
Authorizations												
Claim Inquiry												
Current Benefits												
MA Adult Calls												
Authorizations												
Claim Inquiry												
Current Benefits												
Eligibility												
Other												
Medicaid Limited												
Current Benefits												
Eligibility												
Total Calls												
Denials												
# of Denials												

**Delegated and Vendor Oversight Committee Meeting Minutes  
October 18, 2011**

Attendees	Present	Absent	Attendees	Present	Absent
Nancy Becker	X		Heather Gross	X	
Kelly Bonanno	X		Krista Herbein	X	
Rick Buzard, DO	X		Karen Hinson	X	
Jen Cornish	X		Jodi Johnson		X
Mark DaShiell, RN		X	Kathy Kalcevic	X	
Katrina DeLauter, RN		X	Suzanne Kelley, DO		X
Rick Forman		X	Bernard LaPine		X
Kristin Friends, RN	X		Susan Leitzell	X	
Mike Fuller		X	Donna Maloney		X
Jim Giardina		X	Dawn Milstead, RN		X
Erin Goodard	X		Elaina Wickas, RN		X
Tammy Brackbill		X	Suzanne Wilson	X	

**Time Meeting Called to Order:** 08:30 a.m. EST  
**Meeting Adjourned:** 08:55 a.m. EST

**Date Minutes Completed:** November 8, 2011  
**Minutes Completed By:** Erin Goodard

TOPIC/ISSUES IDENTIFIED FOR TODAY'S MEETING	MEANINGFUL DISCUSSION RELATED TO ISSUE	RECOMMENDED ACTION PLAN TO RESOLVE ISSUE	RESPONSIBLE PARTY
<b>OLD BUSINESS</b>			
Review of Minutes (Attachment I)	The minutes from the September 20 <sup>th</sup> , 2011 DVOC meeting were reviewed and approved as submitted. The minutes from the Ad Hoc meeting were also reviewed and approved as submitted.	(N/A)	N. Becker
NIA UM Timeliness Compliance Update (Medicaid)	R. Forman was unable to attend this month's meeting and will be updated at the next DVOC meeting. This item will remain on the agenda under Old Business.	Status of this issue will be updated at the next DVOC meeting.	R. Forman

**Delegated and Vendor Oversight Committee Meeting Minutes  
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TOPIC/ISSUES IDENTIFIED FOR TODAY'S MEETING	MEANINGFUL DISCUSSION RELATED TO ISSUE	RECOMMENDED ACTION PLAN TO RESOLVE ISSUE	RESPONSIBLE PARTY
<p><b>NEW BUSINESS</b></p> <p>Review of Vendor Reports</p>	<p><u>Davis Vision</u>  <i>Clean Claims</i>            Claims Received – 187            Adjudicated in 30 Days – 187            Not Adjudicated - 0  <i>Service Stats</i>            Total Calls – 20            % in VRU – 65%            # Transferred – 9            Abandonment Rate – 1.98%            % Answered in 30 Seconds – 72.96%</p> <p><i>Provider Services</i>            Authorizations Issued - 546            PSR ASA – 1:00            Abandonment Rate – 4.01%            Denials – 0</p> <p><b>*Note</b> – there is a correction to the August reporting for denials. It was originally reported as 2 denials for the month of August, however this was incorrect and should be 0.</p> <p><i>Claim Payment Accuracy</i>            Payment Accuracy – 99.28%            Financial Accuracy – 96.65%            Overall Accuracy – 99.47%</p> <p><u>DentaQuest</u>  <i>Claims</i>            Claims Received – 1007</p>		

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TOPIC/ISSUES IDENTIFIED FOR TODAY'S MEETING	MEANINGFUL DISCUSSION RELATED TO ISSUE	RECOMMENDED ACTION PLAN TO RESOLVE ISSUE	RESPONSIBLE PARTY
	<p>Adjudicated in 30 days – 1002 Not Adjudicated – 5 DentaQuest adjudicates twice a month, usually in the middle and end of the month. Claims received after the second date would not get run until the next month which would account for this number.)</p> <p>Member Complaints – 2 Provider Complaints - 2 Denials – 145</p> <p><i>Claim Payment Accuracy</i></p> <p>Payment Accuracy – 94.70% Financial Accuracy – 100% Overall Accuracy – 97.35%</p> <p><b><u>MHNet</u></b></p> <p><i>Average Speed of Answer</i></p> <p>% Answered Within 30 Seconds – 98.80% % Abandonment Rate – 1.10%</p> <p>Provider/DOI Complaints - 0 Provider Appeals – 0 Sentinel Events - 1</p> <p><i>Claims</i></p> <p>Denied-Electronic Total Number of Claims – 4216 Average Number of Days – 11 &lt;10 Days – 2403 11-15 Days – 408 16-30 Days – 1411 &gt;30 Days – 264</p> <p>Denied-Paper</p>		

**Delegated and Vendor Oversight Committee Meeting Minutes  
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TOPIC/ISSUES IDENTIFIED FOR TODAY'S MEETING	MEANINGFUL DISCUSSION RELATED TO ISSUE	RECOMMENDED ACTION PLAN TO RESOLVE ISSUE	RESPONSIBLE PARTY
	<p>Total Number of Claims – 60  Average Number of Days – 23.5  &lt;10 Days – 21  11-15 Days – 7  16-30 Days – 14  31-45 Days – 9  46-60 Days – 4  61-90 Days – 1  90+ Days – 4</p> <p>Paid-Electronic  Total Number of Claims – 9455  Average Number of Days – 11  &lt;10 Days – 5031  11-15 Days – 1123  16-30 Days – 2860  31-45 Days – 440  46-60 Days – 1  61-90 Days – 0  90+ Days – 0</p> <p>Paid-Paper  Total Number of Claims – 213  Average Number of Days – 45.5  &lt;10 Days – 37  11-15 Days – 17  16-30 Days – 32  31-45 Days – 45  46-60 Days – 26  61-90 Days – 26  90+ Days – 30</p> <p>The reason for the variance in the metrics this reporting period is due to MHNet switching over to a new IDX platform, and therefore, claims were put into a hold pattern for approximately 15 days.</p>		

## Delegated and Vendor Oversight Committee Meeting Minutes October 18, 2011

TOPIC/ISSUES IDENTIFIED FOR TODAY'S MEETING	MEANINGFUL DISCUSSION RELATED TO ISSUE	RECOMMENDED ACTION PLAN TO RESOLVE ISSUE	RESPONSIBLE PARTY
	<p><i>Claim Payment Accuracy</i></p> <p>Payment Accuracy – 95.20%            Financial Accuracy – 97.40%            Overall Accuracy – 83.10% (Goal is 95%)            MHNNet's response into inquiry regarding this metric being below goal for several months, is that this report includes ALL errors, including many that do not impact the payment of the claim.</p> <p><b><u>NIA</u></b></p> <p><i>Claims</i></p> <p>Total Claims – 8365            Total Average Days - .69            Total Paid Claims – 8239 (99%)            Paid Average Days - .69            Number Denied – 126            Percentage Denied – 1.51%            Denied Average Days - .89</p> <p><i>Call Center Activity</i></p> <p>Incoming Calls – 6493            Calls Answered – 6405            Abandoned – 88            Percent Abandoned – 1%            Answered Within Threshold – 4892            Answered After Threshold – 1513            Abandoned After Threshold – 43            Average Talk Time – 4:57            Average Answer Delay – :25</p> <p><i>UM Timeliness (Commercial)</i></p> <p>Total Cases Processed – 3880            Met Compliance – 3819 (98.43%)</p>		

**Delegated and Vendor Oversight Committee Meeting Minutes  
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TOPIC/ISSUES IDENTIFIED FOR TODAY'S MEETING	MEANINGFUL DISCUSSION RELATED TO ISSUE	RECOMMENDED ACTION PLAN TO RESOLVE ISSUE	RESPONSIBLE PARTY
	<p>Expedited Cases – 73 Exp. Cases Met Compliance – 72 (98.6%) <i>UM Timeliness (Medicare)</i> Standard and Retro Cases Processed – 1881 Met Compliance – 1881 (100%) Expedited Cases – 27 Met Compliance – 27 (100%) <i>UM Timeliness (Medicaid)</i> Cases Processed – 110 Met Compliance – 109 (99.09%) (Goal is 98%) Expedited Cases – 0</p> <p><b><u>McKesson</u></b> No reports were due at this time.</p> <p><b><u>ICORE</u></b> <i>Turnaround Time</i> <u>Standard Cases</u> Notification in 1 Calendar Day – 100% Determination in 24 hours – 88.89% Determination in 48 hours – 4.44% Determination in 72 hours – 2.22% Determination in 120 hours – 4.44% Average TAT – 8.44</p> <p><u>Expedited Cases</u> Notification in 1 Calendar Day – 100% Determination in 24 hours – 100% Average TAT – .08</p> <p><i>Determinations</i> <u>Standard Cases</u></p>		

**Delegated and Vendor Oversight Committee Meeting Minutes  
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TOPIC/ISSUES IDENTIFIED FOR TODAY'S MEETING	MEANINGFUL DISCUSSION RELATED TO ISSUE	RECOMMENDED ACTION PLAN TO RESOLVE ISSUE	RESPONSIBLE PARTY
	<p>Initial Requests – 49            Certified – 38 (77.55%)            Clinical Non-Certified – 3 (6.12%)            Admin. Non-Certified – 5 (10.20%)            Inactivated by Provider – 3 (6.12%)            Expedited Cases – 1            Certified – 1 (100%)</p> <p><i>Claims</i></p> <p>Total Claims – 548            Claims Paid in 5 days – 100%</p> <p><b>Medco</b></p> <p><i>Retail</i></p> <p>Claims Paid – 10729            Claims Rejected – 4596            Total Claims – 15325            Reject Percentage – 29.90%</p> <p><i>Reject Reasons</i></p> <p>Product/Service Not Covered – 689 (15%)            Filled After Coverage Terminated – 1073 (23.30%)            Refill Too Soon – 718 (15.60%)            DUR Reject Error – 397 (8.60%)            Prior Authorization Required – 278 (6%)</p> <p>No quarterly reports were due this month.</p>		
Quarterly Reports			
DentaQuest Corrective Action Plan	HealthAmerica has issued a corrective action plan for DentaQuest based on their encounter acceptance rate in report that is sent to DPW. The CAP is posted on the SharePoint. Deficiencies were found with respect to claim accuracy and claim completeness. The metric goal per the		

## Delegated and Vendor Oversight Committee Meeting Minutes October 18, 2011

TOPIC/ISSUES IDENTIFIED FOR TODAY'S MEETING	MEANINGFUL DISCUSSION RELATED TO ISSUE	RECOMMENDED ACTION PLAN TO RESOLVE ISSUE	RESPONSIBLE PARTY
	<p>contract with DentaQuest was 98% for PROMISE approved/paid status for all MCO paid/approved and specified MCO denied encounters by the last day of the third month. Included in the CAP are the findings of the DPW Timeliness and Accuracy report. The percentages for DentaQuest were in the 60<sup>th</sup> percentile, below the standard of 98%.</p> <p>DentaQuest must increase the file acceptance rate to the following standards and timelines:</p> <p>2011-10 - 88% acceptance            2011-12 - 93% acceptance            2012-01 - 95% acceptance            2012-03 - 98% acceptance</p> <p>Also, response file must be worked and issues identified and addressed within 5 business days of receiving file from Coventry.</p> <p>Part of the issue with the low acceptance rate has to do with DentaQuest having issues with their provider's NPI number matching with the number at the state level.</p> <p>DentaQuest is checking monthly encounter files to check for matching numbers. Providers who have not completed registration for an NPI numbers are being contacted to stress the importance of this. DentaQuest is also verifying all Promise IDs.</p> <p><b>Credentialing/Re-credentialing</b> - policies and procedures are based upon the NCQA standards and all demonstrated compliance with those standards as well as with the DPW's standards.</p> <p><b>Utilization Management</b> - policies and procedures are based upon the NCQA standards and all demonstrated compliance with those</p>		
DentaQuest Annual Delegation Oversight Audit			

## Delegated and Vendor Oversight Committee Meeting Minutes October 18, 2011

TOPIC/ISSUES IDENTIFIED FOR TODAY'S MEETING	MEANINGFUL DISCUSSION RELATED TO ISSUE	RECOMMENDED ACTION PLAN TO RESOLVE ISSUE	RESPONSIBLE PARTY
Davis Vision Annual Delegation Oversight Audit	<p>standards as well as with the DPW's standards.</p> <p><b>Claims Processing</b> – Compliance plan, which includes fraud reports, demonstrates compliance with applicable state and federal laws.</p> <p><b>Network Development</b> – Provider panel was compliant within the state standards.</p> <p>DentaQuest policies were reviewed and accepted at the April DVOC meeting and DentaQuest confirmed there were no changes to the 2010/2011 policies.</p> <p>HealthAmerica recommends continuing the current delegation of dental benefits management to DentaQuest for the Medicaid product.</p>		
	<p>Davis Vision maintains NCQA certification for their credentialing and re-credentialing functions through June 2012.</p> <p><b>2011 Quality Management</b> - plan was reviewed and demonstrated compliance with NCQA and CMS standards.</p> <p><b>2011 UM plan</b> - was reviewed and demonstrated compliance with NCQA, CMS and DPW standards.</p> <p><b>Claims Processing</b> - policies were reviewed and found to be compliant with the DPW program.</p> <p><b>Network Development</b> – Compliant with state standards. From a compliance standpoint, it was found that Davis Vision was <b>out of compliance</b> with state and federal laws. CoventryCares is requesting Davis Vision to incorporate the necessary elements within their Compliance Plan and provide appropriate oversight reports on fraud and abuse investigation and OIG review.</p>		

**Delegated and Vendor Oversight Committee Meeting Minutes  
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TOPIC/ISSUES IDENTIFIED FOR TODAY'S MEETING	MEANINGFUL DISCUSSION RELATED TO ISSUE	RECOMMENDED ACTION PLAN TO RESOLVE ISSUE	RESPONSIBLE PARTY
	<p>Davis Vision policies were reviewed and accepted at the April DVOC meeting and Davis Vision confirmed there were no changes to the 2010/2011 policies.</p> <p>HealthAmerica recommends continuing the current delegation of vision benefits management to Davis Vision for the Medicaid product.</p>		
Next Meeting	The next meeting will occur on November 15 <sup>th</sup> , 2011 at 8:30 am EST.	Minutes will be posted to SharePoint site prior to next meeting.	Erin Goodard Target: Next meeting
Adjournment	With no further business to discuss, the meeting was adjourned at approximately 8:55 a.m. EST.		

Nancy Becker  
Manager, Quality Improvement-Medicaid

Date Minutes Approved by Committee

**HealthAmerica / CoventryCares  
Corrective Action Plan**

**Corrective Action Required (CAR):**

**Contract Standard: Deficiencies have been identified relative to DentaQuest's claim accuracy and completeness per HealthAmerica's HealthChoices Physical Health Agreement with the State of Pennsylvania effective April 1, 2010. Per the Agreement, failure to achieve PROMISE approved/paid status for 98% of all MCO paid/approved and specified MCO denied encounters by the last day of the third month following initial MCO adjudication may result in a penalty.**

HealthAmerica / DentaQuest contract sections relative to meeting reporting requirements are as follow:

**E. Records, Reports and Inspections.**

1. Doral Dental shall submit an encounter report to Health Plan within thirty (30) days of the end of the month in which a claim is adjudicated. A properly completed HCFA 1500 form, or other applicable format as approved by Health Plan, accompanied by the required statistical and descriptive medical and patient information shall constitute an encounter report, unless otherwise required by the governing regulatory agencies. Doral Dental shall maintain and provide, and shall require Doral Dental Providers to maintain and provide, to Health Plan all medical, financial and administrative information and reports as may be necessary for (1) compliance by Health Plan with State and federal law; (2) Health Plan program management purposes; (3) Health Plan compliance with the reporting and quality assurance requirements of any contract between a government agency and Health Plan to provide health care services to a specified category of Members; and (4) such other legal purposes as determined by Health Plan from time to time.

L. Delegation of Claims Processing. Health Plan agrees to delegate to Doral Dental the responsibility of processing claims for and remitting payment to Doral Dental Providers for Covered Services rendered to Members as set forth in the Delegation Agreement attached hereto as Attachment C. Doral Dental shall adjudicate claims according to the requirements set forth in the contracts between Health Plan and the governmental agencies for the provision of health care services to Members, as well as in accordance with State and federal law and regulations. Additionally, Doral Dental shall be responsible for the resolution of complaints of Doral Dental Providers regarding any issues related to payment, the provision of Covered Services to Members and/or other matters regarding the performance of the obligations set forth in this Agreement. Doral Dental shall resolve Doral Dental Provider complaints and grievances in a timely manner and in accordance with any and all laws and regulations and other guidelines set forth by DPW and/or DOH or other State and federal governing regulatory agencies. Doral Dental shall maintain documentation of Doral Dental Provider complaints and the resolution thereof in accordance with the standards set forth by Health Plans and the governing regulatory agencies. Health Plan shall notify Doral Dental of deficiencies in Doral Dental's performance of claims processing duties to the extent that Health Plan is aware of said deficiencies. Doral Dental shall correct identified deficiencies in a manner acceptable to Health Plan. In the event that Doral Dental fails to process and pay claims as required by Health Plan pursuant to this delegation of the function of claims processing and in accordance with State and federal law and regulation, Health Plan may retract the delegation of claims processing. Additionally, in such event that Doral Dental fails to process and pay claims as required by Health Plan in accordance with the delegation of claims processing. Additionally, in such event that Doral Dental fails to process and pay claims as required by Health Plan in accordance with the delegation of the function and in accordance with State and federal law and regulation, the State or federal government agencies which oversee Health Plan may impose penalties and sanctions for such non-compliance, including, but not limited to, mandating retraction of the delegation of claims processing. To the extent that Health Plan is sanctioned, fined or otherwise subjected to a penalty by the State or federal government as a result of failure by Doral Dental to comply with the requirements of this section, Doral Dental shall indemnify Health Plan for the amount of the penalty levied against Health Plan by the government agency. Pursuant to this section, Health Plan may require Doral Dental to pay a penalty levied against Health Plan directly to the sanctioning governmental agency.

**Findings: Refer to PA DPW Timeliness Accuracy Report**

MCO	Cvty	MCO Plan Code	Encounter Type Code	Timeliness						Accuracy					
				90 Days or less	% 90 Days or less	91 - 120 Days	% 91 - 120 Days	121 Days or greater	% 121 or greater	Total ICN	Total Days	Avg Days	Paid	Denied	Accuracy Percentage
11-Jul	Cvty	49	D	1,106	75.86%	33	2.26%	319	21.88%	1,458	133,370	91	1,458	897	61.91%
11-Jun	Cvty	49	0	0	0	0	0	0	0	0	0	0	0	0	0
11-May	Cvty	49	D	522	100.00%	0	0.00%	0	0.00%	522	21,306	41	522	245	68.06%
11-Apr	Cvty	49	D	428	84.58%	7	1.38%	71	14.03%	506	35,077	69	506	457	52.54%

**Corrective Action Plan:**

Intervention Actions	Responsible Party (s)	Time Frame	Monitoring Approach & Frequency	Status
DentaQuest must increase file acceptance rate to the following levels and timeframes specified below: <b>I. Acceptance Rate</b> 2011-10 - 88% acceptance 2011-12 - 93% acceptance 2012-01 - 95% acceptance 2012-03 - 98% acceptance <b>II. Response File</b> Response file worked and issues identified and addressed within 5 business days of receiving file from Coventry	DentaQuest	As specified under intervention actions.	Progress to be monitored and discussed during weekly DentaQuest Encounter Calls and monthly Delegated Vendor Oversight Committee.	The October encounter file submission acceptance rate was 98%.  The November encounter file acceptance rate was 98.05%.  DentaQuest is in compliance with the CAP as of the last 4010 837 file submitted to DPW in 2011. CoventryCares will continue to monitor the

				acceptance rate in 2012 to ensure compliance is maintained with the conversion to the 5010 837 format.
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### **DentaQuest Response and Action Plan:**

- DentaQuest checks the monthly encounter file for provider matches on the PRV415 and PRV430 files.
- If a provider doesn't match on the PRV415/430 files, their claims are removed from the monthly encounter file and the provider's information is sent to Credentialing and Provider Relations to have the provider updated or to coordinate registration with DPW.
- DPW has appointed a personal resource to coordinate this effort and DentaQuest will supply the provider the name, phone number and fax number of the contact.
- Contact is made with DPW to see if the providers have completed the registration. If the provider has not followed up with DPW, another call is made to the provider to stress the importance of this registration.
- When the removed providers are registered with DPW and/or appear on the PRV415 and PRV430 reports, their claims are sent in a supplemental encounter file.
- DentaQuest verifies all promise ID numbers by checking the PRV files.
- DentaQuest updates the providers with the correct Sub Part NPI's as received from DPW relative to the denied encounters.
- The logic used in populating the encounter file was revised to look at the subpart field first and if nothing is there then to look at the business NPI.

[date]

*Certified Mail, Return-Receipt Requested*

[CEO Name]

[Company]

[address]

Dear [name]:

The attached document entitled [insert vendor name] Letter Audit Summary represents the statistical findings and the issues encountered for the [insert audit timeframe] letter audit.

The number of cases reviewed totaled [insert # of cases], which represents a sample of [insert type of letter reviewed] conducted by [insert vendor name] during [insert audit timeframe].

Based on the results of the letter audit and in accordance with the terms of our contract the [(insert vendor name) has been placed on a Corrective Action Plan or Corrective Action Plan remains in effect and deficiencies must be addressed immediately].

We look forward to our continued working relationship and prompt resolution of all outstanding issues. Should you have any questions or concerns please contact me at [number].

Sincerely,

[name and title]

Attachment Enclosed

cc: [insert names]

# Letter Audit Summary

Date of Review [Insert Date]

*ALL of the following requirements MUST be correct in order for each determination letter to pass audit standards:*

- *Correct Member Identification* (Incorrect or incomplete member identification number)
- *Correct Letter Template* (Correct letter template is driven by product type)
- *Compliance with Timeline Standards* (Did the turnaround timeframes meet regulatory/compliance guidelines)
- *Correct Contract Language* (Was the correct contract language chosen that refers to the specific medical necessity description for the plan type)
- *Documentation of Correct Criteria or Guidelines* (Was both criteria/guideline applied in addition to free text to make the letter specific to each member and their condition)
- *Correction of Clinical Documentation Errors* (Were clinical errors lined out and initialed or the word "error" written)
- *Correct Appeal Insert* (Was the correct appeal insert selected specific to the plan type utilized)
- *Reconsideration Process Documented* (Was a denial letter generated before the reconsideration letter was sent)
- *Correct Denial Rationale Utilized* (Was the correct rationale referenced in the denial letter)
- *Correct MD Signature and Stamp* (Was the full signature and signature stamp of the Medical Director documented)

## Summary:

A total of [insert #] letters were randomly selected for HealthAmerica's various lines of business [insert applicable lines of business reviewed] with a breakdown of the findings noted below.

[insert product name]

[insert #] letters reviewed

[list review results below]

- [summary of finding]
- [summary of finding]
- [summary of finding]

[insert product name]

[insert #] letters reviewed

[list review results below]

- [summary of finding]
- [summary of finding]
- [summary of finding]

[insert product name]

[insert #] letters reviewed

[list review results below]

- [summary of finding]

- [summary of finding]
- [summary of finding]

OVERALL AUDIT RESULTS: [insert % of the Letters that Passed Auditing Standards]

Note: [insert applicable notes concerning audit results]

Action Plan:

- [Review of deficiencies with vendor]
- [Summarize applicable vendor contract provisions related to audit findings and delegated functions, including, but not limited to, audit timeframes, information collected, reporting, plan of action, etc. A sample is provided as follows:
  - [Per the terms of the Agreement, Exhibit D, Delegation Addendum, Article 4, Reports, Audits and Access to Documentation, Section 4.1 Audits and Health America Policy #32 – “Delegating Utilization Functions to Contracted Groups”, HealthAmerica’s Utilization Management Department will be responsible for auditing time frames, information gathered to ensure adequate and appropriate response and compliance. Results of audited studies will be reviewed by the Utilization Management Committee and shared with the delegated group on a quarterly basis, or sooner if deemed necessary by the Committee. Deficits in performance will require a plan of action by the delegated group followed by a satisfactory resolution. The following protocol is followed for a determination letter audit:
    1. For a new delegate, for the 1<sup>st</sup> three (3) consecutive months of the effective date of the contract, a random sampling of the delegate’s determination letters will be audited.
    2. HealthAmerica designated staff will review determination letters to ensure that they are fully compliant with all applicable laws and regulations, and NCQA and CMS standards
    3. Results of the letter audit are reviewed by the Vice Presidents of Health Services. If the new delegates results reflect 95% compliance for each element, for 3 consecutive months, the new delegate will receive a certified letter from the Vice President of Health Services noting successful completion of the first 3 months review, and the new delegate will not be subject to further denial file review by the company until one of the following would occur first; either the first annual and/or subsequent annual reviews, or, HealthAmerica becomes aware of a determination letter concern. In the case of the latter, HealthAmerica has the option to begin letter audits which would be subject to the processes as identified in # 4-6 below.
    4. During the new delegates 1st three (3) consecutive months of review, should the audit results for any one of the three months reflect less than a 95% overall

scoring , HealthAmerica will request a corrective action plan (CAP) be implemented by the new delegate.

5. The new delegate will be required to submit a CAP within the time frames as outlined in their contract.
  
6. The above noted audit process will continue monthly until there are at least 3 consecutive months where the audit results indicate an error rate of less than 5%. The Vice President of Health Service will communicate the results of audit findings via letter as certified return receipt requested. All correspondence with the delegate regarding determination letter audits and/or corrective action plans and HealthAmerica expectations will be reviewed and approved by legal before submitted to the delegate.

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# List of Monthly, Quarterly, Annual and Ad-Hoc Reports

## **MEDICAL EXPENSE TREND**

Description: The Medical Expense Trend Report (MET Report) provides a high level overview of the medical expense trends. This application can show, in spreadsheet format or in a number of different charts, what the medical expense trend has been for a given measure.

Reports:

- Cost Per Unit
- PMPM
- Units per 1,000

## **CAPITATION**

Description: Provides detailed capitation agreement type reports

Reports:

- MET Capitation

## **MEDICAL EXPENSE REVIEW**

Description: The Medical Expense Review Reports (MER Reports) provides a high level overview of the medical review trends. This application can show, in spreadsheet format or in a number of different charts, what the medical review trend and normative comparison outliers have been for a given measure.

Reports:

- **High Level Plan View**
  - 1 High Level Plan View
  - 1-1A High Level Plan View
  - 1-1 Trend Review
- **Professional Services**
  - 2-1 Professional Data by Place of Service
  - 2-1A Primary Care by Procedure Code
  - 2-2 Professional Data by Specialty (All Places of Service)
  - 2-2A Specialist Drill-Down (All Places of Service)
  - 2-3 Selected Procedures
- **Outpatient Facility**
  - 3-1 Facility Outpatient Mid-Level
  - 3-2 Facility Outpatient Low Level (Dynamic Drill Down)
  - 3-3 Outpatient Surgery by Place of Service Unit Cost
  - 3-3A Outpatient Surgery by Place of Service Volume
  - 3-4 Outpatient Surgery Unit Cost by Facility
  - 3-5 ASC
  - 3-6 Emergency Room Unit Cost by Facility
  - 4-1 Radiology (Professional + Facility Expense Combined) : PMPM
  - 4-2 Radiology (Professional + Facility Expense Combined) : Utilization
  - 4-3 Radiology (Professional + Facility Expense Combined) : Unit Cost
  - 5 Pathology
  - 6 Injectibles

- **Inpatient Facility**
  - 7-1 Facility Inpatient - Referral Data
  - 7-1A Facility Inpatient - Referral Data Less Catastrophic
  - 7-2 Inpatient by Facility - Unit Cost
  - 7-2A Inpatient by Facility - Unit Cost Less Catastrophic
  - 7-3 Inpatient by Facility - Stop Loss

### **MILLIMAN ROBINSON / AGE GENDER**

Description: Milliman is used to see what the expected utilization will be based on age and sex factors

Reports:

- MER Age/Gender Reports

### **PHARMACY**

Description: Detail pharmacy trending for dollars, units, prescriptions, cost per script, days supply

Reports:

- MER Reports: Schedule 6 & 8 Pharmacy
- 6 Injectibles
- 8 Prescription Drug Detail
- 8-1 Prescription Drug Detail PMPM
- 8-1 Prescription Therapeutic Class Drug Detail PMPM
- 8-2 Prescription Drug Detail Cost per Script
- 8-2 Prescription Therapeutic Class Drug Detail Cost per Script
- 8-3 Prescription Drug Detail Scripts per 1000
- 8-3 Prescription Therapeutic Class Drug Detail Scripts per 1000
- 8a Prescription Paid by Therapeutic Class
- 9 Cardiology Summary
- MET Report - Pharmacy Trend Model

### **OUTPATIENT SURGERY**

Description: Provides episode claim data for outpatient surgeries and supports Medical Expense Review.

Reports:

- ASC Report
- Metric Trend
- Place of Service
- Compare Trend Metrics
- Metric Comparison
- Outpatient Surgery Blank
- Plan Comparison

### **HOSPITAL PROFILING**

Description: The Hospital Profile cube provides facility trending for Medical Expense Review reporting.

Reports:

- Hospital Compare with Graph
- Hospital Comparison Payment Modality
- Hospital DRG Report
- Hospital Metric Comparison
- Hospital Profile Blank
- Hospital Comparison Metrics
- Hospital Comparison Payments
- Hospital Metrics
- Hospital Trend
- Summary of Market Data

**MEDICAL LOSS RATIO (MLR)**

Description: Premium to Expenses for Employer Groups. Subscriber/Tier analysis.

Reports:

- Medical Loss Ratio Report
- Premium and Claims Report
- Age-Sex Population Report
- Subscribers Member Tier Report

**SIU / FRAUD & ABUSE**

Description: To provide the SIU Team access to data for Fraud & Abuse analysis

Reports:

- SIU fraud reporting
- SIU fraud detection reporting

**EMPLOYER GROUP REPORTING**

Description: Provides health care utilization information for Coventry health plans to meet contractual obligations. Employer group reporting is scheduled in coordination with health plans and is available on a monthly basis. Cognos and Excel macros calculate and format the data into Excel reports for the employer groups. In 2006, online reports with drill-down capabilities were deployed.

Reports:

- Paper HCUR Reports:
- Overall Statistics
  - 1-1 Summary of Results
  - 1-1a Medical Claims by Month
  - 1-1b Claims vs. Premium by Month
  - 1-3 Normative Comparisons
- Service Category
  - 2-0 Plan-Wide Comparisons, Medical Utilization
  - 2-1 Inpatient Detail
  - 2-2 Cost and Utilization Trend
  - 2-2a Cost and Utilization - Physician
  - 2-2b Cost and Utilization - Outpatient
- Network Experience
  - 3-1 Cost & Utilization

- 3-2 Top 25 Facility Report
- 3-2a Top 25 Nonfacility Report
- 3-3 Cost & Utilization – In and Out of Network
- 3-3a Cost & Utilization In and Out - Physician
- 3-4 Cost & Utilization Trend -- In-Network
- 3-5 Cost & Utilization Trend -- Out-of-Network
- 3-6 Network Savings/Member Share Report
- Impact Reports
  - 4-1 Claimants by Benefit Category
  - 4-2 Major Diagnostic Categories Summary (MDC)
  - 4-3 High Cost Claimant Report
- Eligibility Summary
  - 5-1 Eligibility Summary Graph
  - 5-2 Members by Age and Gender
  - 5-2a Subscribers by Age and Gender
  - 5-2b Membership by Region
  - 5-3 Members by Tier Type
- Pharmacy Reports
  - 6-0 Plan-Wide Comparisons, Rx Utilization
  - 6-1 Pharmacy Claimants by Benefit Category
  - 6-2 Pharmacy Usage
  - 6-2a Pharmacy Claims by Month
  - 6-3 Top 35 Drugs by Cost
  - 6-3a Top 35 Drugs by Utilization
  - 6-4 Top 25 Therapeutic Classes by Cost
  - 6-5 Pharmacy Utilization by Tier
- Online HCUR Reports
  - Report 1: Summary of Results
  - Report 2: Inpatient Detail
  - Report 3: Utilization Trend
  - Report 3a: Utilization Trend - Network Experience
  - Report 3b: Utilization Trend - In Network
  - Report 3c: Utilization Trend - Out of Network
  - Report 4: Membership Trends (Data)
  - Report 4: Membership Trends (Graph)
  - Report 5: Pharmacy Benefit Usage - Current Period
  - Report 5: Pharmacy Benefit Usage - Prior Period
  - Report 6: Claims by Relationship
  - Report 7: Members by Tier Type

### **HEDIS**

Description: Healthcare Effectiveness Data and Information Set – one of the most widely used set of health care performance measures developed by NCQA. Includes eight domains of care and 70 measures. HEDIS measures health plan performance from a quality of care perspective.

Reports:

- Ambulatory Care

- Newborns - Births and Average Length of Stay
- Chemical Dependency Utilization Inpatient Discharges and ALOS
- Maternity - Discharges and Average Length of Stay
- Effectiveness of Care and Like Measures
- Frequency of Selected Procedures
- Inpatient Utilization - General Hospital/Acute Care
- Inpatient Utilization Non-Acute
- Mental Health Inpatient Discharges and ALOS
- Identification of Alcohol and Other Drug Services
- Outpatient Drug Utilization
- Relative Resource Use for People with Acture Low Back Pain
- Relative Resource Use for People with Diabetes
- Relative Resource Use for People with Asthma

### **ADVERSE EVENTS**

Description: Provides reporting and drill down capabilities on the 23 adverse events which are currently reviewed by Coventry health plans.

Reports:

- Trend Report
- Facility Trend Report
- Event Trend Report
- Overall Trend Report
- High Level Report
- Plan Trend Report

### **DISEASE MANAGEMENT**

Description: Provides a standardized reporting tool to identify Coventry health plan members for enrollment in DM, summary data for the plans to track the effectiveness of their programs and provide detail data for the plans to perform member interventions

Reports:

- Member Demographics
- Member Non-Compliance
- Newly Identified Members
- Asthma Annual Compliance Report
- Asthma Annual Report
- Asthma Quarterly Report
- Annual Report
- Quarterly Report
- CAD Annual Compliance Report
- CAD Annual Report
- CAD Quarterly Report
- CHF Annual Compliance Report
- CHF Annual Report
- CHF Quarterly Report
- Chronic Renal Failure Annual Compliance Report
- Chronic Renal Failure Annual Report

- Chronic Renal Failure Quarterly Report
- COPD Annual Compliance Report
- COPD Annual Report
- COPD Quarterly Report
- Crohns Annual Compliance Report
- Crohns Annual Report
- Crohns Quarterly Report
- Depression Annual Compliance Report
- Depression Annual Report
- Depression Quarterly Report
- Diabetes Annual Compliance Report
- Diabetes Annual Report
- Diabetes Quarterly Report
- Hemophilia Annual Compliance Report
- Hemophilia Annual Report
- Hemophilia Quarterly Report
- HIV/AIDS Annual Compliance Report
- HIV/AIDS Annual Report
- HIV/AIDS Quarterly Report
- Low Back Pain Annual Compliance Report
- Low Back Pain Annual Report
- Low Back Pain Quarterly Report
- Multiple Sclerosis Annual Compliance Report
- Multiple Sclerosis Annual Report
- Multiple Sclerosis Quarterly Report
- Sickle Cell Annual Compliance Report
- Sickle Cell Annual Report
- Sickle Cell Quarterly Report
- Visits Report - Annual

### **OCCURRED BED DAYS**

Description: Provides standardized trend reporting for occurred bed days per thousand for Coventry with reporting by service codes, etc.

- Occurred Bed Days - Yearly Graph
- Occurred Bed Days - Medicaid
- Occurred Bed Days - Yearly Graph Medicaid
- Occurred Bed Days - Service Code

### **MARKET GROUPS / MARKET ANALYSIS**

Description: CDW extract for plans to evaluate group detail at member level. Business Reporting only provides data to the database.

Reports:

- Age and Gender
- Age and Gender by SuperGroup
- Age and Gender for Subscribers (by Contract Type)
- Subscribers and Dependents (Group/benefit plan/lob)

- Employee Spouse Child
- Contract Type
- Contract Type Analysis of Subscribers and Members
- Zip Code Membership
- PCP Addresses and Membership
- PCP Members
- PCP Membership
- Immunization Mailing List
- Nearing 65 Mailing List
- Subscriber Mailing List
- Subscriber Mailing List for 5160 Labels
- Subscriber Mailing List for Custom Labels (5360)
- Group Members Listing
- Benefit Plan Members Listing
- County Membership
- County PCP Count
- County PCP List
- County SuperGroup Count
- Member List
- Average Age
- Membership Reports
- Group Count By Plan Type

### **HIGH VOLUME EPISODES**

Description: Provides the Coventry medical management users with information on the most frequently occurring conditions for the health plan members based on ETG-grouped data.

Reports:

- CVTY All Plans Annual Report - All Places of Service
- CVTY All Plan Annual Report - By Plan of Service
- HVE Blank Report
- Plan Trend Report - All Places of Service
- Plan Trend Report - By Place of Service

### **READMISSIONS**

Description: Provides the Coventry health plans with admission and readmission data to identify quality management issues through trending, to supplement the disease management process and to enhance employer group reporting.

- Blank Report
- Readmission Admit Diagnosis Frequency
- Readmission Admit Facility Frequency
- Readmission Measure Trend Report
- Readmission Normative Report
- Readmission Plan Measures
- Readmission Plan Trend Report
- Readmission Readmit Diagnosis Frequency
- Readmission Readmit Facility Frequency

### **PROSPECTIVE RISK MODELING**

Description: Provides Coventry health plans with reports based upon the risks assigned to members based on the ERG methodology. In addition, the reports indicate which members are enrolled in Case Management and/or Disease Management programs. This allows the plans to better identify and manage those members with high risk of utilizing above average amount of resources.

- Report 1 Overall Prospective Risk Score
- Report 2 Distribution of Members by Risk Score
- Report 3.1 ERG Rollup Ranking by Member Frequency
- Report 3.2 ERG Ranking my Member Frequency
- Report 4 Select ERG Report by Member
- Report 5.1 Top 50 Members by Risk Score Summary
- Report 5.2 Top 50 Members by Risk Score Detail
- Report 6.1 Top 500 Members by Risk Score Summary
- Report 6.2 Top 500 Members by Risk Score Detail

### **1099 REPORTING**

Description: IRS Required 1099 Reporting

- Listing of payments to physicians
- Error Reporting

### **TRANSPLANTS - CLINICAL TRIALS**

Description: The Transplants & Clinical Trials Reporting database is used by the corporate Medical Technology Assessment team to report transplant and clinical trial costs for Coventry members to senior management.

Reports:

- Transplant Plan and Member Summary QTD (cumulative)
- Transplant Plan and Member Summary YTD
- Clinical Trials Plan and Member Summary QTD
- Clinical Trials Plan and Member Summary YTD
- Transplant Plan Summary QTD
- Transplant Plan Summary YTD
- Clinical Trials Plan Summary QTD
- Clinical Trials Plan Summary YTD
- Transplant Plan and Facility Summary QTD
- Transplant Plan and Facility Summary YTD
- Clinical Trials Plan and Facility Summary QTD
- Clinical Trials Plan and Facility Summary YTD
- Transplant Plan and Group Summary QTD
- Transplant Plan and Group Summary YTD
- Clinical Trials Plan and Group Summary QTD
- Clinical Trials Plan and Group Summary YTD
- Transplant Plan and Member Summary QTD (by plan)
- Transplant Plan and Member Summary YTD
- Clinical Trials Plan and Member Summary QTD

- Clinical Trials Plan and Member Summary YTD
- Transplant Employer Group Summary QTD
- Transplant Employer Group Summary YTD
- Clinical Trials Employer Group Summary QTD
- Clinical Trials Employer Group Summary YTD
- Transplant Facility Provider Summary QTD
- Transplant Facility Provider Summary YTD
- Clinical Trials Facility Provider Summary QTD
- Clinical Trials Facility Provider Summary YTD

### **TRANSPLANT NETWORK**

Description: The purpose of the Transplant Network database is to provide Coventry's case managers with a tool to properly document any member who has/had a transplant in his/her life.

#### Reports:

- Transplant Baseline
- Transplant Summary
- Phase 1 Facility Summary
- Phase 2 Facility Summary
- Phase 3 Facility Summary
- Phase 4 Facility Summary
- Phase 1 Transplant by Facility Summary
- Phase 2 Transplant by Facility Summary
- Phase 3 Transplant by Facility Summary
- Phase 4 Transplant by Facility Summary
- CTN Transplant by Plan
- CTN Transplant by Plan by Facility
- CTN Transplant by Plan by Group
- CTN Transplant by Plan by Member
- Exception Report

### **NAVIGATOR**

Activity Report

Average Activity Turnaround

Complaints

Department Production

Activities By Employer

Issue Details Report

Issue High Level

PCP Change Reasons

1st Call Resolution Report

1st Call Resolution – Summary Report

Activities Assigned To Workqueues Report

Activities Assigned To MCRN Workqueues Report

Activities Within 48 Hours\* Report

Activities Within 48 Hours\* – Summary Report

Activities Within 48 Hours With Detail

Data Elements

Activity History Report  
Closed Activities With Age Report  
Closed Activities With Age Range Report  
Complaint Detail Report  
Complaint Summary Report  
Employer Group Detail Report  
Flash Report 2 Or 3  
Mcrn Production Report  
Navigator Letters Report  
Open Activities With Age Report  
Open Activities With Age By Team Report  
Open Activities With Age Range  
PCR Top Five By Team Report  
Pharmacy Complaint Report  
Provider TIN Detail Report  
Purpose, Category, Reason Count Report  
Purpose, Category, Reason Count – Employer Group Report  
Secure E-Mails Report  
Team And User Report  
Workqueue And User Report  
Appeal Category Report  
Appeal Detail Report  
Appeal Overturn Report  
Appeal Overturn Report Excluding Employer Group  
Appeal Rate Report  
Appeal Status Report  
Average Days To Close Appeal  
Open Appeal Report

## **Data Completeness Monitoring Program (Claims and Encounters)**

### **I. Claims/Encounter Data Submitted to PH-MCO**

#### **a. Clean Claims submitted**

Providers and subcontractors are contractually required to submit clean claims to the PH-MCO. Most physician and ancillary providers are required to submit clean claims within 60 days from the date of service. Facility agreements require submission either 90 or 120 days from the date of service. When assuming secondary claim liability, submission is accepted within 120 days from the Third Party Liability (TPL) determination notice. Non-participating providers must submit claims within 180 days from the date of service, or the date of TPL determination notification.

Physicians must submit completed claims and encounter information on a HCFA 1500 Form. The information to be provided includes at least the following: (i) the Covered Individual's name, sex, date of birth and social security number; (ii) the date or dates services were rendered; (iii) CPT-4 codes describing those services; (iv) primary and secondary ICD-9-CM diagnosis codes; (v) tracking number for services requiring precertification; (vi) Physician's usual and customary fee for services rendered; (vii) Physician's federal tax identification number.

Hospitals submit claims for reimbursement and encounter forms, as required by PH-MCO, on a UB92 Form in accordance with the then current Medicare guidelines. Hospital must submit bills to PH-MCO within ninety (90) days of the date of discharge unless extenuating circumstances, including coordination of benefit issues, exist that PH-MCO believes are reasonable, in which case Hospital will notify PH-MCO in writing of such extenuating circumstances within ninety (90) days of discharge. Hospital shall submit claims no later than sixty (60) days after providing PH-MCO with notice of extenuating circumstances. Hospital may not bill PH-MCO for inpatient covered services prior to the date of discharge and cannot separate bills for covered services for purposes of additional payments.

#### **b. Additional information**

Providers are also required to supply additional information reasonably requested by the PH-MCO to verify that the provider rendered covered services, that the charges are usual and customary charges for such services, and that the services rendered were appropriate. Contracts include language that failure to submit claims in accordance with timely filing requirements may result in disallowance of payment. Providers agree to submit encounter information regarding services rendered to Covered Individuals when and as requested by PH-MCO

### **II. Claims/Encounter Data Submitted to DPW**

#### **a. Submission**

#### Weekly

- 837P for professional and drug claims
- 837I for inpatient, long term care and institutional outpatient

#### Bi-Monthly

- NCPDP 1.1 and NCPDP 5.1 requests for pharmacy drug claims
- NCPDP reversal for void of an accepted NCPDP encounter

#### Monthly

- Dental
- Vision

#### b. Monitoring

##### i. U277 – DPW Response file

PH-MCO's Business Reporting team will receive and load the U277 file into an access database on a weekly basis. Errors will be reviewed, logged, distributed to the appropriate department for correction within 72 hours of receipt of the U277 file. Encounter records that deny will be corrected and resubmitted as a "new day" encounter (if appropriate) on or before the last calendar day of the third month after the payment/adjudication calendar month in which the PH-MCO paid/adjudicated the claim.

##### ii. Suspended Encounters

Suspended encounter records will be adjusted on or before the last calendar day of the third month after the payment/adjudication calendar month in which the PH-MCO paid/adjudicated the claim.

##### iii. Rejected Files

Should an entire file be rejected, PH-MCO's Business Reporting team will review, distribute and track the 997 report generated by the BES Translator. Errors will be investigated and resolved and the files will be resubmitted

### III. Business Reporting

#### a. Database

A database is maintained of U277 response files and monitored by Business Reporting to ensure all errors are corrected timely.

PH-MCO's Business Reporting team will also complete a monthly review of all unresolved records tracked in the database to ensure timely correction, comparing date of service to submission date to ensure deadlines are met. Appropriate departments will be notified of upcoming deadlines.

b. Monthly Review

PH-MCO's Business Reporting team performs a monthly review of all encounter files involving a comparison to ensure provider/subcontractor comply with deadlines. Monthly meetings are held with Enrollment, Provider Relations and Claims Processing to discuss any corrections needed to improve encounter submission accuracy.

A detailed report of non-compliant providers/subcontractors will be provided to Provider Relations and/or vendor manager for follow-up.

Provider Relations or vendor manager will contact providers/subcontractors either by mail, or personal visit to review issues and develop appropriate action plans to correct any deficiencies.

Network Providers may be subject to sanctioning by HealthAmerica for failure to submit 100% of Encounters, including Encounters for capitated services. Network Providers may also be subject to sanctioning by HealthAmerica for failure to submit accurate Encounter data in a timely manner. Specific sanctions would depend upon the number and severity of incident. Sanctions, up to and including termination of the Agreement may apply if the provider or subcontractor demonstrates either an ongoing unwillingness or inability to comply with relevant standards and/or to implement corrective actions

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## HealthAmerica / CoventryCares Corrective Action Plan

### Corrective Action Required (CAR):

**Contract Standard: Deficiencies have been identified relative to DentaQuest's claim accuracy and completeness per HealthAmerica's HealthChoices Physical Health Agreement with the State of Pennsylvania effective April 1, 2010. Per the Agreement, failure to achieve PROMISE approved/paid status for 98% of all MCO paid/approved and specified MCO denied encounters by the last day of the third month following initial MCO adjudication may result in a penalty.**

HealthAmerica / DentaQuest contract sections relative to meeting reporting requirements are as follow:

E. Records, Reports and Inspections.

1. Doral Dental shall submit an encounter report to Health Plan within thirty (30) days of the end of the month in which a claim is adjudicated. A properly completed HCFA 1500 form, or other applicable format as approved by Health Plan, accompanied by the required statistical and descriptive medical and patient information shall constitute an encounter report, unless otherwise required by the governing regulatory agencies. Doral Dental shall maintain and provide, and shall require Doral Dental Providers to maintain and provide, to Health Plan all medical, financial and administrative information and reports as may be necessary for (1) compliance by Health Plan with State and federal law; (2) Health Plan program management purposes; (3) Health Plan compliance with the reporting and quality assurance requirements of any contract between a government agency and Health Plan to provide health care services to a specified category of Members; and (4) such other legal purposes as determined by Health Plan from time to time.

L. Delegation of Claims Processing. Health Plan agrees to delegate to Doral Dental the responsibility of processing claims for and remitting payment to Doral Dental Providers for Covered Services rendered to Members as set forth in the Delegation Agreement attached hereto as Attachment C. Doral Dental shall adjudicate claims according to the requirements set forth in the contracts between Health Plan and the governmental agencies for the provision of health care services to Members, as well as in accordance with State and federal law and regulations. Additionally, Doral Dental shall be responsible for the resolution of complaints of Doral Dental Providers regarding any issues related to payment, the provision of Covered Services to Members and/or other matters regarding the performance of the obligations set forth in this Agreement. Doral Dental shall resolve Doral Dental Provider complaints and grievances in a timely manner and in accordance with any and all laws and regulations and other guidelines set forth by DPW and/or DOH or other State and federal governing regulatory agencies. Doral Dental shall maintain documentation of Doral Dental Provider complaints and the resolution thereof in accordance with the standards set forth by Health Plans and the governing regulatory agencies. Health Plan shall notify Doral Dental of deficiencies in Doral Dental's performance of claims processing duties to the extent that Health Plan is aware of said deficiencies. Doral Dental shall correct identified deficiencies in a manner acceptable to Health Plan. In the event that Doral Dental fails to process and pay claims as required by Health Plan pursuant to this delegation of the function of claims processing and in accordance with State and federal law and regulation, Health Plan may retract the delegation of claims processing. Additionally, in such event that Doral Dental fails to process and pay claims as required by Health Plan in accordance with the delegation of the function and in accordance with State and federal law and regulation, the State or federal government agencies which oversee Health Plan may impose penalties and sanctions for such non-compliance, including, but not limited to, mandating retraction of the delegation of claims processing. To the extent that Health Plan is sanctioned, fined or otherwise subjected to a penalty by the State or federal government as a result of failure by Doral Dental to comply with the requirements of this section, Doral Dental shall indemnify Health

Plan for the amount of the penalty levied against Health Plan by the government agency. Pursuant to this section, Health Plan may require Doral Dental to pay a penalty levied against Health Plan directly to the sanctioning governmental agency.

**Findings: Refer to PA DPW Timeliness Accuracy Report**

Timeliness												Accuracy			
MCO	MCO Plan Code	Encounter Type Code	90 Days or less	% 90 Days or less	91 - 120 Days	% 91 - 120 Days	121 Days or greater	% 121 or greater	Total ICN	Total Days	Avg Days	Paid	Denied	Accuracy Percentage	
11-Jul	Cvty	49	D	1,106	75.86%	33	2.26%	319	21.88%	1,458	133,370	91	1,458	897	61.91%
11-Jun	Cvty	49		0	0	0	0	0	0	0	0	0	0	0	0
11-May	Cvty	49	D	522	100.00%	0	0.00%	0	0.00%	522	21,306	41	522	245	68.06%
11-Apr	Cvty	49	D	428	84.58%	7	1.38%	71	14.03%	506	35,077	69	506	457	52.54%

**Corrective Action Plan:**

Intervention Actions	Responsible Party (s)	Time Frame	Monitoring Approach & Frequency	Status
<p>DentaQuest must increase file acceptance rate to the following levels and timeframes specified below:</p> <p><b>I. Acceptance Rate</b></p> <p>2011-10 - 88% acceptance</p> <p>2011-12 - 93% acceptance</p> <p>2012-01 - 95% acceptance</p> <p>2012-03 - 98% acceptance</p> <p><b>II. Response File</b></p> <p>Response file worked and issues identified and addressed within 5 business days of receiving file from Coventry</p>	DentaQuest	As specified under intervention actions.	Progress to be monitored and discussed during weekly DentaQuest Encounter Calls and monthly Delegated Vendor Oversight Committee.	

**FORM B**  
**INSURANCE HOLDING COMPANY SYSTEM**  
**2010 ANNUAL REGISTRATION STATEMENT**

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Filed with the Insurance Department  
of the Commonwealth of Pennsylvania

By  
HealthAmerica Pennsylvania, Inc.

On Behalf of the Following Insurance Companies:

HealthAmerica Pennsylvania, Inc.  
3721 TecPort Drive  
Harrisburg, PA 17111

NAIC Code Number: 95060    State of Domicile: Pennsylvania

HealthAssurance Pennsylvania, Inc.  
3721 TecPort Drive  
Harrisburg, PA 17111

NAIC Code Number: 11102    State of Domicile: Pennsylvania

Coventry Health Care of Pennsylvania, Inc.  
CT Corporation System  
1515 Market Street - Suite 1210  
Philadelphia, PA 19102

NAIC Code Number: 95283    State of Domicile: Pennsylvania

March 31, 2011

Name, Title, Address and Telephone Number of Individual to Whom Notice and Correspondence  
Concerning This Statement Should be Addressed:

N. Timothy Guarneschelli  
Vice President & General Counsel  
HealthAmerica Pennsylvania, Inc.  
3721 TecPort Drive  
Harrisburg, PA 17111  
(717) 541-5957

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**Item 1. Identity and Control of Registrant**

This registration statement is being filed on behalf of the following Registrants:

**HealthAmerica Pennsylvania, Inc.**

Home Office and Principal Executive Office  
3721 TecPort Drive  
Harrisburg, PA 17111

HealthAmerica Pennsylvania, Inc. ("HealthAmerica") became a part of the Coventry Health Care, Inc. ("Coventry") insurance holding company system on April 1, 1998, pursuant to the merger of Coventry Corporation, of which HealthAmerica was a wholly owned subsidiary, with and into Coventry Merger Corporation, a wholly owned subsidiary of Coventry formed for the purpose of effectuating the merger, pursuant to a Capital Contribution and Merger Agreement dated as of December 19, 1997, by and among Coventry Corporation, Coventry, Coventry Health Care, Inc., a Maryland corporation, Principal Health Care, Inc., Principal Holding Company and Principal Mutual Life Insurance Company (the "Merger Agreement"). A copy of the Merger Agreement was filed with the Pennsylvania Insurance Department on January 13, 1998, as Exhibit A to Coventry's Form A filing. In June 2000, Coventry Corporation was merged into Coventry.

HealthAmerica relocated its headquarters from 2575 Interstate Drive, Harrisburg, PA 17110 to 3721 TecPort Drive, Harrisburg, PA 17111 effective August 1, 2002 and subsequently, a Certification by the Secretary of HealthAmerica to that effect was sent to the Pennsylvania Department of Insurance.

**HealthAssurance Pennsylvania, Inc.**

Home Office and Principal Executive Office  
3721 TecPort Drive  
Harrisburg, PA 17111

HealthAssurance Pennsylvania, Inc. ("HealthAssurance") became a part of the Coventry Health Care, Inc. insurance holding company system on May 14, 2001 upon receipt of the Pennsylvania Department of Insurance Certificate of Authority To Operate a Risk-Assuming Preferred Provider Organization Which Is Not A Licensed Insurer.

HealthAssurance relocated its headquarters from 2575 Interstate Drive, Harrisburg, PA 17110 to 3721 TecPort Drive, Harrisburg, PA 17111 effective August 1, 2002 and subsequently, a Certification by the Secretary of HealthAssurance to that effect was sent to the Pennsylvania Department of Insurance.

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**Coventry Health Care of Pennsylvania, Inc.**

Home Office and Principal Executive Office  
CT Corporation System  
1515 Market Street - Suite 1210  
Philadelphia, PA 19102

Coventry Health Care of Pennsylvania ("CHC - PA") became a part of the Coventry Health Care, Inc. insurance holding company system based on the following history:

The Articles of Incorporation were signed by Robert J. Mrizek, the sole incorporator of the Principal Health Care of Pennsylvania, Inc., on January 10, 1994 and filed with the Department of State on March 10, 1994, Entity No. 2563914.

On January 19, 1994, Principal Health Care, Inc. ("Principal") purchased one hundred percent of the authorized common stock of the Company, i.e., 1,000 shares at a par value of \$1 per share, for a total purchase price of one thousand dollars (\$1,000).

On March 9, 1994, the Company filed applications with the Department of Health and the Insurance Department for a Certificate of Authority to operate a Health Maintenance Organization (HMO) within the Commonwealth.

On October 16, 1996, Principal made a capital contribution to the Company in the amount of one million six hundred and forty-nine thousand dollars (\$1,649,000).

On November 22, 1996, the Pennsylvania Department of Health provisionally approved the Company's Plan of Operation and authorized its service area, namely, Chester, Delaware, Philadelphia and Montgomery Counties. The Department licensed Principal Health Care of Pennsylvania, Inc. on December 18, 1996.

Effective April 1, 1998, Principal sold its 100% ownership interest in Principal Health Care of Pennsylvania, Inc. to Coventry at which time CHC-PA became part of the Coventry insurance holding company system.

Principal granted permission to Coventry to use the name "Principal Health Care of Pennsylvania, Inc." under a trademark licensing agreement from April 1, 1998 to April 1, 2001. On May 19, 1999, both parties amended the trademark licensing agreement to provide, in part, for the termination of the trademark licensing agreement to be effective as of January 1, 2000. As per the Unanimous Written Consent of the Board of Directors of Principal Health Care of Pennsylvania, Inc. dated September 22, 1999, the Board voted to change the name to "Coventry Health Care of Pennsylvania, Inc." and amend the Articles of Incorporation, By-laws and any other items that carried the "Principal" name, to reflect the name change. This action was approved by the sole shareholder, Coventry on September 22, 1999. An amended Articles of Incorporation reflecting this change was submitted to the Pennsylvania Department of State on October 4, 1999. The By-laws were similarly amended to reflect the name change in addition to other minor items.

The Company is currently authorized to transact business under NLS 31 § 301.33 (a) (31 Pa.Code § 301.303 (a)) Health Maintenance Organization, Certificate of Authority.

**Item 2. Organization Chart**

An organizational chart of all affiliated persons within the insurance holding company system is attached hereto as **Exhibit A**.

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**Item 3. Ultimate Controlling Person**

The ultimate controlling person of the Registrants is as follows:

A. Coventry Health Care, Inc. ("Coventry") is the ultimate controlling person of the Registrants.

B. The home office address of Coventry is:

Coventry Health Care, Inc.  
6705 Rockledge Drive, Suite 900  
Bethesda, MD 20817

C. The principal executive office of Coventry is:

Coventry Health Care, Inc.  
6705 Rockledge Drive, Suite 900  
Bethesda, MD 20817

D. The organizational structure of Coventry is a Delaware corporation.

E. Coventry is a general business stock company.

F. The following entities currently hold or own ten percent (10%) or more of any class of voting security in Coventry:

Wellington Management (11.88%)

G. There are no current or past court proceedings involving a reorganization or liquidation of Coventry or its affiliates.

**Item 4. Biographical Information**

Current biographical information of the executive officers and directors of Coventry Health Care, Inc., the ultimate controlling person of the Registrants, is attached hereto as **Exhibit B**.

None of the executive officers or directors of Coventry Health Care, Inc. have been convicted of any crimes other than minor traffic violations during the past ten (10) years.

**Item 5. Transactions and Agreements**

- A. Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant and its affiliates:

**HealthAmerica Pennsylvania, Inc.**

None.

**HealthAssurance Pennsylvania, Inc.**

None.

**Coventry Health Care of Pennsylvania, Inc.**

None.

- B. Purchases, sales or exchanges of assets:

**HealthAmerica Pennsylvania, Inc.**

None.

**HealthAssurance Pennsylvania, Inc.**

None.

**Coventry Health Care of Pennsylvania, Inc.**

None.

- C. Transactions not in the ordinary course of business, including contributions of assets to Registrant:

**HealthAmerica Pennsylvania, Inc.**

None.

**HealthAssurance Pennsylvania, Inc.**

None.

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**Coventry Health Care of Pennsylvania, Inc.**

None.

- D. Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business:

**HealthAmerica Pennsylvania, Inc.**

None.

**HealthAssurance Pennsylvania, Inc.**

None.

**Coventry Health Care of Pennsylvania, Inc.**

None.

- E. All management agreements, service contracts and all cost-sharing arrangements:

**HealthAmerica Pennsylvania, Inc.**

1. Management Services Agreement between HealthAmerica and Coventry, entered into effective January 1, 1999. This agreement was amended effective January 1, 2003, a subsequent Second Amendment which was effective January 1, 2007, a subsequent Third Amendment which was effective July 1, 2007 a subsequent Fourth Amendment which was effective March 31, 2008, a Fifth Amendment effective February 1, 2009, and a Sixth Amendment effective March 1, 2010. Said Amendments were approved by HealthAmerica's Board of Directors and filed with the Department of Insurance. This agreement and amendments are attached hereto as **Exhibit D**.

Under this agreement, Coventry provides certain management and systems services to HealthAmerica. Management services include: consulting services in areas such as marketing, advertising and public relations; pharmacy purchasing arrangements; corporate accounting, tax and legal issues; SEC filings and reporting; human resources; and service center services. Fees charged for these management services are based on the number of members in HealthAmerica's health benefits plan each month. During 2010, HealthAmerica paid \$15,766,351.41 to Coventry for services provided by Coventry under this agreement.

2. Administrative Services Agreement between HealthAmerica and its affiliate Coventry Healthcare Management Corporation ("CHMC"), effective January 1, 1999. This

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agreement was amended effective January 1, 2000. This agreement as amended is attached hereto as **Exhibit E**.

Under this agreement, HealthAmerica provided certain administrative services to CHMC in support of the Preferred Provider Organization (“PPO”) and Gatekeeper PPO programs that CHCMC administers in Pennsylvania, Ohio and West Virginia. Such services include: management and general administrative services; sales and marketing services; financial services, such as underwriting and actuarial support and financial record keeping; medical management services; provider relations and contracting services; and facilities and support services. Fees charged for these services are based on the number of members enrolled each month in the PPO and Gatekeeper PPO plans that CHMC administers. During 2010, CHCMC paid \$7,026,455.87 for services provided by HealthAmerica under this agreement.

3. Administrative Services Agreement between HealthAmerica and its affiliate Coventry Health and Life Insurance Company (“CHL”), effective January 1, 1999. This agreement was amended effective January 1, 2000. This agreement as amended is attached hereto as **Exhibit F**.

Under this agreement, HealthAmerica provided certain administrative services to CHL in support of its Preferred Provider Organization (“PPO”) and Gatekeeper PPO programs in Pennsylvania, Ohio and West Virginia. Such services include: management and general administrative services; sales and marketing services; financial services, such as underwriting and actuarial support and financial record keeping; medical management services; provider relations and contracting services; and facilities and support services. Fees charged for these services are based on the number of members in CHL’s PPO and Gatekeeper PPO plans each month in the service area covered by the Agreement. During 2010, CHL paid \$1,876,067.84 to HealthAmerica for services provided by HealthAmerica under this agreement.

4. Trademark Sublicense Agreement between HealthAmerica and Penn Group Corporation (“PGC”), dated December 1, 1992.

Under the terms of an agreement between Coventry Corporation and Maxicare, Maxicare issued to Coventry Corporation a perpetual license for the use of the registered service mark “HealthAmerica” in certain states, including Pennsylvania. Coventry Corporation, in turn, sublicensed the service mark to PGC without charge and PGC sublicensed the service mark to HealthAmerica without charge. As Coventry Corporation and PGC have been merged into Coventry, Coventry has now sublicensed the service mark to HealthAmerica. On March 1, 2001 Coventry assigned its rights in the Agreement to Coventry Financial Management Services, Inc. and Maxicare Health Plans, Inc. This agreement is attached hereto as **Exhibit G**.

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Coventry Financial Management Services subsequently purchased Maxicare's interest in the Trademark Sublicense Agreement. During 2010, HealthAmerica paid \$6,054,355.89 to Coventry Financial Management Services.

5. Credentialing Agreement between HealthAmerica and Carelink Health Plans, Inc. ("Carelink") entered into effective April 1, 2000. This agreement is attached hereto as **Exhibit H**.

Under this agreement, Carelink provides certain credentialing and recredentialing services for HealthAmerica. Carelink provides this service in connection with HealthAmerica's HMO products in accordance with applicable state and federal law, National Committee Quality of Assurance, and American Accreditation HealthCare Commission/URAC standards. There are no payments under the terms of this Agreement.

6. Management Services and Global Capitation Agreement between HealthAmerica and Group Dental Services, Inc. ("GDS") entered into effective January 1, 2009. The Agreement was amended effective July 1, 2010, and September 1, 2010. This agreement and amendments are attached hereto as **Exhibit I**.

Under this agreement, GDS provides certain management services material to the operation of the dental business of HealthAmerica, including but not limited to, management and general administrative services, and financial services, medical management, provider relations and contracting, and facilities support. Fees charged for these services are based on the number of members in HealthAmerica's dental business each month. During 2010, HealthAmerica paid \$1,550,791.48 to GDS under this agreement.

7. Administrative Services Agreements between HealthAssurance and HealthAmerica, entered into effective April 18, 2001. This agreement is attached hereto as **Exhibit J**.

Under this agreement, HealthAmerica provides certain administrative services to HealthAssurance in support of its Preferred Provider Organization ("PPO") and Gatekeeper PPO programs in Pennsylvania. Such services include: management and general administrative services; sales and marketing services; financial services, such as underwriting and actuarial support and financial record keeping; medical management services; network access provider relations and contracting services; and facilities and support services. Fees charged for these services are based on the number of members in HealthAssurance's PPO and Gatekeeper PPO plans each month. During 2010, HealthAmerica received \$25,947,086.41 for services provided to HealthAssurance under this agreement.

8. HealthAmerica and MHNet Specialty Services (“MHNet”), a subsidiary of Coventry, entered into a behavioral health services agreement effective September 1, 2008 for the delivery of mental health and substance abuse services to HealthAmerica members. This agreement was amended effective October 1, 2010, and January 1, 2011. Fees charged by MHNet for these services are based upon the number of HealthAmerica members each month. HealthAmerica paid \$5,595,022.23 to MHNet in 2010. The agreement and amendments are attached hereto as **Exhibit K**.
9. HealthAmerica and Coventry Prescription Management Services, Inc. (CPMS), a subsidiary of Coventry, entered into an agreement pursuant to which CPMS will administer outpatient pharmacy benefits to HealthAmerica’s members. The agreement was effective January 1, 2011. The agreement is attached hereto as Exhibit CC.
10. HealthAmerica and Coventry Prescription Management Services, Inc. (CPMS), a subsidiary of Coventry, pursuant to which CPMS shall administer Medicare Advantage prescription drug benefit plans on behalf of HealthAmerica members. The agreement was effective January 1, 2011. The agreement is attached hereto as Exhibit DD.

#### **HealthAssurance Pennsylvania, Inc.**

1. Management Services Agreement between HealthAssurance and Coventry, entered into effective April 18, 2001. This agreement was amended effective January 1, 2003, January 1, 2007, July 1, 2007, February 1, 2009 and March 1, 2010. Said Amendments were approved by HealthAssurance's Board of Directors and filed with the Department of Insurance. This agreement and amendment are attached hereto as **Exhibit L**.

Under this Agreement, Coventry provided certain management services to Health Assurance. Such services include corporate services, claims processing and member services. During 2010, HealthAssurance paid \$45,097,741.75 to Coventry for services provided under this agreement.

2. Administrative Services Agreements between HealthAssurance and its affiliate HealthAmerica, entered into effective April 18, 2001. This agreement was amended effective February 1, 2003. This agreement and amendment are attached hereto as **Exhibit M**.

Under this agreement, HealthAmerica provides certain administrative services to HealthAssurance in support of its Preferred Provider Organization (“PPO”) and Gatekeeper PPO programs in Pennsylvania. Such services include: management and general administrative services; sales and marketing services; financial services, such as underwriting and actuarial support and financial record keeping;

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medical management services; network access provider relations and contracting services; and facilities and support services. Fees charged for these services are based on the number of members in HealthAssurance's PPO and Gatekeeper PPO plans each month. During 2010, HealthAssurance paid \$25,947,086.41 to HealthAmerica for services provided under agreement.

3. Management Services and Global Capitation Agreements between HealthAssurance and Group Dental Services, Inc. ("GDS") entered into effective January 1, 2009. The agreement was amended effective July 1, 2010, and September 1, 2010. This agreement and amendments are attached hereto as **Exhibit I**.

Under this agreement, GDS provides certain management services material to the operation of the dental business of HealthAssurance, including but not limited to, management and general administrative services, and financial services, medical management, provider relations and contracting, and facilities support. Fees charged by GDS for these services are based on the number of members in HealthAssurance's dental business each month. During 2010, HealthAssurance paid \$482,116.47 to GDS under this agreement.

4. HealthAssurance and MHNet Specialty Services ("MHNet"), a subsidiary of Coventry, entered into a behavioral health services agreement effective September 1, 2008 for the delivery of mental health and substance abuse services to HealthAssurance members. The agreement was amended effective October 1, 2010, and January 1, 2011. Fees charged by MHNet for these services are based upon the number of HealthAssurance members each month. HealthAssurance paid \$16,589,244.29 to MHNet in 2010. The agreement and amendments are attached hereto as **Exhibit K**.
5. Trademark License Agreement between HealthAssurance and HealthAssurance Financial Services, Inc., entered into effective June 1, 2001. This agreement is attached hereto as **Exhibit N**.

Under this agreement, HealthAssurance Financial Services, Inc. granted HealthAssurance a license to use the "HEALTHASSURANCE" service mark pursuant to the terms of the agreement. During 2010, HealthAssurance paid \$14,809,099.07 to HealthAssurance Financial Services, Inc.

6. HealthAssurance and Coventry Prescription Management Services, Inc. (CPMS), a subsidiary of Coventry, entered into an agreement pursuant to which CPMS will administer outpatient pharmacy benefits to HealthAssurance's members. The agreement was effective January 1, 2011. The agreement is attached hereto as Exhibit CC.
7. HealthAssurance and Coventry Prescription Management Services, Inc. (CPMS), a subsidiary of Coventry, pursuant to which CPMS shall administer Medicare Advantage prescription drug benefit plans on behalf of HealthAssurance members. The agreement was effective January 1, 2011. The agreement is attached hereto as Exhibit DD.

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**Coventry Health Care of Pennsylvania, Inc.**

1. Management Services Agreement between CHC-PA and Coventry, entered into effective April 1, 2002. This agreement was amended effective January 1, 2003 and January 1, 2007. Said Amendment was approved by HealthAssurance's Board of Directors and filed with the Department of Insurance. This agreement and amendment are attached hereto as **Exhibit O**.

Under this Agreement, Coventry provided certain management services to CHC-PA. Such services include corporate services, claims processing and member services. During 2010, CHC-PA paid \$0.00 to Coventry for services provided under this agreement.

2. Administrative Services Agreements between CHC-PA and its affiliate, Coventry Health Care of Delaware ("CHD-DE"), entered into effective June 1, 2002. This agreement is attached hereto as **Exhibit P**.

Under this agreement, CHC-DE provides certain administrative services to CHC-PA in support of its Health Maintenance Organization ("HMO") in Pennsylvania. Such services include: management and general administrative services; sales and marketing services; financial services, such as underwriting and actuarial support and financial record keeping; medical management services; network access provider relations and contracting services; and facilities and support services. Fees charged for these services are based on the number of members in CHC-PA's HMO each month. During 2010, CHC-PA paid \$0.00 to CHC-DE for services provided under agreement.

F. Reinsurance Agreements:

**HealthAmerica Pennsylvania, Inc.**

1. HMO Excess Risk Reinsurance Agreement between HealthAmerica and Coventry Health and Life Insurance Company ("CHL") effective April 1, 2001, to be terminated April 1, 2002 and subsequently amended as follows: effective April 1, 2002, effective April 1, 2003, effective April 1, 2004, effective April 1, 2005, effective April 1, 2006, effective April 1, 2007, effective April 1, 2008, April 1, 2009 and to be effective April 1, 2010. This agreement and amendments are attached hereto as **Exhibit Q**.

This agreement provides that CHL will provide HealthAmerica reinsurance coverage in accordance with the limits and deductibles set forth in the agreement. HealthAmerica filed a Form D with the Department of Insurance in connection with this agreement. During 2010, HealthAmerica paid \$2,909,050.00 for reinsurance premiums to CHL.

2. Guarantor Agreement between HealthAmerica and Coventry, entered into effective October 15, 2001. This agreement is attached hereto as **Exhibit R**.

Under this agreement, Coventry agrees to pay expenses and claims incurred by HealthAmerica in the event of HealthAmerica's insolvency.

#### **HealthAssurance Pennsylvania, Inc.**

1. Guarantor Agreement between HealthAssurance and Coventry, attached hereto as **Exhibit S**, entered into effective June 1, 2001 and Guaranty Agreement of Coventry on behalf of HealthAssurance for the Counties of Cumberland, Dauphin, Lancaster, Lebanon and Perry for the HealthChoices Behavioral Health Program dated October 1, 2001, renewed effective October 1, 2004, July 26, 2005, July 28, 2006, and October 1, 2006. The Agreement and the Guarantor Agreement were both terminated effective July 1, 2008. This agreement is attached hereto as **Exhibit C**.

Under this agreement, Coventry agreed to pay expenses and claims incurred by HealthAssurance in the event of HealthAssurance's insolvency.

2. Assignment and Assumption Agreement between HealthAssurance and Coventry Health and Life Insurance Company, entered into effective June 1, 2001. This agreement is attached hereto as **Exhibit T**.

Under this agreement, Coventry Health and Life Insurance Company transferred the assets and liabilities relating to certain businesses to HealthAssurance.

3. Non-Transferred Asset Reinsurance Agreement between HealthAssurance and Coventry Health and Life Insurance Company, entered into effective June 1, 2001. This agreement is attached hereto as **Exhibit U**.

Under this agreement, Coventry Health and Life Insurance Company transferred the assets and liabilities relating to certain businesses to HealthAssurance.

4. Excess Risk Reinsurance Agreement between HealthAssurance and Coventry Health and Life Insurance Company effective June 1, 2001, to be terminated April 1, 2002 and as amended, effective April 1, 2002 and subsequently amended as follows: effective April 1, 2003, effective April 1, 2004, effective April 1, 2005, effective April 1, 2006, effective April 1, 2007, effective April 1, 2008, effective April 1, 2009 and to be effective April 1, 2010. This agreement and the amendments are attached hereto as **Exhibit V**.

This agreement provides that Coventry Health and Life Insurance Company will provide HealthAssurance reinsurance coverage in accordance with the limits and deductibles set forth in the agreement. HealthAssurance filed a Form D with the Department of Insurance in connection with this agreement. During 2010,

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HealthAssurance paid \$14,041,522.00 for reinsurance premiums to Coventry Health and Life Insurance Company.

**Coventry Health Care of Pennsylvania, Inc.**

1. HMO Excess Risk Reinsurance Agreement between CHC-PA and Coventry Health and Life Insurance Company effective April 1, 2003 and a First Amendment effective April 1, 2005. This agreement is attached hereto as **Exhibit W**.

This agreement provides that Coventry Health and Life Insurance Company will provide CHC-PA reinsurance coverage in accordance with the limits and deductibles set forth in the agreement. CHC-PA filed a Form D with the Department of Insurance in connection with this agreement. During 2010, CHC-PA paid no remuneration for reinsurance premiums to Coventry Health and Life Insurance Company.

- G. Dividends and other distributions to shareholders:

**HealthAmerica Pennsylvania, Inc.**

HealthAmerica paid an extraordinary dividend in the amount of \$48,000,000.00 to its parent, Coventry, which was declared on May 26, 2010 and paid on June 28, 2010. This extraordinary dividend was approved by the HealthAmerica Board of Directors and the Pennsylvania Department of Insurance.

**HealthAssurance Pennsylvania, Inc.**

None.

**Coventry Health Care of Pennsylvania, Inc.**

None.

- H. Consolidated tax allocation agreements:

**HealthAmerica Pennsylvania, Inc.**

Federal Tax Allocation Agreement between HealthAmerica and Coventry entered into effective January 1, 1999 and a First Amendment effective December 31, 2004. This agreement is attached hereto as **Exhibit X**.

Under this agreement, federal income taxes paid by Coventry on a consolidated basis for itself and its several subsidiaries are allocated among those subsidiaries. Such allocations are calculated as if the specific subsidiary had filed its own tax

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return. Any funds determined to be payable as taxes are paid by the subsidiary to Coventry, while any funds determined to be refundable to the subsidiary are returned to the subsidiary by Coventry.

**HealthAssurance Pennsylvania, Inc.**

Federal Tax Allocation Agreement between HealthAssurance and Coventry entered into effective May 14, 2001 and a First Amendment effective December 31, 2004. This agreement is attached hereto as **Exhibit Y**.

Under this agreement, federal income taxes paid by Coventry on a consolidated basis for itself and its several subsidiaries are allocated among those subsidiaries. Such allocations are calculated as if the specific subsidiary had filed its own tax return. Any funds determined to be payable as taxes are paid by the subsidiary to Coventry, while any funds determined to be refundable to the subsidiary are returned to the subsidiary by Coventry.

**Coventry Health Care of Pennsylvania, Inc.**

Federal Tax Allocation Agreement between CHC - PA and Coventry entered into effective January 1, 1999 and a First Amendment effective December 31, 2004. This agreement is attached hereto as **Exhibit Z**.

Under this agreement, federal income taxes paid by Coventry on a consolidated basis for itself and its several subsidiaries are allocated among those subsidiaries. Such allocations are calculated as if the specific subsidiary had filed its own tax return. Any funds determined to be payable as taxes are paid by the subsidiary to Coventry, while any funds determined to be refundable to the subsidiary are returned to the subsidiary by Coventry.

- I. Any pledge of the Registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system:

**HealthAmerica Pennsylvania, Inc.**

None.

**HealthAssurance Pennsylvania, Inc.**

None.

**Coventry Health Care of Pennsylvania, Inc.**

None.

**Item 6. Litigation or Administrative Proceedings**

- A. Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party to the prosecutions or proceedings:

None.

- B. Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations:

None.

**Item 7. Statement Regarding Plan or Series of Transactions**

The Registrants has not entered into transactions that are a part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

**Item 8. Financial Statements and Exhibits**

Financial statements and exhibits are attached hereto as follows:

1. Financial statement for Coventry for 2010 that is found in the 2010 10-K filing is attached hereto as **Exhibit AA.**

**Item 9. Form C**

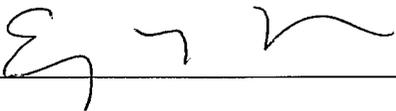
The Form C is attached hereto as **Exhibit BB**.

**Item 10. Signature and Certification**

**Signature**

Pursuant to the requirements of Section 1404 of the Act, the Registrant has caused this annual registration statement to be duly signed on its behalf in the City of Harrisburg and the Commonwealth of Pennsylvania on the 31<sup>st</sup> day of March, 2011.

**HealthAmerica Pennsylvania, Inc.**

By:  \_\_\_\_\_

Name: Evelyn N. Pendleton

Title: Vice President & Chief Financial Officer

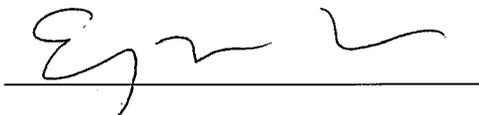
Attest:  \_\_\_\_\_

Name: N. Timothy Guarneschelli

Title: Secretary

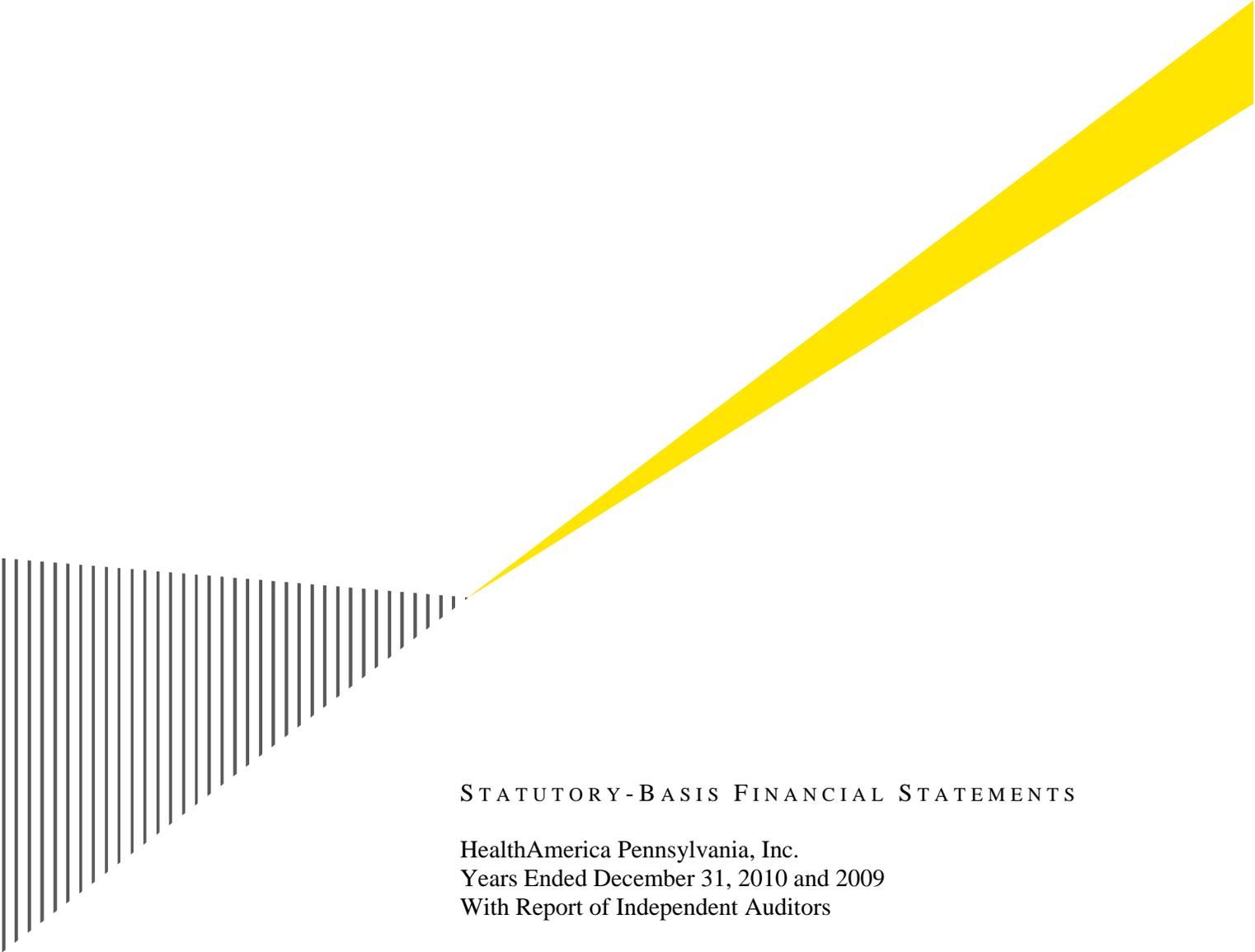
**Certification**

The undersigned deposes and says that he/she has duly executed the attached registration statement dated March 31, 2011 for and on behalf of HealthAmerica Pennsylvania, Inc. and that he/she is the Chief Financial Officer of such company and that he/she is authorized to execute and file such instrument. Deponent further says that he/she is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

Signature: 

Name: Evelyn N. Pendleton

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STATUTORY-BASIS FINANCIAL STATEMENTS

HealthAmerica Pennsylvania, Inc.  
Years Ended December 31, 2010 and 2009  
With Report of Independent Auditors

Ernst & Young LLP

 **ERNST & YOUNG**

HealthAmerica Pennsylvania, Inc.  
Statutory-Basis Financial Statements  
Years Ended December 31, 2010 and 2009

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## Report of Independent Auditors

Board of Directors  
HealthAmerica Pennsylvania, Inc.

We have audited the accompanying statutory-basis balance sheets of HealthAmerica Pennsylvania, Inc. (the Company) as of December 31, 2010 and 2009, and the related statutory-basis statements of operations, changes in capital and surplus, and cash flow for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 2, to the financial statements, the Company presents its financial statements in conformity with accounting practices prescribed or permitted by the Pennsylvania Department of Insurance, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles are described in Note 2. The effects on the financial statements of these variances are not reasonably determinable but are presumed to be material.

In our opinion, because of the effects of the matter described in the preceding paragraph, the financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of HealthAmerica Pennsylvania, Inc. at December 31, 2010 and 2009, or the results of its operations or its cash flows for the years then ended.

However, in our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HealthAmerica Pennsylvania, Inc. at December 31, 2010 and 2009, and the results of its operations and its cash flows for the years then ended, in conformity with accounting practices prescribed or permitted by the Pennsylvania Department of Insurance.

*Ernst & Young LLP*

April 28, 2011

HealthAmerica Pennsylvania, Inc.

Balance Sheets – Statutory-Basis

	<b>December 31</b>	
	<b>2010</b>	<b>2009</b>
<b>Admitted assets</b>		
Cash, cash equivalents, and short-term investments	\$ 40,298,862	\$ 15,780,824
Bonds	119,448,051	160,107,513
Restricted deposits	502,328	502,925
Receivables for securities	13,737	12,777
Total cash and invested assets	<u>160,262,978</u>	176,404,039
Premiums due and unpaid	4,267,733	7,045,891
Accrued retrospective premiums	7,242,720	13,440,911
Deferred tax assets, net	3,649,709	2,249,918
Amounts due from related parties	6,791,914	5,892,699
Other receivables	15,241,307	1,880,713
Total admitted assets	<u>\$ 197,456,361</u>	<u>\$ 206,914,171</u>
<b>Liabilities and capital and surplus</b>		
Liabilities:		
Liability for unpaid claims and claim adjustment expenses	\$ 57,875,127	\$ 59,115,595
Premiums received in advance	826,600	1,334,193
Accrued expenses	15,521,086	13,858,934
Other liabilities	29,650,715	28,483,461
Income taxes payable	2,005,817	3,922,964
Amounts due to related parties	2,327,348	2,359,319
Total liabilities	<u>108,206,693</u>	<u>109,074,466</u>
Capital and surplus:		
Common stock, \$1.00 par value; 5 shares authorized, issued and outstanding	5	5
Additional paid-in capital	2,888,585	2,888,585
Unassigned surplus	86,361,078	94,951,115
Total capital and surplus	<u>89,249,668</u>	<u>97,839,705</u>
Total liabilities and capital and surplus	<u>\$ 197,456,361</u>	<u>\$ 206,914,171</u>

See accompanying notes.

HealthAmerica Pennsylvania, Inc.

Statements of Operations – Statutory-Basis

	<b>Year Ended December 31</b>	
	<b>2010</b>	<b>2009</b>
Premiums, net	<b>\$ 479,769,668</b>	\$ 608,309,210
Expenses:		
Health benefits	<b>388,159,611</b>	526,416,357
General administrative	<b>41,298,424</b>	46,381,785
Total expenses	<b>429,458,035</b>	572,798,142
Gain from operations	<b>50,311,633</b>	35,511,068
Investment income, net	<b>6,212,881</b>	7,413,528
Gain from operations before federal income tax	<b>56,524,514</b>	42,924,596
Federal income tax provision	<b>18,639,904</b>	19,417,042
Net income	<b>\$ 37,884,610</b>	\$ 23,507,554

*See accompanying notes.*

HealthAmerica Pennsylvania, Inc.

Statements of Changes in Capital and Surplus – Statutory-Basis

	<b>Common Stock</b>	<b>Additional Paid-in Capital</b>	<b>Unassigned Surplus</b>	<b>Total</b>
Balance at December 31, 2008	\$ 5	\$ 2,888,585	\$ 87,326,021	\$ 90,214,611
Net income	-	-	23,507,554	23,507,554
Dividend to Parent	-	-	(16,000,000)	(16,000,000)
Increase in nonadmitted assets	-	-	(4,234,390)	(4,234,390)
Change in net deferred taxes	-	-	4,351,930	4,351,930
Balance at December 31, 2009	5	2,888,585	94,951,115	97,839,705
Net income	-	-	<b>37,884,610</b>	<b>37,884,610</b>
Dividend to Parent	-	-	<b>(48,000,000)</b>	<b>(48,000,000)</b>
Decrease in nonadmitted assets	-	-	<b>190,413</b>	<b>190,413</b>
Change in net deferred taxes	-	-	<b>1,334,940</b>	<b>1,334,940</b>
Balance at December 31, 2010	<b>\$ 5</b>	<b>\$ 2,888,585</b>	<b>\$ 86,361,078</b>	<b>\$ 89,249,668</b>

*See accompanying notes.*

HealthAmerica Pennsylvania, Inc.

Statements of Cash Flow – Statutory-Basis

	<b>Year Ended December 31</b>	
	<b>2010</b>	<b>2009</b>
<b>Operating activities</b>		
Premiums collected, net of reinsurance paid	\$ 490,632,568	\$ 619,398,686
Claims and claims adjustment expenses paid	(423,421,621)	(550,753,509)
Administrative expenses paid	(21,483,998)	(23,634,152)
Net investment income received	6,806,973	6,213,955
Federal income taxes paid	(20,233,344)	(12,711,920)
Net cash provided by operating activities	<u>32,300,578</u>	38,513,060
<b>Investing activities</b>		
Proceeds from sales and maturities of bonds	68,776,789	18,727,520
Purchases of bonds	(28,262,491)	(49,078,893)
Net gain on cash, cash equivalents, and short term investments	(323,707)	676
Miscellaneous	(960)	(4,990)
Net cash provided by (used in) investing activities	<u>40,189,631</u>	(30,355,687)
<b>Financing and miscellaneous activities</b>		
Dividend paid to parent	(48,000,000)	(16,000,000)
Other cash provided (used)	27,829	(5,291,921)
Net cash used in financing activities	<u>(47,972,171)</u>	(21,291,921)
Change in cash, cash equivalents, and short-term investments	24,518,038	(13,134,548)
Cash, cash equivalents, and short-term investments at beginning of year	<u>15,780,824</u>	28,915,372
Cash, cash equivalents, and short-term investments at end of year	<u>\$ 40,298,862</u>	<u>\$ 15,780,824</u>

See accompanying notes.

# HealthAmerica Pennsylvania, Inc.

## Notes to Statutory-Basis Financial Statements

December 31, 2010

### **1. Organization**

HealthAmerica Pennsylvania, Inc. (the Company or HAPA) is a federally qualified network model health maintenance organization that provides comprehensive health care services on a prepaid basis to individuals, businesses, and governmental agencies throughout Pennsylvania and Ohio. The Company also provides Medicare Advantage services in central and western Pennsylvania. CoventryCares, HealthAmerica's new Medicaid product, launched April 1, 2010. CoventryCares is currently servicing the Southeastern portion of Pennsylvania.

The Company is a wholly owned subsidiary of Coventry Health Care, Inc. (Coventry). Coventry, headquartered in Bethesda, Maryland, is a national managed health care company that provides a full range of risk and fee-based managed care products and services, including health maintenance organizations, preferred provider organizations, point of service products, Medicare Advantage, Medicare Prescription Drug Plans, Medicare Private Fee-For-Service Plans (PFFS), Medicaid, Workers' Compensation, and Network Rental to a broad cross section of individuals, employer and government-funded groups, government agencies, and other insurance carriers and administrators in all 50 states.

On May 1, 2009, Coventry notified the Centers of Medicare and Medicaid Services that effective January 1, 2010, Coventry will cease offering the PFFS product. Coventry is liable for claim run-out through December 31, 2011.

### **2. Summary of Significant Accounting Policies**

#### **Basis of Presentation**

The Company prepares statutory-basis financial statements in conformity with accounting practices prescribed or permitted by the State of Pennsylvania Department of Insurance. The State of Pennsylvania Department of Insurance requires that insurance companies domiciled in the State of Pennsylvania prepare their statutory-basis financial statements in accordance with the Codified National Association of Insurance Commissioners' Statements of Statutory Accounting Principles' (NAIC SAP), subject to any deviations prescribed or permitted by the State of Pennsylvania insurance commissioner.

Statutory accounting practices differ from accounting principles generally accepted in the United States (GAAP). The effects on the financial statements of these variances are not reasonably determinable but are presumed to be material. Significant variances between GAAP and statutory-basis financial statements are as follows:

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

##### *Nonadmitted Assets*

- Certain assets designated as “nonadmitted,” principally receivables aged greater than 90 days, furniture and equipment, prepaid expenses, certain deferred tax assets, and other assets not specifically identified as an admitted asset by NAIC SAP, are excluded from the accompanying balance sheets – statutory-basis and are charged directly to unassigned surplus. Under GAAP, such assets are included in the balance sheet.

##### *Investments*

- Investments in bonds are reported at amortized cost or fair value based on their National Association of Insurance Commissioners (NAIC) rating; for GAAP, such fixed maturity investments would be designated at purchase as held-to-maturity, trading, or available-for-sale. Held-to-maturity fixed investments would be reported at amortized cost, and the remaining fixed maturity investments would be reported at fair value with unrealized holding gains and losses reported in operations for those designated as trading and as a separate component of capital and surplus for those designated as available-for-sale, except for the impact of other-than-temporary impairments.

##### *Impairment*

- As discussed later in Note 2, the impairment of loan-backed and structured securities is evaluated based on the company’s intent to sell. If the company intends to sell a loan-backed or structured security that is in an unrealized loss position, the difference between fair value and amortized cost is recognized as a realized loss. If the company has the intent and ability to hold a loan-backed or structured security for which fair value is less than amortized cost, an evaluation of the interest-related impairment is performed based on a discounted cash flow analysis, which determines the amount of the impairment charge that is recognized as a realized loss. Any interest-related portion of the unrealized loss is recognized through capital and surplus. Under GAAP, the evaluation of interest-related and non-interest-related impairment charges is not limited to loan-backed and structured securities.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

##### *Deferred Income Taxes*

- Deferred tax assets are first assessed to determine if a statutory valuation allowance is required to reduce gross deferred tax assets to the amount that is more-likely-than-not to be realized. Adjusted gross deferred tax assets are then limited to 1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year, plus 2) the lesser of the remaining adjusted gross deferred tax assets expected to be realized within one year of the balance sheet date or 10% of capital and surplus of the most recently fixed statement with the domiciliary state commissioner adjusted to exclude any net deferred tax assets, electronic data processing equipment and operating software, and any net positive goodwill, plus 3) the amount of remaining adjusted gross deferred tax assets that can be offset against existing gross deferred tax liabilities. The remaining deferred tax assets are nonadmitted. Deferred taxes do not include amounts for state taxes. Under GAAP, state taxes are included in the computation of deferred taxes and a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years.

##### *Negative Cash*

- Certain short-term borrowings are classified as a reduction of cash, cash equivalents, and short-term investments. Under GAAP, these amounts would have been classified as liabilities.

##### *Statements of Cash Flow – Statutory-Basis*

- Cash, cash equivalents, and short-term investments in the statements of cash flow – statutory-basis represents cash balances and investments with remaining maturities of one year or less at the time of acquisition. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments with initial maturities of three months or less.

##### *Loss Contingencies*

- When management estimates a loss contingency using a range of possible outcomes, and no amount within that range is a better estimate than any other amount, the midpoint of the range shall be accrued. Under GAAP, the low point of the range is accrued.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

##### *Reinsurance Recoverables*

- Reinsurance recoverables on unpaid losses are reported as a reduction of liability for unpaid claims and claims adjustment expenses, while under GAAP, they are reported as an asset.

##### *Self-Funded Premiums and Expenses*

- The Company's statements of operations – statutory-basis reflect income and expenses related to claims, losses, premiums, and other amounts unreserved or paid on behalf of uninsured administrative service contracts, as defined by the NAIC SAP, as a net reduction of administrative expense.

In addition, the State of Pennsylvania Insurance Commissioner has the right to permit other specific practices that may deviate from NAIC statutory accounting practices. For the years ended December 31, 2010 and 2009, the Company has no other permitted practices allowed by the State of Pennsylvania Insurance Commissioner.

#### **Changes in Accounting Principles**

Accounting changes adopted to conform to the provisions of NAIC statutory accounting practices are reported as changes in accounting principles. The cumulative effect of any changes is reported as an adjustment to capital and surplus in the period of the change in accounting principle. The cumulative effect is the difference between the amount of capital and surplus at the beginning of the period adopted and the amount of capital and surplus that would have been reported at that date if the new accounting principles had been applied retroactively for all prior periods.

In December 2009, the NAIC adopted SSAP No. 100, *Fair Value Measurements*, which adopted with modification the fair value guidance prescribed under GAAP and is effective for December 31, 2010 financial statements. Included in the new and amended disclosures are:

- Requirements to disclose separately the amounts of significant transfers in and out of Level 1 and 2 fair value measurements and describe the reason for the transfers;
- Elimination of the requirement to differentiate and report fair value measurements on separate recurring and nonrecurring schedules.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### 2. Summary of Significant Accounting Policies (continued)

- Effective for 2011, a requirement to present information about purchases, sales, issuances, and settlements on a gross basis in the reconciliation of Level 3 fair value measurements.

The Company adopted this guidance for the statutory-basis financial statements issued for the year ended December 31, 2010. The Company's adoption of this guidance did not have a material impact on its financial statements.

In December 2009, the NAIC adopted nonsubstantive revisions to SSAP No. 9, *Subsequent Events*, which establishes general standards of accounting for and disclosure of events that occur through the balance sheet date but before financial statements are issued or are available to be issued. Financial statements are considered available to be issued when they are complete in a form and format that complies with SAP and all approvals necessary for issuance have been obtained, for example, from management and/or the Board of Directors. The date through which an entity has evaluated subsequent events and the basis for that date should also be disclosed. The Company adopted this guidance for the statutory-basis financial statements issued for the year ended December 31, 2009. The Company's adoption of this guidance did not have a material impact on its financial statements.

In September 2009, the NAIC issued SSAP No. 43R, *Loan-backed and Structured Securities, a replacement to SSAP No. 43, Loan-backed and Structured Securities and SSAP No. 98, Treatment of Cash Flows When Quantifying Changes in Valuation and Impairments, an Amendment of SSAP No. 43, Loan-backed and Structured Securities* (SSAP No. 43R). SSAP No. 43R provides that for loan-backed and structured securities for which (i) fair value is less than cost, (ii) the company does not intend to sell the securities, and (iii) the company has the intent and ability to retain the securities until recovery, the company should determine if there is a non-interest-related impairment by comparing the present value of the cash flows expected to be collected to the amortized cost basis.

If the cash flows expected to be collected is less than amortized cost, the security is impaired, and the difference is recorded as a realized loss in net income. The new cost basis of the security is the previous amortized cost basis, less the non-interest impairment recognized in net income.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

If the fair value is less than amortized cost, and the company (i) has the intent to sell the security, or (ii) does not have the intent and ability to retain the security until recovery of its carrying value, the security is written down to fair value with the associated realized loss reported in net income. The amount of the other-than-temporary impairment (OTTI) recognized is the entire difference between the security's amortized cost basis and its fair value at the balance sheet date. The fair value at the time of the impairment becomes the security's new cost basis.

The Company adopted SSAP No. 43R effective July 1, 2009. There was no material impact to the financial statements as a result of the adoption of SSAP No. 43R.

In December 2009, the NAIC issued SSAP No. 10R, *Income Taxes – Revised, A Temporary Replacement of SSAP No. 10* (SSAP No. 10R). SSAP No. 10R requires a valuation allowance against gross deferred tax assets if it is more-likely-than-not that some or all of the deferred tax assets will not be realized. Upon adoption of SSAP No. 10R, the Company determined that there were no deferred tax assets that required a valuation allowance. Additionally, SSAP No. 10R allows for an election available to companies that meet certain Risk-Based-Capital (RBC) levels to admit an increased amount of deferred tax assets in accordance with paragraph 10e. The Company has not made this election. In September 2010, the NAIC adopted an extension of the sunset provision of SSAP No. 10R, making it effective through December 31, 2011. In addition, the NAIC adopted expanded disclosures on tax planning strategies; specifically, a company would be required to disclose the impact of tax planning strategies on the determination of adjusted deferred tax assets (DTAs) and net admitted DTAs by percentage and by tax character. There was no material impact to the financial statements as a result of the adoption of SSAP No. 10R.

#### **Use of Estimates**

The preparation of financial statements in conformity with statutory accounting practices requires management to make estimates and assumptions that affect the reported amounts of admitted assets, liabilities, premiums, and expenses in the statutory-basis financial statements and in the disclosures of contingent assets and liabilities. While actual results could differ from those estimates, management believes that actual results will not be materially different from those amounts provided in the accompanying statutory-basis financial statements.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

##### **Fair Value of Financial Instruments**

The following methods and assumptions were used by the Company in estimating its fair value disclosures for financial instruments:

Cash and cash equivalents — The carrying amount reported in the balance sheets – statutory-basis approximates fair value.

Investment securities — Fair values are presented in Note 4 and the process to determine fair value is disclosed in Note 5.

##### **Risk Concentrations**

Assets that potentially subject the Company to credit risk consist primarily of investments in bonds and accident and health premiums due and unpaid. The Company's investments are comprised of investment-grade securities as rated by the NAIC. The Company receives advice through or assigns direct management of investments to professional investment managers selected for their expertise in various markets, within guidelines established by the Board of Directors. These guidelines include broad diversification of investments.

Concentrations of credit risk and business volume with respect to commercial premiums due and unpaid are generally limited due to the large number of employer groups comprising the Company's customer base. The Company performs ongoing credit evaluations of customers and generally does not require collateral. The Company maintains the right to terminate coverage for employers and individuals who fail to pay premiums due within specific timeframes.

As of December 31, 2010 and 2009, the Company recorded premiums due and unpaid from the Federal Employees Health Benefits Program comprising approximately 43% and 37%, respectively, of the total premiums due and unpaid.

For the years ended December 31, 2010 and 2009, the Company also recorded premiums under the Medicare program of \$347,310,441 and \$432,262,313. As of December 31, 2010 and 2009, the Company recorded premiums due and unpaid from this program of \$181,975 and \$469,186, respectively.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

##### **Cash, Cash Equivalents, and Short-Term Investments**

Cash consists of cash-on-hand, deposits in bank accounts, and certificates of deposit with financial institutions with maturity dates of one year or less from the acquisition date. Cash equivalents are short-term, highly liquid investments that are readily convertible to cash and have original maturities of less than three months. Short-term investments consist of any securities with an original maturity of less than one year and generally include U.S. government obligations.

##### **Bonds**

Bonds not backed by other loans are carried at amortized cost, except in cases where NAIC designation requires them to be carried at the lower of cost or fair value. The Company's policy is to recognize any unrealized and realized gains or losses on a specific-identification basis. Changes in admitted asset carrying amounts of bonds are charged directly to unassigned surplus.

Mortgage-backed securities that are included within bonds are valued at amortized cost using the interest method including anticipated prepayments. Prepayment assumptions are obtained from external sources and are based on the current interest rate and economic environment. The retrospective adjustment method is used to value all such securities.

Investment income consists primarily of interest, which is recognized on an accrual basis. Accrual of income is suspended for bonds that are in default or when the receipt of interest payments is in doubt. Realized capital gains and losses are determined on a specific-identification basis.

##### *Impairment – Non-mortgage-backed or loan-backed securities*

Investments are evaluated on an individual security basis at least quarterly to determine if declines in value are other-than-temporary. In making that determination, the Company considers all available evidence relating to the realizable value of a security. This evidence includes, but is not limited to, the following:

- the Company's intent or decision to sell;
- adverse financial conditions of a specific issuer, monoline bond insurer, segment, industry, region or other variables;

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

- the length of the time and the extent to which the fair value has been less than cost;
- the financial condition and near-term prospects of the issuer;
- the Company's intent and ability to retain the investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value;
- elimination or reduction in dividend payments, or scheduled interest and principal;
- rating agency downgrade of a debt security; and
- expected cash flows of a debt security.

Declines in fair value below cost for bonds where it is considered probable that all contractual terms of the security will be satisfied, the decline is due primarily to changes in interest rates (and not because of credit risk), and where the Company intends and has the ability to hold the investment for a period of time to allow a market recovery, are assumed to be temporary.

#### *Impairment – Mortgage-backed or loan-backed securities*

The Company adopted SSAP No. 43R effective July 1, 2009. Accordingly, any non-interest-related impairment related to mortgage-backed and asset-backed securities that the Company does not intend to sell and has the intent and ability to retain until recovery is recognized in investment income, net, with the interest-related impairment recognized in capital and surplus. There was no material impact to the financial statements as a result of the adoption of SSAP No. 43R.

#### *Impairment – General*

Declines in fair value below cost that are deemed to be other-than-temporary are recorded as realized losses and are included in investment income, net in the accompanying statements of operations – statutory-basis.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

##### **Liability for Unpaid Claims and Claim Adjustment Expenses**

Unpaid claims and claim adjustment expenses represent management's best estimate of the ultimate net cost of all reported and unreported claims incurred through December 31, 2010 and 2009. The liability for unpaid claims is computed in accordance with generally accepted actuarial practices and is based upon authorized health care services and past claims payment experience, together with current factors which, in management's judgment, require recognition in the calculation.

These accruals are continually monitored and reviewed. Changes in assumptions for medical and hospital costs, as well as changes in actual experience, could cause these estimates to change in the near term. Such changes are reflected in current operations.

##### **Revenue Recognition**

Premium revenue is recognized in the month for which members are entitled to health care services. Premiums collected in advance are recorded as unearned premiums in the accompanying balance sheets – statutory-basis. The Company provides reserves, on an estimated basis, based on the age of accounts receivable and management's review of other information related to the applicable employer groups. Management believes that the resolution of any adjustments to billed premiums will not be materially different from amounts recorded in the accompanying statutory-basis financial statements.

Membership and category eligibility are periodically reconciled with Centers for Medicare and Medicaid Services (CMS) data and such reconciliations could result in adjustments to revenue. CMS uses a risk adjustment model to determine premium payments to the Company. This risk adjustment model apportions premiums to all health plans according to health severity based on diagnosis data provided to CMS. The Company estimates risk adjustment revenues based on the diagnosis data submitted to CMS. Changes in revenue from periodic changes in risk adjustment scores by CMS are recognized when amounts become determinable and collectability is reasonably assured. Management believes that the resolution of any adjustments to billed premiums will not be materially different from amounts recorded in the accompanying statutory-basis financial statements. As of December 31, 2010 and 2009, the Company has recorded receivables from CMS for risk adjustments of \$4,818,085 and \$13,857,281, respectively. Historical collections have approximated management's estimates.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

CMS periodically performs risk adjustment data validation (RADV) audits and may seek return of premium payments made to the Company if risk adjustment factors are not properly supported by medical record data. The Company estimates and records reserves for CMS audits based on information available at the time the estimates are made. The judgments and uncertainties affecting the application of these policies include significant estimates related to the amount of hierarchical condition category revenue subject to audit and anticipated error rates. Although management believes the Company maintains appropriate reserves for its exposure to the RADV audits, actual results could differ materially from those estimates. Accordingly, CMS audit results could have a material adverse effect on the Company's financial position, results of operations, and cash flows.

#### **Medicare Part D**

The Medicare Part D program gives beneficiaries access to prescription drug coverage. The Company has been awarded contracts by CMS to offer various Medicare Part D plans in accordance with guidelines put forth by the agency. Payments from CMS under these contracts include amounts for premiums, amounts for risk corridor adjustments and amounts for reinsurance and low-income cost subsidies. Premiums received from CMS during the years ended December 31, 2010 and 2009 were \$163,639,160 and \$236,157,196, respectively.

The Company recognizes premium revenue ratably over the contract period for providing insurance coverage. Regarding the CMS risk corridor provision, an estimated risk-sharing receivable or payable is recognized based on activity-to-date. Activity for CMS risk-sharing is accumulated at the contract level and recorded within the accompanying balance sheets – statutory-basis in other receivables or other liabilities depending on the net contract balance at the end of the reporting period with corresponding adjustments to premium revenue. Costs for covered prescription drugs are expensed as incurred.

Subsidy amounts received for reinsurance and for cost sharing related to low-income individuals are recorded in other liabilities and will offset medical costs when paid. Premium revenue and claims expense for these subsidies are not recognized, as the Company does not incur any risk with this part of the program.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

A reconciliation of the final risk-sharing, low-income subsidy, and reinsurance subsidy amounts is performed following the end of the contract year. As of December 31, 2010, the CMS risk-sharing payable and the subsidy amounts receivable were \$(206,960) and \$2,631,595, respectively. The risk-sharing payable amount of \$(206,960) is comprised of a \$(101,531) payable related to the 2010 contract year and a \$(105,429) payable related to the prior contract years. The subsidy amounts receivable of \$2,631,595, is comprised of a \$1,861,082 receivable related to the 2010 contract year and a \$770,513 receivable for the prior contract years. The 2009 settlement amount that was recorded in 2010 approximated the Company's liability as of December 31, 2009.

As of December 31, 2009, the CMS risk-sharing payable and the subsidy amounts payable were \$(112,243) and \$(1,726,805), respectively. The risk-sharing payable amount of \$(112,243) is comprised of a \$50,127 receivable related to the 2009 contract year and a \$(162,370) payable related to prior contract years. The subsidy amounts payable of \$(1,726,805), is comprised of a \$(2,464,663) payable related to the 2009 contract year and a \$737,858 receivable for prior contract years. The 2008 settlement amount that was recorded in 2009 approximated the Company's liability as of December 31, 2008.

As of December 31, 2008, the CMS risk-sharing payable and the subsidy amounts receivable were \$(1,083,909) and \$457,324, respectively. The risk-sharing payable amount of \$(1,083,909) is comprised of a \$(924,963) payable related to the 2008 contract year and a \$(158,946) payable related to prior contract years. The subsidy amounts receivable of \$457,324, is comprised of a \$(352,379) payable related to the 2008 contract year and a \$809,703 receivable for prior contract years.

Accrued retrospective premiums are recorded as adjustments to earned premium. The amount of net premiums written that are subject to retrospective rating features is \$263,294,865, which represents approximately 54.9% of total net premiums written.

#### **Health Benefits**

The Company negotiates contractual agreements with medical management groups to provide defined health benefits services to certain of its members in exchange for monthly capitation fees. Certain of these contracts also include risk-sharing arrangements based on hospital arrangements and other claims experience. Health benefits services that cannot be provided to the Company's members by contracted medical management groups are provided by physician and hospitals to whom the Company pays fees based on negotiated charges.

HealthAmerica Pennsylvania, Inc.

Notes to Statutory-Basis Financial Statements (continued)

**2. Summary of Significant Accounting Policies (continued)**

**Reclassifications**

Certain prior-year amounts have been reclassified to conform to the current-year presentation.

**3. Liability for Unpaid Claims and Claim Adjustment Expenses**

Activity in the claim reserves accounts is summarized as follows:

	<b>Year Ended December 31</b>	
	<b>2010</b>	<b>2009</b>
Balance at January 1	\$ 57,931,680	\$ 65,137,792
Incurred related to:		
Current year	397,516,145	537,121,827
Prior year	(9,356,534)	(10,705,470)
Total incurred	<u>388,159,611</u>	<u>526,416,357</u>
Paid related to:		
Current year	342,445,628	481,168,834
Prior year	45,450,451	51,625,445
Total paid	<u>387,896,079</u>	<u>532,794,279</u>
Balance at December 31, prior to reinsurance	58,195,212	58,759,870
Less reinsurance recoverable	(1,249,906)	(828,190)
Net balance at December 31	<u>\$ 56,945,306</u>	<u>\$ 57,931,680</u>

The methodology used in calculating the liability has been consistently applied between years. As of December 31, 2010 and 2009, accrued claim adjustment expenses, were \$929,821 and \$1,071,672, respectively, and were included on the balance sheets – statutory-basis. This reserve is determined as a percentage of claims reserves and fluctuates with changes in claims reserves.

The liability for incurred claims and claim adjustment expenses attributable to insured events of prior years for the years ended December 31, 2010 and 2009 has been adjusted favorably by \$9,356,534 and \$10,705,470, respectively, as a result of actual claims payments, re-estimation of unpaid claims and claim adjustment expenses principally on group contracts. The re-estimation of unpaid claims is recorded prospectively as changes in claims payment patterns, membership, and utilization trends are identified and quantified.

HealthAmerica Pennsylvania, Inc.

Notes to Statutory-Basis Financial Statements (continued)

**4. Investments**

The amortized cost and fair value of investments in bonds, excluding restricted deposits of \$502,328 and \$502,925 as of December 31, 2010 and 2009, respectively, are summarized as follows:

	Amortized Cost	Unrealized Gains	Unrealized Losses	Fair Value
<b>As of December 31, 2010</b>				
State and municipal bonds	\$ 59,706,916	\$ 2,562,283	\$ (118,075)	\$ 62,151,124
Mortgage-backed securities	12,975,930	741,325	(28,072)	13,689,183
U.S. treasury and agency securities	5,554,578	285,323	-	5,839,901
Corporate bonds and other securities	41,210,627	1,603,428	(99,330)	42,714,725
Total bonds	<u>\$ 119,448,051</u>	<u>\$ 5,192,359</u>	<u>\$ (245,477)</u>	<u>\$ 124,394,933</u>

	Amortized Cost	Unrealized Gains	Unrealized Losses	Fair Value
<b>As of December 31, 2009</b>				
State and municipal bonds	\$ 91,085,167	\$ 4,045,411	\$ (148,136)	\$ 94,982,442
Mortgage-backed securities	14,291,037	628,524	(11,386)	14,908,175
U.S. treasury and agency securities	5,670,698	176,083	-	5,846,781
Corporate bonds and other securities	49,060,611	829,295	(161,428)	49,728,478
Total bonds	<u>\$ 160,107,513</u>	<u>\$ 5,679,313</u>	<u>\$ (320,950)</u>	<u>\$ 165,465,876</u>

The following table shows gross unrealized losses and fair values of bonds, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position.

	Less than 12 Months		12 Months or More		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
<b>As of December 31, 2010</b>						
State and municipal bonds	\$ 3,799,036	\$ (118,075)	\$ -	\$ -	\$ 3,799,036	\$ (118,075)
Mortgage-backed securities	1,971,023	(28,072)	-	-	1,971,023	(28,072)
Corporate bonds and other securities	3,758,776	(99,330)	-	-	3,758,776	(99,330)
Total bonds	<u>\$ 9,528,835</u>	<u>\$ (245,477)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 9,528,835</u>	<u>\$ (245,477)</u>

HealthAmerica Pennsylvania, Inc.

Notes to Statutory-Basis Financial Statements (continued)

**4. Investments (continued)**

	Less than 12 Months		12 Months or More		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
<b>As of December 31, 2009</b>						
State and municipal bonds	\$ 4,442,860	\$ (72,709)	\$ 1,132,566	\$ (75,427)	\$ 5,575,426	\$ (148,136)
Mortgage-backed securities	1,971,932	(11,386)	-	-	1,971,932	(11,386)
Corporate bonds and other securities	17,317,676	(161,428)	-	-	17,317,676	(161,428)
Total bonds	<u>\$ 23,732,468</u>	<u>\$ (245,523)</u>	<u>\$ 1,132,566</u>	<u>\$ (75,427)</u>	<u>\$ 24,865,034</u>	<u>\$ (320,950)</u>

As of December 31, 2010 and 2009, the Company held 16 and 28 investments, respectively, which had an unrealized loss. The unrealized loss in these securities was caused primarily by increases in volatility and changes to interest rates. Because the decline in fair value is primarily attributable to either changes in interest rates and current market volatility and not credit quality of the individual security and because the Company does not intend to sell securities, and has the ability and intent to hold investments until a recovery of fair value occurs, which may be maturity, the Company did not consider these investments to be other-than-temporarily impaired at December 31, 2010 and 2009.

A summary of the amortized cost and fair value of as the Company's investments in bonds at December 31, 2010 by contractual maturity date are as follows:

	Amortized	
	Cost	Fair Value
Years to maturity:		
One or less	\$ 5,478,080	\$ 5,557,048
One through five	63,438,782	66,341,646
Five through ten	23,799,936	24,796,032
After ten	13,755,323	14,011,024
Mortgage-backed securities	12,975,930	13,689,183
Total	<u>\$ 119,448,051</u>	<u>\$ 124,394,933</u>

The expected maturities in the foregoing table may differ from the contractual maturities because certain borrowers have the right to call or prepay obligations with or without call or prepayment penalties.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **4. Investments (continued)**

For mortgage-backed and asset-backed securities, a critical component of the evaluation for the OTTI is the identification of securities that have non-interest-related declines, where the Company does not expect to receive cash flows sufficient to recover the entire amortized cost basis of the security. The difference between the present value of projected future cash flows expected to be collected and the amortized cost basis is recognized as non-interest-related OTTI in investment income, net. If fair value is less than the present value of projected future cash flows expected to be collected, the interest-related OTTI is recorded in capital and surplus.

When determining the collectibility and the period over which the mortgage-backed and asset-backed security is expected to recover, the Company considers the same factors utilized in its overall impairment evaluation process described above. Additional considerations are made when assessing the unique features that apply to certain structured securities such as residential mortgage-backed, commercial mortgage-backed and asset-backed securities. These additional features include, but are not limited to: the quality of underlying collateral; expected prepayment speeds; current and forecasted loss severity; consideration of payment terms of underlying assets backing a particular security; and the payment priority within the tranche structure of the security. For the years ended December 31, 2010 and 2009, the Company concluded there were no factors that caused the future cash flows to be less than the current amortized cost basis of the individual security. Therefore, any declines in fair value were determined to be temporary.

The Company maintains restricted deposits held by two states in which it does business. The purpose of these deposits is to comply with the states' deposit statutes. As of December 31, 2010 and 2009, restricted deposits were \$502,328 and \$502,925, respectively.

Proceeds from the sales of investments in debt securities during 2010 were \$68,776,789 (including proceeds from maturities and bond repayments of \$13,689,846); gross gains of \$1,074,256 and gross losses of \$(149,379) were realized on those sales. Proceeds from the sales of investments in debt securities during 2009 were \$18,727,520 (including proceeds from the maturities and bond repayments were \$10,445,275); gross gains of \$1,940,116 and gross losses of \$(33,785) were realized on those sales.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### 4. Investments (continued)

Net investment income by type of investment as of December 31, 2010 and 2009 excluding net realized gains of \$924,877 and \$1,906,331, respectively, is as follows:

	Year Ended December 31	
	2010	2009
Bonds	\$ 5,494,695	\$ 5,644,537
Cash on deposit:		
Short-term investments	80,050	184,413
Investment fees	(286,741)	(321,753)
Total	<u>\$ 5,288,004</u>	<u>\$ 5,507,197</u>

#### 5. Fair Value Measurements

Included in the financial statements are certain financial instruments carried at fair value, including cash and short-term investments and certain bonds that are carried at the lower of amortized cost or market. SSAP No. 100 provides guidance on fair value measurements establishes a framework for measuring fair value and expands disclosures about fair value measurements. The Company has adopted the guidance, which establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers include: Level 1 – defined as observable inputs such as quoted prices in active markets; Level 2 – defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3 – defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

HealthAmerica Pennsylvania, Inc.

Notes to Statutory-Basis Financial Statements (continued)

**5. Fair Value Measurements (continued)**

The following table presents the fair value hierarchy for the Company's financial assets measured at fair value on a recurring basis at December 31, 2010 and 2009:

	<b>Total</b>	<b>Quoted Prices in Active Markets for Identical Assets Level 1</b>	<b>Significant Other Observable Inputs Level 2</b>	<b>Significant Unobservable Inputs Level 3</b>
<b>As of December 31, 2010</b>				
Cash, cash equivalents and short-term investments	\$ 43,231,080	\$ 91,392	\$ 43,139,688	\$ –
<b>As of December 31, 2009</b>				
Cash, cash equivalents and short-term investments	\$ 24,390,388	\$ 5,028,597	\$ 19,361,791	\$ –

The Company's Level 1 securities primarily consist of U.S. Treasury securities and cash excluding negative cash amounts of \$2,932,218 and \$8,609,564 at December 31, 2010 and 2009, respectively. The Company determines the estimated fair value for its Level 1 securities using quoted (unadjusted) prices for identical assets or liabilities in active markets.

The Company's Level 2 securities primarily consist of money market funds. The Company determines the estimated fair value for its Level 2 securities using the following methods: quoted prices for similar assets/liabilities in active markets, inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves volatilities, default rates, etc.), and inputs that are derived principally from or corroborated by other observable market data.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### 6. Income Taxes

The Company is taxed at corporate rates based on existing tax laws. The Company's taxable income or loss is included in the consolidated federal income tax return of Coventry. The tax benefit of any current and prior operating losses that are permissible under Internal Revenue Service (IRS) guidelines has been realized as a result of the intercompany tax allocation agreement with Coventry. The method of tax allocation between the companies is subject to written agreement approved by management of the respective companies and regulatory authorities. The tax allocation agreement with Coventry is based on separate-return calculations, with the current credit for the tax benefit of net losses or current charges for taxes incurred on net income being charged to the Company. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future net losses that it may incur or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany tax balances are settled on a monthly basis.

Under statutory accounting practices, only the current portion of the federal tax allocation is included in the provision for income taxes in the accompanying statements of operations – statutory-basis. Accordingly, the Company records a provision that reflects the current taxes payable, adjusted for the impact of any changes in estimates related to the prior-year taxes payable amounts.

The components of the net deferred tax asset (DTA) and deferred tax liability (DTL) are as follows:

	<b>December 31, 2010</b>		
	<b>Capital</b>	<b>Ordinary</b>	<b>Total</b>
Gross deferred tax assets	\$ –	\$11,160,743	\$ 11,160,743
Statutory valuation allowance	–	–	–
Adjusted gross deferred tax assets	–	11,160,743	11,160,743
Gross deferred tax liabilities	–	(2,107,605)	(2,107,605)
Net deferred tax asset before admissibility test	–	9,053,138	9,053,138
Nonadmitted deferred tax assets	–	(5,403,429)	(5,403,429)
Net admitted deferred tax asset	<u>\$ –</u>	<u>\$ 3,649,709</u>	<u>\$ 3,649,709</u>
Decrease in DTAs nonadmitted			\$ (64,850)

HealthAmerica Pennsylvania, Inc.

Notes to Statutory-Basis Financial Statements (continued)

**6. Income Taxes (continued)**

	<b>December 31, 2009</b>		
	<b>Capital</b>	<b>Ordinary</b>	<b>Total</b>
Gross deferred tax assets	\$ —	\$ 9,719,568	\$ 9,719,568
Statutory valuation allowance	—	—	—
Adjusted gross deferred tax assets	—	9,719,568	9,719,568
Gross deferred tax liabilities	—	(2,001,370)	(2,001,370)
Net deferred tax asset before admissibility test	—	7,718,198	7,718,198
Nonadmitted deferred tax assets	—	(5,468,280)	(5,468,280)
Net admitted deferred tax asset	\$ —	\$ 2,249,918	\$ 2,249,918
Increase in DTAs nonadmitted			\$ 4,126,198

HealthAmerica Pennsylvania, Inc.

Notes to Statutory-Basis Financial Statements (continued)

**6. Income Taxes (continued)**

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 10R during 2010 and 2009 is as follows:

		<b>December 31, 2010</b>		
		<b>Capital</b>	<b>Ordinary</b>	<b>Total</b>
Federal Income Taxes Recoverable through loss carryback	<b>10.a</b>	\$ —	\$ —	\$ —
Adjusted Gross DTA expected to be realized in one year	<b>10.b.i</b>	—	<b>3,649,709</b>	<b>3,649,709</b>
10% adjusted capital and surplus limit	<b>10.b.ii</b>	—	—	<b>6,837,131</b>
Admitted pursuant to paragraph 10.b (lesser of i. or ii.)		—	<b>3,649,709</b>	<b>3,649,709</b>
Additional admitted pursuant to paragraph 10.c	<b>10.c</b>	—	<b>2,107,605</b>	<b>2,107,605</b>
Risk-based capital:				
Total adjusted capital	<b>10.d</b>	—	—	—
Authorized control level		—	—	—
Additional admitted pursuant to paragraph 10.e.i	<b>10.e.i</b>	—	—	—
Adjusted gross DTA expected to be realized in three years	<b>10.e.ii.a</b>	—	—	—
15% adjusted statutory capital and surplus limit	<b>10.e.ii.b</b>	—	—	—
Additional admitted pursuant to paragraph 10.e.ii (lesser of a or b)		—	—	—
Additional admitted pursuant to paragraph 10.e.iii	<b>10.e.iii</b>	—	—	—
Total admitted DTA		—	<b>5,757,314</b>	<b>5,757,314</b>
Total DTL		—	<b>(2,107,605)</b>	<b>(2,107,605)</b>
Net admitted DTA		<b>\$ —</b>	<b>\$ 3,649,709</b>	<b>\$ 3,649,709</b>
Nonadmitted DTA		<b>\$ —</b>	<b>\$ 5,403,429</b>	<b>\$ 5,403,429</b>

HealthAmerica Pennsylvania, Inc.

Notes to Statutory-Basis Financial Statements (continued)

**6. Income Taxes (continued)**

		<b>December 31, 2009</b>		
		<b>Capital</b>	<b>Ordinary</b>	<b>Total</b>
Federal Income Taxes Recoverable through loss carryback	10.a	\$ —	\$ —	\$ —
Adjusted Gross DTA expected to be realized in one year	10.b.i	—	2,249,918	2,249,918
10% adjusted capital and surplus limit	10.b.ii	—	—	9,726,883
Admitted pursuant to paragraph 10.b (lesser of i. or ii.)		—	2,249,918	2,249,918
Additional admitted pursuant to paragraph 10.c	10.c	—	2,001,370	2,001,370
Risk-based capital:				
Total adjusted capital		—	—	—
Authorized control level	10.d	—	—	—
Additional admitted pursuant to paragraph 10.e.i	10.e.i	—	—	—
Adjusted gross DTA expected to be realized in three years	10.e.ii.a	—	—	—
15% adjusted statutory capital and surplus limit	10.e.ii.b	—	—	—
Additional admitted pursuant to paragraph 10.e.ii (lesser of a or b)		—	—	—
Additional admitted pursuant to paragraph 10.e.iii	10.e.iii	—	—	—
Total admitted DTA		—	4,251,288	4,251,288
Total DTL		—	(2,001,370)	(2,001,370)
Net admitted DTA		\$ —	\$ 2,249,918	\$ 2,249,918
Nonadmitted DTA		\$ —	\$ 5,468,280	\$ 5,468,280

The Company has elected not to admit additional deferred tax assets pursuant to SSAP No. 10R, paragraph 10e. The current-period election does not differ from the prior reporting period.

HealthAmerica Pennsylvania, Inc.

Notes to Statutory-Basis Financial Statements (continued)

**6. Income Taxes (continued)**

The tax effects of temporary differences that give rise to significant portions of deferred tax assets and deferred tax liabilities are as follows:

	December 31		Change	Character
	2010	2009		
Deferred tax assets:				
Unpaid claims	\$ 399,090	\$ 406,869	\$ (7,779)	Ordinary
Unearned premiums	57,862	93,394	(35,532)	Ordinary
Intangible amortization	187,928	379,354	(191,426)	Ordinary
Depreciation	712,382	1,105,057	(392,675)	Ordinary
Other accrued liabilities	6,754,055	5,418,620	1,335,435	Ordinary
Other liabilities	1,466,263	689,164	777,099	Ordinary
Nonadmitted assets	1,583,163	1,627,110	(43,947)	Ordinary
Total deferred tax assets	<u>11,160,743</u>	<u>9,719,568</u>	<u>1,441,175</u>	
Nonadmitted deferred tax assets	<u>(5,403,429)</u>	<u>(5,468,280)</u>	<u>64,851</u>	Ordinary
Admitted deferred tax assets	<u>5,757,314</u>	<u>4,251,288</u>	<u>1,506,026</u>	
Deferred tax liabilities:				
Other	<u>(2,107,605)</u>	<u>(2,001,370)</u>	<u>(106,235)</u>	Ordinary
Total deferred tax liabilities	<u>(2,107,605)</u>	<u>(2,001,370)</u>	<u>(106,235)</u>	
Net admitted deferred tax asset	<u>\$ 3,649,709</u>	<u>\$ 2,249,918</u>	<u>\$ 1,399,791</u>	

The provision for incurred taxes on earnings for the years ended December 31 are:

	2010	2009
Federal	\$ 18,841,129	\$ 17,622,877
Tax on capital gains	323,707	667,216
Change in estimate	(524,932)	1,126,949
Federal taxes incurred	<u>\$ 18,639,904</u>	<u>\$ 19,417,042</u>

HealthAmerica Pennsylvania, Inc.

Notes to Statutory-Basis Financial Statements (continued)

**6. Income Taxes (continued)**

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before taxes. The differences may be summarized as follows:

	<b>Year Ended December 31</b>	
	<b>2010</b>	<b>2009</b>
Provision computed at statutory rate	<b>\$ 19,783,580</b>	\$ 15,023,609
Change in estimate	<b>(1,133,380)</b>	1,126,949
Tax-exempt interest	<b>(879,087)</b>	(1,017,065)
Unearned premiums	<b>(35,532)</b>	(14,633)
Allowance for doubtful accounts	<b>(6,969)</b>	6,050
Depreciation and amortization	<b>(326,918)</b>	(292,042)
State taxes	–	154,986
Capital losses	–	(429,233)
Unpaid claims	<b>(7,780)</b>	(48,563)
Other accrued liabilities	<b>867,395</b>	4,797,845
Other permanent	<b>(165,047)</b>	(145,698)
Other temporary	<b>543,642</b>	254,837
Income tax provision per accompanying statements of operations statutory-basis	<b><u>\$ 18,639,904</u></b>	<b><u>\$ 19,417,042</u></b>

The company has no operating loss carryovers from prior years.

The amount of federal income taxes incurred in the current year and each preceding year that are available for recoupment in the event of future losses are:

2010	\$ 18,639,904
2009	19,417,042

The Company does not have any current or prior operating losses that have not been realized as a result of the intercompany tax allocation with Coventry.

This Company does not have any deposits under Section 6603 of the Internal Revenue Code.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### 7. Related-Party Transactions

The amounts due from related parties consist of the following:

	<b>December 31</b>	
	<b>2010</b>	<b>2009</b>
HealthAssurance Pennsylvania, Inc.	\$ 4,025,845	\$ 2,142,902
Coventry Health Care Management Corp	2,299,287	2,799,040
Coventry Health and Life Insurance Co.	263,671	829,985
Coventry Financial Management Services	203,111	120,772
Amounts due from related parties	<b>\$ 6,791,914</b>	<b>\$ 5,892,699</b>

The Company provides management services to certain subsidiaries of Coventry. These services provided to subsidiaries were charged monthly based on an allocation of membership. Under the terms of a management agreement, the Company recognized management fees of approximately \$40,926,376 and \$35,514,109 for the years ended December 31, 2010 and 2009, respectively. These fees are recorded as a reduction to administrative expenses on the statement of operations-statutory-basis.

The amounts due to related parties consist of the following:

	<b>December 31</b>	
	<b>2010</b>	<b>2009</b>
Coventry Health Care, Inc	\$ 2,327,348	\$ 2,359,319
Amounts due to related parties	<b>\$ 2,327,348</b>	<b>\$ 2,359,319</b>

Coventry provides management, consulting, and administrative services to the Company, including claims adjudication and payment, group setup and maintenance, and billing and collections. The Company also reimburses Coventry for certain expenses paid by Coventry on behalf of the Company. All significant intercompany balances are settled on a monthly basis. Under the terms of the management agreement, the Company incurred management fees to Coventry of \$15,781,000 and \$16,368,000 in 2010 and 2009, respectively.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### 7. Related-Party Transactions (continued)

The Company has a trademark sublicense agreement with Coventry Financial Management Services, Inc for the right to use the service mark "HealthAmerica." The sublicense fee is 1.25% of gross premium revenue and administrative fees on self-insured accounts, but it cannot cause the statutory net income to fall below 1% of gross premium revenue. Trademark sublicense fees included in administration expenses on the statements of operations – statutory-basis were \$5,972,017 and \$7,852,751 for the years ended December 31, 2010 and 2009, respectively.

#### 8. Reinsurance

The Company carries reinsurance coverage for instances in which medical costs for an individual member exceed certain limitations. This coverage is currently through Coventry Health and Life Insurance Company (CH&L), an affiliate of Coventry. Total reinsurance premiums paid to CH&L for the years ended December 31, 2010 and 2009 were \$3,810,485 and \$5,302,733, respectively, and are included as reductions of premiums, net. Total reinsurance recoveries from CH&L of \$2,151,576 and \$3,367,256 are included as a reduction of health benefits expense for the years ended December 31, 2010 and 2009, respectively.

The Company is contingently liable for its reinsured losses to the extent that the reinsurance company cannot meet its obligations under the reinsurance contracts.

#### 9. Leases

The Company leases its office facilities and certain office equipment under noncancelable operating leases, with escalation clauses ranging in the amount of 1.7% to 2.9% increasing minimum rent payments each year. As of December 31, 2010, future minimum lease payments are as follows:

	<b>Operating Lease</b>
2011	\$ 1,020,377
2012	1,046,753
2013	1,066,580
2014	723,465
2015	69,110
	<u>\$ 3,926,285</u>

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### 9. Leases (continued)

Rent expense for the years ended December 31, 2010 and 2009 was approximately \$1,388,000 and \$1,628,000, respectively.

#### 10. Regulatory Matters

The State of Pennsylvania requires the Company to maintain a minimum statutory surplus of the greater of \$1 million or three months' uncovered health care expenditures (as defined) for Pennsylvania enrollees as reported on the most recent Annual Statement filed with the Pennsylvania Department of Insurance. As of December 31, 2010 and 2009, the Company's minimum statutory capital and surplus requirement for Pennsylvania was approximately \$1.3 million and \$1.7 million, respectively. As of December 31, 2010 and 2009, the minimum statutory capital and surplus requirement for Ohio was \$1 million. The Company can pay dividends without regulatory approval at an amount up to the greater of 10% of the prior year's capital and surplus or the prior year net gain from operations. Dividends in excess of this amount require regulatory approval prior to payment. The Company paid an extraordinary dividend of \$48,000,000 on June 28, 2010.

In addition to the statutory net worth requirement, Pennsylvania and Ohio have adopted the NAIC RBC requirements. RBC is a method measuring the minimum amount of capital appropriate for an insurance organization to support its overall business operations in consideration of its size and risk profile. The insurance organization's RBC is calculated by applying factors to various assets, premium, and reserve items. The factor is higher for those items with greater underlying risk and lower for less risky items. The adequacy of an insurance organization's actual capital can then be measured by a comparison to its RBC as determined by the formula. The Company believes that its statutory net worth exceeds the Company Action Level (200% of authorized control level) calculated for its RBC requirements.

The Company has no preferred stock outstanding. The portion of capital and surplus as of December 31, 2010 and 2009 reduced by nonadmitted assets is as follows:

	<u>2010</u>	<u>2009</u>
Nonadmitted assets	<b>\$ 9,926,760</b>	\$ 10,117,173

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **11. Employee Benefit Plans**

##### **Employee Savings Plan**

The Company's employees participate in the Coventry Health Care, Inc. Retirement Savings Plan (the Coventry Plan), which qualifies under the Internal Revenue Code section 401(k). Under the terms of the Coventry Plan, subject to certain limitations, employees may contribute up to 75% of their eligible salary to the Coventry Plan, limited by the maximum compensation deferral amount permitted by applicable law, which the Company matches. For every dollar a participant contributes to the Coventry Plan up to 3% of plan-eligible pay, the Company will add another dollar to the participant's account and will allocate it to the Company stock fund. On the next 3% of Coventry plan-eligible pay that a participant contributes, the Company will add 50 cents to their account in the Company stock fund. The Company contributed approximately \$1,027,000 and \$991,000 to the Coventry Plan during 2010 and 2009, respectively.

##### **Stock Incentive Plan**

Coventry also sponsors a Stock Incentive Plan under which shares of Coventry's common stock were authorized for issuance to key employees, consultants and directors in the form of stock options, restricted stock, deferred stock units and other stock-based awards.

Under the Stock Incentive Plan, the terms and conditions of option grants are established on an individual basis, with the exercise price of the options being equal to not less than 100% of the market value of the underlying stock at the date of grant. Options generally become exercisable after one year in 33 1/3% increments per year and expire ten years from the date of grant. The Stock Incentive Plan is authorized to grant either incentive stock options or nonqualified stock options, stock appreciation rights, restricted stock, deferred stock units and other stock-based awards at the discretion of the Compensation Committee of Coventry's Board of Directors. The Company recognized no expense from this Stock Incentive Plan for the years ended December 31, 2010 and 2009.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### 12. Administrative Services Only Uninsured Plans

The result of the Company's ASO contracts are as follows:

	<b>Year Ended December 31</b>	
	<b>2010</b>	<b>2009</b>
Net reimbursement for administrative expenses less than actual expenses	\$ (2,538,469)	\$ (1,575,840)
Total net other income and expenses	—	—
Net loss from operations	<u>\$ (2,538,469)</u>	<u>\$ (1,575,840)</u>

The total claim payment volume was approximately \$93 million and \$91 million for the years ended December 31, 2010 and 2009, respectively.

#### 13. Commitments and Contingencies

The healthcare and health insurance industries are subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse.

Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare insurers and providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for services previously billed.

Management believes that the Company is in compliance with fraud and abuse statutes as well as other applicable governmental laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

The Company is named as defendant in various legal actions arising principally from claims made under insurance policies and contracts. Those actions are considered by the Company in estimating reserves for policy and contract liabilities. The Company's management believes the resolution of those actions will not have a material effect on the Company's financial position or results of operations.

## HealthAmerica Pennsylvania, Inc.

### Notes to Statutory-Basis Financial Statements (continued)

#### **13. Commitments and Contingencies (continued)**

The Company carries professional liability and employment practices liability insurance coverage through Coventry Casualty Risk Retention Group (CRRG), a wholly owned subsidiary of Coventry and an affiliate to the Company. CRRG provides professional liability coverage for individual and class action claims. Additionally, CRRG provides employment practices liability coverage through a separate policy. Both professional and employment practices liability coverage are subject to policy-specific coverage limits. Each year, Coventry will reevaluate the most effective method for insuring these types of claims.

The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary association consisting of the state life and health insurance guaranty organizations located throughout the U.S. State life and health insurance guaranty organizations, working together with NOLHGA, provide a safety net for their state's policyholders, ensuring that they continue to receive coverage even if their insurer is declared insolvent. The Company is aware that the Pennsylvania Insurance Commissioner, or Insurance Commissioner, has placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. The Insurance Commissioner has petitioned the state court for liquidation, however, the Company does not know when a decision will be made, although the Company believes it is likely the state court will rule within the next 12 months. In the event that Penn Treaty is declared insolvent and placed in liquidation, the Company and other insurers may be required to pay a portion of their policyholder claims through NOLHGA guaranty association assessments in future periods. Given the uncertainty around whether Penn Treaty will ultimately be declared insolvent and, if so, the amount of the insolvency, the amount and timing of any associated future guaranty fund assessments and the availability and amount of any potential premium tax and other offsets, the Company currently cannot estimate our net exposure, if any, to this potential insolvency. The Company will continue to monitor the situation and may record a liability and expense in future reporting periods, which could be material to the Company operating results.

#### **14. Reconciliation to Statutory Annual Statements**

The following table is a reconciliation of amounts previously reported to state regulatory authorities in the 2010 Annual Statement to those reported in the accompanying statutory-basis financial statements, as it relates to the other liabilities adjustments.

HealthAmerica Pennsylvania, Inc.

Notes to Statutory-Basis Financial Statements (continued)

**14. Reconciliation to Statutory Annual Statements (continued)**

	<b>December 31, 2010 (As Reported in 2010 Annual Statement)</b>	<b>Other Liabilities Adjustment</b>	<b>December 31, 2010 – Revised (As Reported in the Accompanying Audited Financial Statements)</b>
Other liabilities	\$ 31,389,139	\$ (1,738,424)	\$ 29,650,715
Total liabilities	\$ 109,945,117	<u>\$ (1,738,424)</u>	\$ 108,206,693
Unassigned surplus	\$ 84,622,654	\$ 1,738,424	\$ 86,361,078
Total capital and surplus	\$ 87,511,244	<u>\$ 1,738,424</u>	\$ 89,249,668

	<b>December 31, 2010 (As Reported in 2010 Annual Statement)</b>	<b>Other Liabilities Adjustment</b>	<b>Capital Gains Adjustment</b>	<b>December 31, 2010 – Revised (As Reported in the Accompanying Audited Financial Statements)</b>
Premiums, net	\$ 478,031,244	\$ 1,738,424	\$ –	\$ 479,769,668
Investment income, net	5,889,174	–	323,707	6,212,881
Gain from operations before federal income tax	54,462,383	1,738,424	323,707	56,524,514
Federal income tax provision	18,316,197	–	323,707	18,639,904
Net income	\$ 36,146,186	<u>\$ 1,738,424</u>	<u>\$ –</u>	\$ 37,884,610

**15. Subsequent Events**

The Company has evaluated subsequent events through April 28, 2011, the date at which the financial statements were available to be issued, and has determined there are no significant events to report.

Ernst & Young LLP

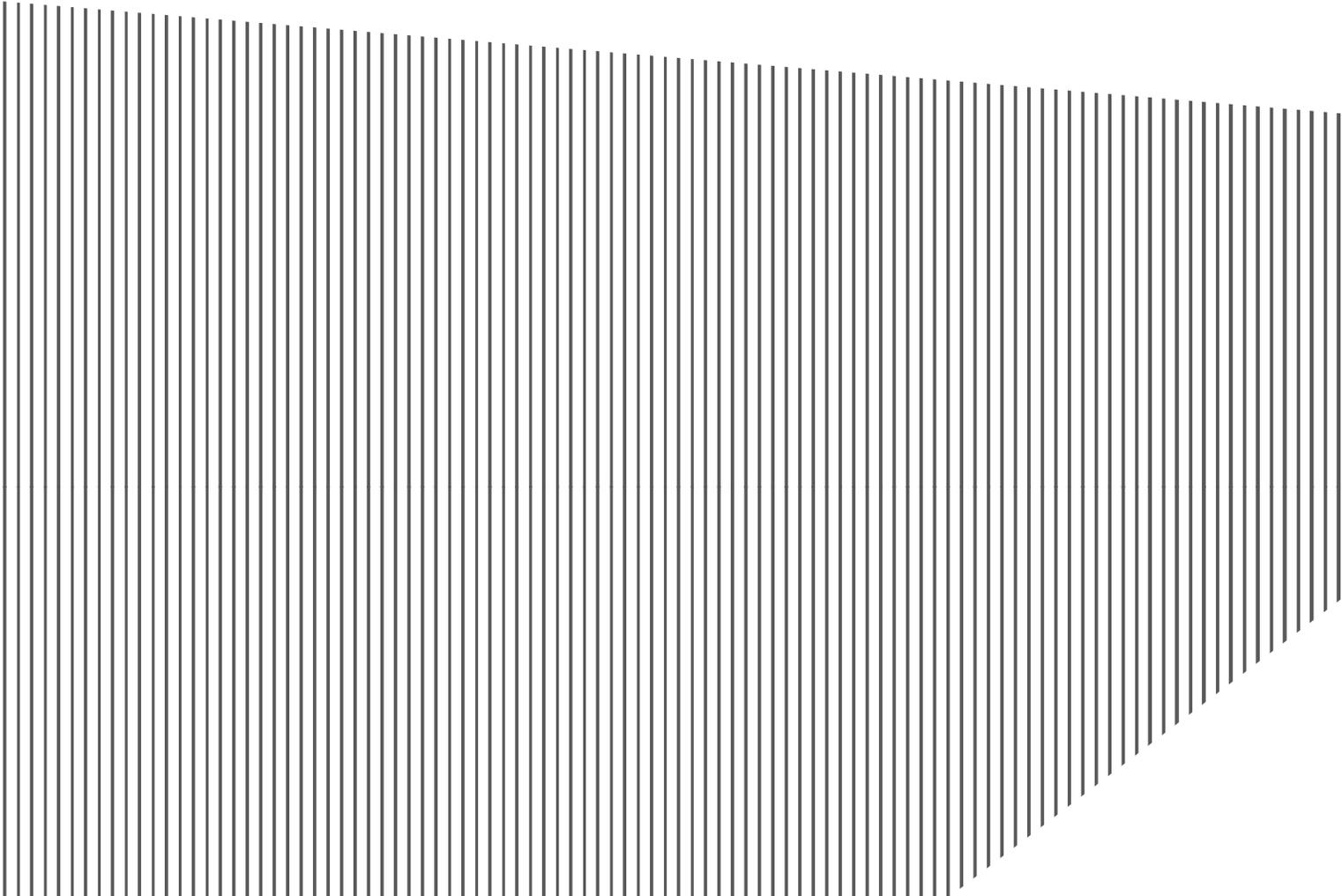
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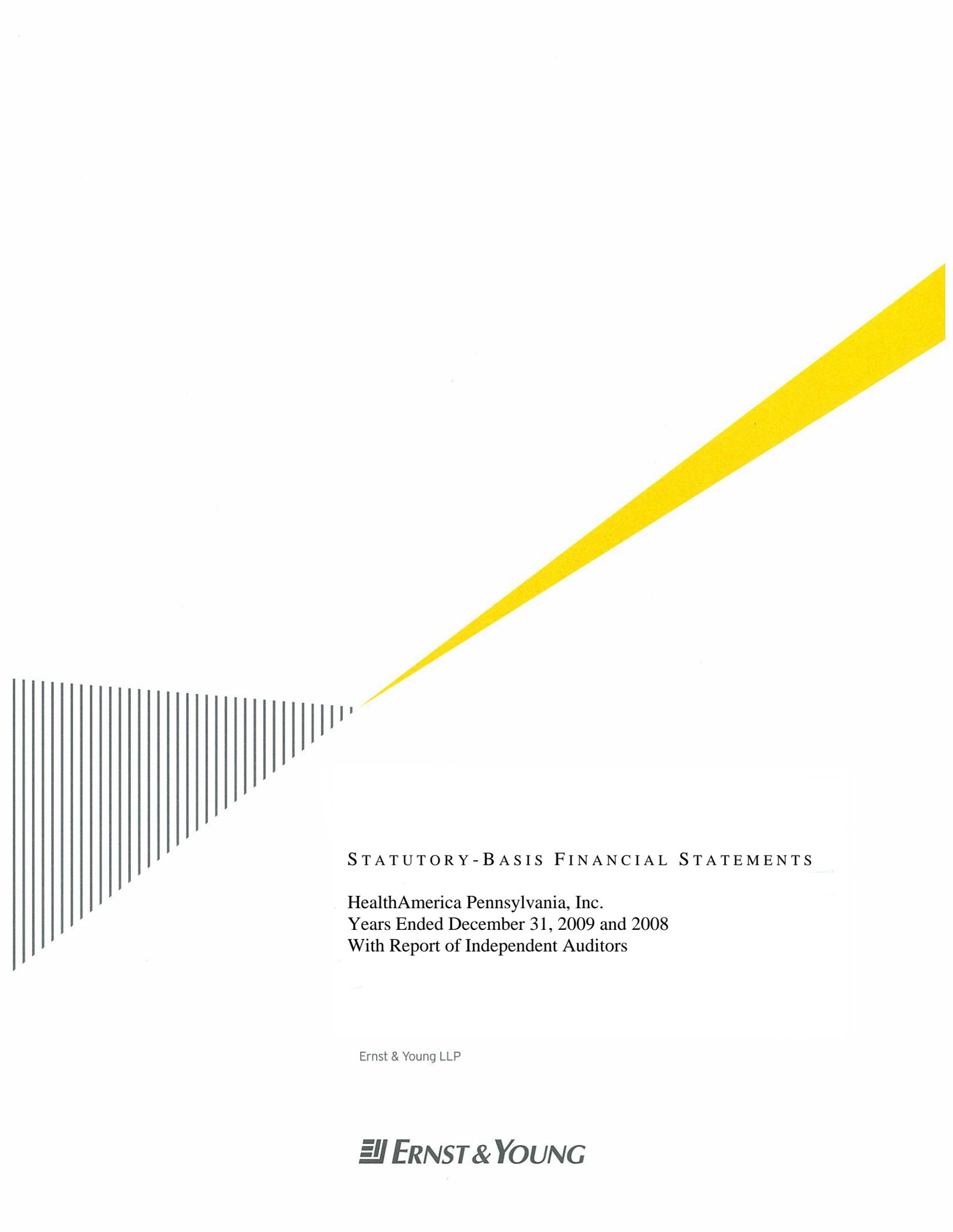
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STATUTORY-BASIS FINANCIAL STATEMENTS

HealthAmerica Pennsylvania, Inc.  
Years Ended December 31, 2009 and 2008  
With Report of Independent Auditors

Ernst & Young LLP

 **ERNST & YOUNG**

HealthAmerica Pennsylvania, Inc.  
Statutory-Basis Financial Statements  
Years Ended December 31, 2009 and 2008

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## Report of Independent Auditors

Board of Directors  
HealthAmerica Pennsylvania, Inc.

We have audited the accompanying statutory-basis balance sheets of HealthAmerica Pennsylvania, Inc. (the Company) as of December 31, 2009 and 2008, and the related statutory-basis statements of operations, changes in capital and surplus, and cash flow for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As described in Note 2 to the financial statements, the Company presents its financial statements in conformity with accounting practices prescribed by the Pennsylvania Department of Insurance, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles are also described in Note 2. The effects on the financial statements of these variances are not reasonably determinable but are presumed to be material.

In our opinion, because of the effects of the matter described in the preceding paragraph, the financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of HealthAmerica Pennsylvania, Inc., as of December 31, 2009 or 2008, or the results of its operations or its cash flows for the years then ended.

However, in our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HealthAmerica Pennsylvania, Inc., as of December 31, 2009 and 2008, and the results of its operations and its cash flows for the years then ended, in conformity with accounting principles prescribed by the Pennsylvania Department of Insurance.

*Ernst & Young LLP*

April 29, 2010

HealthAmerica Pennsylvania, Inc.

Balance Sheets—Statutory-Basis

	<b>December 31</b>	
	<b>2009</b>	<b>2008</b>
<b>Admitted assets</b>		
Cash, cash equivalent, short-term investments	\$ 15,780,824	\$ 28,915,372
Restricted deposits	502,925	501,353
Receivables for securities	12,777	7,786
Bonds	160,107,513	128,852,835
Total cash and invested assets	<u>176,404,039</u>	158,277,346
Premiums due and unpaid	20,486,802	14,586,288
Due from affiliates	5,892,699	4,385,316
Other receivables	1,880,713	5,895,602
Deferred tax asset, net	2,249,918	2,024,186
Total admitted assets	<u>\$ 206,914,171</u>	<u>\$ 185,168,738</u>
<b>Liabilities and capital and surplus</b>		
Liability for unpaid claims and claim adjustment expenses	\$ 59,115,595	\$ 67,129,815
Accounts payable and accrued expenses	13,858,934	8,169,528
Other liabilities	28,483,461	13,001,146
Due to affiliates	2,359,319	5,110,402
Unearned premiums	1,334,193	1,543,236
Federal income taxes payable	3,922,964	—
Total liabilities	<u>109,074,466</u>	94,954,127
Capital and surplus:		
Common stock, \$1.00 par value, 5 shares authorized, issued, and outstanding	5	5
Paid-in surplus	2,888,585	2,888,585
Unassigned surplus	94,951,115	87,326,021
Total capital and surplus	<u>97,839,705</u>	90,214,611
Total liabilities and capital and surplus	<u>\$ 206,914,171</u>	<u>\$ 185,168,738</u>

See accompanying notes.

HealthAmerica Pennsylvania, Inc.

Statements of Operations—Statutory-Basis

	<b>Year Ended December 31</b>	
	<b>2009</b>	<b>2008</b>
Premiums, net	<b>\$ 608,309,210</b>	\$ 636,491,258
Expenses:		
Health benefits	<b>526,416,357</b>	550,380,150
Administration	<b>46,381,785</b>	44,627,140
Total expenses	<b>572,798,142</b>	595,007,290
Gain from operations	<b>35,511,068</b>	41,483,968
Net investment income	<b>7,413,528</b>	5,875,524
Gain from operations before federal income taxes	<b>42,924,596</b>	47,359,492
Provision for federal income taxes	<b>19,417,042</b>	14,717,480
Net income	<b>\$ 23,507,554</b>	\$ 32,642,012

*See accompanying notes.*

HealthAmerica Pennsylvania, Inc.

Statements of Changes in Capital and Surplus—Statutory-Basis

	<b>Common Stock</b>	<b>Paid-In Surplus</b>	<b>Unassigned Surplus</b>	<b>Total</b>
Balance at December 31, 2007	\$ 5	\$ 2,888,585	\$ 111,214,012	\$ 114,102,602
Net income	—	—	32,642,012	32,642,012
Increase in non-admitted assets	—	—	(199,595)	(199,595)
Change in net unrealized capital gains	—	—	113,715	113,715
Change in net deferred taxes	—	—	(844,123)	(844,123)
Dividend to Parent	—	—	(55,600,000)	(55,600,000)
Balance at December 31, 2008	5	2,888,585	87,326,021	90,214,611
Net income	—	—	<b>23,507,554</b>	<b>23,507,554</b>
Increase in non-admitted assets	—	—	<b>(4,234,390)</b>	<b>(4,234,390)</b>
Change in net deferred taxes	—	—	<b>4,351,930</b>	<b>4,351,930</b>
Dividend to Parent	—	—	<b>(16,000,000)</b>	<b>(16,000,000)</b>
Balance at December 31, 2009	<b>\$ 5</b>	<b>\$ 2,888,585</b>	<b>\$ 94,951,115</b>	<b>\$ 97,839,705</b>

*See accompanying notes.*

HealthAmerica Pennsylvania, Inc.

Statements of Cash Flow—Statutory-Basis

	<b>Year Ended December 31</b>	
	<b>2009</b>	<b>2008</b>
<b>Operations</b>		
Premiums collected, net of reinsurance paid	<b>\$ 619,398,686</b>	\$ 638,724,608
Claims and claims adjustment expenses paid	<b>(550,753,509)</b>	(564,712,945)
Administration expenses paid	<b>(23,634,152)</b>	(28,000,475)
Net investment income received	<b>6,213,955</b>	8,506,331
Federal income taxes paid	<b>(12,711,920)</b>	(17,689,730)
Net cash provided by operations	<b>38,513,060</b>	36,827,789
<b>Investment activities</b>		
Proceeds from sales and maturities of bonds	<b>18,727,520</b>	82,296,564
Purchases of bonds	<b>(49,078,893)</b>	(27,915,375)
Net gain on cash, cash equivalents, and short-term investments	<b>676</b>	17,367
Other	<b>(4,990)</b>	(1,611,514)
Net cash (used in) provided by investment activities	<b>(30,355,687)</b>	52,787,042
<b>Financing and miscellaneous activities</b>		
Dividend paid	<b>(16,000,000)</b>	(55,600,000)
Other uses	<b>(5,291,921)</b>	(3,041,625)
Net cash used in financing and miscellaneous activities	<b>(21,291,921)</b>	(58,641,625)
(Decrease) increase in cash, cash equivalents, and short-term investments	<b>(13,134,548)</b>	30,973,206
Cash, cash equivalents, and short-term investments at beginning of year	<b>28,915,372</b>	(2,057,834)
Cash, cash equivalents, and short-term investments at end of year	<b>\$ 15,780,824</b>	\$ 28,915,372

*See accompanying notes.*

# HealthAmerica Pennsylvania, Inc.

## Notes to Financial Statements—Statutory-Basis

December 31, 2009

### 1. Organization

HealthAmerica Pennsylvania, Inc. (the Company) is a federally qualified network model health maintenance organization (HMO) that provides comprehensive health care services on a prepaid basis to individuals, businesses, and governmental agencies throughout Pennsylvania and Ohio. The Company also provides Medicare Advantage services in central and western Pennsylvania.

The Company is a wholly-owned subsidiary of Coventry Healthcare, Inc. (Coventry). Coventry, headquartered in Bethesda, Maryland, is a national managed health care company that provides a full range of risk and fee-based managed care products and services, including HMO, preferred provider organizations (PPO), point of service products (POS), Medicare Advantage, Medicare Prescription Drug Plans, Medicare Private Fee-For Service Plans, Medicaid, Workers' Compensation, and Network Rental to a broad cross section of individuals, employer and government-funded groups, government agencies, and other insurance carriers and administrators in all 50 states.

### 2. Summary of Significant Accounting Policies

#### Basis of Presentation

The Company prepares its statutory-basis financial statements in conformity with accounting practices prescribed by the Pennsylvania Department of Insurance. The Pennsylvania Department of Insurance requires that insurance companies domiciled in the Commonwealth of Pennsylvania (Pennsylvania) prepare their statutory-basis financial statements in accordance with the Codified National Association of Insurance Commissioners' *Statements of Statutory Accounting Principles* (NAIC SAP), version effective January 1, 2001, subject to any deviations prescribed by the Commonwealth of Pennsylvania Insurance Commissioner.

Statutory accounting practices differ from accounting practices generally accepted in the United States (GAAP). Significant variances between GAAP and statutory-basis financial statements are as follows:

#### *Investments*

- Investments in bonds and mandatory redeemable preferred stocks are reported at amortized cost or fair value based on their National Association of Insurance Commissioners (NAIC) rating; for GAAP, such fixed maturity investments would be designated at purchase as held-to-maturity, trading, or available-for-sale. Held-to-

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### 2. Summary of Significant Accounting Policies (continued)

maturity fixed investments would be reported at amortized cost, and the remaining fixed maturity investments would be reported at fair value with unrealized holding gains and losses reported in operations for those designated as trading and as a separate component of capital and surplus for those designated as available-for-sale, except for the impact of other-than-temporary impairments.

#### *Nonadmitted Assets*

- Certain assets designated as “nonadmitted,” principally certain receivables, furniture and equipment, prepaid expenses, intangible assets, and other assets not specifically identified as an admitted asset within the *Accounting Practices and Procedures Manual*, are excluded from the accompanying balance sheets—statutory-basis and are charged directly to unassigned surplus. Under GAAP, such assets are included in the balance sheets.

#### *Deferred Income Taxes*

Gross deferred tax assets are first assessed to determine if a statutory valuation allowance is required to reduce gross deferred tax assets to the amount that is more likely than not to be realized. Adjusted gross deferred tax assets are then admitted in an amount equal to the sum of 1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; plus 2) the lesser of the remaining gross deferred tax assets expected to be realized within one year of the balance sheet date or 10% of statutory capital and surplus as reported on the most recently filed statement with the domiciliary state commissioner adjusted to exclude any net deferred tax assets, EDP equipment and operating system software, and any net positive goodwill; plus 3) the amount of remaining gross deferred tax assets that can be offset against existing gross deferred tax liabilities. The remaining gross deferred tax assets are nonadmitted. Deferred taxes do not include amounts for state taxes. Under GAAP, state taxes are included in the computation of deferred taxes and a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years.

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

##### *Statements of Cash Flow – Statutory Basis*

- Cash, cash equivalents, and short-term investments in the statements of cash flow—statutory-basis represent cash balances including negative cash and investments with initial maturities of one year or less. Under GAAP, the corresponding caption of cash and cash equivalents include cash balances and investments with initial maturities of three months or less.

##### *Negative Cash*

- Certain short-term borrowings are classified as a reduction of cash, cash equivalents, and short-term investments. Under GAAP, these amounts would have been classified as liabilities.

##### *Impairment*

- As discussed later in Note 2, the impairment of loan-backed and structured securities is evaluated based on the company's intent to sell. If the company intends to sell a loan-backed or structured security that is in an unrealized loss position, the difference between fair value and amortized cost is recognized as a realized loss. If the company has the intent and ability to hold a loan-backed or structured security for which fair value is less than amortized cost, an evaluation of the non-interest-related impairment is performed based on a discounted cash flow analysis, which determines the amount of the impairment charge that is recognized as a realized loss. Any interest-related portion of the unrealized loss is recognized through capital and surplus. Under GAAP, the evaluation of credit-related and non-credit-related impairment charges is not limited to loan-backed and structured securities.

##### *Reinsurance Recoverables*

- Reinsurance recoverable on unpaid losses are reported as a reduction of liability for unpaid claims, while under GAAP, they are reported as an asset.

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

##### *Loss Contingencies*

- When management estimates a loss contingency using a range of possible outcomes, and no amount within that range is a better estimate than any other amount, the midpoint of the range shall be accrued. Under GAAP, the low point of the range is accrued.

In addition, the Commonwealth of Pennsylvania Insurance Commissioner has the right to permit other specific practices that may deviate from NAIC statutory accounting practices.

##### **Changes in Accounting Principles**

Accounting changes adopted to conform to the provisions of NAIC statutory accounting practices are reported as changes in accounting principles. The cumulative effect of any changes is reported as an adjustment to capital and surplus in the period of the change in accounting principle. The cumulative effect is the difference between the amount of capital and surplus at the beginning of the period adopted and the amount of capital and surplus that would have been reported at that date if the new accounting principles had been applied retroactively for all prior periods.

In September 2009, the NAIC issued SSAP No. 43R, *Loan-backed and Structured Securities a replacement to SSAP No. 43 Loan-backed and Structured Securities and SSAP No. 98 Treatment of Cash Flows When Quantifying Changes in Valuation and Impairments, an Amendment of SSAP No. 43 Loan-backed and Structured Securities* (SSAP No. 43R). SSAP No. 43R provides that for loan-backed and structured securities for which (i) fair value is less than cost, (ii) the company does not intend to sell the securities, and (iii) the company has the intent and ability to retain the securities until recovery, the company should determine if there is a non-interest related impairment by comparing the present value of the cash flows expected to be collected to the amortized cost basis. If the cash flows expected to be collected is less than amortized cost, the security is impaired, and the difference is recorded as a realized loss in net income. The new cost basis of the security is the previous amortized cost basis, less the non-interest impairment recognized in net income.

If the fair value is less than amortized cost, and the company (i) has the intent to sell the security, or (ii) does not have the intent and ability to retain the security until recovery of its carrying value, the security is written down to fair value with the associated realized loss reported in net

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

income. The amount of the OTTI recognized is the entire difference between the security's amortized cost basis and its fair value at the balance sheet date. The fair value at the time of the impairment becomes the security's new cost basis.

The Company adopted SSAP No. 43R effective July 1, 2009. There was no impact to the financial statements as a result of the adoption of SSAP No. 43R.

In December 2009, the NAIC issued SSAP No. 10R *Income Taxes – Revised, A Temporary Replacement of SSAP No. 10* (SSAP 10R). SSAP 10R requires a valuation allowance against gross deferred tax assets if it is more likely than not that some or all of the deferred tax assets will not be realized. Upon adoption of SSAP 10R, the Company determined there were no deferred tax assets that required a valuation allowance. Additionally, SSAP 10R allows for an election available to companies that meet certain Risk-Based-Capital (RBC) levels to admit an increased amount of deferred tax assets in accordance with paragraph 10e. The Company has not made this election.

#### **Use of Estimates**

The preparation of financial statements in conformity with statutory accounting practices requires management to make estimates and assumptions that affect the reported amounts of admitted assets, liabilities, premiums, and expenses in the financial statements and in the disclosures of contingent assets and liabilities. While actual results could differ from those estimates, management believes that with the exception of the risk adjustment data validation audits, actual results will not be materially different from those amounts provided in the accompanying statutory-basis financial statements.

#### **Fair Value of Financial Instruments**

The following methods and assumptions were used by the Company in estimating its fair value disclosures for financial instruments:

Cash and cash equivalents – The carrying amount reported in the balance sheets approximates fair value.

Investment securities – Fair values are presented in Note 4 and the process to determine fair value is discussed in Note 13.

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

##### **Risk Concentrations**

Financial instruments that potentially subject the Company to credit risk consist primarily of short-term and long-term investments in bonds and premiums due and unpaid. The Company's investments are primarily comprised of investment-grade securities as rated by the NAIC. The Company receives advice through or assigns direct management of investments to professional investment managers selected for their expertise in various markets, within guidelines established by the Board of Directors. These guidelines include broad diversification of investments.

Concentrations of credit risk with respect to commercial premiums due and unpaid are generally limited because of the large number of employer groups comprising the Company's customer base. The Company performs ongoing credit evaluations of customers and generally does not require collateral.

As of December 31, 2009 and 2008, the Company recorded premiums due and unpaid from the Federal Employees Health Benefits Program comprising approximately 37% and 69%, respectively, of the total premiums due and unpaid.

For the years ended December 31, 2009 and 2008, the Company recorded premiums under the Medicare Advantage Program that represented approximately 71% and 64%, respectively, of the total premiums.

##### **Cash, Cash Equivalents, and Short-term Investments**

Cash consists of cash on hand, deposits in bank accounts, and certificates of deposit with financial institutions with maturity dates of one year or less from the acquisition date. Cash equivalents are short-term, highly liquid investments that are readily convertible to cash and have original maturities of less than three months. Short-term investments consist of any securities with an original maturity of less than one year and generally include commercial paper and government obligations.

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### 2. Summary of Significant Accounting Policies (continued)

##### **Bonds**

Bonds not backed by other loans are carried at amortized cost, except in cases where NAIC designation requires them to be carried at the lower of cost or fair value. The Company's policy is to recognize any realized gains or losses on a specific identification basis. Changes in admitted asset carrying amounts of bonds are charged directly to unassigned surplus.

Mortgage-backed securities that are included within bonds are valued at amortized cost using the interest method, including anticipated prepayments. When determining fair value, prepayment assumptions are obtained from external sources and are based on the current interest rate and economic environment. The retrospective adjustment method is used to value all such securities.

Investment income consists primarily of interest, which is recognized on an accrual basis. Accrual of income is suspended for bonds that are in default or when the receipt of interest payments is in doubt. Realized capital gains and losses are determined on a specific identification basis.

##### *Impairment – Non-loan backed or structured securities*

Investments are evaluated on an individual security basis at least quarterly to determine if declines in value are other-than-temporary. In making that determination, we consider all available evidence relating to the realizable value of a security. This evidence includes, but is not limited to, the following:

- the Company's intent or decision to sell
- adverse financial conditions of a specific issuer, monoline bond insurer, segment, industry, region or other variables;
- the length of the time and the extent to which the fair value has been less than cost;
- the financial condition and near-term prospects of the issuer;
- the Company's intent and ability to retain the investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value;
- elimination or reduction in dividend payments, or scheduled interest and principal;

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

- rating agency downgrade of a debt security; and
- expected cash flows of a debt security.

Declines in fair value below cost for bonds where it is considered probable that all contractual terms of the security will be satisfied, the decline is due primarily to changes in interest rates (and not because of credit risk), and where the Company intends and has the ability to hold the investment for a period of time to allow a market recovery, are assumed to be temporary.

#### *Impairment – Mortgaged-backed or Loan-backed Securities*

The Company adopted SSAP No. 43R effective July 1, 2009. Accordingly, any non-interest related impairment related to mortgage-backed and asset-backed securities that the Company does not intend to sell and has the intent and ability to retain until recovery is recognized in net investment income with the interest related impairment recognized in capital and surplus. For the years ended December 31, 2009 and 2008, the Company did not hold a material amount of loan-backed and structured securities and therefore, there was no material impact to the financial statements as a result of the adoption of SSAP No. 43R.

#### *Impairment – General*

The current economic environment and recent volatility of securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Declines in fair value below cost that are deemed to be other than temporary are recorded as realized losses and are included in net investment income in the accompanying statements of operations – statutory basis and statements of changes in capital and surplus – statutory basis.

#### **Liability for Unpaid Claims and Claim Adjustment Expenses**

Unpaid claims and claim adjustment expenses represent management's best estimate of the ultimate net cost of all reported and unreported claims incurred through December 31. The liability for unpaid claims is computed in accordance with generally accepted actuarial practices and is based upon authorized health care services and past claims payment experience, together with current factors which, in management's judgment, require recognition in the calculation.

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

These accruals are continually monitored and reviewed. Changes in assumptions for health benefits, as well as changes in actual experience, could cause these estimates to change in the near term. Such changes are reflected in current operations.

#### **Revenue Recognition**

Premium revenue is recognized in the month members are entitled to health care services. Premiums collected in advance are recorded as unearned premiums in the accompanying balance sheets—statutory-basis. A major customer maintains the right to retrospectively adjust its premiums based on audits that may be performed several years in arrears. The Company provides reserves, on an estimated basis, based on the age of accounts receivable and management's review of other information related of the applicable employer groups. Management believes that the resolution of any adjustments to billed premiums will not be materially different from amounts recorded in the accompanying statutory-basis financial statements.

#### **Medicare**

##### *Part D Program*

The Medicare Part D program, which gives beneficiaries access to prescription drug coverage, took effect January 1, 2006. The Company has been awarded contracts by the Center for Medicare & Medicaid Services (CMS) to offer various Medicare Part D plans, in accordance with guidelines put forth by the agency. Payments from CMS under these contracts include amounts for premiums, amounts for risk corridor adjustments and amounts for reinsurance and low-income cost subsidies.

The Company recognizes premium revenue ratably over the contract period for providing insurance coverage. Regarding the CMS risk corridor provision, an estimated risk sharing receivable or payable is recognized based on activity-to-date. Activity for CMS risk sharing is accumulated at the contract level and recorded within the accompanying statutory-basis balance sheets in premiums unpaid or other liabilities depending on the net contract balance at the end of the reporting period with corresponding adjustments to premium revenue. Costs for covered prescription drugs are expensed as incurred.

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### **2. Summary of Significant Accounting Policies (continued)**

Subsidy amounts received for reinsurance and for cost sharing related to low income individuals are recorded in other liabilities and will offset medical costs when paid. Premium revenue and claims expense for these subsidies are not recognized, as the Company does not incur any risk with this part of the program.

A reconciliation of the final risk sharing, low-income subsidy, and reinsurance subsidy amounts is performed following the end of the contract year. As of December 31, 2009, the CMS risk sharing payable and the subsidy amounts payable were \$112,243 and \$1,726,805, respectively. As of December 31, 2008, the CMS risk sharing payable of \$1,083,909 and the subsidy amounts receivable of \$457,324. As of December 31, 2007, the CMS net risk sharing receivable, and subsidy amounts receivable were \$ 78,342 and \$2,831,707, respectively.

#### *Risk Adjustment Model*

CMS uses a risk adjustment model to determine premium payments to the Company. This risk adjustment model apportions premiums paid to all health plans according to health severity based on diagnosis data provided to CMS. The Company estimates risk adjustment revenues based on the diagnosis data submitted to CMS. Changes in revenue from periodic changes in risk adjustments scores by CMS are recognized when the amounts become determinable and the collectibility is reasonably assured. Management believes that the resolution of any adjustments to billed premiums will not be materially different from amounts recorded in the accompanying statutory-basis financial statements. As of December 31, 2009 and 2008, the Company has recorded receivables from CMS for risk adjustments of \$13,857,281 and \$5,954,536, respectively.

CMS periodically performs Risk Adjustment Data Valuation (RADV) audits and may seek return of premium payments made to the company if risk adjustment factors are not properly supported by medical record data. The Company estimates and records reserves for CMS audits based on information available at the time the estimates are made. The judgments and uncertainties affecting the application of these policies include significant estimates related to the amount of hierarchical condition category (“HCC”) revenue subject to audit and anticipated error rates. Although management believes the Company maintains appropriate reserves for its exposure to the RADV audits, actual results could differ materially from those estimates. Accordingly, CMS audit results could have a material adverse effect on the Company’s financial position, results of operations, and cash flows.

HealthAmerica Pennsylvania, Inc.

Notes to Financial Statements—Statutory-Basis (continued)

**2. Summary of Significant Accounting Policies (continued)**

**Health Benefits**

The Company negotiates contractual agreements with medical management groups to provide defined health benefits services to certain of its members in exchange for monthly capitation fees. Health benefits services that cannot be provided to the Company's members by contracted medical management groups are provided by physicians and hospitals to whom the Company pays fees based upon negotiated charges.

**Reclassifications**

Certain prior year amounts have been reclassified to conform to current year presentation. Such reclassifications had no impact on 2008 net income or total capital and surplus at December 31, 2008.

**3. Liability for Unpaid Claims and Claim Adjustment Expenses**

Activity in the unpaid claims account is summarized as follows:

	<b>Year Ended December 31</b>	
	<b>2009</b>	<b>2008</b>
Balance at January 1	\$ 65,137,792	\$ 62,556,531
Incurred related to:		
Current year	537,121,827	566,655,044
Prior years	(10,705,470)	(16,274,894)
Total incurred	<u>526,416,357</u>	<u>550,380,150</u>
Paid related to:		
Current year	481,168,834	502,202,539
Prior years	51,625,445	43,987,269
Total paid	<u>532,794,279</u>	<u>546,189,808</u>
Balance at December 31	58,759,870	66,746,873
Less reinsurance recoverables	(828,190)	(1,609,081)
Net balance at December 31	<u>\$ 57,931,680</u>	<u>\$ 65,137,792</u>

HealthAmerica Pennsylvania, Inc.

Notes to Financial Statements—Statutory-Basis (continued)

**3. Liability for Unpaid Claims and Claim Adjustment Expenses (continued)**

The liability for incurred claims and claim adjustment expenses attributable to insured events of prior years for the years ended December 31, 2009 and 2008 has been adjusted by \$10,705,470 and \$16,274,894, respectively, as a result of actual claims payment, re-estimation of unpaid claims, and claims adjustment expenses. These adjustments occurred because claim estimates were settled for amounts less than originally anticipated. Significant factors which can influence the estimate of claim costs are changes in medical utilization, changes in the mix of provider rates and other components of medical trend.

The methodology used in calculating the liability has been consistently applied between years.

As of December 31, 2009 and 2008, accrued claim adjustments expenses were \$1,071,672 and \$908,114, respectively. The unpaid claims account is net of reinsurance recoverable on unpaid losses. Included in the liability for unpaid claims and claims adjustment expenses in the statutory-basis financial statement is the CMS risk sharing payable of \$112,243 and \$1,083,909 as of December 31, 2009 and 2008, respectively.

**4. Investments**

The Company classifies investments as short-term or long-term based on the maturity date at the time of purchase. The carrying value of all investments, excluding restricted deposits of \$502,925 and \$501,353 as of December 31, 2009 and 2008, respectively, are as follows:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
<b>December 31, 2009</b>				
State and municipal bonds	\$ 91,085,167	\$ 4,045,411	\$ (148,136)	\$ 94,982,442
Mortgage-backed securities	14,291,037	628,524	(11,386)	14,908,175
U.S. Treasury and agency securities	5,670,698	176,083	-	5,846,781
Corporate bonds and other securities	49,060,611	829,295	(161,428)	49,728,478
Total debt securities	<u>\$ 160,107,513</u>	<u>\$ 5,679,313</u>	<u>\$ (320,950)</u>	<u>\$ 165,465,876</u>

HealthAmerica Pennsylvania, Inc.

Notes to Financial Statements—Statutory-Basis (continued)

**4. Investments (continued)**

	<b>Amortized Cost</b>	<b>Gross Unrealized Gains</b>	<b>Gross Unrealized Losses</b>	<b>Fair Value</b>
<b>December 31, 2008</b>				
State and municipal bonds	\$ 89,471,174	\$ 2,745,820	\$ (356,708)	\$ 91,860,286
Mortgage-backed securities	16,806,721	418,444	(406,618)	16,818,547
U.S. Treasury and agency securities	5,700,696	383,534	—	6,084,230
Corporate bonds and other securities	16,874,244	1,648,644	(86,760)	18,436,128
Total debt securities	<u>\$ 128,852,835</u>	<u>\$ 5,196,442</u>	<u>\$ (850,086)</u>	<u>\$ 133,199,191</u>

As of December 31, 2009 and 2008, the Company held 28 and 31 investments, respectively, that had an unrealized loss. The following tables show gross unrealized losses and fair values of bonds, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position:

	<b>Fair Value Losses &lt; 1 year</b>	<b>Unrealized Losses &lt; 1 year</b>	<b>Fair Values Losses &gt; 1 year</b>	<b>Unrealized Losses &gt; 1 year</b>	<b>Total Unrealized Losses</b>
<b>December 31, 2009</b>					
State and municipal bonds	\$ 4,442,860	\$ 72,709	\$ 1,132,566	\$ 75,427	\$ 148,136
Mortgage-backed securities	1,971,932	11,386	—	—	11,386
Corporate bonds and other securities	17,317,676	161,428	—	—	161,428
Total debt securities	<u>\$ 23,732,468</u>	<u>\$ 245,523</u>	<u>\$ 1,132,566</u>	<u>\$ 75,427</u>	<u>\$ 320,950</u>
<b>December 31, 2008</b>					
State and municipal bonds	\$ 13,590,883	\$ 191,346	\$ 2,120,823	\$ 165,362	\$ 356,708
Mortgage-backed securities	465,779	79,602	1,547,764	327,016	406,618
Corporate bonds and other securities	5,195,537	84,387	146,435	2,373	86,760
Total debt securities	<u>\$ 19,252,199</u>	<u>\$ 355,335</u>	<u>\$ 3,815,022</u>	<u>\$ 494,751</u>	<u>\$ 850,086</u>

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### 4. Investments (continued)

The amortized cost and estimated fair value of all debt securities as of December 31, 2009, by maturity date, is as follows:

	<b>Amortized Cost</b>	<b>Fair Value</b>
Due in less than 1 year	\$ 11,364,917	\$ 11,561,264
Due after 1 year through 5 years	64,136,587	66,326,114
Due after 5 years through 10 years	48,299,064	50,170,664
Due after 10 years	22,015,908	22,499,659
Mortgage-backed securities	14,291,037	14,908,175
	<b>\$ 160,107,513</b>	<b>\$ 165,465,876</b>

For mortgage-backed and asset-backed securities, a critical component of the evaluation for the OTTI is the identification of securities that have non-interest related declines, where the Company does not expect to receive cash flows sufficient to recover the entire amortized cost basis of the security. The difference between the present value of projected future cash flows expected to be collected and the amortized cost basis is recognized as non-interest related OTTI in investment income, net. If fair value is less than the present value of projected future cash flows expected to be collected, the interest related OTTI is recorded in capital and surplus.

When determining the collectability and the period over which the mortgage-backed or asset-backed security is expected to recover, the Company considers the same factors utilized in its overall impairment evaluation process described above. Additional considerations are made when assessing the unique features that apply to certain structured securities such as residential mortgage-backed, commercial mortgage-backed and asset-backed securities. These additional features include, but are not limited to: the quality of underlying collateral; expected prepayment speeds; current and forecasted loss severity; consideration of payment terms of underlying assets backing a particular security; and the payment priority within the tranche structure of the security.

For the year ended December 31, 2008, the Company recognized an other-than-temporary impairment charge of \$1,823,854. The other-than-temporary impairment charge related to its investments in certain corporate bonds. Management believes that it has adequately reviewed its investment securities for impairment and that its investments securities are fairly stated within the balance sheets – statutory-basis.

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### 4. Investments (continued)

Proceeds from the sales of investments in debt securities during 2009 were \$8,282,245 (proceeds from maturities and bond repayments were \$10,445,275); gross gains of \$1,937 and gross losses of \$33,785 were realized on those sales. Proceeds from the sales of investments in debt securities during 2008 were \$65,698,039 (proceeds from the maturities and bond repayments were \$16,598,525); gross gains of \$935,199 and gross losses of \$271,841 were realized on those sales.

Securities with an amortized cost of \$502,925 and \$501,353 were on deposit with state regulatory authorities, as required by law, at December 31, 2009 and 2008, respectively.

Net investment income includes interest on bonds, restricted deposits, short-term investments, and cash and cash equivalents, net of investment fees.

#### 5. Reinsurance

The Company carries reinsurance coverage for instances in which medical costs for an individual member exceed certain limitations. This coverage is currently through Coventry Health and Life Insurance Company (CH&L), an affiliate. Total reinsurance premiums incurred under this agreement with CH&L for the years ended December 31, 2009 and 2008, were \$5,302,733 and \$6,745,335, respectively, and are included as a reduction of premiums, net. Estimated reinsurance recoveries from CH&L for the years ended December 31, 2009 and 2008 of \$3,367,256 and \$2,764,315, respectively, are included as a reduction of health benefits expense. The Company is contingently liable for its reinsured losses to the extent that the reinsurance company cannot meet its obligations under the reinsurance contracts.

#### 6. Leases

The Company leases certain office facilities and certain office equipment under noncancelable operating leases. As of December 31, 2009, future minimum lease payments were as follows:

2010	\$ 1,092,501
2011	1,020,377
2012	1,046,753
2013	1,066,580
2014	723,465
Thereafter	69,110
	<u>\$ 5,018,786</u>

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### **6. Leases (continued)**

Rent expense for the years ended December 31, 2009 and 2008 was approximately \$1,628,000 and \$1,542,000, respectively.

#### **7. Related Party Transactions**

Coventry provides management, consulting, and administrative services to the Company, including claims adjudication and payment, group setup and maintenance, and billing and collections. The Company also reimburses Coventry for certain expenses paid by Coventry on behalf of the Company. Under the terms of a management agreement, the Company incurred management fees of approximately \$16,368,000 and \$15,555,000, for the years ended December 31, 2009 and 2008, respectively, which are included in administrative expenses on the statements of operations—statutory-basis.

The Company provides management services to certain subsidiaries of Coventry. These services provided to subsidiaries were charged monthly based on an allocation of membership. Under the terms of a management agreement, the Company recognized management fees of approximately \$35,514,109 and \$29,979,410 for the years ended December 31, 2009 and 2008, respectively. These fees are recorded as a reduction to administration expenses on the statements of operations—statutory-basis.

The Company has a trademark sublicense agreement with Coventry Financial Management Services, Inc. for the right to use the service mark “HealthAmerica.” The sublicense fee is 1.25% of gross premium revenue and administrative fees on self-insured accounts, but it cannot cause the statutory net income to fall below 1% of gross premium revenue. Trademark sublicense fees included in administration expenses on the statements of operations—statutory-basis were approximately \$7,852,751 and \$8,153,013 for the years ended December 31, 2009 and 2008, respectively.

#### **8. Income Taxes**

The Company is taxed at corporate rates based on existing tax laws. The Company’s taxable income or loss is included in the consolidated federal income tax return of Coventry. The tax benefit of any current and prior operating losses that are permissible under Internal Revenue Service (IRS) guidelines has been realized as a result of the intercompany tax allocation agreement with Coventry. The method of tax allocation between the companies is subject to written agreement approved by management of the respective companies and regulatory

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### **8. Income Taxes (continued)**

guidelines. The tax allocation agreement with Coventry is based upon separate return calculations, with the current credit for the tax benefit of net losses or current charges for taxes incurred on net income being charged to the Company. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future net losses that it may incur or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany tax balances are settled on a monthly basis.

Under statutory accounting practices, only the current portion of the federal tax allocation is included in provision for income taxes in the accompanying statements of operations—statutory-basis. Accordingly, the Company records a provision that reflects the current taxes payable, adjusted for the impact of any changes in estimates related to the prior year taxes payable amounts.

HealthAmerica Pennsylvania, Inc.

Notes to Financial Statements—Statutory-Basis (continued)

**8. Income Taxes (continued)**

The components of the net deferred tax asset (DTA) and deferred tax liability (DTL) as of December 31, 2009 and 2008 are as follows:

	2009			2008		
	Capital	Ordinary	Total	Capital	Ordinary	Total
Gross deferred tax assets	\$ —	\$ 9,719,568	\$ 9,719,568	\$ 638,349	\$ 4,802,791	\$ 5,441,140
Statutory valuation allowance	—	—	—	—	—	—
Adjusted gross deferred tax assets	—	9,719,568	9,719,568	638,349	4,802,791	5,441,140
Gross deferred tax liabilities	—	2,001,370	2,001,370	—	2,074,872	2,074,872
Net deferred tax asset before admissibility test	—	7,718,198	7,718,198	638,349	2,727,919	3,366,268
Less: Deferred tax asset nonadmitted	—	5,468,280	5,468,280	638,349	703,733	1,342,082
Net admitted deferred tax asset	\$ —	\$ 2,249,918	\$ 2,249,918	\$ —	\$ 2,024,186	\$ 2,024,186
Increase (decrease) in DTAs nonadmitted			<u>\$ 4,126,198</u>			<u>\$ (583,518)</u>

HealthAmerica Pennsylvania, Inc.

Notes to Financial Statements—Statutory-Basis (continued)

**8. Income Taxes (continued)**

The amount of admitted adjusted gross deferred tax assets under each component of SSAP 10R during 2009 and 2008 is as follows:

	2009			2008		
	Capital	Ordinary	Total	Capital	Ordinary	Total
Federal Income Taxes Recoverable through loss carryback	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Adjusted Gross DTA expected to be realized in one year	-	2,249,918	2,249,918	-	2,024,186	2,024,186
10% adjusted capital and surplus limit Admitted pursuant to Paragraph 10.b (lesser of i. or ii.)	-	-	9,726,883	-	-	8,527,955
Additional admitted pursuant to 10.c	-	2,249,918	2,249,918	-	2,024,186	2,024,186
Risk-based capital: Total adjusted capital Authorized control level	-	-	-	-	-	-
Additional admitted pursuant to paragraph 10.e.i	-	-	-	-	-	-
Adjusted gross DTA expected to be realized in three years	-	-	-	-	-	-
15% adjusted statutory capital and surplus limit	-	-	-	-	-	-
Additional admitted pursuant to paragraph 10.e.ii (lesser of a or b)	-	-	-	-	-	-
Additional admitted pursuant to paragraph 10.e.iii	-	-	-	-	-	-
Total admitted DTA	-	4,251,288	4,251,288	-	4,099,058	4,099,058
Total DTL	-	2,001,370	2,001,370	-	2,074,872	2,074,872
Net admitted DTA	\$ -	\$ 2,249,918	\$ 2,249,918	\$ -	\$ 2,024,186	\$ 2,024,186
Nonadmitted DTA	\$ -	\$ 5,468,280	\$ 5,468,280	\$ 638,349	\$ 703,733	\$ 1,342,082

HealthAmerica Pennsylvania, Inc.

Notes to Financial Statements—Statutory-Basis (continued)

**8. Income Taxes (continued)**

The Company has not elected to admit deferred tax assets pursuant to SSAP 10R, paragraph 10(e). The current period election does not differ from the prior reporting period.

The tax effect of temporary differences that give rise to significant portions of deferred tax assets and deferred tax liabilities was as follows:

	<b>December 31</b>			
	<b>2009</b>	<b>2008</b>	<b>Change</b>	<b>Character</b>
Unpaid claims	\$ 406,869	\$ 455,433	(48,564)	Ordinary
Unearned premiums	93,394	108,026	(14,632)	Ordinary
Amortization of insurance in force	379,354	570,781	(191,427)	Ordinary
Depreciation	1,105,057	1,096,892	8,165	Ordinary
Other accrued liabilities	689,164	387,861	301,303	Ordinary
Disallowed and limited capital losses	–	638,349	(638,349)	Capital
Nonadmitted assets	1,627,110	1,589,243	37,867	Ordinary
Other liabilities	5,418,620	594,555	4,824,065	Ordinary
Total deferred tax assets	9,719,568	5,441,140	4,278,428	
Nonadmitted deferred tax assets	(5,468,280)	(1,342,082)	(4,126,198)	
Admitted deferred tax assets	4,251,288	4,099,058	152,230	
Total deferred tax liabilities	(2,001,370)	(2,074,872)	73,502	
Net admitted deferred tax assets	<u>\$ 2,249,918</u>	<u>\$ 2,024,186</u>	<u>225,732</u>	

The provision for incurred taxes on earnings for the years ended December 31 are:

	<b>2009</b>	<b>2008</b>
Federal	\$ 17,622,877	\$ 13,961,937
Tax on capital gains	667,216	–
Foreign	–	–
Prior year underaccrual	1,126,949	755,543
Federal taxes incurred	<u>\$ 19,417,042</u>	<u>\$ 14,717,480</u>

HealthAmerica Pennsylvania, Inc.

Notes to Financial Statements—Statutory-Basis (continued)

**8. Income Taxes (continued)**

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before taxes. These differences may be summarized as follows:

	<b>Year Ended December 31</b>	
	<b>2009</b>	<b>2008</b>
Provision computed at statutory rate	<b>\$ 15,023,609</b>	\$ 16,575,822
Change in estimates	<b>1,126,949</b>	755,543
Tax-exempt interest, net	<b>(1,047,951)</b>	(1,258,208)
Unpaid claims	<b>(48,563)</b>	24,796
Stock options and incentive compensation	<b>(201,602)</b>	(484,962)
Amortization of insurance in force	<b>(191,427)</b>	(191,427)
Unearned premiums	<b>(14,633)</b>	(5,421)
Depreciation and amortization	<b>8,164</b>	8,224
State taxes	<b>154,986</b>	68,651
Disallowed and limited capital losses	<b>(429,233)</b>	638,349
Other accrued liabilities	<b>5,392,751</b>	(800,768)
Nonadmitted assets and other	<b>(356,008)</b>	(613,119)
Income tax provision per accompanying statements of operations—statutory-basis	<b><u>\$ 19,417,042</u></b>	<b><u>\$ 14,717,480</u></b>

The Company has no operating loss carryforwards.

The amount of federal income taxes incurred in the current year and each preceding year that are available for recoupment in the event of future losses are:

2009	\$ 19,417,042
2008	14,717,480

This Company does not have any deposits under Section 6603 of the Internal Revenue Code.

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### **9. Regulatory Matters**

The Company is licensed in Pennsylvania and Ohio and is subject to certain minimum statutory capital and surplus requirements determined by the insurance departments of the respective states. The minimum statutory capital and surplus requirement for Pennsylvania is the greater of \$1 million or three months' uncovered health care expenditures (as defined) for Pennsylvania enrollees as reported on the most recent Annual Statement filed with the Pennsylvania Department of Insurance. As of December 31, 2009 and 2008, the Company's minimum statutory capital and surplus requirement for Pennsylvania was approximately \$1.7 million and \$1.8 million, respectively. As of December 31, 2009 and 2008, the minimum statutory capital and surplus requirement for Ohio was \$1 million.

In addition to the statutory capital and surplus requirement, both Pennsylvania and Ohio have adopted the NAIC RBC requirements. RBC is a method of measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. The managed care organization's RBC is calculated by applying factors to various assets, premiums and reserve items. The factor is higher for those items with greater underlying risk and lower for less risky items.

The adequacy of a managed care organization's actual capital can then be measured by a comparison to its RBC as determined by the formula. The Company's statutory net worth exceeds the Company action level (200% of authorized control level) calculated for its RBC requirements.

As of December 31, 2009 and 2008, the Company exceeded its various capital and surplus requirements.

#### **10. Employee Benefit Plans**

##### **Employee Savings Plan**

The Company's employees participate in the Coventry Health Care, Inc. Retirement Savings Plan (the Coventry Plan), which qualifies under the Internal Revenue Code Section 401(k). Under the terms of the Coventry Plan, subject to certain limitations, employees may contribute up to 75% of their salary, limited by the maximum compensation deferral amount permitted by applicable law, which the Company matches by making contributions equal to 100% of the employee's contribution up to the first 3% of the employee's compensation deferral and an

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### 10. Employee Benefit Plans (continued)

amount equal to 50% of the employee's contribution on the second 3% of the employee's compensation deferral. The Company contributed approximately \$990,823 and \$934,638 to the Coventry Plan during 2009 and 2008, respectively.

#### Stock Incentive Plan

Coventry also sponsors a stock incentive plan under which shares of Coventry's common stock were authorized for issuance to key employees, consultants, and directors in the form of stock options, restricted stock, and other stock-based awards.

Under the stock incentive plan, the terms and conditions of option grants are established on an individual basis, with the exercise price of the options being equal to not less than 100% of the fair value of the underlying stock at the date of grant. Options generally become exercisable after one year in 25% increments per year and expire 10 years from the date of grant. The stock incentive plan is authorized to grant either incentive stock options or nonqualified stock options, stock appreciation rights, restricted stock, and other stock-based awards at the discretion of the Compensation and Benefits Committee of Coventry's Board of Directors. For the years ended December 31, 2009 and 2008, respectively, no compensation expenses were recorded by the Company under the stock incentive plan.

#### 11. Administrative Services Only Uninsured Plans

Under Administrative Services Only (ASO) contracts, the Company provides administrative and claims processing services to certain self-insured groups. The self-insured groups retain the liability risk for all claims. Accordingly, the Company does not reflect receipts for funding of claims or the payment of these claims in its statements of operations—statutory-basis.

The results of the ASO contracts for the years ended December 31, 2009 and 2008 were as follows:

	<u>2009</u>	<u>2008</u>
Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	<b>\$(1,575,840)</b>	\$ 2,811,792

The total claim payment volume was approximately \$91.0 million and \$89.5 million for the years ended December 31, 2009 and 2008, respectively.

HealthAmerica Pennsylvania, Inc.

Notes to Financial Statements—Statutory-Basis (continued)

**12. Capital and Surplus**

The Company has no preferred stock outstanding. The portion of capital and surplus as of December 31, 2009 and 2008 reduced by nonadmitted assets is as follows:

	<u>2009</u>	<u>2008</u>
Nonadmitted assets	<b>\$10,117,173</b>	\$ 5,882,783

**13. Fair Value Measurements**

Included in the financial statements are certain financial instruments carried at fair value, including cash, cash equivalents, short-term investments and certain bonds that are carried at the lower of amortized cost or market. The Financial Accounting Standards Board (FASB) guidance on fair value measurements establishes a framework for measuring fair value and expands disclosures about fair value measurements. The Company has adopted the guidance, which establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers include: Level 1 – defined as observable inputs such as quoted prices in active markets; Level 2 – defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3 – defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

The following table presents the fair value hierarchy for the Company’s financial assets measured at fair value on a recurring basis at December 31, 2009 and 2008:

	<b>Quoted Prices in Active Markets for Identical Assets</b>	<b>Significant Other Observable Inputs</b>	<b>Significant Unobservable Inputs</b>	
	<b>Total</b>	<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
<b>As of December 31, 2009</b>				
Cash, cash equivalents, and short-term investments	\$ 24,390,388	\$ 5,028,597	\$ 19,361,791	\$ –
<b>As of December 31, 2008</b>				
Cash and cash equivalents and short-term investments	\$ 37,255,674	\$ 36,053,324	\$ 1,202,350	\$ –

## HealthAmerica Pennsylvania, Inc.

### Notes to Financial Statements—Statutory-Basis (continued)

#### **13. Fair Value Measurements (continued)**

The Company's Level 1 securities primarily consist of US Treasury securities and cash excluding negative cash amounts of \$8,609,564 and \$8,340,302 at 2009 and 2008 respectively. The Company determines the estimated fair value for its Level 1 securities using quoted (unadjusted) prices for identical assets or liabilities in active markets.

The Company's Level 2 securities primarily consist of money market funds. The Company determines the estimated fair value for its Level 2 securities using the following methods: quoted prices for similar assets/liabilities in active markets, inputs other than quoted prices that are observable for the asset/liability (e.g. interest rates, yield curves volatilities, default rates, etc.), and inputs that are derived principally from or corroborated by other observable market data.

#### **14. Commitments and Contingencies**

The Company is named as defendant in various legal actions arising principally from claims made under insurance policies and contracts. Those actions are considered by the Company in estimating reserves for policy and contract liabilities. The Company's management believes the resolution of those actions will not have a material effect on the Company's financial position or results of operations.

The Company carries professional liability and employment practices liability insurance coverage through Coventry Casualty Risk Retention Group (CRRG), a wholly owned subsidiary of Coventry and an affiliate to the Company. CRRG provides professional liability coverage for individual and class action claims. Additionally, CRRG provides employment practices liability coverage through a separate policy. Both professional and employment practices liability coverage are subject to policy-specific coverage limits. Each year, Coventry will reevaluate the most effective method for insuring these types of claims.

The health care and health insurance industries are subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse.

Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care insurers and providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for services previously billed.

HealthAmerica Pennsylvania, Inc.

Notes to Financial Statements—Statutory-Basis (continued)

**14. Commitments and Contingencies (continued)**

Management believes that the Company is in compliance with fraud and abuse statutes as well as other applicable governmental laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

**15. Subsequent Events**

The Company has evaluated subsequent events through April 29, 2010, and has determined there are no significant events to report.

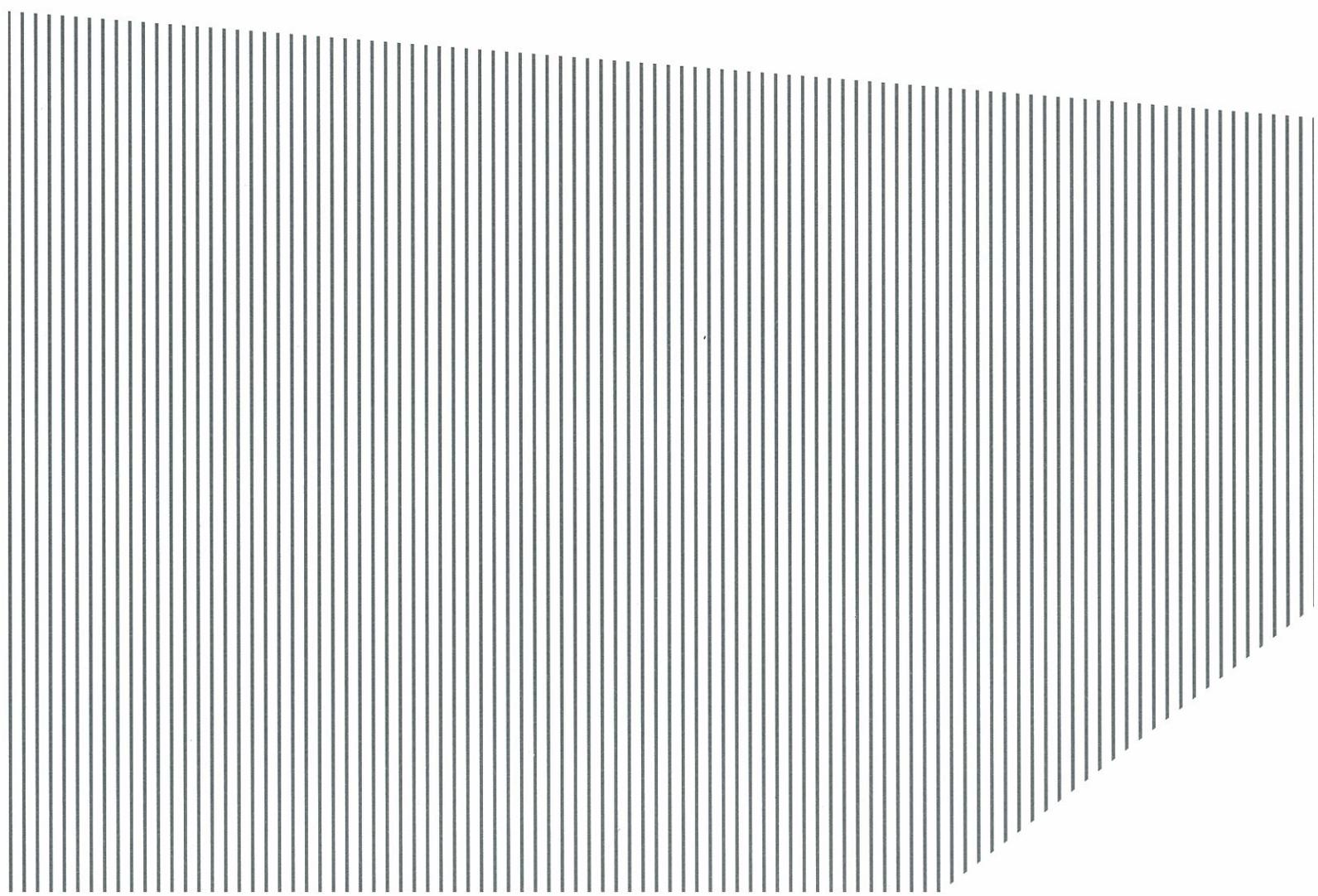
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**UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
Washington, D. C. 20549  
FORM 10-K**

- ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)  
OF THE SECURITIES EXCHANGE ACT OF 1934  
For the Fiscal Year Ended December 31, 2010  
OR  
 TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d)  
OF THE SECURITIES EXCHANGE ACT OF 1934

COMMISSION FILE NUMBER 1-16477



**COVENTRY HEALTH CARE, INC.**  
(Exact name of registrant as specified in its charter)

**Delaware** (State or other jurisdiction of incorporation or organization) **52-2073000** (I.R.S. Employer Identification Number)

**6705 Rockledge Drive, Suite 900, Bethesda, Maryland 20817**  
(Address of principal executive offices) (Zip Code)  
Registrant's telephone number, including area code: (301)581-0600

Securities registered pursuant to Section 12(b) of the Act:  
**Title of each class:** Common Stock, \$.01 par value  
**Name of each exchange on which registered:** New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes  No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes  No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes  No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes  No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer" and "large accelerated filer" in Rule 12b-2 of the Exchange Act (check one). Large accelerated filer  Accelerated filer  Non-accelerated filer  Smaller reporting company

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes  No

The aggregate market value of the registrant's voting and non-voting common equity held by non-affiliates of the registrant as of June 30, 2010 (computed by reference to the closing sales price of such stock on the NYSE® stock market on such date) was \$2,624,188,069.

As of January 31, 2011, there were 149,775,281 shares of the registrant's voting Common Stock outstanding.

**DOCUMENTS INCORPORATED BY REFERENCE**

Parts of the registrant's Proxy Statement for its 2011 Annual Meeting of Shareholders to be filed with the Commission pursuant to Regulation 14A subsequent to the filing of this Form 10-K Report are incorporated by reference in Items 10 through 14 of Part III hereof.

**COVENTRY HEALTH CARE, INC.**  
**FORM 10-K**  
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**PART I**

**Cautionary Statement Regarding Forward-Looking Statements**

This Form 10-K contains forward-looking statements which are subject to risks and uncertainties in accordance with the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. Forward-looking statements are defined as statements that are not historical facts and include those statements relating to future events or future financial performance. Forward-looking statements typically include assumptions, estimates or descriptions of our future plans, strategies and expectations, and are generally identifiable by the use of the words “anticipate,” “will,” “believe,” “estimate,” “expect,” “intend,” “seek,” or other similar expressions. Examples of these include discussions regarding our operating and growth strategy, projections of revenue, income or loss and future operations. Unless this Form 10-K indicates otherwise or the context otherwise requires, the terms “Coventry,” “we,” “our,” “our Company,” “the Company” or “us” as used in this Form 10-K refer to Coventry Health Care, Inc. and its subsidiaries as of December 31, 2010.

These forward-looking statements may be affected by a number of factors, including, but not limited to those contained in Item 1A, “Risk Factors,” of this Form 10-K. Actual operations and results may differ materially from those expressed in this Form 10-K. Among the factors that may materially affect our business, operations or financial condition are the ability to accurately estimate and control future health care costs; the ability to increase premiums to offset increases in our health care costs; general economic conditions and disruptions in the financial markets; changes in laws or regulations or government investigations; changes in government funding and various other risks associated with our participation in Medicare and Medicaid programs; a reduction in the number of members in our health plans; the ability to acquire additional managed care business and to successfully integrate acquired businesses into our operations; an ability to attract new members or to increase or maintain our premium rates; the non-renewal or termination of our government contracts or unsuccessful bids for business with government agencies; failure of our independent agents and brokers to continue to market our products to employers; a failure to obtain cost-effective agreements with a sufficient number of providers that could result in higher medical costs and a decrease in our membership; negative publicity regarding the managed health care industry generally or our Company in particular; a failure to effectively protect, maintain and develop our information technology systems; periodic reviews, audits and investigations under our contracts with federal and state government agencies; litigation including litigation based on new or evolving legal theories; volatility in our stock price and trading volume; our indebtedness, which imposes certain restrictions on our business and operations; an inability to generate sufficient cash to service our indebtedness; a substantial amount of our cash flow is generated by regulated subsidiaries; our certificate of incorporation and bylaws and Delaware law, which could delay, discourage or prevent a change in control of our Company that our stockholders may consider favorable; and an impairment of our intangible assets.

**Item 1: Business**

**General**

We are a diversified national managed healthcare company based in Bethesda, Maryland, operating health plans, insurance companies, network rental and workers’ compensation services companies. Through our Health Plan and Medical Services, Specialized Managed Care, and Workers’ Compensation reportable segments, which we also refer to as “Divisions,” we provide a full range of risk and fee-based managed care products and services to a broad cross section of individuals, employer and government-funded groups, government agencies, and other insurance carriers and administrators.

Coventry was incorporated under the laws of the State of Delaware on December 17, 1997 and is the successor to Coventry Corporation, which was incorporated on November 21, 1986. Our Annual Report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and amendments to these reports, as well as recent press releases can be accessed free of charge on the Internet at [www.coventryhealthcare.com](http://www.coventryhealthcare.com).

Our Health Plan and Medical Services Division is primarily comprised of our traditional health plan commercial risk, Medicare Advantage and Medicaid products. Our health plans offer commercial risk products, including health maintenance organization (“HMO”), preferred provider organization (“PPO”) and point of service (“POS”) products, to individuals and employer groups of all sizes. We offer these products on an underwritten or “risk” basis where we receive a monthly premium in exchange for assuming underwriting risks, including all medical and administrative costs. Additionally, through this Division we contract with various federal employee organizations to provide health insurance benefits under the Federal Employees Health Benefits Program (“FEHBP”) and offer managed care and administrative products to businesses that self-insure the health care benefits of their employees where we perform administrative services only (“ASO”), including medical claims administration, pharmacy benefits management and clinical programs such as utilization management and quality assurance for a fixed fee with the customer assuming the risk for medical costs. Within these products, we also offer consumer-directed benefit options including health reimbursement accounts (“HRA”) and health savings accounts (“HSA”) to our commercial customers. This Division provides comprehensive health benefits on a risk basis to members participating in the Medicare Advantage HMO, Medicare Advantage PPO, and Medicaid programs for which it receives premium payments from federal and state governments. Through December 31, 2009, this Division also provided services to members participating in Medicare Advantage Private-Fee-For-Service (“PFFS”). Effective January 1, 2010, we did not renew the Medicare PFFS product for the 2010 plan year. This Division also contains our dental services business.

We operate local health plans that serve 24 markets, primarily in the Mid-Atlantic, Midwest, Mountain West and Southeast United States. Our health plans are operated under the names Altius Health Plans, Carelink Health Plans, Coventry Health Care, Coventry Health and Life, Group Health Plan, HealthAmerica, HealthAssurance, HealthCare USA, Mercy Health Plans, OmniCare, PersonalCare, Preferred Health Systems, Southern Health, and WellPath. Our health plans generally are located in small to mid-sized metropolitan areas. For a complete list of our subsidiaries, refer to Exhibit 21 included with this Annual Report on Form 10-K.

Our Specialized Managed Care Division includes Medicare Part D, network rental, and our behavioral health benefits businesses. Our Medicare Part D program provides eligible beneficiaries access to prescription drug coverage and receives premium payments from the federal government. Our network rental business offers provider network rental services through a national PPO network to national, regional and local third-party administrators (“TPA”) and insurance carriers. Our behavioral health benefits business provides coordination of comprehensive mental health and substance abuse treatment. Additionally, as discussed in Note D, Discontinued Operations, to the consolidated financial statements, prior to its sale on July 31, 2009, our Medicaid/Public entity (“Public Sector”) provided products and services to state Medicaid agencies and other government funded programs.

Our Workers’ Compensation Division is comprised of our workers’ compensation services businesses which provide fee-based, managed care services such as provider network access, bill review, care management services and pharmacy benefit management to underwriters and administrators of workers’ compensation insurance and large employer groups.

### **Health Plan and Medical Services Division**

#### **Health Plan Commercial Risk Products**

Our health plans offer employer groups a full range of commercial risk products designed to meet the needs and objectives of a wide range of employers and members as well as to comply with regulatory requirements. Our health plans also offer major medical and high-deductible products to individual consumers. The distribution of these products is through independent licensed brokers, directly from our sales organization or through our website. Our health plans had 1.6 million commercial risk members as of December 31, 2010 that accounted for \$5.2 billion of revenue in 2010.

Our health plan products vary with respect to product features, the level of benefits provided, the costs to be paid by employers and members, including deductibles and co-payments, and our members’ access to providers without referral or preauthorization requirements.

#### **Health Maintenance Organizations**

Our health plan HMO products provide comprehensive health care benefits, including ambulatory and inpatient physician services, hospitalization, pharmacy, mental health, ancillary diagnostic and therapeutic services. In general, a fixed monthly premium covers all HMO services although benefit plans typically require co-payments or deductibles in addition to the basic premium. A primary care physician assumes overall responsibility for the care of a member, including preventive and routine medical care and referrals to specialists and consulting physicians. While an HMO member’s choice of providers is limited to those within the health plan’s HMO network, the HMO member is typically entitled to coverage of a broader range of health care services than is covered by typical reimbursement or indemnity policies. Furthermore, many of our HMO products have added features to more easily allow “direct access” to providers.

#### **Preferred Provider Organizations and Point of Service**

Our health plan risk-based PPO and POS products also provide comprehensive managed health care benefits while allowing members to choose their health care providers at the time medical services are required. Members may use providers that do not participate in our health plan managed care networks but may incur higher co-payments and other out-of-pocket costs than if the member chooses a participating provider. Our health plans also offer high deductible products in conjunction with our consumer directed products. Premiums for our PPO and POS products typically are lower than HMO premiums due to the increased out-of-pocket costs borne by the members.

## **Commercial Management Services Products**

Our health plans offer management services and access to their provider networks to employers that self-insure their employee health benefits. The management services provided under these ASO arrangements typically include medical claims administration, pharmacy benefits management, utilization management and quality assurance. Other features commonly provided to fully insured customers (such as value-added wellness benefits) are generally also available to ASO customers. These ASO arrangements, through which our health plans typically do not assume underwriting risk, include a fixed fee for these management services and access to our provider networks. As of December 31, 2010, our health plans had approximately 698,000 non-risk health plan members.

We offer stop-loss insurance to enable us to serve as an integrated, single source for the managed care needs of our self-insured clients. Stop-loss policies help curtail the risk assumed by our self-insured clients by covering such clients' expenses after they have paid out a predetermined amount. Stop-loss policies are written through our wholly-owned insurance subsidiaries and can be written for specific and/or aggregate stop-loss insurance.

In addition, we provide management services to plans in the FEHBP, which is the largest employer-sponsored group health program in the United States. In the FEHBP, federal employees have the opportunity to choose a health benefits carrier from a number of offered plans each year. We provide management services and/or serve as the plan administrator to multiple FEHBP plan sponsors, including the Mail Handlers Benefit Plan ("MHBP"), our largest client. The MHBP offers health care benefits under the FEHBP to federal employees and annuitants nationwide. Commercial management services accounted for \$327.1 million of revenue for the year ended December 31, 2010.

## **Medicare Advantage**

As of December 31, 2010, our health plans operated Medicare Advantage Coordinated Care Plans ("Medicare Advantage CCP") in 12 states. The Centers for Medicare & Medicaid Services ("CMS") pays a county-specific fixed premium per member per month ("PMPM") under our health plan Medicare contracts. Our health plans may also receive a monthly premium from their Medicare members and/or their employer. Our Medicare Advantage line of business covered 224,000 members as of December 31, 2010 and accounted for \$2.1 billion of revenue in 2010.

## **Medicaid**

Certain of our health plans offer health care coverage to Medicaid recipients in eight states which, as of December 31, 2010, covered 468,000 members and accounted for \$1.1 billion of revenue in 2010. These health plans enter into a Medicaid Management Care contract with each of these individual states. Under a Medicaid contract, the participating state pays a premium PMPM based on the age, sex, eligibility category and, in some states, county or region of the Medicaid member enrolled. In some states, these premiums are adjusted according to the health risk associated with the individual member. The majority of our Medicaid members are in the Florida, Michigan, Missouri, Nebraska, Pennsylvania and West Virginia markets, representing 90% of our total Medicaid membership.

## **Dental Benefit Services**

We offer a full suite of dental services, including insured and administrative plans for individuals and groups, a full-service dental third-party administrator specializing in private-label programs and a full suite of discount products. These services are offered through Group Dental Service, Inc. ("GDS"), which is based in Rockville, Maryland. GDS accounted for \$30.2 million of revenue, after intercompany eliminations, for the year ended December 31, 2010.

## **Health Plan Markets**

The geographic markets in which our health plans operate and the products offered in each are described as follows:

- **Arkansas** — commercial products primarily in Northwest Arkansas, Fort Smith and Hot Springs; and Medicare Advantage products in 11 counties.
- **Delaware** — commercial products throughout the state.
- **Florida** — commercial products in South Florida, the Tampa Bay area and certain counties in North Florida; Medicaid products in South Florida as well as certain counties in North Florida and the state's panhandle; and Medicare Advantage products in South Florida and the Tampa Bay area.
- **Georgia** — commercial products in the greater Atlanta, Savannah, Augusta, Macon and Columbus metropolitan areas; and Medicare Advantage products in Atlanta, Savannah and Columbus.
- **Idaho** — commercial products throughout the state.

- **Illinois** — commercial products primarily in the Western, Northern and Central Illinois areas; and Medicare Advantage products in portions of Eastern, Central, Western and Northern Illinois.
- **Iowa** — commercial products primarily in the Des Moines, Waterloo, Sioux City and Ames metropolitan areas; and Medicare Advantage products in 44 counties.
- **Kansas** — commercial products in Kansas City and Wichita metropolitan areas, including portions of Western Missouri and Kansas; and Medicare Advantage products in the Kansas City, Springfield, MO and Wichita metropolitan areas.
- **Louisiana** — commercial products primarily in the New Orleans, Baton Rouge and Shreveport metropolitan areas.
- **Maryland** — commercial products primarily in the Baltimore metropolitan area and the Eastern and Western Shore areas; and Medicaid products in the Baltimore metropolitan area.
- **Michigan** — Medicaid and Children’s Health Insurance Program products in Wayne and Oakland counties (Detroit metropolitan areas).
- **Missouri** — commercial and Medicare Advantage products in the St. Louis metropolitan and Central Missouri areas, including portions of Southwestern Missouri and Southern Illinois; and Medicaid products in Eastern, Central and Western Missouri.
- **Nebraska** — commercial products primarily in the Omaha and Lincoln metropolitan areas, including Central and Western Nebraska; Medicare Advantage products in 18 counties; and Medicaid products in 10 counties.
- **Nevada** — commercial products primarily in the Las Vegas metropolitan area.
- **North Carolina** — commercial products primarily in the Raleigh-Durham and Charlotte metropolitan areas; and Medicare Advantage products primarily in Central North Carolina.
- **Oklahoma** — commercial products in both the Oklahoma City and Tulsa markets.
- **Pennsylvania** — commercial products in all Pennsylvania markets and portions of Eastern Ohio; Medicare Advantage products in the Pittsburgh, Harrisburg and State College metropolitan areas; and Medicaid products in Southeastern Pennsylvania.
- **South Carolina** — commercial products in the Charleston and Columbia metropolitan areas.
- **South Dakota** — commercial products primarily in the Sioux Falls and Yankton metropolitan areas; and Medicare Advantage products in 11 counties.
- **Tennessee** — commercial products primarily in the metropolitan Memphis and West Tennessee areas, with additional networks in the far northern Mississippi counties of DeSoto and Tate and Eastern Arkansas.
- **Utah** — commercial products throughout the state; and Medicare Advantage products throughout the state, excluding Washington County.
- **Wyoming** — commercial products primarily in the lower Southwestern counties near Utah; and Medicare Advantage products in Uinta County.
- **Virginia** — commercial and Medicaid products primarily in the Richmond, Roanoke and Charlottesville metropolitan areas and the Shenandoah Valley.
- **West Virginia** — commercial and Medicaid products throughout the majority of the state.

### **Specialized Managed Care Division**

#### **Medicare Part D**

The Medicare Part D program provides eligible beneficiaries with access to prescription drug coverage. As part of the Medicare Part D program, eligible Medicare recipients are able to select a prescription drug plan. The Medicare Part D prescription drug benefit is subsidized by the federal government and is additionally supported by risk-sharing with the federal government through risk corridors designed to limit the profits or losses of the drug plans and through reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid, by Medicare region, by participating plans for this coverage, adjusted for member demographics and risk factor payments. The beneficiaries will be responsible for the difference between the government subsidy and their benefit plan’s bid, together with the amount of their benefit plan’s supplemental premium. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries.

Our Medicare Part D business accounted for \$1.6 billion of revenue in 2010 and had 1.6 million members as of December 31, 2010. The Medicare Part D plans are marketed under the brand names of Advantra Rx, First Health Premier and First Health Secure. For 2010, certain of these plans include an option with first dollar coverage (no deductible) and options for generic coverage within the coverage gap in which no insurance coverage under the standard Part D program is available. We have established partnerships with Medicare Supplement insurance carriers and brokerage channels nationwide to distribute Medicare Part D prescription drug products to Medicare beneficiaries on our behalf. Medicare beneficiaries can also purchase our Medicare Part D products via an internet-based Medicare Plan Finder tool. The Plan Finder tool, developed by CMS, allows Medicare beneficiaries to search and compare Medicare coverage options and products from their geographic area. The Medicare eligible beneficiaries can then purchase their product via the Plan Finder tool or by calling us.

**Network Rental**

We offer our national PPO network and other managed care products to national, regional and local TPAs and insurance carriers. Primarily operating on a business-to-business basis, network rental focuses on delivering managed care and administrative solutions that increase client efficiency and improve their product offerings. Network services are supplemented with a variety of product offerings, including clinical management programs. Our network rental businesses accounted for \$93.1 million of revenue in 2010.

**Behavioral Health Services**

We operate in the managed behavioral healthcare industry and provide coordination of comprehensive mental health, substance abuse treatment and employee assistance programs throughout the United States. These services are provided through MHNNet Specialty Services, LLC and associated subsidiaries (“MHNNet”) based in Austin, Texas. MHNNet provides services to health plans and employer clients and accounted for \$24.1 million of revenue, after intercompany eliminations, in 2010.

**Workers’ Compensation Division**

We provide workers’ compensation services whereby our customers pay fees to access our national workers’ compensation provider network. Similar to our network rental business, the workers’ compensation clients make the final pay determination and our products are designed to help our customers drive industry-leading medical outcomes and identify appropriate cost savings at every step of an injured worker’s recovery. Our workers’ compensation products accounted for \$755.1 million of revenue in 2010.

**Bill Review**

Our workers’ compensation Bill Review system provides national and multi-regional workers’ compensation clients with a system to integrate and manage their workers’ compensation medical data. Our Bill Review system enables our clients to have an accurate and consistent application of state fee schedule pricing, including applicable rules, regulations and clinical guidelines. State fee schedules, which typically represent the maximum reimbursement for medical services provided to the injured worker, differ by state and change as state laws and regulations are passed and/or amended. Our Bill Review system features full integration with our provider network and provides a seamless process for determining claim payment rates. As part of the bill adjudication process, we subject bills to a sophisticated, proprietary process to detect duplicate bills and correct billing irregularities and inappropriate billing practices.

In addition, our Bill Review system has a comprehensive reporting database that produces a standard set of client savings and management reports. Clients who utilize our Bill Review system have online access to their data and are able to create reports at their desktops.

**Pharmacy Benefit Management**

Insurance carriers, TPAs and employers contract with our First Script pharmacy benefit management (“PBM”) program. First Script provides access to a retail network of over 61,000 pharmacies that can be accessed by workers’ compensation claimants immediately after an injury has occurred. First Script continues to provide service to these claimants upon compensability confirmation throughout the duration of their workers’ compensation claims. Home delivery of medication is included as part of First Script’s integrated prescription solution.

In addition to providing network access to workers’ compensation claimants, First Script also offers a full suite of drug utilization review tools and reports to assist its clients in controlling their pharmacy costs. These tools go beyond basic formulary management and include predictive indicators of claim severity and direction. The application of these cost control tools must be balanced with the need for claimants to receive their drugs in a convenient and timely manner. Claimants who follow their doctors’ prescription orders are more likely to recover quicker and return to work earlier. Both of these outcomes further contribute to lowering the client’s overall workers’ compensation claim costs.

**Care Management Services**

Our Care Management Services seek to promote appropriate healthcare access and utilization by performing services designed to monitor cases and facilitate the return to work of injured or ill employees who have been out of work, receiving healthcare, or both for an extended period of time due to a work-related or auto incident or disability.

We provide field case management services for workers’ compensation cases through case managers working on a one-on-one basis with injured employees and their healthcare professionals, employers, TPAs and insurance company adjusters. Our telephonic case management services consist of telephonic management of workers’ compensation, as well as short-term disability, long-term disability and employee absences covered under the Family and Medical Leave Act. We provide our customers with access to healthcare professionals who perform independent medical examinations to evaluate the medical conditions and treatment plans of patients. Our technology enables customers to make on-line referrals and check on the current status of their cases. Customers use our pre-certification and concurrent review services to ensure that a physician or registered nurse reviews, and pre-certifies if appropriate, specified medical procedures for medical necessity and appropriateness which are certified by URAC (formerly known as Utilization Review Accreditation Commission).

## **Operational Areas**

### **Provider Network**

Our provider network is the core of our health plan, network rental, and workers' compensation businesses, providing the foundation for our products and services. We contract with hospitals, physicians and other health care providers that provide health care services at pre-negotiated rates to members and customers of various payors, including employee groups, workers' compensation payors, insurance carriers, TPAs, HMOs, self-insured employers, union trusts and government employee plans. Provider networks offer a means of managing health care costs by reducing the per-unit price of medical services accessed through the network while providing an increased number of patients to providers.

Our provider network optimizes client savings through a combination of increased penetration to a broad network and discounted unit costs savings. The majority of the facility contracts feature fixed rate structures that ensure cost effectiveness while incentivizing providers to control utilization. The fixed rate structures include per diems based on the intensity of care and/or Diagnosis Related Group based pricing for inpatient care. Hospital outpatient charges are typically controlled by fixed fee schedules or on a per case basis. For facilities or procedures not covered by fixed pricing arrangements, charge master controls are generally negotiated, limiting the increasing trend of health care unit cost.

Our health plans maintain provider networks in the local markets in which they operate. All of our health plans currently offer an open panel delivery system where individual physicians or physician groups contract with the health plans to provide services to members but also maintain independent practices in which they provide services to individuals who are not members of our health plans.

Most of our health plan contracted primary care and specialist physicians are compensated under an established local fee schedule that is structured around the resource-based relative value scale. The majority of our health plans contract with hospitals to provide for inpatient care through per diem or per case hospital rates. Outpatient services are contracted on a discounted fee-for-service or a per case basis. Our health plans pay ancillary providers on a fixed fee schedule or a capitation basis. Prescription drug benefits are provided through a formulary and drug prices are negotiated at discounted rates through a national network of pharmacies.

Our health plans have capitation arrangements for certain ancillary health care services, such as laboratory services and, in some cases, physician and radiology services. Under some capitated and professional capitation arrangements, physicians may also receive additional compensation from risk sharing and other incentive arrangements. Capitation arrangements limit our health plans' exposure to the risk of increasing medical costs but expose them to risk as to the adequacy of the financial and medical care resources of the provider organization. Our health plans are ultimately responsible for the coverage of their members pursuant to the customer agreements. To the extent that a provider organization faces financial difficulties or otherwise is unable to perform its obligations under capitation arrangements, our health plans will be required to perform such obligations. Consequently, our health plans may have to incur costs in excess of the amounts they would otherwise have to pay under the original capitation arrangements. Medical costs associated with capitation arrangements made up approximately 6.4%, 2.9% and 4.1% of our total medical costs for the years ended December 31, 2010, 2009 and 2008, respectively. We do not consider the financial risk associated with our existing capitation arrangements to be material.

Additionally, in response to healthcare reform we are beginning to implement Accountable Care Organizations ("ACO") and gain share arrangements that align quality of care and cost incentives with our providers. ACOs are designed to deliver coordinated and efficient medical care to our members whereby the integrated delivery system and physician groups receive additional payments if each meets quality of care and cost targets.

### **Medical Management**

We have established systems to monitor the availability, appropriateness and effectiveness of the patient care that our network providers provide to our members. We collect utilization data that is used to analyze over-utilization or under-utilization of services and to assist in arranging for appropriate care for our members and improving patient outcomes in a cost efficient manner. Our corporate medical department monitors the medical management policies of our subsidiaries and assists in implementing disease management programs, quality assurance programs and other medical management tools. In addition, we have internal quality assurance review committees made up of practicing physicians and staff members whose responsibilities include periodic review of medical records, development and implementation of standards of care based on current medical literature and the collection of data relating to results of treatment.

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We have developed a comprehensive disease management program that identifies those members having certain chronic diseases, such as asthma and diabetes. Our case managers proactively work with members and their physicians to facilitate appropriate treatment, help to ensure compliance with recommended therapies and educate members on lifestyle modifications to manage the disease. We believe that our disease management program promotes the delivery of efficient care and helps to improve the quality of health care delivered.

Our medical directors supervise medical managers who review and approve, for coverage in accordance with the health benefit plan, requests by physicians to perform certain diagnostic and therapeutic procedures. We use nationally recognized clinical guidelines developed based on nationwide benchmarks that maximize efficiency in health care delivery and InterQual, a nationally recognized evidence-based set of criteria developed through peer reviewed medical literature. Medical managers also continually review the status of hospitalized patients and compare their medical progress with established clinical criteria, make hospital rounds to review patients' medical progress and perform quality assurance and utilization functions.

Medical directors also monitor the utilization of diagnostic services and encourage the use of outpatient surgery and testing where appropriate. Data showing each physician's utilization profile for diagnostic tests, specialty referrals and hospitalization are collected and presented to physicians. The medical directors monitor these results in an attempt to ensure the use of cost-effective, medically appropriate services.

We focus on the satisfaction of our members. We monitor appointment availability, member-waiting times, provider environments and overall member satisfaction. We continually conduct membership surveys of existing employer groups concerning the quality of services furnished and suggestions for improvement.

### **Information Technology**

We believe that integrated and reliable information technology systems are critical to our success. We have implemented information systems to improve our operating efficiency, support medical management, underwriting and quality assurance decisions and effectively service our customers, members and providers. Each of our health plans operates on a single financial reporting system along with a common, fully integrated application which encompasses all aspects of our health plan commercial, government and non-risk business, including enrollment, provider referrals, premium billing and claims processing.

We have dedicated in-house teams providing infrastructure and application support services to our members. Our data warehouse collects information from all of our health plans and uses it in medical management to support our underwriting, product pricing, quality assurance, rate setting, marketing and contracting functions. We have dedicated in-house teams that convert acquired companies to our standard information systems as soon as practicable following the closing of the acquisition.

We have dedicated information technology teams that are efficiently addressing information system needs in support of new business requirements mandated by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, "PPACA"). We have already implemented changes to support new PPACA provisions effective September 23, 2010 as described in Item 1A, "Risk Factors," of this Form 10-K.

In 2010, approximately 83.0% of our claim transactions were received from providers in a Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant electronic data interface format. In 2010, our claims system auto adjudicated approximately 82.3% of all claims, which improves our claims processing efficiency and accuracy.

### **Marketing**

We market our products and services directly to individuals, employer groups, multi-site accounts, self-insured employers and government employees. We also market on a business-to-business basis to our group health insurance carriers and TPAs, who then have primary responsibility for offering our services to their underlying clients. We also market through FEHBP health plan sponsors and directly to federal employees. Marketing is provided through our own direct sales staff and a network of non-exclusive, independent insurance brokers and agents focused on developing new business as well as retaining existing business.

Our commercial HMO, PPO and POS products are offered on a fully insured and self-funded basis. Our local health plans continue to expand the number of lower cost medical and pharmacy product options to improve health insurance affordability. These options include a family of "consumer-driven" products, whereby the employee bears a substantially greater proportion of health care costs.

While our large group accounts may have benefit products offered to their employees by multiple carriers, our small and medium size groups are most commonly offered our services on an exclusive basis. In the case of insurance carriers, we typically enter into a master service agreement under which we agree to provide our cost management services to health plans maintained by the carrier's customers. Our services are offered to new insurance policyholders and to existing policyholders at the time group health benefits are renewed.

Medicaid products are marketed to Medicaid recipients by state Medicaid authorities and through educational and community outreach programs.

Medicare Advantage products, which can include both medical and pharmacy benefits, are commonly promoted through direct sales, including mass media and direct mail to both individuals and retirees of employer groups that provide benefits to retirees. Networks of independent brokers are also used in the marketing of Medicare products. Our Medicare Part D product is marketed through our existing channels as well as through joint marketing arrangements with Medicare Supplement health insurers, TPAs and related broker distribution entities. Additionally, we have established partnerships with Medicare Supplement health insurers and brokerage channels nationwide to provide Medicare Advantage products to Medicare beneficiaries.

Workers' compensation services are marketed to insurance carriers and TPAs who in turn take responsibility for marketing our services to their prospects and clients. We also market directly to state funds, municipalities, self-insured payors and other distribution channels.

### **Significant Customers**

The MHPB represented 11.2%, 11.3% and 10.7% of our management services revenue for the years ended December 31, 2010, 2009 and 2008, respectively.

Our health plan commercial business is diversified across a large customer base and no customer group comprises 10% or more of our managed care premiums. We received 35.6%, 50.7% and 38.1% of our managed care premiums for the years ended December 31, 2010, 2009 and 2008, respectively, from the federal Medicare programs throughout our various health plan markets and from national Medicare Part D and Medicare PFFS products. The decline in 2010 is primarily a result of our non-renewal of the Medicare PFFS product effective January 1, 2010. We also received 10.9%, 8.4% and 10.3% of our managed care premiums for the years ended December 31, 2010, 2009 and 2008, respectively, from our state-sponsored Medicaid programs throughout our various health plan markets. In 2010, the State of Missouri accounted for almost half of our health plan Medicaid premiums.

### **Competition**

The managed care industry is highly competitive, both nationally and in the individual markets we serve. Generally, in each market, we compete against local health plans, and nationally focused health insurers and managed care plans. We compete for employer groups and members primarily on the basis of the price of the benefit plans offered, locations of the health care providers, reputation for quality care and service, financial stability, comprehensiveness of coverage, diversity of product offerings and access to care. We also compete with other managed care organizations and indemnity insurance carriers in obtaining and retaining favorable contracts for health care services and supplies.

We compete in a highly fragmented market with national, regional and local firms specializing in utilization review and PPO cost management services and with major insurance carriers and TPAs that have implemented their own internal cost management services. In addition, other managed care programs, such as HMOs and group health insurers, compete for the enrollment of benefit plan participants. We are subject to intense competition in each market segment in which we operate. We distinguish ourselves on the basis of our program quality, cost-effectiveness, proprietary computer-based integrated information systems, emphasis on commitment to service with a high degree of physician involvement, national provider network, including its penetration into secondary and tertiary markets, and our role as an integrated provider of PBM services.

Workers' compensation competition includes regional and national managed care companies and other service providers with an emphasis on PPO, clinical programs, PBM services or bill review. We differentiate ourselves based on our national PPO coverage and the ability to provide an integrated product, coupled with technology that reduces administrative cost. We compete with a multitude of PPOs, technology companies that provide bill review services, clinical case management companies, pharmacy benefit managers and rehabilitation companies for the business of these insurers. While experience differs with various clients, obtaining a workers' compensation insurer as a new client typically requires extended discussions and a significant investment of time. Given these characteristics of the competitive landscape, client relationships are critical to the success of our workers' compensation products.

**Financial Information**

Required financial information related to our business segments is set forth in Note B, Segment Information, to the consolidated financial statements.

**Corporate Governance**

Our Board of Directors has adopted a Code of Business Conduct and Ethics applicable to our directors and officers, including our Chief Executive Officer, Interim Chief Financial Officer, Corporate Controller, and employees. In addition, the Board of Directors has adopted Corporate Governance Guidelines and a Related Person Transactions Policy for our directors and committee charters for our Audit Committee, Compensation Committee and Nominating/Corporate Governance Committee. All of these documents, as amended, can be accessed on our website at [www.coventryhealthcare.com](http://www.coventryhealthcare.com) through the "Corporate Governance" link under "Investor Relations."

**Government Regulation**

As a managed health care company, we are subject to extensive government regulation of our products and services. The laws and regulations affecting our industry generally give state and federal regulatory authorities broad discretion in their exercise of supervisory, regulatory and administrative powers. These laws and regulations are intended primarily for the benefit of the members of the health plans. Managed care laws and regulations vary significantly from jurisdiction to jurisdiction and changes are frequently considered and implemented. For additional information, refer to Item 1A, "Risk Factors," of this Form 10-K.

**Health Care Reform**

In March 2010, President Obama signed PPACA into law which imposes numerous provisions on managed care companies and represents significant change across the health care industry.

PPACA, as enacted, seeks to decrease the number of uninsured individuals and expand coverage through a number of health insurance market reforms. In order to expand coverage, PPACA requires states to expand eligibility under existing Medicaid programs to those at or below 133% of the federal poverty level. In addition, PPACA, as enacted, requires individuals to obtain health insurance or pay penalties and mandates that employers with more than 50 full time employees offer affordable insurance to employees or pay an assessment. PPACA also prohibits the use of gender, health status, family history or occupation in setting premium rates and eliminates pre-existing condition exclusions. Further, PPACA requires the Department of Health and Human Services ("HHS") to award loans and grants to new non-profit entities that will offer qualified health plans. PPACA also requires states to establish a health insurance exchange and permits states to create federally funded, non-Medicaid plans for low-income residents not eligible for Medicaid. PPACA requires states to expand eligibility under existing Medicaid programs to those at or below 133% of the federal poverty level.

Many of the provisions intended to expand insurance coverage, such as a mandate for individuals to obtain health insurance and for employers to provide insurance to employees, become effective in 2014. Additional provisions effective January 1, 2014 that address expansion of insurance coverage include prohibiting use of pre-existing conditions exclusions for adults, limiting premium ratings based on age, eliminating premium rating based on gender or health status and prohibiting annual benefit limits. Other market reforms are more immediate in nature; for example, for plan years beginning on or after September 23, 2010, PPACA bans lifetime limits on essential health benefits, prohibits the use of pre-existing condition exclusions for children up to age 19, creates new benefit mandates, including requiring preventative services and immunizations to be provided without cost-sharing, and provides for increased dependent coverage for dependents up to age 26.

Beginning January 1, 2011, PPACA mandates minimum medical loss ratios for health plans such that the percentage of health coverage premium revenue spent on health care medical costs and quality improvement expenses be at least 80% for individual and small group health coverage and 85% for large group coverage, with rebates to policyholders if the actual loss ratios fall below these minimums. On November 22, 2010, HHS issued interim final regulations clarifying the minimum medical loss ratio requirements. These regulations require each health plan to report by June 1<sup>st</sup> of each year (beginning June 1, 2011) data regarding aggregate premiums, claims experience, quality improvement expenditures and non-claims costs incurred for policies issued in the large group, small group and individual markets for each state in which it issues policies. We continue to focus on selling, general and administrative expense efficiencies and on maintaining medical loss ratios across our business lines at levels that we believe will contribute to continued profitability. As a result of the mandated minimum loss ratios, states may request waivers to these requirements for the individual market if the insurance commissioner determines there is a reasonable likelihood that destabilization will occur when the MLR requirement is applied.

Further, PPACA imposes significant Medicare Advantage funding cuts by freezing rates for 2011 at the levels for 2010 and reducing payment rates, during a two, four or six year period beginning in 2012, based on fee-for-service benchmarks and quality rankings. PPACA also provides for significant new taxes, including an industry user tax paid by health insurance companies beginning in 2014, as well as an excise tax of 40% on employers offering high cost health coverage plans beginning in 2018. The new legislation also prohibits us from deducting annual compensation exceeding \$500,000 for any employee on our Corporate income tax returns, which will result in a higher effective income tax rate.

In addition, PPACA will lead to increased state legislative and regulatory initiatives in order for states to comply with new federal mandates and to participate in grants and other incentive opportunities. For example, by 2014, states must establish insurance exchanges (either as a governmental entity or non-profit entity) that facilitate individual purchases of qualified health plans and assist qualified small employers with enrolling their employees in qualified health plans. PPACA also requires states to expand eligibility under existing Medicaid programs to those at or below 133% of the poverty level by 2014. PPACA requires insurers to submit to HHS and state regulators justifications for certain predefined rate increases and mandates that these justifications be publicly disclosed. On December 23, 2010, HHS issued a proposed rule that would make any rate increase of 10% or more subject to additional review for reasonableness. Such review would be performed by the state or, if the state lacks an adequate process, by HHS. In addition to state reform efforts related to PPACA, several states are considering, or may consider, legislative proposals that could affect our ability to obtain appropriate premium rates and that would mandate certain benefits and forbid certain policy provisions. We cannot predict the full effect of PPACA and the changes that government authorities will approve in the future. It is probable that those changes will have an adverse effect on our business or results of operations.

Implementation of PPACA, particularly those provisions expanding health insurance coverage, could be delayed or even blocked due to court challenges and efforts to repeal or amend the law. Further, court challenges and legislative efforts could revise or eliminate all or portions of PPACA. More than 20 challenges to PPACA have been filed in federal courts. Some federal district courts have upheld the constitutionality of PPACA or dismissed the cases on procedural grounds. Others have held the requirement that individuals maintain health insurance or pay a penalty to be unconstitutional and have either found PPACA void in its entirety or left the remainder of the law intact. These lawsuits are subject to appeal, and it is unclear how federal lawsuits challenging the constitutionality of PPACA will be resolved or what the effect will be on any resulting changes to the law. For example, should the requirement that individuals maintain health insurance coverage ultimately be deemed unconstitutional but the prohibition on health plans excluding coverage due to pre-existing conditions be maintained, our business could be adversely affected.

PPACA and state reform efforts, whether independent of or related to PPACA, represent significant change across the health insurance industry, the effect of which is not fully known due to PPACA's complexity, the numerous regulations still to be issued or finalized that will detail its requirements, the lack of interpretive guidance, the gradual and potentially delayed implementation, pending court challenges, possible amendment of PPACA and uncertainty around state reform efforts. We cannot predict the full effect of PPACA and state reform efforts at this time or provide assurance that those changes will not have an adverse effect on our business or results of operations.

### **State Regulation**

The states served by our health plans provide the principal legal and regulatory framework for the commercial risk products offered by our insurance companies and HMO subsidiaries. One of our insurance company subsidiaries, Coventry Health and Life Insurance Company ("CH&L"), offers managed care products, primarily PPO and POS products, in conjunction with our HMO subsidiaries in states where HMOs are not permitted to offer these types of health care benefits. CH&L does not currently offer traditional health indemnity insurance. In addition, one of our subsidiaries, First Health Life & Health Insurance Company ("FHL&H"), offers a small group PPO product in certain states. CH&L and FHL&H are domiciled in Delaware and Texas, respectively, which have principal regulatory jurisdiction over their operations.

Our regulated subsidiaries are required by state law to file periodic reports, to meet certain minimum capital and deposit and/or reserve requirements and may be restricted from paying dividends to the parent or making other distributions or payments under certain circumstances. They also are required to provide their members with certain mandated benefits. Our HMO subsidiaries are required to have quality assurance and educational programs for their professionals and enrollees. Certain states' laws further require that representatives of the HMOs' members have a voice in policy making. Most states impose requirements regarding the prompt payment of claims and several states permit "any willing provider" to join our network. Compliance with "any willing provider" laws could increase our costs of assembling and administering provider networks.

We also are subject to the insurance holding company regulations in the states in which our regulated subsidiaries operate. These laws and associated regulations generally require registration with the state department of insurance and the filing of reports describing capital structure, ownership, financial condition, certain inter-company transactions and business operations. Most state insurance holding company laws and regulations require prior regulatory approval or, in some states, prior notice of acquisitions or similar transactions involving regulated companies and of certain transactions between regulated companies and their parents. In connection with obtaining regulatory approvals of acquisitions, we may be required to agree to maintain the capital of our regulated subsidiaries at specified levels, guarantee the solvency of such subsidiaries or satisfy other conditions. Generally, our regulated subsidiaries are limited in their ability to pay dividends to their parent due to the requirements of state regulatory agencies that the subsidiaries maintain certain minimum capital balances.

Most states now impose risk-based or other net worth-based capital requirements on our regulated entities. These requirements assess the capital adequacy of the regulated subsidiary based upon the investment asset risks, insurance risks, interest rate risks and other risks associated with the subsidiary's business. If a subsidiary's capital level falls below certain required capital levels, it may be required to submit a capital corrective plan to regulatory authorities and, at certain levels, may be subjected to regulatory orders, including regulatory control through rehabilitation or liquidation proceedings. See Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources," of this Form 10-K for more information.

Our workers' compensation customers are also subject to state governmental regulation. Historically, governmental strategies to contain medical costs in the workers' compensation field have been limited to legislation on a state-by-state basis. Many states have adopted guidelines for utilization management and have implemented fee schedules that list maximum reimbursement levels for health care procedures. In certain states that have not authorized the use of a fee schedule, we adjust bills to the usual and customary levels authorized by the payor.

## **Federal Regulation**

### **Privacy, Security and other HIPAA Requirements**

The use, disclosure and secure handling of individually identifiable health information by our business is regulated at the federal level, including the privacy provisions of the Gramm-Leach-Bliley Act and privacy and security regulations pursuant to HIPAA. Further, our privacy and security practices are subject to various state laws and regulations. Varying requirements and enforcement approaches in the different states may adversely affect our ability to standardize our products and services across state lines. These state and federal requirements change frequently as a result of legislation, regulations and judicial or administrative interpretations. The American Recovery and Reinvestment Act of 2009 ("ARRA") broadened the scope of the HIPAA privacy and security regulations. Among other things, ARRA strengthened the enforcement provisions of HIPAA, which may result in increased enforcement activity. Under ARRA, HHS is required to conduct periodic compliance audits of entities covered by the HIPAA regulations, known as covered entities, and their business associates (entities that handle identifiable health information on behalf of covered entities). Many of our business operations are considered to be covered entities under HIPAA, while others are classified as business associates.

ARRA broadened the applicability of the criminal penalty provisions under HIPAA to employees of covered entities and requires HHS to impose penalties for violations resulting from willful neglect. ARRA also significantly increased the amount of the civil penalties, with penalties of up to \$50,000 per HIPAA violation for a maximum civil penalty of \$1,500,000 in a calendar year for violations of the same requirement. In addition, ARRA authorized state attorneys general to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. Further, ARRA extended the application of certain provisions of the HIPAA security and privacy regulations to business associates and subjected business associates to civil and criminal penalties for violation of the regulations. State and local authorities are increasingly focused on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to notify individuals of security breaches involving personal information. Covered entities are required by regulations issued pursuant to ARRA to report breaches of unsecured protected health information to affected individuals without unreasonable delay, but not to exceed 60 days of discovery of the breach by the covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media.

HIPAA includes administrative requirements directed at simplifying electronic data interchange through standardizing transactions and establishing uniform health care provider, payor and employer identifiers. HIPAA also imposes obligations for health insurance issuers and health benefit plan sponsors. HIPAA requires guaranteed health care coverage for small employers having two to 50 employees and for individuals who meet certain eligibility requirements. HIPAA also requires guaranteed renewability of health coverage for most employers and individuals and contains nondiscrimination requirements. HIPAA limits exclusions based on pre-existing conditions for individuals covered under group policies to the extent the individuals had prior creditable coverage.

Failure to comply with any of the statutory and regulatory HIPAA requirements, state privacy and security requirements and other similar federal requirements could subject us to significant penalties.

## **ERISA**

The provision of services to certain employee health benefit plans is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA regulates certain aspects of the relationships between us and employers who maintain employee benefit plans subject to ERISA. Some of our administrative services and other activities may also be subject to regulation under ERISA. For instance, the U.S. Department of Labor regulations under ERISA (insured and self-insured) regulate the time allowed for health and disability plans to respond to claims and appeals, establish requirements for plan responses to appeals and expand required disclosures to participants and beneficiaries. These requirements and the provisions thereunder have been expanded by PPACA, including external review procedures. In addition, some states require licensure or registration of companies providing third-party claims administration services for benefit plans. We provide a variety of products and services to employee benefit plans that are covered by ERISA.

## **Medicare and Medicaid**

Some of our subsidiaries contract with CMS to provide services to Medicare beneficiaries pursuant to the Medicare Advantage program. Some of our health plans also contract with states to provide health benefits to Medicaid recipients. As a result, we are subject to extensive federal and state regulations.

CMS periodically performs risk adjustment data validation (“RADV”) audits for any health plan operating under a Medicare managed care contract to determine the plan’s compliance with state and federal law and contractual obligations. Additionally, in some instances states engage peer review organizations to perform quality assurance and utilization review oversight of Medicare managed care plans. Our health plans are required to abide by the peer review organizations’ standards.

CMS rules require Medicaid managed care plans to have beneficiary protections and protect the rights of participants in the Medicaid program. Specifically, states must assure continuous access to care for beneficiaries with ongoing health care needs who transfer from one health plan to another. States and plans must identify enrollees with special health care needs and assess the quality and appropriateness of their care. These requirements have not had a material adverse effect on our business.

The federal anti-kickback statute imposes criminal and civil penalties for paying or receiving remuneration (which is deemed to include a kickback, bribe or rebate) in connection with any federal health care program, including the Medicare, Medicaid and the FEHBP. The law and related regulations have been interpreted to prohibit the payment, solicitation, offering or receipt of any form of remuneration in return for the referral of federal health care program patients or any item or service that is reimbursed, in whole or in part, by any federal health care program. Similar anti-kickback provisions have been adopted by many states, which apply regardless of the source of reimbursement.

With respect to the federal anti-kickback statute, there exists a statutory exception and two safe harbors addressing certain risk-sharing arrangements. A safe harbor is a regulation that describes relationships and activities that are deemed not to violate the federal anti-kickback statute. However, failure to satisfy each criterion of an applicable safe harbor does not mean that the arrangement constitutes a violation of the law; rather the arrangement must be analyzed on the basis of its specific facts and circumstances. We believe that our risk agreements satisfy the requirements of these safe harbors. In addition, the Office of the Inspector General (“OIG”) has adopted other safe harbor regulations that relate to managed care arrangements. We believe that the incentives offered by our subsidiaries to Medicare and Medicaid beneficiaries and the discounts our plans receive from contracting health care providers satisfy the requirements of these safe harbor regulations. We believe that our arrangements do not violate the federal or similar state anti-kickback laws.

CMS has promulgated regulations that prohibit health plans with Medicare contracts from including any direct or indirect payment to physicians or other providers as an inducement to reduce or limit medically necessary services to a Medicare beneficiary. These regulations impose disclosure and other requirements relating to physician incentive plans such as bonuses or withholds that could result in a physician being at “substantial financial risk” as defined in Medicare regulations. Our ability to maintain compliance with such regulations depends, in part, on our receipt of timely and accurate information from our providers. Although we believe we are in compliance with all such Medicare regulations, we are subject to future audit and review.

The federal False Claims Act prohibits knowingly submitting false claims to the federal government. Private individuals known as relators or whistleblowers may bring actions on the government’s behalf under the False Claims Act and share in any settlement or judgment. Violations of the federal False Claims Act may result in treble damages and civil penalties of up to \$11,000 for each false claim. In some cases, whistleblowers, the federal government and some courts have taken the position that providers who allegedly have violated other statutes such as the federal anti-kickback statute have thereby submitted false claims under the False Claims Act. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the False Claims Act by, among other things, creating liability for knowingly or improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Deficit Reduction Act of 2006 (“DEFRA”), every entity that receives at least \$5 million annually in Medicaid payments must establish written policies for all employees, contractors or agents, providing detailed information about false claims, false statements and whistleblower protections under certain federal laws, including the federal False Claims Act, and similar state laws. We have established written policies that we believe comply with this provision of DEFRA.

A number of states, including states in which we operate, have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. DEFRA creates an incentive for states to enact false claims laws that are comparable to the federal False Claims Act. From time to time, companies in the healthcare industry, including ours, may be subject to actions under the False Claims Act or similar state laws.

In July 2008, the Medicare Improvements for Patients and Providers Act of 2008 (“MIPPA”) became law. MIPPA increased restrictions on marketing and sales activities of Medicare Advantage plans, including limitations on compensation systems for agents and brokers, limitations on solicitation of beneficiaries and prohibitions regarding many sales activities. MIPPA also imposed restrictions on Special Needs Plans, increased penalties for reimbursement delays under Part D, required weekly reporting of pricing standards by Medicare Part D plans, and implemented focused cuts to certain Medicare Advantage programs. Failure to comply with MIPPA or the regulations promulgated pursuant to MIPPA could result in penalties, including suspension of enrollment, suspension of payment, suspension of marketing, fines and/or civil monetary penalties.

### **Federal Employees Health Benefits Program**

We contract with the United States Office of Personnel Management (“OPM”) and with various federal employee organizations to provide health insurance benefits under the FEHBP. These contracts are subject to government regulatory oversight by the OIG of OPM who perform periodic audits of these benefit program activities to ensure that contractors meet their contractual obligations with OPM. For our managed care contracts, the OIG conducts periodic audits to, among other things, verify that premiums established under its contracts are in compliance with community rating requirements under the FEHBP. The OPM may seek premium refunds or institute other sanctions against health plans that participate in the program. For our experience-rated plans, the OIG focuses on the appropriateness of contract charges, the effectiveness of claims processing, financial and cost accounting systems, and the adequacy of internal controls to ensure proper contract charges and benefits payments. The OIG may seek refunds of costs charged under these contracts or institute other sanctions against health plans. These audits are generally a number of years in arrears.

### **Risk Management**

In the normal course of business, we have been named as a defendant in various legal actions such as actions seeking payments for claims for medical services denied by the Company, medical malpractice actions, employment related claims and other various claims seeking monetary damages. The claims are in various stages of proceedings and some may ultimately be brought to trial. Incidents occurring through December 31, 2010 may result in the assertion of additional claims. We maintain general liability, professional liability and employment practices liability insurances in amounts that we believe are appropriate, with varying deductibles for which we maintain reserves. The professional errors and omissions liability and employment practices liability insurances are carried through our captive subsidiary.

### **Employees**

At January 31, 2011, we employed approximately 14,000 persons, none of whom are covered by a collective bargaining agreement.

### **Acquisition Growth**

We began operations in 1987 with the acquisition of the American Service Companies entities, including Coventry Health and Life Insurance Company. We have grown substantially through acquisitions. The table below summarizes all of our significant acquisitions since 2005.

<b>Acquisition</b>	<b>Markets</b>	<b>Type of Business</b>	<b>Year Acquired</b>
First Health Group Corp.	Multiple Markets	Multiple Products	2005
FirstGuard Health Plan Missouri	Missouri	Medicaid	2007
Certain workers' compensation business from Concentra, Inc.	Multiple Markets	Management Services	2007
Certain group health insurance business from Mutual of Omaha	Nebraska & Iowa	Multiple Products	2007
Florida Health Plan Administrators, LLC	Florida	Multiple Products	2007
Mental Health Network Institutional Services, Inc.	Multiple Markets	Mental Health Products	2008
Majority Interest in Group Dental Services	Multiple Markets	Dental Products	2008
Preferred Health Systems, Inc.	Kansas	Multiple Products	2010
MHP, Inc.	Missouri & Arkansas	Multiple Products	2010

**Executive Officers of Our Company**

The following table sets forth information with respect to our executive officers as of February 1, 2011:

Allen F. Wise	68	Chief Executive Officer and Director
Harvey C. DeMovick, Jr.	64	Executive Vice President
Thomas C. Zielinski	59	Executive Vice President and General Counsel
Michael D. Bahr	52	Executive Vice President, Commercial Business
Kevin P. Conlin	52	Executive Vice President
John J. Stelben	49	Interim Chief Financial Officer and Treasurer
Patrisha L. Davis	55	Senior Vice President and Chief Human Resources Officer
Kenneth A. Burdick	52	Senior Vice President, Medicaid Business
John J. Ruhlmann	48	Senior Vice President and Corporate Controller
David W. Young	46	President and Chief Executive Officer, Workers Compensation Business

**Allen F. Wise** was appointed Chief Executive Officer of our Company in January 2009. He has been a director of our Company since October 1996 and Executive Chairman since December 2008. He was non-executive Chairman of the Board from January 2005 to December 2008. Mr. Wise was a private investor and principal investor from January 2005 to January 2009. Prior to that, he was President and Chief Executive Officer of our Company from October 1996 to December 2004.

**Harvey C. DeMovick, Jr.** rejoined our Company in March 2009 and was elected Executive Vice President of our Company in May 2009. From July 2007 to March 2009, Mr. DeMovick had retired from our Company and was a private investor and business consultant. From January 2005 to July 2007, Mr. DeMovick was an Executive Vice President of our Company. He served as our Chief Information Officer from April 2001 to July 2007 and managed our Customer Service Operations from September 2001 to July 2007.

**Thomas C. Zielinski** was elected Executive Vice President of our Company, effective November 2007. He is also General Counsel of our Company and has served in that capacity since August 2001. He served as Senior Vice President of our Company from August 2001 to November 2007. Prior to that time, Mr. Zielinski worked for 19 years in various capacities for the law firm of Cozen and O'Connor, P.C., including as a senior member, shareholder and Chair of the firm's Commercial Litigation Department.

**Michael D. Bahr** was elected Executive Vice President of our Company in August 2009. From September 2003 to September 2009 he was President and Chief Executive Officer of our Utah health plan. Mr. Bahr is an associate of the Society of Actuaries and a member of the American Academy of Actuaries.

**Kevin P. Conlin** joined our Company in January 2011 as an Executive Vice President with strategic and operational responsibilities, including medical management and network operations. From February 2004 to December 2010, he was the President and Chief Executive Officer of Via Christi Health System, Inc., the largest provider of health care services in Kansas. For more than 20 years prior to 2004, Mr. Conlin held leadership roles with various healthcare organizations and hospitals.

**John J. Stelben** was elected Interim Chief Financial Officer and Treasurer of our Company in November 2009. Since May 2005, he has been a Senior Vice President of our Company. He was a Vice President, Business Development, of our Company from October 1998 to May 2005. Mr. Stelben joined our Company in 1994 as the Controller of our Missouri health plan.

**Patrisha L. Davis** was elected Senior Vice President of our Company, effective June 2007. Since November 2000, she has been the Chief Human Resources Officer of our Company. She was a Vice President of our Company from March 2005 to June 2007. Ms. Davis has been a Human Resources executive with our Company since April 1998.

**Kenneth A. Burdick** joined our Company in August 2010 as a Senior Vice President and manages our Medicaid and Behavioral Health (MHNNet) businesses. Prior to joining our Company, from October 1995 to May 2009, Mr. Burdick was with UnitedHealth Group, a diversified health and well-being company, serving in the following positions: from May 2008 to May 2009, he was the Chief Executive Officer of Secure Horizons, a Medicare business; from November 2006 to May 2008, he was the Chief Executive Officer of United Healthcare's Commercial Business; from April 2004 to November 2006, he was Chief Executive Officer of United Healthcare's Southwest Region and President of United Healthcare Public Sector; from January 2000 to April 2004 he was the Chief Executive Officer of United Healthcare of Arizona. Prior to 2000 he was the head of the national underwriting organization for all lines of business and the general manager of the central Texas operation.

**John J. Ruhlmann** was elected Senior Vice President of our Company in November 2006. Prior to that he was Vice President of our Company from November 1999 to November 2006. He has served as the Corporate Controller of our Company since November 1999.

**David W. Young** was elected President and Chief Executive Officer of our subsidiary, Coventry Health Care Workers Compensation, Inc., in April 2009. From April 2007 to April 2009 he served as Senior Vice President and Chief Operating Officer of the Workers Compensation Division of our Company. Prior to that time, from June 2003 to April 2007, he served in the positions of President, Chief Operating Officer and Vice President of Operations at Concentra Network Services, Inc., a private insurance consulting company.

#### **Item 1A: Risk Factors**

The risks described below are not the only ones that we face. Additional risks not presently known to us or that we currently deem immaterial may also impair our business operations.

Our business, financial condition or results of operations could be materially adversely affected by any of these risks. Further, the trading price of our common stock could decline due to any of these risks, and you may lose all or part of your investment.

#### **Our results of operations may be adversely affected if we are unable to accurately estimate and control future health care costs.**

Most of the premium revenue we receive is based upon rates set months before we deliver services. As a result, our results of operations largely depend on our ability to accurately estimate and control future health care costs. We base the premiums we charge, at least in part, on our estimate of expected health care costs over the applicable premium period. Accordingly, costs we incur in excess of our cost projections generally are not recovered in the contract year through higher premiums. We estimate our costs of future benefit claims and related expenses using actuarial methods and assumptions based upon claim payment patterns, inflation, historical developments (including claim inventory levels and claim receipt patterns) and other relevant factors. We also record benefits payable for future payments. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves. These estimates involve extensive judgment and have considerable inherent variability that is sensitive to payment patterns and medical cost trends. Factors that may cause health care costs to exceed our estimates include:

- an increase in the cost of health care services and supplies, including pharmaceuticals;
- higher than expected utilization of health care services;
- periodic renegotiations of hospital, physician and other provider contracts;
- the occurrence of catastrophic events, including epidemics and natural disasters;
- changes in the demographics of our members and medical trends affecting them;
- general inflation or economic downturns;
- new mandated benefits or other legislative or regulatory changes that increase our costs;
- clusters of high cost cases;
- changes in or new technology; and
- other unforeseen occurrences.

PPACA provides for significant health insurance market reforms and other changes to the health care industry that will affect our future premium revenue and health care costs. For example, generally effective for plan years beginning on or after September 23, 2010, PPACA prohibits lifetime limits on essential health benefits and rescinding coverage absent fraud or intentional misrepresentation, expands dependent coverage to include dependents up to age 26 and implements new mandated benefits for certain preventive services. Beginning January 1, 2014, PPACA, among other things, prohibits group health plans from establishing annual limits on essential health benefits and excluding individuals based on pre-existing conditions. PPACA, as enacted, also will require a plan to issue coverage to every employer and individual who apply and obligates plans to renew coverage once issued. Further, PPACA will prohibit plans from establishing eligibility rules and premium rates based on most health status-related factors. In addition, PPACA provides for significant new taxes, including an industry user tax paid by health insurance companies beginning in 2014 and an excise tax of 40% on health insurers and employers offering high cost health coverage plans. These, among other changes, will affect our ability to predict or control future health care costs and could have an adverse effect on the results of our operations. Because PPACA is complex, will be implemented gradually and is subject to possible amendment, we are unable to predict its effect on our costs.

In addition, medical liabilities in our financial statements include our estimated reserves for incurred but not reported and reported but not paid claims. The estimates for medical liabilities are made on an accrual basis. We believe that our reserves for medical liabilities are adequate, but we cannot assure you of this. Increases from our current estimates of liabilities could adversely affect our results of operations.

**Our results of operations will be adversely affected if we are unable to increase premiums to offset increases in our health care costs.**

Our results of operations depend on our ability to increase premiums to offset increases in our health care costs. Although we attempt to base the premiums we charge on our estimate of future health care costs, we may not be able to control the premiums we charge as a result of competition, government regulations and other factors. PPACA provides for a number of health insurance reforms, as well as an industry tax, that may increase our health care costs. At the same time, PPACA contains provisions that will require insurers to submit to HHS and state regulators justifications for “unreasonable” rate increases and mandates these justifications be publicly disclosed. On December 23, 2010, HHS issued a proposed rule that would make any rate increase of 10% or more subject to additional review for reasonableness. Such review would be performed by the state or, if the state lacks an adequate process, by HHS. Further, by plan year 2014, PPACA provides for monitoring of all premium increases and requires plans with excessive rate increases to be excluded from the insurance exchanges created under PPACA. Our results of operations could be adversely affected if we are unable to set premium rates at appropriate levels or adjust premium rates in the event our health care costs increase.

**General economic conditions and disruptions in the financial markets could adversely affect our business, results of operations and investment portfolio.**

Unfavorable economic conditions, particularly high unemployment and reduced economic growth, could adversely affect our business, results of operations and investment portfolio.

For instance, a decline in members covered under our plans could result from layoffs and downsizing or the elimination of health benefits by employers seeking to cut costs. Economic conditions could cause our existing members to seek health coverage alternatives that we do not offer or could, in addition to significant membership loss, result in lower average premium yields or decreased margins on continuing membership. In addition, the economic downturn could negatively affect our employer group renewals and our ability to increase premiums.

The state of the economy also adversely affects the states’ budgets, which can result in states attempting to reduce payments to Medicaid plans in those states in which we offer Medicaid plans and to increase taxes and assessments on our activities. Although we could attempt to mitigate our exposure from such increased costs through, among other things, increases in premiums, there can be no assurance that we will be able to do so.

A drop in the prices of securities across global financial markets could negatively affect our investment portfolio. Additionally, defaults by issuers of the corporate and municipal bonds in which we invest may also adversely affect our investment portfolio. For example, while investments in municipal bonds have historically experienced relatively low rates of default, the current economic environment has resulted in many municipalities operating at a deficit. These conditions could negatively affect the valuation of our municipal bond portfolio as well as our ability to collect from such issuers. Some of our investments could further experience other-than-temporary declines in fair value, requiring us to record impairment charges that adversely affect our financial results.

**We conduct business in a heavily regulated industry and changes in laws or regulations or government investigations could adversely affect our business and results of operations.**

Our business is heavily regulated by federal, state and local authorities. We are required to obtain and maintain various regulatory approvals to offer many of our products. Delays in obtaining or failure to obtain or maintain these approvals could adversely affect our results of operations. Legislation or other regulatory reform that increases the regulatory requirements imposed on us or that changes the way we currently do business may in the future adversely affect our business and results of operations.

Federal, state and local authorities frequently consider changes to laws and regulations, including regulatory changes resulting from PPACA. Legislative or regulatory changes that could adversely affect our business and our subsidiaries include changes that:

- impose increased liability for adverse consequences of medical decisions;
- increase limits or regulatory oversight of premium levels or establish new or more stringent minimum medical expense ratios for certain products;
- increase minimum capital, reserves and other financial viability requirements;
- increase government sponsorship of competing health plans;
- impose new or higher fines or other penalties for the failure to pay claims promptly;
- impose new or higher fines or other penalties as a result of market conduct reviews;
- increase regulation of or prohibit rental access to health care provider networks;
- increase regulation of or prohibit provider financial incentives and provider risk-sharing arrangements;
- require health plans to offer expanded or new benefits;

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- increase limits on the ability of health plans to manage care and utilization, including “any willing provider” and direct access laws that restrict or prohibit product features that encourage members to seek services from contracted providers or through referral by a primary care provider;
- increase limits on contractual terms with providers, including audit, payment and termination provisions;
- implement new mandatory third-party review processes for coverage denials;
- impose additional health care information privacy or security requirements; and
- increase restrictions on marketing Medicare Advantage, Prescription Drug Plans or other products to individuals.

These or other changes could have a material adverse effect on our business operations and financial condition. For example, several states are considering, or may consider, legislative proposals that could affect our ability to obtain appropriate premium rates and that would mandate certain benefits and forbid certain policy provisions, or otherwise materially adversely affect our business operations and financial condition.

PPACA represents significant change across the health care industry. PPACA, as enacted, seeks to decrease the number of uninsured individuals and expand coverage through a combination of public program expansion and private sector health insurance reforms. In order to expand coverage, PPACA, as enacted, requires individuals to obtain health insurance or pay penalties and mandates that employers with more than 50 full-time employees offer affordable insurance to employees or pay an assessment. PPACA also prohibits the use of gender, health status, family history or occupation in setting premium rates and eliminates pre-existing condition exclusions. Further, PPACA requires HHS to award loans and grants to new non-profit entities that will offer qualified health plans. PPACA also requires states to establish a health insurance exchange and permits states to create federally funded, non-Medicaid plans for low-income residents not eligible for Medicaid. PPACA requires states to expand eligibility under existing Medicaid programs to those at or below 133% of the federal poverty level. In addition, PPACA may lead to increased state legislative and regulatory initiatives in order for states to comply with new federal mandates and to participate in grants and other incentive opportunities.

Many of these provisions of PPACA do not become effective until 2014. Other provisions of PPACA are more immediate in nature and have already taken effect. For example, PPACA bans lifetime limits on essential health benefits and the rescission of health care coverage absent fraud or intentional misrepresentation, effective for plan years beginning on or after September 23, 2010. PPACA also expands dependent coverage to include children up to age 26 and mandates minimum medical loss ratios for health plans such that the percentage of health coverage premium revenue spent on health care medical costs and quality improvement expenses be at least 80% for individual and small group health coverage and 85% for large group coverage, with rebates to policyholders if the actual loss ratios fall below these minimums. Further, PPACA imposes new benefit mandates, including requiring preventative services and immunizations to be provided without cost-sharing.

Implementation of PPACA, particularly those provisions expanding health insurance coverage, could be delayed or even blocked due to court challenges and efforts to repeal or amend the law. Further, court challenges and legislative efforts could revise or eliminate all or portions of PPACA. More than 20 challenges to PPACA have been filed in federal courts. Some federal district courts have upheld the constitutionality of PPACA or dismissed the cases on procedural grounds. Others have held the requirement that individuals maintain health insurance or pay a penalty to be unconstitutional and have either found PPACA void in its entirety or left the remainder of the law intact. These lawsuits are subject to appeal, and it is unclear how federal lawsuits challenging the constitutionality of PPACA will be resolved or what the effect will be on any resulting changes to the law. For example, should the requirement that individuals maintain health insurance coverage ultimately be deemed unconstitutional but the prohibition on health plans excluding coverage due to pre-existing conditions be maintained, our business could be adversely affected. As a result of the mandated minimum loss ratios, states may request waivers to these requirements for the individual market if the insurance commissioner determines there is a reasonable likelihood that destabilization will occur when the MLR requirement is applied.

These or other changes could have a material adverse effect on our business operations and financial condition. In addition, several states are considering legislative proposals that could affect our ability to obtain appropriate premium rates and that would mandate certain benefits and forbid certain policy provisions, or otherwise materially adversely affect our business operations and financial condition.

Given the complexities of PPACA, the numerous regulations still to be issued that will detail its requirements, the lack of interpretive guidance and our inability to foresee how individuals and businesses will respond to the choices afforded them by the law, we cannot predict the full effect of PPACA on us at this time. We also cannot predict the changes that government authorities will approve in the future or assure you that those changes will not have an adverse effect on our business or results of operations.

We also may be subject to governmental investigations or inquiries from time to time. The existence of such investigations in our industry could negatively affect the market value of all companies in our industry. As a result of recent investigations, including audits, CMS has imposed sanctions and fines including immediate suspension of all enrollment and marketing activities and civil monetary penalties on certain Medicare Advantage plans run by our competitors. In addition, suits may be brought by a private individual under a qui tam suit, or “whistleblower” suit; such whistleblower suits have resulted in significant settlements between governmental agencies and healthcare companies. When a private individual brings such a whistleblower suit, the defendant often will not be made aware of the lawsuit for many months or even years, until the government commences its own investigation or makes a determination as to whether it will intervene. The significant incentives and protections provided under the Dodd-Frank Wall Street Reform and Consumer Protection Act increase the risk that these whistleblower suits will become more frequent. Further, it is possible that governmental entities could directly initiate investigations or litigation involving our Company. Any governmental investigations of Coventry could have a material adverse effect on our financial condition, results of operations or business or result in significant liabilities to our Company, as well as adverse publicity.

**We may be adversely affected by changes in government funding and various other risks associated with our participation in Medicare and Medicaid programs.**

The federal government and many states from time to time consider altering the level of funding for government healthcare programs, including Medicare and Medicaid. DEFRA included Medicaid cuts of approximately \$4.8 billion over five years. State budget deficits could lead to changes in eligibility, coverage or other program changes in efforts to reduce Medicaid funding. MIPPA reduced federal spending on the Medicare Advantage program by \$48.7 billion over the 2008-2018 period. PPACA imposes additional cuts to the Medicare Advantage program of approximately \$145 billion over ten years and subjects plans to fee adjustments based on whether the plans meet service benchmarks and their quality rankings. We cannot predict future Medicare or Medicaid funding levels or ensure that changes to Medicare or Medicaid funding will not have an adverse effect on our business or results of operations.

Additional risks associated with the Medicare Advantage and Medicare prescription drug plans include potential uncollectability of receivables resulting from processing and/or verifying enrollment, uncollectability of premiums from members, inadequacy of underwriting assumptions, inability to receive and process correct information (including inability due to systems issues by federal and state governments or us), increased medical or pharmaceutical costs, and the underlying seasonality of this business. If we are unable to maintain the administrative and operational capabilities to address the additional needs and increasing regulation of our Medicare programs, it could have a material adverse effect on our Medicare business and operating results.

In addition, if the cost or complexity of Medicare programs exceed our expectations or prevent effective program implementation, if the government alters or reduces funding of Medicare programs, if we fail to design and maintain programs that are attractive to Medicare participants or if we are not successful in winning contract renewals or new contracts during the competitive bidding process, our current Medicare business and our ability to expand our Medicare operations could be materially and adversely affected.

**A reduction in the number of members in our health plans could adversely affect our results of operations.**

A reduction in the number of members in our health plans could reduce revenues and adversely affect our results of operations. Factors that could contribute to the loss of membership include:

- competition in premium or plan benefits from other health care benefit companies;
- reductions in the number of employers offering health care coverage;
- reductions in work force by existing customers;
- adverse economic conditions;
- our increases in premiums or benefit changes;
- our exit from a market or the termination of a health plan;
- legislative or regulatory changes that may affect our ability to maintain membership;
- negative publicity and news coverage relating to our Company or the managed health care industry generally; and
- catastrophic events, including natural disasters, epidemics, man-made catastrophes and other unforeseen occurrences.

**Our growth strategy is dependent in part upon our ability to acquire additional managed care businesses and successfully integrate those businesses into our operations.**

Part of our growth strategy is to grow through the acquisition of additional health plans and other managed care businesses. Historically, we have significantly increased our revenues through a number of acquisitions. We cannot assure you that we will be able to continue to locate suitable acquisition candidates, obtain required governmental approvals, successfully integrate the businesses we acquire and realize anticipated operational improvements and cost savings. The businesses we acquire also may not achieve our anticipated levels of profitability. Our future growth rate will be adversely affected if we are not able to successfully complete acquisitions. In such acquisitions, we may assume liabilities that could adversely affect our business. Additionally, we may issue stock in connection with such acquisitions, which would result in dilution to existing stockholders, or we could incur debt to finance such acquisitions.

**Competition may limit our ability to attract new members or to increase or maintain our premium rates, which would adversely affect our results of operations.**

We operate in a highly competitive environment that may affect our ability to attract new members and increase premium rates. We compete with other health plans for members. We believe the principal factors influencing the choice among health care options are:

- price of benefits offered and cost and risk of alternatives such as self-insurance;
- location and choice of health care providers;
- quality of customer service;
- comprehensiveness of coverage offered;
- reputation for quality care;
- financial stability of the plan; and
- diversity of product offerings.

We compete with other managed care companies that may have broader geographical coverage, more established reputations in our markets, greater market share, larger contracting scale, lower costs and/or greater financial and other resources. We also may face increased rate competition from certain Blue Cross plan competitors that might be required by state regulation to reduce capital surpluses that may be deemed excessive. In addition, by 2014, PPACA, as enacted, will significantly expand Medicaid and require states to establish a health insurance exchange which may affect competition among health plans.

**The non-renewal or termination of our government contracts or unsuccessful bids for business with government agencies could adversely affect our business, financial condition and results of operations.**

Our contracts with state government programs are subject to renewal, termination and competitive bidding procedures. In particular, the contract between our HealthCare USA subsidiary and the Missouri Medicaid program, MO HealthNet, is subject to two successive one-year extensions running through June 30, 2012, if MO HealthNet so elects. MO HealthNet did elect to continue our first one-year extension which runs from July 1, 2010 through June 30, 2011.

Certain health plans contract directly with the federal government, specifically the OPM. Our subcontracts to administer fee-for-service plans in the FEHBP are also tied to annual contracts held between the employee organizations that sponsor those plans and OPM. These contracts are subject to annual renewals.

If we are unable to renew or successfully re-bid for these and/or other of our state or federal contracts, or if such contracts were terminated or renewed on less favorable terms, our business, financial condition and results of operations could be adversely affected.

**We depend on the services of non-exclusive independent agents and brokers to market our products to employers, and we cannot assure you that they will continue to market our products in the future.**

We depend on the services of independent agents and brokers to market our managed care products and services, particularly to small employer group members. We do not have long term contracts with independent agents and brokers, who typically are not dedicated exclusively to us and frequently market the health care products of our competitors. Due to mandates imposed on our industry by PPACA, we must spend a certain percentage of every premium dollar on medical care. As a result, we may need to change our commission schedules in order to remain profitable. We face intense competition for the services and allegiance of independent agents and brokers, and we cannot assure you that agents and brokers will continue to market our products in a fair and consistent manner.

**If we fail to obtain cost-effective agreements with a sufficient number of providers we may experience higher medical costs and a decrease in our membership.**

Our future results largely depend on our ability to enter into cost-effective agreements with hospitals, physicians and other health care providers. The terms of those provider contracts will have a material effect on our medical costs and our ability to control these costs. Our ability to contract successfully with a sufficiently large number of providers in a particular geographic market will affect the relative attractiveness of our managed care products in those markets. In addition, our ability to contract at competitive rates with our PPO and workers' compensation related providers will affect the attractiveness and profitability of our products in the national account, network rental and workers' compensation businesses.

In some of our markets, there are large provider systems that have a major presence. Some of these large provider systems have operated their own health plans in the past or may choose to do so in the future. These provider systems could adversely affect our product offerings and results of operations if they refuse to contract with us, place us at a competitive disadvantage or use their market position to negotiate contracts that are less favorable to us. Provider agreements are subject to periodic renewal and renegotiation. We cannot assure you that these large provider systems will continue to contract with us or that they will contract with us on terms that are favorable to us.

**Negative publicity regarding the managed health care industry generally, or our Company in particular, could adversely affect our results of operations or business.**

Over the last several years, the managed health care industry has been subject to a significant amount of negative publicity. Negative publicity regarding the managed health care industry generally, or our Company in particular, may result in increased regulation and legislative review of industry practices, further increasing our costs of doing business and adversely affecting our results of operations by:

- requiring us to change our products and services;
- increasing the regulatory burdens under which we operate; or
- adversely affecting our ability to market our products or services to employers, individuals or other customers.

Negative publicity relating to our Company also may adversely affect our ability to attract and retain members.

**The failure to effectively protect, maintain and develop our information technology systems could adversely affect our business and results of operations.**

We depend on our information technology systems for timely and accurate information. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and report our financial results timely and accurately depends significantly on the integrity of the data in our information technology systems. Our information technology systems require an ongoing commitment of significant resources to protect, maintain and enhance existing systems and develop and integrate new systems in order to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards and changing customer preferences.

There can be no assurance that our process of protecting, maintaining and enhancing existing systems, developing and integrating new systems and improving service levels will not be delayed, disrupted or adversely affected by internal or external factors, or that additional systems issues will not arise in the future. If the information we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to protect, maintain, enhance or develop our information technology systems effectively, we could:

- lose existing customers;
- have difficulty attracting new customers;
- have problems in determining medical cost estimates and establishing appropriate pricing and reserves;
- have difficulty preventing, detecting and controlling fraud;
- have disputes with customers, physicians and other health care professionals;
- have regulatory sanctions or penalties imposed;
- have disruptions in our business operations;
- have increases in administrative costs; or
- suffer other adverse consequences.

In addition, we may from time to time contract and obtain significant portions of our systems-related or other services or facilities from independent third parties. This dependence makes our operations vulnerable to such independent third parties' failure to perform adequately under the contract. The failure by an independent third party to perform could adversely affect our operations and hinder our ability to effectively maintain and use our information technology systems.

**We face periodic reviews, audits and investigations under our contracts with federal and state government agencies which could have adverse findings that may negatively affect our business.**

We contract with various federal and state governmental agencies to provide managed health care services. Pursuant to these contracts, we are subject to various governmental reviews, audits and investigations to verify our compliance with the contracts and applicable laws and regulations. Any adverse review, audit or investigation could result in:

- refunding of amounts we have been paid pursuant to our government contracts;
- imposition of fines, penalties and other sanctions on us;
- loss of our right to participate in various federal programs;
- damage to our reputation in various markets;

- increased difficulty in selling our products and services; and
- loss of one or more of our licenses to act as an insurer or HMO or to otherwise provide a service.

CMS periodically performs RADV audits and may seek return of premium payments made to our Company if risk adjustment factors are not properly supported by medical record data. We estimate and record reserves for CMS audits based on information available at the time the estimates are made. The judgments and uncertainties affecting the application of these policies include significant estimates related to the amount of hierarchical condition category (“HCC”) revenue subject to audit and anticipated error rates. Although our Company maintains reserves for its exposure to the RADV audits, actual results could differ materially from those estimates. Accordingly, CMS RADV audit results could have a material adverse effect on our financial position, results of operations and cash flows.

**We are subject to litigation, including litigation based on new or evolving legal theories that could adversely affect our results of operations.**

Due to the nature of our business, we are subject to a variety of legal actions relating to our business operations including claims relating to:

- our denial of non-covered benefits;
- vicarious liability for medical malpractice claims filed against our providers;
- disputes with our providers alleging RICO and antitrust violations;
- disputes with our providers over reimbursement and termination of provider contracts;
- disputes related to our non-risk business, including actions alleging breach of fiduciary duties, claim administration errors and failure to disclose network rate discounts and other fee and rebate arrangements;
- disputes over our co-payment calculations;
- customer audits of our compliance with our plan obligations; and
- disputes over payments for out-of-network benefits.

We describe certain litigation to which we are or have been a party in Note L, Commitments and Contingencies, to the consolidated financial statements. In addition, plaintiffs continue to bring new types of legal claims against managed care companies. Recent court decisions and legislative activity increase our exposure to these types of claims. In some cases, plaintiffs may seek class action status and substantial economic, non-economic or punitive damages. The loss of even one of these claims, if it resulted in a significant damage award, could have an adverse effect on our financial condition or results of operations. In the event a plaintiff was to obtain a significant damage award it may make reasonable settlements of claims more difficult to obtain. We cannot determine with any certainty what new theories of recovery may evolve or what their effect may be on the managed care industry in general or on us in particular.

We have, and expect to maintain, liability insurance coverage for some of the potential legal liabilities we may incur. Currently, professional errors and omissions liability and employment practices liability insurance is covered through our captive subsidiary. Potential liabilities that we incur may not be covered by insurance. Further, our insurers may dispute coverage or be unable to meet their obligations, or the amount of our insurance coverage may be inadequate. We cannot assure you that we will be able to obtain insurance coverage in the future or that insurance coverage will continue to be available on a cost effective basis, if at all.

**Our stock price and trading volume may be volatile.**

From time to time, the price and trading volume of our common stock, as well as the stock of other companies in the health care industry, may experience periods of significant volatility. Company-specific issues and developments generally in the health care industry (including the regulatory environment) and the capital markets and the economy in general may cause this volatility. Our stock price and trading volume may fluctuate in response to a number of events and factors, including:

- variations in our operating results;
- changes in the market’s expectations about our future operating results;
- changes in financial estimates and recommendations by securities analysts concerning our Company or the health care industry generally;
- operating and stock price performance of other companies that investors may deem comparable;
- news reports relating to trends in our markets;
- changes or proposed changes in the laws and regulations affecting our business;
- acquisitions and financings by us or others in our industry; and
- sales of substantial amounts of our common stock by our directors and executive officers or principal stockholders, or the perception that such sales could occur.

**Our indebtedness imposes certain restrictions on our business and operations.**

The indentures for our senior notes and bank credit agreement impose restrictions on our business and operations. These restrictions may limit our ability to, among other things:

- incur additional debt;
- pay dividends, repurchase common stock, or make other restricted payments;
- create or permit certain liens on our assets;
- sell assets;
- create or permit restrictions on the ability of certain of our restricted subsidiaries to pay dividends or make other distributions to us;
- enter into transactions with affiliates;
- enter into sale and leaseback transactions; and
- consolidate or merge with or into other companies or sell all or substantially all of our assets.

**Our ability to generate sufficient cash to service our indebtedness will depend on numerous factors beyond our control.**

Our ability to service our indebtedness will depend on our ability to generate cash in the future. Our ability to generate the cash necessary to service our indebtedness is subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control. We cannot assure you that our business will generate sufficient cash flow from operations or that future borrowings will be available in an amount sufficient to enable us to service our indebtedness or to fund other liquidity needs. In addition, we will be more vulnerable to economic downturns, adverse industry conditions and competitive pressures as a result of our significant indebtedness. We may need to refinance all or a portion of our indebtedness before maturity. We cannot assure you that we will be able to refinance any of our indebtedness or that we will be able to refinance our indebtedness on commercially reasonable terms.

**A substantial amount of our cash flow is generated by our regulated subsidiaries.**

Our regulated subsidiaries conduct a substantial amount of our consolidated operations. Consequently, our cash flow and our ability to pay our debt and fund future acquisitions depends, in part, on the amount of cash that the parent company receives from our regulated subsidiaries. Our subsidiaries' ability to make any payments to the parent company will depend on their earnings, business and tax considerations, legal and regulatory restrictions and economic conditions. Our regulated subsidiaries are subject to HMO and insurance regulations that require them to meet or exceed various capital standards and may restrict their ability to pay dividends or make cash transfers to the parent company. If our regulated subsidiaries are restricted from paying the parent company dividends or otherwise making cash transfers to the parent company, it could have a material adverse effect on the parent company's cash flow. For additional information regarding our regulated subsidiaries' statutory capital requirements, see Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources - Statutory Capital Requirements," of this Form 10-K.

**Our certificate of incorporation and bylaws and Delaware law could delay, discourage or prevent a change in control of our Company that our stockholders may consider favorable.**

Provisions in our certificate of incorporation and bylaws and Delaware law may delay, discourage or prevent a merger, acquisition or change in control involving our Company that our stockholders may consider favorable. These provisions could also discourage proxy contests and make it more difficult for stockholders to elect directors and take other corporate actions. Among other things, these provisions:

- provide for a classified board of directors with staggered three-year terms so that no more than one-third of our directors can be replaced at any annual meeting;
- provide that directors may be removed without cause only by the affirmative vote of the holders of two-thirds of our outstanding shares;
- provide that amendment or repeal of the provisions of our certificate of incorporation establishing our classified board of directors must be approved by the affirmative vote of the holders of three-fourths of our outstanding shares; and
- establish advance notice requirements for nominations for election to the board of directors or for proposing matters that can be acted on by stockholders at a meeting.

These provisions of our certificate of incorporation and bylaws and Delaware law may discourage transactions that otherwise could provide for the payment of a premium over prevailing market prices for our common stock and also could limit the price that investors are willing to pay in the future for shares of our common stock.

**Our results of operations and shareholders' equity could be materially adversely affected if we have an impairment of our intangible assets.**

Due largely to our past acquisitions, goodwill and other intangible assets represent a substantial portion of our total assets, as described in Note A, Organization and Summary of Significant Accounting Policies, and Note E, Goodwill and Other Intangible Assets, to the consolidated financial statements. In accordance with applicable accounting standards, we perform periodic assessments of our goodwill and other intangible assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to earnings may be necessary. This impairment testing requires us to make assumptions and judgments regarding the estimated fair value of our reporting units. Fair value is calculated using a blend of a projected income and market value approach. Estimated fair values developed based on our assumptions and judgments might be significantly different if other assumptions and estimates were to be used. Any future evaluations requiring an asset impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs.

**Item 1B: Unresolved Staff Comments**

None.

**Item 2: Properties**

As of December 31, 2010, we leased approximately 89,000 square feet of space for our corporate office in Bethesda, Maryland. We also leased approximately 1,936,000 aggregate square feet for office space, subsidiary operations and customer service centers for the various markets where our health plans and other subsidiaries operate, of which approximately 4% is subleased. Our leases expire at various dates from 2011 through 2020. We also own nine buildings throughout the country with approximately 798,000 square feet, which is used for administrative services related to our subsidiaries' operations, of which approximately 3% is subleased. We believe that our facilities are adequate for our operations.

**Item 3: Legal Proceedings**

See Legal Proceedings in Note L, Commitments and Contingencies, to the consolidated financial statements, which is incorporated herein by reference.

**Item 4: (Removed and Reserved)**

Not Applicable.

PART II

Item 5: Market for the Registrant’s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Price Range of Common Stock

Our common stock is traded on the New York Stock Exchange (“NYSE”) stock market under the ticker symbol “CVH.” The following table sets forth the quarterly range of the high and low sales prices of the common stock on the NYSE stock markets during the calendar period indicated. Such quotations represent inter-dealer prices without retail markup, markdown or commission and may not necessarily represent actual transactions:

	2010		2009	
	High	Low	High	Low
First Quarter	\$ 27.27	\$ 21.82	\$ 17.33	\$ 7.97
Second Quarter	25.53	17.59	20.10	12.29
Third Quarter	22.14	16.61	24.84	17.45
Fourth Quarter	27.44	20.35	25.78	18.18

On January 31, 2011, we had approximately 574 stockholders of record, not including beneficial owners of shares held in nominee name. On January 31, 2011, our closing price was \$29.97.

We have not paid any cash dividends on our common stock and expect for the foreseeable future to retain all of our earnings to finance the development of our business, repurchase our common stock or pay down our debt. Our ability to pay dividends is limited by certain covenants and restrictions contained in our debt obligations and by insurance regulations applicable to our subsidiaries. Subject to the terms of such insurance regulations and debt covenants, any future decision as to the payment of dividends will be at the discretion of our Board of Directors and will depend on our earnings, financial position, capital requirements and other relevant factors. See Part II, Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources.”

Issuer Purchases of Equity Securities

The Company’s Board of Directors has approved a program to repurchase our outstanding common shares. Share repurchases may be made from time to time at prevailing prices on the open market, by block purchase, or in private transactions. Under the share repurchase program, the Company did not repurchase any shares of its common stock during 2010. The Company previously repurchased 1.5 million shares of its common stock during 2009 at an aggregate cost of \$30.0 million and 7.3 million shares during 2008 at an aggregate cost of \$318.0 million. As of December 31, 2010, the total remaining number of common shares the Company is authorized to repurchase under this program is 5.2 million.

The following table shows our purchases of our common shares during the quarter ended December 31, 2010 (in thousands, except average price per share information).

	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans	Maximum Number of Shares That May Yet Be Purchased Under The Plan or Program (2)
October 1-31, 2010	4	\$ 23.34	-	5,213
November 1-30, 2010	11	\$ 25.40	-	5,213
December 1-31, 2010	1	\$ 26.25	-	5,213
<b>Totals</b>	<b>16</b>	<b>\$ 25.02</b>	<b>-</b>	<b>5,213</b>

(1) Includes shares purchased in connection with the vesting of restricted stock awards to satisfy employees’ minimum statutory tax withholding obligations.

(2) These shares are under a stock repurchase program previously announced on December 20, 1999, as amended.

**Item 6: Selected Financial Data**  
**(in thousands, except per share and membership data)**

	December 31,				
	2010	2009	2008	2007	2006
<b>Operations Statement Data <sup>(1,2)</sup></b>					
Operating revenues	\$ 11,587,916	\$ 13,903,526	\$ 11,734,227	\$ 9,694,176	\$ 7,549,253
Operating earnings	689,285	501,951	585,529	901,328	828,539
Earnings before income taxes	686,534	504,554	571,861	963,212	883,021
Income from continuing operations	438,616	315,334	362,000	605,444	551,457
(Loss) income from discontinued operations, net of tax	-	(73,033)	19,895	20,650	8,588
Net earnings	438,616	242,301	381,895	626,094	560,045
Basic earnings per share from continuing operations	3.00	2.15	2.43	3.91	3.48
Basic (loss) earnings per share from discontinued operations	-	(0.50)	0.13	0.13	0.05
Total basic earnings per share	3.00	1.65	2.56	4.04	3.53
Diluted earnings per share from continuing operations	2.97	2.14	2.41	3.85	3.42
Diluted (loss) earnings per share from discontinued operations	-	(0.50)	0.13	0.13	0.05
Total diluted earnings per share	2.97	1.64	2.54	3.98	3.47
Dividends declared per share	-	-	-	-	-
<b>Balance Sheet Data <sup>(1,2)</sup></b>					
Cash and investments	\$ 4,055,443	\$ 3,855,647	\$ 3,171,121	\$ 2,859,237	\$ 2,793,800
Total assets	8,495,585	8,166,532	7,727,398	7,158,791	5,665,107
Total medical liabilities	1,237,690	1,605,407	1,446,391	1,161,963	1,121,151
Other long-term liabilities	414,025	456,518	368,482	445,470	309,616
Debt	1,599,396	1,599,027	1,902,472	1,662,021	760,500
Stockholders' equity	4,199,166	3,712,554	3,430,669	3,301,479	2,953,002
<b>Operating Data <sup>(1,2)</sup></b>					
Medical loss ratio	79.4%	85.4%	84.0%	79.6%	79.3%
Operating earnings ratio	5.9%	3.6%	5.0%	9.3%	11.0%
Administrative expense ratio	16.9%	15.5%	16.5%	17.0%	15.6%
Basic weighted average shares outstanding	146,169	146,652	148,893	154,884	158,601
Diluted weighted average shares outstanding	147,579	147,395	150,208	157,357	161,434
Total risk membership	3,961,000	4,020,000	3,281,000	3,140,000	2,620,000
Total non-risk membership	1,157,000	1,249,000	1,347,000	1,533,000	1,487,000

<sup>(1)</sup> Balance Sheet Data includes acquisition balances as of December 31 of the year of acquisition. Operating Data includes the results of operations of acquisitions from the date of the respective acquisition. See the notes to the consolidated financial statements for information about our acquisitions.

<sup>(2)</sup> Unless noted as discontinued operations, Operating Data excludes First Health Services Corporation ("FHSC") operating results for each year presented due to the sale of this business in July 2009. Balance Sheet Data does not exclude FHSC balances for 2008 and prior periods as amounts are immaterial. See the notes to the consolidated financial statements for additional information about our discontinued operations presentation.

## **Item 7: Management’s Discussion and Analysis of Financial Condition and Results of Operations**

The following discussion should be read in conjunction with the accompanying audited consolidated financial statements and notes thereto.

This Item 7 contains forward-looking statements as described in Part I. These forward-looking statements involve risks and uncertainties described in Part I, Item 1A, “Risk Factors,” of this Form 10-K. The organization of our Management’s Discussion and Analysis of Financial Condition and Results of Operations is as follows:

- Executive-Level Overview
- Critical Accounting Policies
- New Accounting Standards
- Acquisitions
- Membership
- Results of Operations
- Liquidity and Capital Resources
- Other Disclosures

### **Executive-Level Overview**

#### **General Operations**

We are a diversified national managed healthcare company based in Bethesda, Maryland, operating health plans, insurance companies, network rental and workers’ compensation services companies. Through our Health Plan and Medical Services, Specialized Managed Care, and Workers’ Compensation reportable segments, which we also refer to as “Divisions,” we provide a full range of risk and fee-based managed care products and services to a broad cross section of individuals, employer and government-funded groups, government agencies, and other insurance carriers and administrators.

#### **Summary of 2010 Performance**

- Revenues from continuing operations, excluding Medicare Advantage Private-Fee-For-Service (“PFFS”), increased 5.5% from the prior year.
- Health Plan Commercial Group Risk membership growth of 223,000 from the prior year-end, an increase of 15.7%.
- Medicaid membership growth of 64,000 from the prior year-end, an increase of 16.4%.
- Cash flow from operations of \$272.3 million, a decrease from the prior year primarily due to the run out of medical claims from the PFFS product.
- Debt to capital ratio of 27.6%, a decrease of 8.3% from the prior year.
- Operating earnings as a percentage of revenues were 5.9%, compared to 3.6% in the prior year.
- Income from continuing operations of \$438.6 million, an increase of 39.1% from 2009 income from continuing operations.
- Diluted EPS from continuing operations of \$2.97, an increase of 38.8% from 2009 diluted EPS from continuing operations.

#### **Operating Revenue and Products**

We operate health plans, insurance companies, managed care services companies and workers’ compensation services companies and generate our operating revenues from premiums and fees for a broad range of managed care and management service products. Managed care premiums for our commercial risk products, for which we assume full underwriting risk, can vary. For example, premiums for our PPO and POS products are typically lower than our HMO premiums due to medical underwriting and higher deductibles and co-payments that are typically required of the PPO and POS members. Managed care premium rates for our government programs, Medicare and state-sponsored managed Medicaid are largely established by governmental regulatory agencies. These government products are offered in select markets where we believe we can achieve profitable growth based upon favorable reimbursement levels, provider costs and regulatory climates.

Revenue for our management services products (“non-risk”) is generally derived from a fixed administrative fee, provided on a predetermined contractual basis or on a percentage-of-savings basis, for access to our health care provider networks and health care management services, for which we do not assume underwriting risk. The management services we provide typically include health care provider network management, clinical management, pharmacy benefit management (“PBM”), bill review, claims repricing, claims processing, utilization review and quality assurance.

## **Operating Expenses**

We incur medical costs related to our products for which we assume underwriting risk. Our medical costs include medical claims paid under contractual relationships with a wide variety of providers and capitation arrangements. Medical costs also include an estimate of claims incurred but not reported.

We maintain provider networks that furnish health care services through contractual arrangements with physicians, hospitals and other health care providers. Prescription drug benefits are provided through a formulary comprised of an extensive list of drugs. Drug prices are negotiated at discounted rates through a national network of pharmacies. Drug costs for our risk products are included in medical costs.

We have capitation arrangements for certain ancillary health care services, such as laboratory services and, in some cases, physician and radiology services. A small percentage of our membership is covered by global capitation arrangements. Under the typical arrangement, the provider receives a fixed percentage of premium to cover costs of all medical care or of the specified ancillary services provided to the capitated members. Under some capitated and professional capitation arrangements, physicians may also receive additional compensation from risk sharing and other incentive arrangements. Capitation arrangements limit our exposure to the risk of increasing medical costs but expose us to risk as to the adequacy of the financial and medical care resources of the provider organization. We are ultimately responsible for the coverage of our members pursuant to the customer agreements. To the extent a provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangements, we will be required to perform such obligations. Consequently, we may have to incur costs in excess of the amounts we would otherwise have to pay under the original global or ancillary capitation through our contracted network arrangements. Medical costs associated with capitation arrangements made up approximately 6.4% of our total medical costs for the year ended December 31, 2010.

We have established systems to monitor the availability, appropriateness and effectiveness of the patient care we provide. We collect utilization data in each of our markets that we use to analyze over-utilization or under-utilization of services and assist our health plans in arranging for appropriate care for their members and improving patient outcomes in a cost efficient manner. Medical directors also monitor the utilization of diagnostic services and encourage the use of outpatient surgery and testing where appropriate. Each health plan collects data showing each physician's utilization profile for diagnostic tests, specialty referrals and hospitalization and presents such data to the health plan's physicians. The medical directors monitor these results in an effort to ensure the use of medically appropriate, cost-effective services.

We incur cost of sales expense for prescription drugs provided by our workers' compensation pharmacy benefit manager and for the independent medical examinations performed by physicians on injured workers. These costs are associated with fee-based products.

Our selling, general and administrative expenses consist primarily of salaries and related costs for personnel involved in the administration of services we offer as well as commissions paid to brokers and agents who assist in the sale of our products. To a lesser extent, our selling, general and administration expenses include other administrative and facility costs needed to provide these administrative services. We operate regional service centers that perform claims processing, premium billing and collection, enrollment and customer service functions. Our regional service centers enable us to take advantage of economies of scale, implement standardized management practices and capitalize on the benefits of our integrated information technology systems.

## **Cash Flows**

We generate cash through operations. As a profitable company in an industry that is not capital equipment intensive, we have generally not needed to use external financing to fund operations. Our primary use of cash is to pay medical claims. Any excess cash has historically been used for acquisitions, to repay indebtedness and for repurchases of our common stock.

## **Critical Accounting Policies**

We consider the accounting policies described below critical in preparing our consolidated financial statements. Critical accounting policies are ones that require difficult, subjective or complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain. The judgments and uncertainties affecting the application of these policies include significant estimates and assumptions made by us using information available at the time the estimates are made. Actual results could differ materially from those estimates.

## **Revenue Recognition**

Managed care premiums are recorded as revenue in the month in which members are entitled to service. Premiums are based on both a per subscriber contract rate and the number of subscribers in our records at the time of billing. Premium billings are generally sent to employers in the month preceding the month of coverage. Premium billings may be subsequently adjusted to reflect changes in membership as a result of retroactive terminations, additions or other changes. Due to early timing of the premium billing, we are able to identify in the current month the retroactive adjustments included on two subsequent months' billings. Current period revenues are adjusted to reflect these retroactive adjustments.

Based on information received subsequent to generating premium billings, historical trends, bad debt write-offs and the collectibility of specific accounts, we estimate, on a monthly basis, the amount of bad debt and future membership retroactivity and adjust our revenue and allowances accordingly.

As of December 31, 2010, we maintained allowances for retroactive billing adjustments of approximately \$25.8 million, compared with approximately \$22.6 million at December 31, 2009. We also maintained allowances for doubtful accounts of approximately \$7.1 million and \$21.4 million as of December 31, 2010 and 2009, respectively. The decrease from the prior year is primarily a result of our non-renewal of the PFFS product, which generated \$2.9 billion of revenue in 2009, and an improvement in our ongoing Medicare Part D collections. The calculation for these allowances is based on a percentage of the gross accounts receivable with the allowance percentage increasing for older receivables.

We receive premium payments from the Centers for Medicare and Medicaid Services (“CMS”) on a monthly basis for our Medicare membership to provide healthcare benefits to our Medicare members. Premiums are fixed (subject to retroactive risk adjustment) on an annual basis by contracts with CMS. Membership and category eligibility are periodically reconciled with CMS and can result in adjustments to revenue. CMS uses a risk adjustment model that incorporates the use of hierarchical condition category (“HCC”) codes to determine premium payments to health plans. We estimate risk adjustment revenues based on the individual member diagnosis data (risk scores) submitted to CMS. Changes in revenue from CMS resulting from the periodic changes in risk adjustments scores for our membership are recognized when the amounts become determinable and the collectibility is reasonably assured.

CMS periodically performs audits and may seek return of premium payments made to us if risk adjustment factors are not properly supported by underlying medical record data. We estimate and record reserves for CMS audits based on information available at the time the estimates are made. The judgments and uncertainties affecting the application of these policies include significant estimates related to the amount of HCC revenue subject to audit and anticipated error rates. Although the Company maintains reserves for its exposure to the risk adjustment data validation (“RADV”) audits, actual results could differ materially from those estimates.

We contract with the United States Office of Personnel Management (“OPM”) and with various federal employee organizations to provide health insurance benefits under the Federal Employees Health Benefits Program (“FEHBP”). These contracts are subject to government regulatory oversight by the Office of the Inspector General (“OIG”) of OPM, which performs periodic audits of these benefit program activities to ensure that contractors meet their contractual obligations with OPM. For our managed care contracts, the OIG conducts periodic audits to, among other things, verify that premiums established under its contracts are in compliance with community rating requirements under the FEHBP. The OPM may seek premium refunds or institute other sanctions against health plans that participate in the program. For our experience-rated plans, the OIG focuses on the appropriateness of contract charges, the effectiveness of claims processing, financial and cost accounting systems, and the adequacy of internal controls to ensure proper contract charges and benefits payments. The OIG may seek refunds of costs charged under these contracts or institute other sanctions against health plans. These audits are generally a number of years in arrears. We estimate and record reserves for audit and other contract adjustments for both our managed care contracts and our experience rated plans based on appropriate guidelines and historical results. Any differences between actual results and estimates are recorded in the year the audits are finalized.

### **Medical Claims Expense and Liabilities**

Medical liabilities consist of actual claims reported but not paid and estimates of health care services incurred but not reported. Medical liabilities estimates are developed using actuarial principles and assumptions that consider, among other things, historical claims payment patterns, provider reimbursement changes, historical utilization trends, current levels of authorized inpatient days, other medical cost inflation factors, membership levels, benefit design changes, seasonality, demographic mix change and other relevant factors.

We employ a team of actuaries that have developed, refined and used the same set of reserve models over the past several years. These reserve models do not calculate separate amounts for reported but not paid claims and incurred but not reported claims, but rather a single estimate of medical claims liabilities. These reserve models make use of both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Within these models, historical data of paid claims is formatted into claim triangles which compare claim incurred dates to the claim payment dates. This information is analyzed to create “completion factors” that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the financial statement date to estimate the ultimate claim expense incurred for the current period. Actuarial estimates of claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

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Actuarial standards of practice generally require the actuarially developed medical claims estimates to cover obligations under an assumption of moderately adverse conditions. Adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims. In many situations, the claims paid amount experienced will be less than the estimate that satisfies the actuarial standards of practice. Medical claims liabilities are recorded at an amount we estimate to be appropriate. Adjustments of prior years' estimates may result in additional medical costs or, as we experienced during the last several years, a reduction in medical costs in the period an adjustment was made. Our reserve models have historically developed favorably suggesting that the accrued liabilities calculated from the models were more than adequate to cover our ultimate liability for unpaid claims.

The following table presents the components of the change in medical claims liabilities for the years ended December 31, 2010, 2009 and 2008, respectively (in thousands).

	<u>2010</u>	<u>2009</u>	<u>2008</u>
<b>Medical liabilities, beginning of year</b>	<b>\$ 1,605,407</b>	<b>\$ 1,446,391</b>	<b>\$ 1,161,963</b>
Acquisitions <sup>(1)</sup>	71,548	-	7,590
Reported Medical Costs			
Current year	8,507,460	11,049,227	8,916,644
Prior year development	(241,513)	(189,833)	(48,065)
<b>Total reported medical costs</b>	<b>8,265,947</b>	<b>10,859,394</b>	<b>8,868,579</b>
Claim Payments			
Payments for current year	7,491,891	9,598,222	7,577,939
Payments for prior year	1,185,476	1,123,131	1,013,216
<b>Total claim payments</b>	<b>8,677,367</b>	<b>10,721,353</b>	<b>8,591,155</b>
Change in Part D Related Subsidy Liabilities	(27,845)	20,975	(586)
<b>Medical liabilities, end of year</b>	<b>\$ 1,237,690</b>	<b>\$ 1,605,407</b>	<b>\$ 1,446,391</b>

**Supplemental Information:**

Prior year development <sup>(2)</sup>	2.2%	2.1%	0.7%
Current year paid percent <sup>(3)</sup>	88.1%	86.9%	85.0%

<sup>(1)</sup> Acquisition Balances represent medical liabilities of the acquired company as of the applicable acquisition date.

<sup>(2)</sup> Prior year reported medical costs in the current year as a percentage of prior year reported medical costs.

<sup>(3)</sup> Current year claim payments as a percentage of current year reported medical costs.

The negative medical cost amounts noted as “prior year development” are favorable adjustments for claim estimates being settled for amounts less than originally anticipated. As noted above, these favorable developments from original estimates occur due to changes in medical utilization, mix of provider rates and other components of medical cost trends. Medical claim liabilities are generally paid within several months of the member receiving service from the provider. Accordingly, the 2010 prior year development relates almost entirely to claims incurred in calendar year 2009.

The significant favorable factors driving the overall 2010 favorable prior year development, excluding PFFS, include:

- Lower than anticipated medical cost increases of \$84.4 million.
- Higher than expected completion factors of \$27.2 million.
- Lower than anticipated large claim liabilities of \$18.2 million.
- Lower than anticipated other specific case liabilities of \$6.0 million.

The significant favorable factors driving the overall 2010 favorable prior year development for the PFFS product include:

- Lower than anticipated medical cost increases of \$67.6 million.
- Higher than expected completion factors of \$29.7 million.
- Lower than anticipated large claim liabilities of \$0.5 million.
- Lower than anticipated other specific case liabilities of \$6.4 million.

The reduction in total reported medical cost from 2009 to 2010 was driven primarily as a result of our non-renewal of the Medicare PFFS product effective January 1, 2010. Prior year development experienced in 2010 was more favorable compared to amounts experienced in 2009. The higher favorable development is primarily due to lower than expected medical cost increases in the Medicare Advantage Coordinated Care Plan (“Medicare Advantage CCP”) and PFFS products for 2009.

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The change in Medicare Part D related subsidy liabilities identified in the table above represents subsidy amounts received from CMS for reinsurance and for cost sharing related to low-income individuals. These subsidies are recorded in medical liabilities and we do not recognize premium revenue or claims expense for these subsidies.

For the more recent incurred months, the percentage of claims paid relative to claims incurred in those months is generally low. As a result, the completion factor methodology is less reliable for such months. For that reason, incurred claims for recent months are not projected solely from historical completion and payment patterns. Instead, they are projected by estimating the claims expense for those months based upon recent claims expense levels and health care trend levels, or “trend factors.” As these months mature over time, the two estimates (completion factor and trend) are blended with completion factors being used exclusively for older months.

Within the reserve setting methodologies for inpatient and non-inpatient services, we use certain assumptions. For inpatient services, authorized days are used for utilization factors, while cost trend assumptions are incorporated into per diem amounts. The per diem estimates reflect anticipated effects of changes in reimbursement structure and severity mix. For non-inpatient services, a composite trend assumption is applied which reflects anticipated changes in cost per service, provider contracts, utilization and other factors.

Changes in the completion factors, trend factors and utilization factors can have a significant effect on the claim liability. The following example (in thousands, except percentages) provides the estimated effect to our December 31, 2010 unpaid claims liability assuming hypothetical changes in the completion, trend and inpatient day factors. While we believe the selection of factors and ranges provided are reasonable, certain factors and actual results may differ.

<b>Completion Factor</b>		<b>Claims Trend Factor</b>		<b>Inpatient Day Factor</b>	
<b>Increase (Decrease) in Completion Factor</b>	<b>(Decrease) Increase in Unpaid Claims Liabilities</b>	<b>(Decrease) Increase in Claims Trend Factor</b>	<b>(Decrease) Increase in Unpaid Claims Liabilities</b>	<b>(Decrease) Increase in Inpatient Day Factor</b>	<b>(Decrease) Increase in Unpaid Claims Liabilities</b>
1.0 %	(54,248)	(4.0) %	(73,763)	(1.5) %	(3,272)
0.7 %	(36,467)	(2.5) %	(46,102)	(1.0) %	(2,181)
0.3 %	(18,023)	(1.0) %	(18,441)	(0.5) %	(1,091)
(0.3)%	18,145	1.0%	18,441	0.5%	1,091
(0.7) %	36,967	2.5%	46,102	1.0%	2,181
(1.0) %	55,362	4.0%	73,763	1.5%	3,272

We also establish reserves, if required, for the probability that anticipated future health care costs and contract maintenance costs under our existing provider contracts will exceed anticipated future premiums and reinsurance recoveries on those contracts.

A regular element of our unpaid medical claim liability estimation process is the examination of actual results and, if appropriate, the modification of assumptions and inputs related to the process based upon past experience. Our reserve setting methodologies have taken these changes into consideration when determining the factors used in calculating our medical claims liabilities as of December 31, 2010 by choosing factors that reflect more recent experience.

We believe that the amount of medical liabilities is adequate to cover our ultimate liability for unpaid claims as of December 31, 2010. However, actual claim payments and other items may differ from established estimates.

### Investments

We account for investments in accordance with Accounting Standards Codification (“ASC”) Topic 320 “Investments – Debt and Equity Securities.” We invest primarily in fixed income securities and classify all of our investments as available-for-sale. Investments are evaluated on an individual security basis at least quarterly to determine if declines in value are other-than-temporary. In making that determination, we consider all available evidence relating to the realizable value of a security. This evidence includes, but is not limited to, the following:

- the length of time and the extent to which the fair value has been less than the amortized cost basis;
- adverse conditions specifically related to the security, an industry or geographic area;
- the historical and implied volatility of the fair value of the security;
- the payment structure of the debt security and the likelihood of the issuer being able to make payments that increase in the future;
- failure of the issuer of the security to make scheduled interest or principal payments;
- any changes to the rating of the security by a rating agency;

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- recoveries or additional declines in fair value subsequent to the balance sheet date; and
- if we have decided to sell the security or it is more-likely-than-not that we will be required to sell the security before recovery of its amortized cost.

For debt securities, if we intend to either sell or determine that we will more-likely-than-not be required to sell a debt security before recovery of the entire amortized cost basis or maturity of the debt security, we recognize the entire impairment in earnings. If we do not intend to sell the debt security and we determine that we will not more-likely-than-not be required to sell the debt security but we do not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other cases, which are recognized in other comprehensive income. Realized gains and losses on the sale of investments are determined on a specific identification basis.

We use prices from independent pricing services and, to a lesser extent, indicative (non-binding) quotes from independent brokers to measure the fair value of our investment securities. We utilize multiple independent pricing services and brokers to obtain fair values; however, we generally obtain one price/quote for each individual security.

We perform an analysis on market liquidity and other market related conditions to assess if the evaluated prices represent a reasonable estimate of their fair value. Examples of the procedures performed include, but are not limited to, an on-going review of pricing service methodologies, review of the prices received from the pricing service and comparison of prices for certain securities with two different price sources for reasonableness. We monitor pricing inputs to determine if the markets from which the data is gathered are active. As further validation, we sample a security's past fair value estimates and compare the valuations to actual transactions executed in the market on similar dates. As a result of this analysis, if we determine there is a more appropriate fair value based upon available market data, which happens infrequently, the price of the security is adjusted accordingly.

Generally, we do not adjust prices received from pricing services or brokers unless it is evident from our verification procedures the fair value measurement is not consistent with ASC Topic 820. Based upon our internal price verification procedures and review of fair value methodology documentation provided by independent pricing services, we have concluded that the fair values provided by pricing services and brokers are consistent with the guidance in ASC Topic 820.

The following table includes only our investments in an unrealized loss position at December 31, 2010. For these investments, the table shows the gross unrealized losses and fair value aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position (in thousands).

Description of Securities	Less than 12 months		12 months or more		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
State and municipal bonds	\$ 156,894	\$ (3,068)	\$ -	\$ -	\$ 156,894	\$ (3,068)
U.S. Treasury securities	5,890	(7)	-	-	5,890	(7)
Government sponsored enterprises	19,551	(318)	-	-	19,551	(318)
Residential mortgage-backed securities	59,738	(1,269)	17	(1)	59,755	(1,270)
Commercial mortgage-backed securities	-	-	-	-	-	-
Asset-backed securities	-	-	-	-	-	-
Corporate debt and other securities	34,405	(588)	-	-	34,405	(588)
Total	<u>\$ 276,478</u>	<u>\$ (5,250)</u>	<u>\$ 17</u>	<u>\$ (1)</u>	<u>\$ 276,495</u>	<u>\$ (5,251)</u>

The unrealized losses presented in this table do not meet the criteria for an other-than-temporary impairment. The unrealized losses are the result of interest rate movements. We do not intend to sell and it is not more-likely-than-not that we will be required to sell before a recovery of the amortized cost basis of these securities.

Our municipal bond investments remain at an investment grade status based on their own merits (excluding monoline insurers). Although we do not rely on bond insurers exclusively to maintain our high level of investment credit quality, \$331.7 million of our \$883.7 million total state and municipal bond holdings are insured through a monoline insurer. For our mortgaged-backed and asset-backed securities, our holdings remain at investment grade with an AAA rating. We participate in only the higher level investment tranches. For our asset-backed securities, we only participate in offerings that are over collateralized to further protect our principal investment.

## **Goodwill and Other Intangible Assets**

### *Goodwill*

Goodwill is subject to an annual assessment and periodic assessments if other indicators are present for impairment by applying a fair-value-based test. We performed a goodwill impairment analysis, at the reporting unit level, as of October 1, our annual impairment test date. However, each year we could be required to evaluate the recoverability of goodwill and other indefinite lived intangible assets prior to the required annual assessment if there is any indication of a potential impairment. Those indications may include experiencing disruptions to business, unexpected significant declines in operating results, regulatory actions (such as health care reform) that may affect operating results, divestiture of a significant component of the business or a sustained decline in market capitalization.

The goodwill impairment test compares the fair value of a reporting unit with its carrying amount, including goodwill. If the fair value of a reporting unit exceeds its carrying amount, goodwill of the reporting unit is considered not impaired. For our impairment analysis we relied on both the income and market approaches. The income approach is based on the present value of expected future cash flows. The income approach involves estimating the present value of our estimated future cash flows utilizing a risk adjusted discount rate. The market approach estimates the Company's fair value by comparing our Company to similar publicly traded entities and also by analyzing the recent sales of similar companies. The approaches were reviewed together for consistency and commonality.

In order to further validate the fair values determined using the income and market approach for each of our reporting units, we compare the aggregate fair value of our reporting units to our market capitalization. The objective of this comparison is to determine whether the quoted market price is indicative of the fair value of its reporting units. In addressing the relationship of the determined fair value of our reporting units to our market capitalization, we considered factors outlined in ASC Topic 350, "Intangibles – Goodwill and Other," including:

- the fair value of a reporting unit refers to the amount at which the unit as a whole could be bought or sold in a current transaction between willing parties;
- quoted market prices in active markets are the best evidence of fair value and shall be used as the basis for the measurement, if available;
- the market price of an individual equity security (and thus the market capitalization of a reporting unit with publicly traded equity securities) may not be representative of the fair value of the reporting unit as a whole; and
- the quoted market price of an individual equity security, therefore, need not be the sole measurement basis of the fair value of a reporting unit.

As of October 1, 2010 our market capitalization was below our book value. We concluded that this did not affect the overall goodwill impairment analysis, as we believe our suppressed market capitalization to be primarily attributed to negative market conditions as a result of the recent economic recession and the enactment of health care reform. We will continue to monitor our market capitalization as a potential impairment indicator considering overall market conditions and managed care industry events. Any impairment charges that may result will be recorded in the period in which the impairment is identified.

We reconcile the aggregate fair value of our reporting units to our market capitalization, the difference of which is generally referred to as an implied control premium. We then collect data on historical control premiums that resulted from business combinations of entities of a similar size and/or within our industry and concluded that our implied control premium was reasonable. While we believe we have made reasonable estimates and assumptions to calculate the fair values of the reporting units and other intangible assets, it is possible a material change could occur. Under the income approach, we assumed certain growth rates, capital expenditures, discount rates and terminal growth rates in our calculations. If the assumptions used in our fair-value-based tests differ from actual results, the estimates underlying our goodwill impairment tests could be adversely affected.

See Note E, Goodwill and Other Intangible Assets, to the consolidated financial statements for additional disclosure related to our goodwill and other intangible assets which is incorporated herein by reference.

### *Other Intangible Assets*

In accordance with ASC 350-30, "General Intangibles Other than Goodwill," we test intangible assets not subject to amortization for impairment annually or more frequently if events or changes in circumstances indicate that the asset might be impaired. The impairment test consists of a comparison of the fair value of an intangible asset with its carrying amount. If the carrying amount of the intangible asset exceeds its fair value, an impairment loss shall be recognized in an amount equal to that excess. We have chosen October 1 as our annual impairment testing date. Our only intangible asset that is not subject to amortization is a trade name which we determined was not impaired based on the result of the October 1, 2010 analysis.

Also in accordance with ASC 350-30 we review intangible assets that are subject to amortization for recoverability whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. An impairment loss shall be recognized if the carrying amount of an intangible asset is not recoverable and its carrying amount exceeds its fair value. In 2010, we did not incur an impairment charge related to our other intangible assets. Our intangible assets that are subject to amortization consist of our customer lists, licenses, and provider networks.

See Note E, Goodwill and Other Intangible Assets, to the consolidated financial statements for additional disclosure related to our goodwill and other intangible assets which is incorporated herein by reference.

### **Stock-Based Compensation Expense**

We account for share-based compensation in accordance with the provisions of ASC Topic 718 “Compensation – Stock Compensation.” Under the fair value recognition provisions of ASC Topic 718, determining the appropriate fair value model and calculating the fair value of share-based payment awards require the input of subjective assumptions, including the expected life of the share-based payment awards and stock price volatility. We believe that a blend of the implied volatility of our tradeable options and the historical volatility of our share price is a better indicator of expected volatility and future stock price trends than historical volatility alone. Therefore, the expected volatility was based on a blend of market-based implied volatility and the historical volatility of our stock. The assumptions used in calculating the fair value of share-based payment awards represent our best estimates. In addition, we are required to estimate the expected forfeiture rate and recognize expense only for those shares expected to vest. If our actual forfeiture rate is materially different from our estimate, the stock-based compensation expense could be significantly different from what we have recorded in the current period. See Note H, Stock-Based Compensation, to the consolidated financial statements for additional information on stock-based compensation which is incorporated herein by reference.

### **New Accounting Standards**

See Note A, Organization and Summary of Significant Accounting Policies, to the consolidated financial statements for information and disclosures related to new accounting standards which is incorporated herein by reference.

### **Acquisitions**

See Note C, Acquisitions, to the consolidated financial statements for information and disclosures related to acquisitions which is incorporated herein by reference.

### **Membership**

The following table presents our membership as of December 31, 2010 and 2009 (in thousands).

<b>Membership by Product</b>	<b>As of December 31,</b>	
	<b>2010</b>	<b>2009</b>
Health Plan Commercial Risk	1,641	1,418
Health Plan Commercial ASO	698	685
Medicare Advantage CCP	224	186
Medicaid Risk	468	402
<b>Health Plan Total</b>	<b>3,031</b>	<b>2,691</b>
Medicare Advantage PFFS	-	329
Other National Risk	-	2
Other National ASO	459	564
<b>Total Medical Membership</b>	<b>3,490</b>	<b>3,586</b>
Medicare Part D	1,628	1,683
<b>Total Membership</b>	<b>5,118</b>	<b>5,269</b>

Total Health Plan membership increased 340,000 compared to December 31, 2009, primarily reflecting an increase in Commercial and Medicare Advantage CCP membership from our acquisitions of Preferred Health Systems, Inc. (“PHS”) in the first quarter of 2010 and MHP, Inc. (“MHP”) in the fourth quarter of 2010. The increase also included organic growth in the Commercial membership and increases in the Medicaid membership. Medicaid membership increased as we began enrolling Medicaid members in the Commonwealth of Pennsylvania and the state of Nebraska during 2010, as well as steady growth in other Medicaid markets due to higher unemployment. These increases were partially offset by organic Commercial ASO membership losses as a result of group terminations outpacing new sales.

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The decrease in Medicare PFFS membership of 329,000 members is due to our decision not to renew our PFFS product for the 2010 plan year. Other National ASO membership decreased 105,000 members, primarily due to the attrition of membership associated with our loss of National Accounts business.

The decrease in Medicare Part D of 55,000 members is the result of a reduction in the number of low-income regions in which we have contracts, from 29 in 2009 to 21 in 2010, which was offset by growth in our other Medicare Part D products.

### **Results of Continuing Operations**

The following table is provided to facilitate a discussion regarding the comparison of our consolidated results of continuing operations for each of the three years in the period ended December 31, 2010 (in thousands, except diluted earnings per share amounts):

<b><u>Continuing Operations</u></b>	<b><u>2010</u></b>	<b><u>2009</u></b>	<b><u>Increase (Decrease)</u></b>	<b><u>2009</u></b>	<b><u>2008</u></b>	<b><u>Increase (Decrease)</u></b>
Total operating revenues	\$ 11,587,916	\$ 13,903,526	(16.7%)	\$ 13,903,526	\$ 11,734,277	18.5%
Operating earnings	\$ 689,285	\$ 501,951	37.3%	\$ 501,951	\$ 585,529	(14.3%)
Operating earnings as a % of revenue	5.9%	3.6%	2.3%	3.6%	5.0%	(1.4%)
Income from continuing operations	\$ 438,616	\$ 315,334	39.1%	\$ 315,334	\$ 362,000	(12.9%)
Diluted earnings per share	2.97	2.14	38.8%	2.14	2.41	(11.2%)
Selling, general and administrative as a percentage of revenue	16.9%	15.5%	1.4%	15.5%	16.5%	(1.0%)

### **Comparison of 2010 to 2009**

As discussed in Note D, Discontinued Operations, to the consolidated financial statements which is incorporated herein by reference, on July 31, 2009 the Company sold its Medicaid/Public entity business, First Health Services Corporation ("FHSC"), and therefore its operations were classified as "discontinued" on the Company's consolidated statements of operations and excluded from the information below. Accordingly, the amounts and discussion below relate to only the Company's results from continuing operations for all years presented.

Managed care premium revenue decreased from the prior year as a result of our exit from the PFFS product line. This exit accounted for a decline of \$2.9 billion in revenue during the current year. Partially offsetting this decrease was an increase in revenue as a result of the acquisitions of PHS and MHP in 2010, an increase in revenue from Medicare Advantage CCP due to an increase in membership, and an increase in Medicare Part D revenue due to a slightly higher premium yield in 2010.

Medical costs decreased from the prior year primarily as a result of not renewing our PFFS product. Partially offsetting this decrease was an increase in medical costs as a result of the acquisitions of PHS and MHP in 2010. Total medical costs as a percentage of premium revenue, "medical loss ratio" or "MLR," decreased 6.0% over the prior year to 79.4% from 85.4% as a result of the change in the mix of business resulting from the exit of the PFFS product, which had a higher MLR of 92.0%. Additionally, we experienced lower than expected medical trend levels in 2010 which resulted in improved MLR percentages in all lines of business.

Cost of sales increased during the current year due to the growth of our pharmacy benefit management program in the Workers' Compensation Division.

Selling, general and administrative expense decreased from the prior year primarily due to lower salaries and benefits costs as well as decreased broker commissions. The salaries and benefits costs decrease resulted from a reduction in the number of full-time employees associated with the non-renewal of the PFFS product and continued general headcount reductions. Additionally, salaries and benefits declined as a result of executive severance accruals that occurred during the prior year that did not occur in the current year. Broker commissions decreased primarily as a result of the non-renewal of the PFFS product. Although lower in absolute terms, selling, general and administrative expense as a percentage of operating revenues increased as a result of the large decrease in operating revenues in the current year associated with the non-renewal of the PFFS product which had a high premium rate and a low relative expense level.

The charge for provider class action results from the Court of Appeal, Third Circuit for the State of Louisiana decision to affirm the trial court's decision to grant summary judgment against a wholly-owned subsidiary of Coventry in provider class action litigation in Louisiana state court. As of December 31, 2010 this amount was accrued in "accounts payable and other accrued liabilities" in the accompanying balance sheets. For additional information regarding this matter, refer to Note L, Commitments and Contingencies, to the consolidated financial statements which is incorporated herein by reference.

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Depreciation and amortization expense was lower during the current year primarily due to the prior year including a write down in value of certain long-lived assets as well as certain assets becoming fully depreciated.

Interest expense decreased during the current year due to the lower average debt balance outstanding compared to the prior year. Other income, net was lower during the current year as the prior year included a gain on the repayment of outstanding debt.

The provision for income taxes increased from the prior year due to the increase in earnings. The effective tax rate on continuing operations decreased to 36.1% as compared to 37.5% for the prior year due primarily to the proportion of our earnings in states with lower tax rates.

**Comparison of 2009 to 2008**

Managed care premium revenue increased primarily as a result of higher membership in our Medicare business in Part D, PFFS, and CCP as a result of successful enrollment for 2009. The revenue increases were also a result of increased individual membership. Partially offsetting this increase was lower revenue for our Commercial Risk business due to membership declines.

Management services revenue increased primarily due to the growth of our pharmacy benefit management program in the Workers' Compensation Division.

Medical costs increased primarily as a result of the increase in Medicare membership, as discussed above. MLR increased over the prior year as a result of a change in our mix of business primarily related to Medicare Advantage, Part D, and Commercial Risk.

Cost of sales increased due to the growth of the pharmacy benefit management program revenues in the Workers' Compensation Division.

Selling, general and administrative expense increased primarily due to the costs associated with the growth in the Medicare business, including higher wage expense, an increase in broker commission costs and other member related costs due to the higher Medicare membership. Additionally there was higher wage expense related to annual incentive compensation accruals in the current year, while such types of incentive payments were not earned and accrued in 2008; new executive hires in the current year; and severance expense related to terminated employees in 2009. Selling, general and administrative expense as a percentage of revenue improved as a result of expenses being controlled at a rate lower than the increase in revenue.

Depreciation and amortization expense increased in 2009 primarily due to impairment charges to our customer list balances during 2009.

Interest expense decreased due to the repayment of the Company's revolving credit facility and repurchase of senior notes during 2009 as well as decreased interest rates on the revolving credit facility during the current year.

Other income, net increased for the current year due to a charge of \$33.5 million for the other-than-temporary impairment of investment securities recorded in 2008. This other-than-temporary impairment loss did not reoccur in 2009. Additionally, other income, net increased due to gains of \$8.4 million on the repurchase of outstanding senior notes during 2009. Partially offsetting the increases was a \$39 million current year interest income decrease resulting from lower interest rates on the large percentage of the portfolio invested in Treasury instruments and money market funds.

The effective tax rate on continuing operations increased to 37.5% as compared to 36.7% for the prior year due primarily to the proportion of our earnings in states with higher tax rates.

**Segment Results from Continuing Operations**

The Company's segment results are as follows.

Continuing Operations	Year Ended December 31,		Increase (Decrease)	Year Ended December 31,		Increase (Decrease)
	2010	2009		2009	2008	
<b>Operating Revenues (in thousands)</b>						
Commercial Risk	\$ 5,540,470	\$ 5,174,772	\$ 365,698	\$ 5,174,772	\$ 5,421,984	\$ (247,212)
Commercial Management Services	327,084	346,042	(18,958)	346,042	352,369	(6,327)
Medicare Advantage	2,114,205	4,901,918	(2,787,713)	4,901,918	3,177,244	1,724,674
Medicaid Risk	1,133,353	1,066,231	67,122	1,066,231	1,087,189	(20,958)
<b>Health Plan and Medical Services</b>	<b>9,115,112</b>	<b>11,488,963</b>	<b>(2,373,851)</b>	<b>11,488,963</b>	<b>10,038,786</b>	<b>1,450,177</b>
Medicare Part D	1,604,198	1,545,858	58,340	1,545,858	847,702	698,156
Other Premiums	100,130	94,562	5,568	94,562	64,783	29,779
Other Management Services	101,017	93,079	7,938	93,079	89,626	3,453
<b>Specialized Managed Care</b>	<b>1,805,345</b>	<b>1,733,499</b>	<b>71,846</b>	<b>1,733,499</b>	<b>1,002,111</b>	<b>731,388</b>
<b>Workers' Compensation</b>	<b>755,055</b>	<b>757,105</b>	<b>(2,050)</b>	<b>757,105</b>	<b>736,695</b>	<b>20,410</b>
Other/Eliminations	(87,596)	(76,041)	(11,555)	(76,041)	(43,365)	(32,676)
<b>Total Operating Revenues</b>	<b>\$ 11,587,916</b>	<b>\$ 13,903,526</b>	<b>\$ (2,315,610)</b>	<b>\$ 13,903,526</b>	<b>\$ 11,734,227</b>	<b>\$ 2,169,299</b>
<b>Gross Margin (in thousands)</b>						
Health Plan and Medical Services	\$ 2,180,210	\$ 1,957,265	\$ 222,945	\$ 1,957,265	\$ 1,887,998	\$ 69,267
Specialized Managed Care	396,584	339,861	56,723	339,861	250,158	89,703
Workers' Compensation	503,003	516,277	(13,274)	516,277	541,095	(24,818)
Other/Eliminations	(9,880)	(10,099)	219	(10,099)	(9,203)	(896)
<b>Total</b>	<b>\$ 3,069,917</b>	<b>\$ 2,803,304</b>	<b>\$ 266,613</b>	<b>\$ 2,803,304</b>	<b>\$ 2,670,048</b>	<b>\$ 133,256</b>

**Revenue and Medical Cost Statistics****Managed Care Premium Yields (PMPM):**

Health plan commercial risk	\$ 314.58	\$ 301.63	4.3%	\$ 301.63	\$ 286.30	5.4%
Medicare Advantage risk <sup>(1)</sup>	\$ 876.67	\$ 855.16	2.5%	\$ 855.16	\$ 862.60	(0.9%)
Medicare Part D <sup>(2)</sup>	\$ 87.96	\$ 84.40	4.2%	\$ 84.40	\$ 88.34	(4.5%)
Medicaid risk	\$ 218.98	\$ 229.94	(4.8%)	\$ 229.94	\$ 208.50	10.3%

**Medical Loss Ratios:**

Health plan commercial risk	79.2%	81.9%	(2.7%)	81.9%	81.7%	0.2%
Medicare Advantage risk	82.0%	89.9%	(7.9%)	89.9%	89.0%	0.9%
Medicare Part D	83.7%	85.7%	(2.0%)	85.7%	84.1%	1.6%
Medicaid risk	85.7%	87.6%	(1.9%)	87.6%	85.3%	2.3%
<b>Total</b>	<b>79.4%</b>	<b>85.4%</b>	<b>(6.0%)</b>	<b>85.4%</b>	<b>84.0%</b>	<b>1.4%</b>

<sup>(1)</sup> Revenue PMPM excludes the effect of revenue ceded to external parties.

<sup>(2)</sup> Revenue PMPM excludes the effect of CMS risk-share premium adjustments and revenue ceded to external parties.

**Comparison of 2010 to 2009****Health Plan and Medical Services Division**

Health Plan and Medical Services Division revenue decreased for the year primarily due to our exit from the PFFS product line which resulted in a decline of \$2.9 billion. Partially offsetting this decrease in revenue was an increase across each of our other risk products. The increase in Commercial Risk revenue was due to the acquisitions of PHS and MHP in 2010. There was an increase in the average realized premium per member per month for the Commercial Risk business due to renewal rate increases.

The increase in Medicare Advantage CCP revenue was attributable to the acquisition of MHP as well as the increase in organic membership associated with that product. The Medicare Advantage premium per member per month increased in 2010 as a result of the exit from the PFFS product which had a lower premium rate than the Medicare Advantage CCP product. The PFFS premium yield was lower than the Medicare Advantage CCP premium rate since PFFS typically did not include a pharmacy benefit. The increase in Medicaid revenue was attributable to commencing operations during 2010 in the Nebraska and Pennsylvania markets. The Medicaid premium per member per month decreased in 2010 as a result of program benefit changes in Missouri, our largest Medicaid market. Effective October 1, 2009, the pharmacy benefit was removed from the program and thus was no longer included in the Missouri Medicaid rate payment.

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Gross margin increased for the year, primarily due to the improved medical loss ratios for the Health Plan Commercial Risk and Medicare Advantage CCP products. The Commercial Risk MLR decreased from the prior year primarily due to the lower than expected utilization trends and more benign flu season than 2009. The Medicare Advantage CCP MLR decrease resulted from lower than expected utilization trends and demographic changes within the product. Partially offsetting these increases in gross margin was a decrease in gross margin resulting from our exit from the PFFS product.

### **Specialized Managed Care Division**

Specialized Managed Care Division revenue increased for the year primarily due to an increase in Medicare Part D revenue which resulted from the higher membership volumes in the early portion of 2010. Including the effect of the CMS risk sharing premium adjustments as well as ceded revenue, the premium per member per month was \$82.86 in 2010 compared to \$80.98 in 2009. Excluding the effect of CMS risk sharing premium adjustments and revenue ceded to external parties, Medicare Part D premium per member per month for 2010 increased to \$87.96 compared to \$84.40 in 2009, primarily due to pharmacy cost trends.

When reviewing the premium yield for Medicare Part D business, we believe that adjusting for the ceded revenue is useful for comparisons to competitors that may not have similar ceding arrangements. When reviewing the Medicare Part D business, adjusting for the risk sharing amounts is useful to understand the results of the Part D business because of our expectation that the risk sharing revenue will eventually be insignificant on a full year basis.

The increase in gross margin was primarily driven by improved MLR for the Medicare Part D product in 2010 compared to the prior year periods. The improvement in MLR was primarily attributed to improved performance in our mainstream products which make up the majority of our Part D business.

### **Workers' Compensation Division**

Revenue in the Workers' Compensation Division decreased slightly from the prior year period primarily due to a decline in volume in our network and clinical programs, partially offset by the growth of our pharmacy benefit management program.

Workers' Compensation gross margin decreased for the current year due to declines in our network and clinical program volumes, which are higher margin products, partially offset by increases attributable to the growth of our pharmacy benefit management program which operates at a lower margin.

### **Comparison of 2009 to 2008**

#### **Health Plan and Medical Services Division**

Health Plan and Medical Services revenue increased over the prior year primarily due to membership growth in the Medicare PFFS products, coupled with an increase in the average realized premium yield PMPM for the product. After deducting revenue ceded to third parties, the Medicare Advantage risk premium yield PMPM for the year increased to \$798.16 in 2009 from \$742.07 in 2008. The increase is a result of a smaller portion of our Medicare PFFS business in 2009 being ceded to external parties through quota share arrangements. When reviewing the premium yield for Medicare Advantage business, we believe that adjusting for the ceded revenue is useful for comparisons to competitors that may not have similar ceding arrangements. Additionally, the Medicare Advantage risk premium yields have increased as a result of higher risk scores.

Medicaid premium yields increased as a result of rate increases in Missouri, our largest Medicaid market, effective July 1, 2008 and July 1, 2009 as well as rate increases in Virginia and West Virginia effective July 1, 2009. The yields also increased due to the termination of our Pennsylvania Medicaid behavioral health contract, which had a lower premium yield. These increases in premium yield were offset by declines in the membership of the Medicaid Risk product. Membership declines also contributed to the reduction in revenue for Commercial Risk products.

Gross margin increased primarily due to the growth in the Medicare PFFS and Medicare Advantage businesses as well as the improved medical loss ratios for the Medicare PFFS product. The Medicare PFFS MLRs decreased over the prior year as the prior year included unfavorable IBNR reserve development. The increases in gross margin were partially offset by gross margin declines in Commercial Risk and Medicaid. The Commercial Risk decline in gross margin is a result of the decline in Commercial Risk membership discussed earlier. The decline in Medicaid gross margin was due to a higher medical loss ratio in 2009 as a result of higher medical cost trends and higher inpatient utilization without rate increases sufficient to cover these cost increases.

### **Specialized Managed Care Division**

Specialized Managed Care Division revenue experienced a significant increase over the prior year due to the large increase in membership for the Medicare Part D product. Medicare Part D premium yields for 2009, excluding the effect of CMS risk sharing premium adjustments and revenue ceded to external parties, decreased compared to 2008, primarily due to the mix of products sold in 2009. The majority of the Medicare Part D growth was in the lower cost, leaner benefit plans, which have a lower premium. Including the effect of the CMS risk sharing premium adjustments as well as the ceded revenue, the premium yields were \$80.98 for 2009 compared to \$78.84 in 2008. The increase is a result of a smaller portion of our Medicare Part D business in 2009 being ceded to external parties through quota share arrangements.

When reviewing the premium yield for Medicare Part D business, we believe that adjusting for the ceded revenue is useful for comparisons to competitors that may not have similar ceding arrangements. When reviewing the Medicare Part D business, adjusting for the risk sharing amounts is useful to understand the results of the Part D business because of our expectation that the risk sharing revenue will eventually be insignificant on a full year basis.

The gross margin for the Specialized Managed Care Division improved for 2009 primarily as a result of increased Part D membership during the current periods, offset by an increase in the Part D MLR due to higher than anticipated pharmacy costs in one product.

### **Workers' Compensation Division**

Revenue in the Workers' Compensation Division increased in 2009 primarily due to the growth of our pharmacy benefit management program. The increase was partially offset by lower revenue in the Division's other business lines as a result of lower claim volume.

Workers' Compensation gross margin decreased over the prior year due to the decline in claims volume in our bill review business, which is a higher margin product, and growth in the pharmacy benefit management program which operates at a lower margin.

### **Liquidity and Capital Resources**

#### **Liquidity**

The nature of a majority of our operations is such that cash receipts from premium revenues are typically received up to two months prior to the expected cash payment for related medical costs. Premium revenues are typically received at the beginning of the month in which they are earned, and the corresponding incurred medical expenses are paid in a future time period, typically 15 to 60 days after the date such medical services are rendered. The lag between premium receipts and claims payments creates positive cash flow and overall cash growth. As a result, we typically hold approximately one to two months of "float." In addition, accumulated earnings provide further positive cash flow.

Our investment guidelines require our fixed income securities to be investment grade in order to provide liquidity to meet future payment obligations and minimize the risk to the principal. The fixed income portfolio includes government and corporate securities with an average quality rating of "AA" and a modified duration of 3.61 years as of December 31, 2010. Typically, the amount and duration of our short-term assets are more than sufficient to pay for our short-term liabilities and we do not anticipate that sales of our long-term investment portfolio will be necessary to fund our claims liabilities.

Our cash and investments, consisting of cash, cash equivalents, short-term investments, and long-term investments, but excluding deposits of \$79.9 million restricted under state regulations, increased \$195.2 million to \$4.0 billion at December 31, 2010 from \$3.8 billion at December 31, 2009.

The demand for our products and services is subject to many economic fluctuations, risks and uncertainties that could materially affect the way we do business. For instance, due to the non-renewal of our PFFS product, we paid medical claims in 2010 without the benefit of premium collections for this product. As a result, this had a negative effect on cash flows in our regulated subsidiaries. Despite the effect, we have ample current liquidity as a result of planning for the non-renewal of the PFFS product. See Part I, Item 1A, "Risk Factors," in this Form 10-K for more information. Management believes that the combination of our ability to generate cash flows from operations, cash and investments on hand, and the excess funds held in certain of our regulated subsidiaries will be sufficient to fund continuing operations, capital expenditures, debt interest costs, debt principal repayments, required payments resulting from judgments or settlements in the Louisiana provider class action litigation, and any other reasonably likely future cash requirements. In addition, our long-term investment portfolio is available for further liquidity needs including satisfaction of policy holder benefits.

#### **Cash Flows**

##### *Operating Activities*

Net cash from operating activities for the year ended December 31, 2010 was a result of net earnings generated by our normal operations during the period and non-cash adjustments to earnings including the class action charge. These cash inflows were partially offset by a decrease in medical claim liabilities associated with the non-renewal of the PFFS product. Since premium revenues are generally received in advance of the expected cash payment for the related medical costs, the result is strong cash inflows upon the implementation of a benefit program and cash outflows upon the termination. The cash outflows for PFFS for the year ended December 31, 2010 were approximately \$338.5 million. Also partially offsetting the operating cash inflow for the period was a decrease in other payables primarily as a result of the timing of Federal and State income tax payments.

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Our net cash from operating activities in 2010 was \$609.6 million lower than the 2009 period as the current year period reflects the medical claim payments associated with the PFFS product run out. During 2009, we experienced large positive cash flows from operating activities primarily due to membership growth across the Medicare products.

### *Investing Activities*

Capital expenditures in 2010 of approximately \$63.3 million consisted primarily of computer hardware, software and related costs associated with the development and implementation of improved operational and communication systems. Projected capital expenditures in 2011 of approximately \$65 to \$75 million consist primarily of computer hardware, software and other equipment.

Net cash from investing activities for the year ended December 31, 2010 was an inflow due to proceeds received from investment maturities and sales during the period, partially offset by investment purchases and the payment for our acquisitions of PHS and MHP, net of cash acquired.

### *Financing Activities*

Our Board of Directors has approved a program to repurchase our outstanding common stock. Stock repurchases may be made from time to time at prevailing prices on the open market, by block purchase or in private transactions. As a part of this program, no shares were repurchased in 2010, 1.5 million shares were purchased in 2009 at an aggregate cost of \$30.0 million and 7.3 million shares of our common stock were purchased in 2008 at an aggregate cost of \$318.0 million. As of December 31, 2010, the total remaining common shares we are authorized to repurchase under this program is 5.2 million. Excluded from these share repurchase program amounts are shares purchased in exchange for employee payroll taxes on vesting of restricted stock awards as these purchases are not part of the program.

We did not make any debt repayments during 2010. Refer to Note K, Debt, to the consolidated financial statements for more information regarding our debt.

### **Health Plans**

Our regulated HMO and insurance company subsidiaries are required by state regulatory agencies to maintain minimum surplus balances, thereby limiting the dividends the parent may receive from our regulated entities. During 2010, we received \$319.4 million in dividends from our regulated subsidiaries and we made \$11.5 million in capital contributions to them. We had \$1.9 billion of regulated capital and surplus at December 31, 2010.

The National Association of Insurance Commissioners (“NAIC”) has proposed that states adopt risk-based capital (“RBC”) standards which are a method of measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. The managed care organization’s RBC is calculated by applying factors to various assets, premiums and reserve items. The factor is higher for those items with greater underlying risk and lower for less risky items. The adequacy of a managed care organization’s actual capital can then be measured by a comparison to its RBC as determined by the formula. Our health plans are required to submit a RBC report to the NAIC and their domiciled state’s department of insurance with their annual filing.

Regulators will use the RBC results to determine if any regulatory actions are required. Regulatory actions that could take place, if any, range from filing a financial action plan explaining how the plan will increase its statutory net worth to the approved levels, to the health plan being placed under regulatory control.

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The majority of states in which we operate health plans have adopted a RBC policy that recommends the health plans maintain statutory reserves at or above the “Company Action Level” which is currently equal to 200% of their RBC. Some states in which our regulated subsidiaries operate require deposits to be maintained with the respective states’ departments of insurance. The table below summarizes our statutory reserve information, as of December 31, 2010 and 2009 (in millions, except percentage data).

	<u>2010</u>	<u>2009</u>
	<i>(unaudited)</i>	
Regulated capital and surplus	\$ 1,908.7	\$ 1,636.2
200% of RBC <sup>(1, 2)</sup>	\$ 633.8	\$ 812.2
Excess capital and surplus above 200% of RBC <sup>(1, 2)</sup>	\$ 1,274.9	\$ 824.0
Capital and surplus as percentage of RBC <sup>(1, 2)</sup>	602%	403%
Statutory deposits	\$ 79.9	\$ 75.3

<sup>(1)</sup> RBC amounts are not audited.

<sup>(2)</sup> The State of Florida does not have a RBC requirement for its regulated HMOs. Accordingly, the statutory reserve information provided for our health plans domiciled in Florida is based on the actual statutory minimum capital required by the State of Florida.

The increase in capital and surplus for our regulated subsidiaries primarily resulted from net earnings and capital contributions made by the parent company and the acquisitions of PHS and MHP, partially offset by dividends paid to the parent company.

We believe that all subsidiaries which incur medical claims maintain more than adequate liquidity and capital resources to meet these short-term obligations as a matter of both Company policy and applicable department of insurance regulations.

Excluding funds held by entities subject to regulation and excluding our equity method investments, we had cash and investments of approximately \$1.1 billion and \$713.0 million at December 31, 2010 and 2009, respectively. The increase resulted from earnings from non-regulated businesses and dividends from our regulated subsidiaries. These were partially offset by cash paid for acquisitions and capital infusions into our subsidiaries.

**Other**

As of December 31, 2010, we were contractually obligated to make the following payments during the next five years and thereafter (in thousands):

<u>Contractual Obligations</u>	<u>Total</u>	<u>Payments Due by Period</u>			
		<u>Less than 1 Year</u>	<u>1 - 3 Years</u>	<u>3 - 5 Years</u>	<u>More than 5 Years</u>
Senior notes	\$ 1,219,367	\$ -	\$ 233,903	\$ 603,109	\$ 382,355
Interest payable on senior notes	338,769	76,912	133,508	116,746	11,603
Credit facilities	380,029	-	380,029	-	-
Interest payable on credit facilities <sup>(1)</sup>	4,831	3,160	1,671	-	-
Operating leases	125,484	34,116	47,074	30,154	14,140
Total contractual obligations	<u>2,068,480</u>	<u>114,188</u>	<u>796,185</u>	<u>750,009</u>	<u>408,098</u>
Less sublease income	(5,418)	(1,751)	(2,273)	(1,318)	(76)
Net contractual obligations	<u>\$ 2,063,062</u>	<u>\$ 112,437</u>	<u>\$ 793,912</u>	<u>\$ 748,691</u>	<u>\$ 408,022</u>

<sup>(1)</sup> Interest payable on credit facilities has been estimated based on interest rates as of December 2010 and assumes no additional changes in the principal amount.

The table above does not reflect the timing of cash payments related to income taxes or legal contingencies. Refer to Note I, Income Taxes, and Note L, Commitments and Contingencies, to the consolidated financial statements for additional information related to our income taxes, operating leases and other contingencies.

We have typically paid 90% to 95% of medical claims within six months of the date incurred and approximately 99% of medical claims within nine months of the date incurred. Accordingly, we believe medical claims liabilities are short-term in nature and therefore do not meet the listed criteria for classification as contractual obligations and have been excluded from the table above. As of December 31, 2010, we had \$136.3 million of unrecognized tax benefits. The above table excludes these amounts due to uncertainty of timing and amounts regarding future payments.

## **Other Disclosures**

### **Legislation and Regulation**

As a managed health care company, we are subject to extensive government regulation of our products and services. The laws and regulations affecting our industry generally give state and federal regulatory authorities broad discretion in their exercise of supervisory, regulatory and administrative powers. These laws and regulations are intended primarily for the benefit of the members of the health plans. Managed care laws and regulations vary significantly from jurisdiction to jurisdiction and changes are frequently considered and implemented. Likewise, interpretations of these laws and regulations are also subject to change.

The full effect of any current or future legislation provisions adopted at the state or federal level cannot be accurately predicted at this time. See “Government Regulation” under Part I, Item 1, “Business” for additional discussion of government regulation that affects our businesses.

### **Inflation**

In recent years, health care cost inflation has exceeded the general inflation rate. To reduce the effect of health care cost inflation on our business operations in which we assume underwriting risk, we have, where possible, increased premium rates and implemented cost control measures in our patient care management and provider contracting. We cannot be certain that we will be able to increase future premium rates at a rate that equals or exceeds the health care cost inflation rate or that our other cost control measures will be effective.

### **2011 Outlook**

*Health Plan and Medical Services Division* – We expect our Commercial Risk membership will be flat to slightly down for 2011 as compared to approximately 1.6 million members in 2010. The forecasted Commercial group MLR is expected to be in the range of 80.5% to 81.5%, an increase from the 2010 MLR of 79.2% largely driven by compliance with new healthcare reform regulations. The forecasted Commercial Individual MLR is expected to be in the range of 75.0% to 77.0%, an increase from the 2010 MLR of 66.1%, largely driven by compliance with new healthcare reform regulations.

For our Health Plan based Medicare Advantage CCP product, we are forecasting membership to be flat to slightly down for 2011 as compared to 2010 results. We expect the 2011 Medicare Advantage MLR to be consistent with our Medicare bids in the mid 80%, an increase from the 2010 MLR of 82.0%.

For our Health Plan based Medicaid business, we are forecasting 2011 membership to grow in the mid single digits as compared to 2010 with a MLR in the high 80%.

*Specialized Managed Care Division* – We anticipate membership in our Medicare Part D product to be down by approximately 500,000 members in 2011 from the 2010 ending membership of approximately 1.6 million. This decrease reflects the loss of auto assign regions as well as membership losses driven by a reduction in product offerings from five in 2010 to two in 2011. Our MLR expectation for 2011 will be similar to our actual results in 2010, which was in the mid 80%.

*Workers Compensation Division* – We believe our Workers Compensation Division will grow slightly compared to 2010 with continued focus on the supporting administrative cost structure.

Regarding our balance sheet and liquidity, we ended the year with approximately \$850 million in free cash at the parent level. We have a net balance owing on our revolving line of credit of \$380 million. As usual, our first priority with our free cash will be to support the regulatory capital needs of our subsidiaries and to maintain liquidity.

Regarding our effective tax rate, we expect it will range from 36% to 37% for the full year of 2011.

**Item 7A: Quantitative and Qualitative Disclosures About Market Risk**

Under an investment policy approved by our Board of Directors, we invest primarily in marketable U.S. government and agency, state, municipal, mortgage-backed and asset-backed securities and corporate debt obligations that are investment grade. Our Investment Policy and Guidelines generally do not permit the purchase of equity-type investments or fixed income securities that are below investment grade. Our investment guidelines include a permitted exception to allow for such investments if those investments are obtained through a business combination and, if in our best interest, such investments were not disposed within 90 days after acquisition. As described in the notes to the consolidated financial statements, we acquired investments in an equipment leasing limited liability company through our acquisition of First Health. We have classified all of our investments as available-for-sale. We are exposed to certain market risks including interest rate risk and credit risk.

We have established policies and procedures to manage our exposure to changes in the fair value of our investments. Our policies include an emphasis on credit quality and the management of our portfolio’s duration and mix of securities. We believe our investment portfolio is diversified and currently expect no material loss to result from the failure to perform by the issuers of the debt securities we hold. The mortgage-backed securities are insured by several associations, including Government National Mortgage Administration, Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation.

We invest primarily in fixed income securities. Investments are evaluated on an individual security basis at least quarterly to determine if declines in value are other-than-temporary. In making that determination, we consider all available evidence relating to the realizable value of a security. This evidence includes, but is not limited to, the following:

- the length of time and the extent to which the fair value has been less than the amortized cost basis;
- adverse conditions specifically related to the security, an industry or geographic area;
- the historical and implied volatility of the fair value of the security;
- the payment structure of the debt security and the likelihood of the issuer being able to make payments that increase in the future;
- failure of the issuer of the security to make scheduled interest or principal payments;
- any changes to the rating of the security by a rating agency;
- recoveries or additional declines in fair value subsequent to the balance sheet date; and
- if we have decided to sell the security or it is more-likely-than-not that we will be required to sell the security before recovery of its amortized cost.

For debt securities, if we intend to either sell or determine that we will more-likely-than-not be required to sell a debt security before recovery of the entire amortized cost basis or maturity of the debt security, we recognize the entire impairment in earnings. If we do not intend to sell the debt security and we determine that we will not more-likely-than-not be required to sell the debt security but we do not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other cases, which are recognized in other comprehensive income. Realized gains and losses on the sale of investments are determined on a specific identification basis. See Note G, Investments and Fair Value Measurements, to our consolidated financial statements in this Form 10-K for more information concerning other-than-temporary impaired investments.

Our investments at December 31, 2010 mature according to their contractual terms, as follows, in thousands (actual maturities may differ because of call or prepayment rights):

<b>As of December 31, 2010</b>	<b>Amortized Cost</b>	<b>Fair Value</b>
Maturities:		
Within 1 year	\$ 174,639	\$ 176,400
1 to 5 years	889,990	922,696
5 to 10 years	499,632	519,296
Over 10 years	543,137	554,473
Total	<u>\$ 2,107,398</u>	<u>2,172,865</u>
Equity method investments <sup>(1)</sup>		28,590
Total short-term and long-term securities		<u>\$ 2,201,455</u>

<sup>(1)</sup> Includes investments in entities accounted for under the equity method of accounting and therefore are presented at their carrying value.

Our projections of hypothetical net gains (losses) in fair value of our market rate sensitive instruments, should potential changes in market rates occur, are presented below. The projections are based on a model, which incorporates effective duration, convexity and price to forecast hypothetical instantaneous changes in interest rates of positive and negative 100, 200 and 300 basis points. The model only takes into account the fixed income securities in the portfolio and excludes all cash. While we believe that the potential market rate change is reasonably possible, actual results may differ.

**Increase (decrease) in fair value of portfolio  
given an interest rate (decrease) increase of X basis points  
As of December 31, 2010  
(in thousands)**

<b>(300)</b>		<b>(200)</b>		<b>(100)</b>		<b>100</b>		<b>200</b>		<b>300</b>	
\$	154,059	\$	126,679	\$	72,249	\$	(77,929)	\$	(153,959)	\$	(227,122)

**Item 8: Financial Statements and Supplementary Data**

**REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM**

**To the Board of Directors and Stockholders of Coventry Health Care, Inc.**

We have audited the accompanying consolidated balance sheets of Coventry Health Care, Inc. as of December 31, 2010 and 2009, and the related consolidated statements of operations, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2010. Our audits also included the financial statement schedule listed in the Index at Item 15(a)(2). These financial statements and schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Coventry Health Care, Inc. at December 31, 2010 and 2009, and the consolidated results of their operations and their cash flows for each of the three years in the period ended December 31, 2010, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule referred to above, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Coventry Health Care, Inc.'s internal control over financial reporting as of December 31, 2010, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 25, 2011 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP  
Baltimore, Maryland  
February 25, 2011

**Coventry Health Care, Inc. and Subsidiaries**  
**Consolidated Balance Sheets**  
(in thousands)

	<u>December 31,</u> <u>2010</u>	<u>December 31,</u> <u>2009</u>
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents	\$ 1,853,988	\$ 1,418,554
Short-term investments	16,849	442,106
Accounts receivable, net of allowance of \$7,073 and \$21,350 as of December 31, 2010 and 2009, respectively	276,694	258,993
Other receivables, net	515,882	496,059
Other current assets	371,528	234,446
Total current assets	<u>3,034,941</u>	<u>2,850,158</u>
Long-term investments	2,184,606	1,994,987
Property and equipment, net	262,282	271,931
Goodwill	2,550,570	2,529,284
Other intangible assets, net	431,886	471,693
Other long-term assets	31,300	48,479
Total assets	<u>\$ 8,495,585</u>	<u>\$ 8,166,532</u>
<b>LIABILITIES AND STOCKHOLDERS' EQUITY</b>		
Current liabilities:		
Medical liabilities	\$ 1,237,690	\$ 1,605,407
Accounts payable and other accrued liabilities	942,226	682,171
Deferred revenue	103,082	110,855
Total current liabilities	<u>2,282,998</u>	<u>2,398,433</u>
Long-term debt	1,599,396	1,599,027
Other long-term liabilities	414,025	456,518
Total liabilities	<u>4,296,419</u>	<u>4,453,978</u>
Stockholders' equity:		
Common stock, \$.01 par value; 570,000 authorized 191,512 issued and 149,427 outstanding in 2010 190,462 issued and 147,990 outstanding in 2009	1,915	1,905
Treasury stock, at cost; 42,085 in 2010; 42,472 in 2009	(1,268,456)	(1,282,054)
Additional paid-in capital	1,784,826	1,750,113
Accumulated other comprehensive income, net	41,081	41,406
Retained earnings	3,639,800	3,201,184
Total stockholders' equity	<u>4,199,166</u>	<u>3,712,554</u>
Total liabilities and stockholders' equity	<u>\$ 8,495,585</u>	<u>\$ 8,166,532</u>

See accompanying notes to the consolidated financial statements.

**Coventry Health Care, Inc. and Subsidiaries**  
**Consolidated Statements of Operations**  
(in thousands, except per share data)

	<b>For the years ended December 31,</b>		
	<b>2010</b>	<b>2009</b>	<b>2008</b>
Operating revenues:			
Managed care premiums	\$ 10,414,640	\$ 12,717,399	\$ 10,563,163
Management services	1,173,276	1,186,127	1,171,064
Total operating revenues	<u>11,587,916</u>	<u>13,903,526</u>	<u>11,734,227</u>
Operating expenses:			
Medical costs	8,265,947	10,859,394	8,868,579
Cost of sales	252,052	240,828	195,600
Selling, general and administrative	1,961,947	2,151,799	1,940,820
Charge for provider class action	278,000	-	-
Depreciation and amortization	140,685	149,554	143,699
Total operating expenses	<u>10,898,631</u>	<u>13,401,575</u>	<u>11,148,698</u>
Operating earnings	689,285	501,951	585,529
Interest expense	80,418	84,875	96,386
Other income, net	<u>77,667</u>	<u>87,478</u>	<u>82,718</u>
Earnings before income taxes	686,534	504,554	571,861
Provision for income taxes	<u>247,918</u>	<u>189,220</u>	<u>209,861</u>
Income from continuing operations	<u>438,616</u>	<u>315,334</u>	<u>362,000</u>
(Loss) income from discontinued operations, net of tax	<u>-</u>	<u>(73,033)</u>	<u>19,895</u>
Net earnings	<u>\$ 438,616</u>	<u>\$ 242,301</u>	<u>\$ 381,895</u>
Net earnings per share:			
Basic earnings per share from continuing operations	\$ 3.00	\$ 2.15	\$ 2.43
Basic (loss) earnings per share from discontinued operations	-	(0.50)	0.13
Total basic earnings per share	<u>\$ 3.00</u>	<u>\$ 1.65</u>	<u>\$ 2.56</u>
Diluted earnings per share from continuing operations	\$ 2.97	\$ 2.14	\$ 2.41
Diluted (loss) earnings per share from discontinued operations	-	(0.50)	0.13
Total diluted earnings per share	<u>\$ 2.97</u>	<u>\$ 1.64</u>	<u>\$ 2.54</u>
Weighted average common shares outstanding:			
Basic	146,169	146,652	148,893
Effect of dilutive options and restricted stock	1,410	743	1,315
Diluted	<u>147,579</u>	<u>147,395</u>	<u>150,208</u>

See accompanying notes to the consolidated financial statements.

**Coventry Health Care, Inc. and Subsidiaries**  
**Consolidated Statements of Stockholders' Equity**  
**Years Ended December 31, 2010, 2009 and 2008**  
(in thousands, except shares which are in millions)

	Common Stock		Treasury Stock, at Cost	Additional Paid-In Capital	Accumulated Other Comprehensive Income (Loss), Net	Retained Earnings	Total Stockholders' Equity
	Shares	Amount					
<b>Balance, December 31, 2007</b>	189.9	\$ 1,899	\$ (987,132)	\$ 1,702,989	\$ 6,735	\$ 2,576,988	\$ 3,301,479
Comprehensive income:							
Net earnings						381,895	381,895
Other comprehensive income:							
Holding gain, net					7,652		
Reclassification adjustment					(3,996)		
Other comprehensive income							3,656
Deferred tax effect					(1,426)		(1,426)
Comprehensive income							384,125
Employee stock plans activity	0.4	4	22,607	45,591			68,202
Treasury shares acquired			(323,137)				(323,137)
<b>Balance, December 31, 2008</b>	190.3	\$ 1,903	\$ (1,287,662)	\$ 1,748,580	\$ 8,965	\$ 2,958,883	\$ 3,430,669
Comprehensive income:							
Net earnings						242,301	242,301
Other comprehensive income:							
Holding gain, net					64,791		
Reclassification adjustment					(11,609)		
Other comprehensive income							53,182
Deferred tax effect					(20,741)		(20,741)
Comprehensive income							274,742
Employee stock plans activity	0.2	2	35,568	1,533			37,103
Treasury shares acquired			(29,960)				(29,960)
<b>Balance, December 31, 2009</b>	190.5	\$ 1,905	\$ (1,282,054)	\$ 1,750,113	\$ 41,406	\$ 3,201,184	\$ 3,712,554
Comprehensive income:							
Net earnings						438,616	438,616
Other comprehensive income:							
Holding gain, net					10,501		
Reclassification adjustment					(11,034)		
Other comprehensive income							(533)
Deferred tax effect					208		208
Comprehensive income							438,291
Employee stock plans activity	1	10	13,598	34,713			48,321
Treasury shares acquired			-				-
<b>Balance, December 31, 2010</b>	191.5	\$ 1,915	\$ (1,268,456)	\$ 1,784,826	\$ 41,081	\$ 3,639,800	\$ 4,199,166

See accompanying notes to the consolidated financial statements.

**Coventry Health Care, Inc. and Subsidiaries**  
**Consolidated Statements of Cash Flows**  
(in thousands)

	<b>Years Ended December 31,</b>		
	<b>2010</b>	<b>2009</b>	<b>2008</b>
Cash flows from operating activities:			
Net earnings	\$ 438,616	\$ 242,301	\$ 381,895
Adjustments to reconcile net earnings to cash provided by operating activities:			
Depreciation and amortization	140,685	151,815	150,226
Amortization of stock compensation	40,532	47,047	60,582
Deferred income tax benefit	(130,749)	(87,610)	(34,178)
Loss on other-than-temporarily impaired securities	-	-	36,160
Charge for provider class action	278,000	-	-
Loss on disposal of FHSC	-	81,557	-
Gain on repurchase of debt	-	(8,371)	(4,628)
Other adjustments	18,586	8,642	10,243
Changes in assets and liabilities, net of effects of the purchase of subsidiaries:			
Accounts receivable	(2,389)	12,258	(28,699)
Other receivables	(2,399)	19,235	(198,904)
Medical liabilities	(439,265)	159,095	276,417
Accounts payable and other accrued liabilities	(46,174)	223,182	(49,689)
Other changes in assets and liabilities	(23,191)	32,692	27,931
Net cash from operating activities	<u>272,252</u>	<u>881,843</u>	<u>627,356</u>
Cash flows from investing activities:			
Capital expenditures, net	(63,257)	(60,323)	(69,371)
Proceeds from sales of investments	561,457	292,515	696,806
Proceeds from maturities of investments	573,625	522,144	166,034
Purchases of investments	(819,808)	(1,140,475)	(1,034,892)
(Payments) / proceeds for acquisitions, net	(102,356)	10,197	(137,374)
Proceeds from FHSC disposal, net	-	115,437	-
Net cash from investing activities	<u>149,661</u>	<u>(260,505)</u>	<u>(378,797)</u>
Cash flows from financing activities:			
Proceeds from issuance of stock	15,484	1,224	7,233
Payments for repurchase of stock	(4,888)	(32,796)	(323,137)
Proceeds from issuance of debt, net	-	-	668,409
Repayment of debt	-	(294,930)	(423,872)
Excess tax benefit from stock compensation	2,925	604	387
Net cash from financing activities	<u>13,521</u>	<u>(325,898)</u>	<u>(70,980)</u>
Net change in cash and cash equivalents	435,434	295,440	177,579
Cash and cash equivalents at beginning of period	1,418,554	1,123,114	945,535
Cash and cash equivalents at end of period	<u>\$ 1,853,988</u>	<u>\$ 1,418,554</u>	<u>\$ 1,123,114</u>
Supplemental disclosure of cash flow information:			
Cash paid for interest	\$ 77,973	\$ 84,383	\$ 93,219
Income taxes paid	\$ 471,479	\$ 190,703	\$ 273,917

See accompanying notes to the consolidated financial statements.

**COVENTRY HEALTH CARE, INC. AND SUBSIDIARIES**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**December 31, 2010, 2009 and 2008**

**A. ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

Coventry Health Care, Inc. (together with its subsidiaries, the “Company” or “Coventry”) is a diversified national managed health care company based in Bethesda, Maryland operating health plans, insurance companies, network rental and workers’ compensation services companies. Through its Health Plan and Medical Services, Specialized Managed Care and Workers’ Compensation reportable segments, the Company provides a full range of risk and fee-based managed care products and services to a broad cross section of individuals, employer and government-funded groups, government agencies, and other insurance carriers and administrators.

Since the Company began operations in 1987 with the acquisition of the American Service Companies entities, including Coventry Health and Life Insurance Company (“CH&L”), the Company has grown substantially through acquisitions. See Note C, Acquisitions, to the consolidated financial statements for information on the Company’s recent acquisitions.

**Significant Accounting Policies**

**Basis of Presentation** - The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States and include the accounts of the Company and its subsidiaries. All inter-company transactions have been eliminated.

**Use of Estimates** - The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those amounts.

**Significant Customers** - The Company’s health plan commercial business is diversified across a large customer base and no customer group comprises 10% or more of Coventry’s managed care premiums. The Company received 35.6%, 50.7% and 38.1% of its managed care premiums for the years ended December 31, 2010, 2009 and 2008, respectively, from the federal Medicare program throughout its various health plan markets and from national Medicare Part D and Medicare Advantage Private-Fee-For-Service (“PFFS”) products. The decline in 2010 is primarily a result of the Company’s non-renewal of the Medicare PFFS product effective January 1, 2010. The Company also received 10.9%, 8.4% and 10.3% of its managed care premiums for the years ended December 31, 2010, 2009 and 2008, respectively, from state-sponsored Medicaid programs throughout its various health plan markets. For the years ended December 31, 2010, 2009 and 2008, the State of Missouri accounted for almost half of the Company’s Medicaid premiums. Additionally, the Company received 11.2%, 11.3% and 10.7% of its management services revenue from a single customer, Mail Handlers Benefit Plan (“MHBP”), for the years ended December 31, 2010, 2009 and 2008, respectively.

**Cash and Cash Equivalents** - Cash and cash equivalents consist principally of money market funds, commercial paper, certificates of deposit, and treasury bills. The Company considers all highly liquid securities purchased with an original maturity of three months or less to be cash equivalents.

**Investments** - The Company accounts for investments in accordance with the Financial Accounting Standards Board (“FASB”) issued Accounting Standards Codification (“ASC”) 320-10 “Accounting for Certain Investments in Debt and Equity Securities,” ASC 320-10-35-35 “Accounting for Debt Securities After an Other-than-Temporary Impairment,” and Accounting Standards Update (“ASU”) 2010-06, “Improving Disclosures about Fair Value Measurements.” The Company adopted the new disclosure provisions of ASU 2010-06 during the first quarter of 2010, except for the gross disclosures regarding purchases, sales, issuances and settlements in the roll forward of activity in Level 3 fair value measurements, which are required for the Company beginning with the filing of its quarterly filing on Form 10-Q for the quarter ended March 31, 2011. The Company invests primarily in fixed income securities and classifies all of its investments as available-for-sale. Investments are evaluated on an individual security basis at least quarterly to determine if declines in value are other-than-temporary. In making that determination, the Company considers all available evidence relating to the realizable value of a security. This evidence is reviewed at the individual security level and includes, but is not limited to, the following:

- the length of time and the extent to which the fair value has been less than the amortized cost basis;
- adverse conditions specifically related to the security, an industry or geographic area;
- the historical and implied volatility of the fair value of the security;

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- the payment structure of the debt security and the likelihood of the issuer being able to make payments that increase in the future;
- failure of the issuer of the security to make scheduled interest or principal payments;
- any changes to the rating of the security by a rating agency;
- recoveries or additional declines in fair value subsequent to the balance sheet date; and
- if the Company has decided to sell the security or it is more-likely-than-not that the Company will be required to sell the security before recovery of its amortized cost.

For debt securities, if the Company intends to either sell or determine that it will more-likely-than-not be required to sell a debt security before recovery of the entire amortized cost basis or maturity of the debt security, the Company recognizes the entire impairment in earnings. If the Company does not intend to sell the debt security and the Company determines that it will not more-likely-than-not be required to sell the debt security but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other cases, which are recognized in other comprehensive income. Realized gains and losses on the sale of investments are determined on a specific identification basis.

Investments with original maturities in excess of three months and less than one year are classified as short-term investments and generally consist of corporate bonds, U.S. Treasury notes and commercial paper. Long-term investments have original maturities in excess of one year and primarily consist of fixed income securities.

**Other Receivables** - Other receivables include pharmacy rebate receivables of \$310.7 million and \$314.9 million at December 31, 2010 and 2009, respectively. Other receivables also include Medicare Part D program related risk share and subsidy receivables, Medicare risk adjuster receivables, Office of Personnel Management (“OPM”) receivables, interest receivables, and any other receivables that do not relate to premiums. The increase in other receivables during 2010 primarily resulted from an increase in the Medicare Part D related receivables.

**Other Current Assets** - Other Current Assets primarily include deferred tax assets and also includes prepaid expenses. See Note I, Income Taxes, to the consolidated financial statements for additional information.

**Property and Equipment** - Property, equipment and leasehold improvements are recorded at cost. Depreciation is computed using the straight-line method over the shorter of the estimated lives of the related assets or over the term of the respective leases, if applicable. In accordance with ASC 350-40, “Internal – Use Software,” the cost of internally developed software is capitalized and included in property and equipment. The Company capitalizes costs incurred during the application development stage for the development of internal-use software. These costs primarily relate to payroll and payroll-related costs for employees along with costs incurred for external consultants who are directly associated with the internal-use software project. See Note F, Property and Equipment, to the consolidated financial statements for additional information.

**Long-term Assets** - Long-term assets primarily include assets associated with senior note issuance costs and reinsurance recoveries. The reinsurance recoveries were obtained with the acquisition of First Health Group Corp. (“First Health”) and are related to certain life insurance receivables from a third party insurer for liabilities that have been ceded to that third party insurer.

**Business Combinations, Accounting for Goodwill and Other Intangibles** - The Company accounts for Business Combinations in accordance with ASC 805-10 and accounts for goodwill and other intangibles in accordance with ASC 350-10. Goodwill and other intangible assets that have indefinite lives are subject to a periodic assessment for impairment by applying a fair-value-based test. The Company’s annual impairment test date is October 1 of each fiscal year. For goodwill, the Company performs a two-step impairment test. In the first step, the Company compares the fair value of each reporting unit to its carrying value. The Company has five reporting units: Health Plans, Workers’ Compensation, MHNet, Medicare Part D, and Network Rental. The Company determines the fair value of its reporting units based on a weighting of income and market approaches. The market approach estimates the reporting unit’s fair value by utilizing market multiples of revenue or earnings for comparable companies. The income approach is based on the present value of estimated future cash flows. If the fair value of the reporting unit exceeds the carrying value of the net assets assigned to that unit, goodwill is not impaired and no further testing is performed. If the carrying value of the net assets assigned to the reporting unit exceeds the fair value of the reporting unit, then the Company must perform the second step of the impairment test in order to determine the implied fair value of the reporting unit’s goodwill. If the carrying value of a reporting unit’s goodwill exceeds its implied fair value, the Company records an impairment charge equal to the difference. Impairment charges are recorded in the period incurred. See Note E, Goodwill and Other Intangible Assets, to the consolidated financial statements for disclosure related to these assets.

The fair value of the indefinite-lived intangible asset is estimated and compared to the carrying value. The Company estimates the fair value of the indefinite-lived intangible asset using an income approach. The Company recognizes an impairment loss when the estimated fair value of the indefinite-lived intangible asset is less than the carrying value.

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Other acquired intangible assets are separately recognized upon meeting certain criteria. Such intangible assets include, but are not limited to, trade and service marks, health provider contracts, customer lists and licenses. An intangible asset that is subject to amortization is tested for recoverability whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. The Company amortizes other acquired intangible assets with finite lives using the straight-line method over the estimated economic lives of the assets, ranging from three to 20 years.

**Discontinued Operations** – The Company accounts for discontinued operations in accordance with ASC 360-10 “Accounting for the Impairment or Disposal of Long-Lived Assets.” The Company determines whether the group of assets being disposed of comprises a component of the entity, which requires cash flows that can be clearly distinguished from the rest of the entity. The Company also determines whether the cash flows associated with the group of assets have been or will be eliminated from the ongoing operations of the Company as a result of the disposal transaction and whether the Company has no significant continuing involvement in the operations of the group of assets after disposal. If these determinations result in an affirmative response, the results of operations of the asset group being disposed of, as well as the gain or loss on disposal are aggregated for separate presentation apart from the continuing operating results of the Company in the Consolidated Statements of Operations. See Note D, Discontinued Operations, to the consolidated financial statements for additional disclosure related to discontinued operations.

**Medical Liabilities and Expense** - Medical liabilities consist of actual claims reported but not paid and estimates of health care services incurred but not reported. The estimated claims incurred but not reported are based on historical data, current enrollment, health service utilization statistics and other related information. In determining medical liabilities, the Company employs standard actuarial reserve methods that are specific to each market’s membership, product characteristics, geographic territories and provider network. The Company also considers utilization frequency and unit costs of inpatient, outpatient, pharmacy and other medical expenses, as well as claim payment backlogs and the timing of provider reimbursements. The Company also establishes reserves, if required, for the probability that anticipated future health care costs and contract maintenance costs under the group of existing contracts will exceed anticipated future premiums and reinsurance recoveries on those contracts. These accruals are continually monitored and reviewed, and as settlements are made or accruals adjusted, differences are reflected in current operations. Changes in assumptions for medical costs caused by changes in actual experience could cause these estimates to change in the near term.

The following table presents the components of the change in medical claims liabilities for the years ended December 31, 2010, 2009 and 2008, respectively (in thousands).

	<b>2010</b>	<b>2009</b>	<b>2008</b>
<b>Medical liabilities, beginning of year</b>	<b>\$ 1,605,407</b>	<b>\$ 1,446,391</b>	<b>\$ 1,161,963</b>
Acquisitions <sup>(1)</sup>	71,548	-	7,590
Reported Medical Costs			
Current year	8,507,460	11,049,227	8,916,644
Prior year development	(241,513)	(189,833)	(48,065)
<b>Total reported medical costs</b>	<b>8,265,947</b>	<b>10,859,394</b>	<b>8,868,579</b>
Claim Payments			
Payments for current year	7,491,891	9,598,222	7,577,939
Payments for prior year	1,185,476	1,123,131	1,013,216
<b>Total claim payments</b>	<b>8,677,367</b>	<b>10,721,353</b>	<b>8,591,155</b>
Change in Part D Related Subsidy Liabilities	(27,845)	20,975	(586)
<b>Medical liabilities, end of year</b>	<b>\$ 1,237,690</b>	<b>\$ 1,605,407</b>	<b>\$ 1,446,391</b>
<b>Supplemental Information:</b>			
Prior year development <sup>(2)</sup>	2.2%	2.1%	0.7%
Current year paid percent <sup>(3)</sup>	88.1%	86.9%	85.0%

<sup>(1)</sup> Acquisition balances represent medical liabilities of the acquired company as of the applicable acquisition date.

<sup>(2)</sup> Prior year reported medical costs in the current year as a percentage of prior year reported medical costs.

<sup>(3)</sup> Current year claim payments as a percentage of current year reported medical costs.

The negative medical cost amounts noted as “prior year development” are favorable adjustments for claim estimates being settled for amounts less than originally anticipated. As noted above, these favorable developments from original estimates occur due to changes in medical utilization, mix of provider rates and other components of medical cost trends. Medical claim liabilities are generally paid within several months of the member receiving service from the provider. Accordingly, the 2010 prior year development relates almost entirely to claims incurred in calendar year 2009.

The change in Medicare Part D related subsidy liabilities identified in the table above represent subsidy amounts received from Centers for Medicare & Medicaid Services (“CMS”) for reinsurance and for cost sharing related to low-income individuals. These subsidies are recorded in medical liabilities and the Company does not recognize premium revenue or claims expense for these subsidies.

**Other Long-term Liabilities** - Other long-term liabilities consist primarily of deferred tax liabilities, liability for unrecognized tax benefits and liabilities associated with the 401(k) Restoration and Deferred Compensation Plan.

**Comprehensive Income** – Comprehensive income includes net earnings and unrealized net gains and losses on investment securities. Other comprehensive income is net of reclassification adjustments to adjust for items currently included in net earnings, such as realized gains and losses on investment securities. The deferred tax provision for unrealized holding gains arising from investment securities during the years ended December 31, 2010, 2009 and 2008 was \$4.1 million, \$25.3 million, and \$3.0 million, respectively. The deferred tax provision for reclassification adjustments for gains included in net earnings on investment securities during the years ended December 31, 2010, 2009 and 2008 was \$4.3 million, \$4.5 million, and \$1.6 million, respectively.

**Revenue Recognition** - Managed care premiums are recorded as revenue in the month in which members are entitled to service. Premiums are based on a per subscriber contract rate and the subscribers in the Company’s records at the time of billing. Premium billings are generally sent to employers in the month preceding the month of coverage. Premium billings may be subsequently adjusted to reflect changes in membership as a result of retroactive terminations, additions or other changes. Payments received in advance of the period of coverage are recognized as deferred revenue. The Company also receives premium payments from CMS on a monthly basis for its Medicare membership. Membership and category eligibility are periodically reconciled with CMS and such reconciliations could result in adjustments to revenue. CMS uses a risk adjustment model to determine premium payments to health plans. This risk adjustment model apportions premiums paid to all health plans according to health severity based on diagnosis data provided to CMS. The Company estimates risk adjustment revenues based on the diagnosis data submitted to CMS. Changes in revenue from CMS resulting from the periodic changes in risk adjustments scores for the Company’s membership are recognized when the amounts become determinable and the collectibility is reasonably assured.

The Company also receives premium payments on a monthly basis from the state Medicaid programs with which the Company contracts for the Medicaid members for whom it provides health coverage. Membership and category eligibility are periodically reconciled with the state Medicaid programs and such reconciliations could result in adjustments to revenue. Premiums collected in advance are recorded as deferred revenue.

The Medicare Part D program gives beneficiaries access to prescription drug coverage. Coventry has been awarded contracts by CMS to offer various Medicare Part D plans on a nationwide basis, in accordance with guidelines put forth by the agency. Payments from CMS under these contracts include amounts for premiums, amounts for risk corridor adjustments, and amounts for reinsurance and low-income cost subsidies.

The Company recognizes premium revenue for the Medicare Part D program ratably over the contract period for providing insurance coverage. Regarding the CMS risk corridor provision, an estimated risk sharing receivable or payable is recognized based on activity-to-date. Activity for CMS risk sharing is accumulated at the contract and plan benefit package level and recorded within the consolidated balance sheet in other receivables or other accrued liabilities depending on the net contract balance at the end of the reporting period with corresponding adjustments to premium revenue. Costs for covered prescription drugs are expensed as incurred.

Subsidy amounts received for reinsurance and for cost sharing related to low-income individuals are recorded in medical liabilities and will offset medical costs when paid. The Company does not recognize premium revenue or claims expense for these subsidies as the Company does not incur any risk with this part of the program. The majority of these receivables and payables are related to low-income subsidy and reinsurance amounts either owed by or owed to CMS. A reconciliation of the final risk sharing, low-income subsidy and reinsurance subsidy amounts is performed following the end of each contract year.

The table below summarizes the CMS receivables and payables, for all contract years, at December 31, 2010 and 2009, respectively (in thousands).

	<u>December 31, 2010</u>	<u>December 31, 2009</u>
<b>Total Medicare Part D CMS Receivables, net</b>	<b>\$ 58,202</b>	<b>\$ 9,146</b>
<b>Total Medicare Part D CMS Payables, net</b>	<b>\$ (53,280)</b>	<b>\$ (62,519)</b>

The CMS risk sharing receivables are included in other receivables while the CMS risk sharing payables are included in accounts payable and other accrued liabilities. The reinsurance and low-income subsidy receivables are included in other receivables while the reinsurance and low-income subsidy payables are included in medical liabilities.

The Company has quota share arrangements on business with certain individual and employer groups with some of its Medicare distribution partners covering portions of the Company's Medicare Part D and, previously, Medicare PFFS products. The Medicare PFFS products were not renewed for the 2010 plan year and, accordingly, the quota share arrangements were discontinued with a two year run out provision. As a result of the quota share arrangements, for the years ended December 31, 2010, 2009, and 2008, the Company ceded premium revenue of \$49.8 million, \$416.5 million and \$574.1 million, respectively, and the associated medical costs to these partners. The ceded amounts are excluded from the Company's results of operations. The Company is not relieved of its primary obligation to the policyholder under this ceding arrangement.

Management services revenue is generally a fixed administrative fee, provided on a predetermined contractual basis or on a percentage-of-savings basis, for access to the Company's health care provider networks and health care management services, for which it does not assume underwriting risk. Percentage of savings revenue is determined using the difference between charges billed by contracted medical providers and the contracted reimbursement rates for the services billed and is recognized based on claims processed. The management services the Company provides typically include health care provider network access, clinical management, pharmacy benefit management, bill review, claims repricing, claims processing, utilization review and quality assurance.

The Company enters into performance guarantees with employer groups where it pledges to meet certain standards. These standards vary widely and could involve customer service, member satisfaction, claims processing, claims accuracy and telephone response time, among others. The Company also enters into financial guarantees which can take various forms including, among others, achieving an annual aggregate savings threshold, achieving a targeted level of savings per-member per-month, or achieving overall network penetration in defined demographic markets. For each guarantee, the Company estimates and records performance based revenue after considering the relevant contractual terms and the data available for the performance based revenue calculation. Pro-rata performance based revenue is recognized on an interim basis taking into account the ultimate rights and obligations of the parties upon termination of the contracts.

Revenue for pharmacy benefit management services for the Workers' Compensation business is derived on a pre-negotiated amount per pharmacy claim which includes the cost of the pharmaceutical. Revenue and a corresponding cost of sales to a third-party vendor related to the sale of pharmaceuticals is recorded when a pharmacy transaction is processed by the Company. No pharmacy rebate revenue is collected or recorded related to the Company's Workers' Compensation business.

Based on information received subsequent to premium billings being sent, historical trends, bad debt write-offs and the collectibility of specific accounts, the Company estimates, on a monthly basis, the amount of bad debt and future retroactivity and adjusts its revenue and reserves accordingly.

Premiums for services to federal employee groups are subject to audit and review by the OPM on a periodic basis. Such audits are usually a number of years in arrears. The Company estimates and records reserves for audit and other contract adjustments for both its managed care contracts and experience rated plans based on appropriate guidelines and historical results. Adjustments are recorded as additional information regarding the audits and reviews becomes available. Any differences between actual results and estimates are recorded in the period the audits are finalized.

**Cost of Sales** – Cost of sales consists of the expense for prescription drugs provided by the Company's Workers' Compensation pharmacy benefit manager and for the independent medical examinations performed by physicians on injured workers. These costs are associated with fee-based products and exclude the cost of drugs related to the risk products recorded in medical costs.

**Contract Acquisition Costs** – Costs related to the acquisition of customer contracts, such as commissions paid to outside brokers, are paid on a monthly basis and expensed as incurred. For the Medicare Advantage business, the Company advances commissions and defers amortization of these costs to the period in which revenue associated with the acquired customer is earned, which is generally not more than one year.

**Income Taxes** – The Company files a consolidated federal tax return for the Company and its subsidiaries. The Company accounts for income taxes in accordance with ASC Topic 740, "Income Taxes." The deferred tax assets and/or liabilities are determined by multiplying the differences between the financial reporting and tax reporting bases for assets and liabilities by the enacted tax rates expected to be in effect when such differences are recovered or settled. The effect on deferred taxes of a change in tax rates is recognized in income in the period that includes the enactment date. The realization of total deferred tax assets is contingent upon the generation of future taxable income in the tax jurisdictions in which the deferred tax assets are located. Taxable income includes the effect of the reversal of deferred tax liabilities. Valuation allowances are provided to reduce such deferred tax assets to amounts more-likely-than-not to be ultimately realized.

**Earnings Per Share** - Basic earnings per share are based on the weighted average number of common shares outstanding during the year. Diluted earnings per share assume the exercise of all options and the vesting of all restricted stock using the treasury stock method. Potential common stock equivalents to purchase 10.3 million, 12.2 million and 8.3 million shares for the years ended December 31, 2010, 2009 and 2008, respectively, were excluded from the computation of diluted earnings per share because the potential common stock equivalents were anti-dilutive.

**Other Income, net** - Other income, net includes interest income, net of fees, gains on the repayment of debt, realized gains and losses on sales of investments and charges on the other-than-temporary impairment of investment securities.

### **New Accounting Standards**

In January 2010, the FASB issued ASU 2010-06, "Improving Disclosures about Fair Value Measurements." ASU 2010-06 requires the disclosure of additional information about transfers in and out of Level 1 and Level 2 of the fair value hierarchy, requires the separate presentation (gross basis) of information about purchases, sales, issuances, and settlements of financial instruments in the roll forward of activity in fair value measurements using significant unobservable inputs (Level 3), and requires expanded disclosures regarding the determination of fair value measurements. The Company adopted the new disclosure provisions during the first quarter of 2010, except for the gross disclosures regarding purchases, sales, issuances and settlements in the roll forward of activity in Level 3 fair value measurements, which are required for the Company beginning with its filing on Form 10-Q for the quarter ended March 31, 2011. The adoption of ASU 2010-06 did not affect the Company's financial position or results of operations.

### **B. SEGMENT INFORMATION**

The Company has the following three reportable segments: Health Plan and Medical Services, Specialized Managed Care and Workers' Compensation. Each of these reportable segments, which the Company also refers to as "Divisions," is separately managed and provides separate operating results that are evaluated by the Company's chief operating decision maker.

The Health Plan and Medical Services Division is primarily comprised of the Company's traditional health plan commercial risk, Medicare Advantage and Medicaid businesses and products. Additionally, through this Division the Company contracts with various federal employee organizations to provide health insurance benefits under the Federal Employees Health Benefits Program ("FEHBP") and offers managed care and administrative products to businesses that self-insure the health care benefits of their employees. This Division also contains the dental services business. The Company did not renew its Medicare PFFS products effective for the 2010 plan year. Prior to the non-renewal, PFFS was part of this Division.

The Specialized Managed Care Division includes the Company's Medicare Part D, network rental and behavioral health benefits businesses. As discussed in Note D, Discontinued Operations, to the consolidated financial statements, prior to its sale on July 31, 2009 the Company's Medicaid/Public entity, First Health Services Corporation ("FHSC"), provided products and services to State Medicaid agencies and other government funded programs. FHSC operations are excluded from the Company's results of continuing operations.

The Workers' Compensation Division is comprised of the Company's workers' compensation services businesses which provide fee-based, managed care services such as provider network access, bill review, care management services and pharmacy benefit management to underwriters and administrators of workers' compensation insurance.

The table below summarizes the results from continuing operations of the Company's reportable segments through the gross margin level, as that is the measure of profitability used by the chief operating decision maker to assess segment performance and make decisions regarding the allocation of resources. A reconciliation of gross margin to operating earnings at a consolidated level for continuing operations is also provided. Total assets by reportable segment are not disclosed as these assets are not reviewed separately by the Company's chief operating decision maker. The dollar amounts in the segment tables are presented in thousands.

## Year Ended December 31, 2010

	<b>Health Plan and Medical Services</b>	<b>Specialized Managed Care</b>	<b>Workers' Comp.</b>	<b>Elim.</b>	<b>Continuing Operations Total</b>
Operating revenues					
Managed care premiums	\$ 8,788,028	\$ 1,704,328	\$ -	\$ (77,716)	\$ 10,414,640
Management services	327,084	101,017	755,055	(9,880)	1,173,276
Total operating revenues	9,115,112	1,805,345	755,055	(87,596)	11,587,916
Medical costs	6,934,902	1,408,761	-	(77,716)	8,265,947
Cost of sales	-	-	252,052	-	252,052
Gross margin	\$ 2,180,210	\$ 396,584	\$ 503,003	\$ (9,880)	\$ 3,069,917
Selling, general and administrative					1,961,947
Charge for provider class action					278,000
Depreciation and amortization					140,685
Operating earnings					\$ 689,285

## Year Ended December 31, 2009

	<b>Health Plan and Medical Services</b>	<b>Specialized Managed Care</b>	<b>Workers' Comp.</b>	<b>Elim.</b>	<b>Continuing Operations Total</b>
Operating revenues					
Managed care premiums	\$ 11,142,921	\$ 1,640,420	\$ -	\$ (65,942)	\$ 12,717,399
Management services	346,042	93,079	757,105	(10,099)	1,186,127
Total operating revenues	11,488,963	1,733,499	757,105	(76,041)	13,903,526
Medical costs	9,531,698	1,393,638	-	(65,942)	10,859,394
Cost of sales	-	-	240,828	-	240,828
Gross margin	\$ 1,957,265	\$ 339,861	\$ 516,277	\$ (10,099)	\$ 2,803,304
Selling, general and administrative					2,151,799
Depreciation and amortization					149,554
Operating earnings					\$ 501,951

## Year Ended December 31, 2008

	<b>Health Plan and Medical Services</b>	<b>Specialized Managed Care</b>	<b>Workers' Comp.</b>	<b>Elim.</b>	<b>Continuing Operations Total</b>
Operating revenues					
Managed care premiums	\$ 9,686,417	\$ 912,485	\$ -	\$ (35,739)	\$ 10,563,163
Management services	352,369	89,626	736,695	(7,626)	1,171,064
Total operating revenues	10,038,786	1,002,111	736,695	(43,365)	11,734,227
Medical costs	8,150,788	751,953	-	(34,162)	8,868,579
Cost of sales	-	-	195,600	-	195,600
Gross margin	\$ 1,887,998	\$ 250,158	\$ 541,095	\$ (9,203)	\$ 2,670,048
Selling, general and administrative					1,940,820
Depreciation and amortization					143,699
Operating earnings					\$ 585,529

## C. ACQUISITIONS

During the three years ended December 31, 2010, the Company completed four business combinations. These business combinations were accounted for using the acquisition method of accounting and therefore the operating results of each acquisition have been included in the Company's consolidated financial statements since the date of their acquisition. The purchase price for each business combination was allocated to the assets, including the identifiable intangible assets and liabilities based on estimated fair values. The excess of the purchase price over the net identifiable assets acquired was allocated to goodwill.

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The following table summarizes the business combinations for the year ended December 31, 2010. The allocation of the purchase price is preliminary and is based upon information that was available to management at the time the consolidated financial statements were prepared. The purchase price, inclusive of all retroactive balance sheet settlements to date and transaction cost adjustments, is presented below (in millions):

	<u>Effective Date</u>	<u>Market</u>	<u>Price</u>
Preferred Health Systems, Inc. ("PHS")	February 1, 2010	Multiple Markets	\$ 93.8
MHP, Inc. ("MHP")	October 1, 2010	Multiple Markets	\$ 102.8

On February 1, 2010, the Company completed its acquisition of PHS, a commercial health plan based in Wichita, Kansas serving approximately 100,000 commercial group risk members and 20,000 commercial self-funded members. The acquisition of PHS strengthens Coventry's presence in the Kansas market. As part of the acquisition, the Company recognized a liability for potential contingent earn-outs that are attributed to certain performance measures by PHS. At December 31, 2010, the liability was not significant.

On October 1, 2010, the Company completed its acquisition of MHP, a diversified health plan with approximately 90,000 commercial risk members, 60,000 commercial self-funded members and 30,000 Medicare Advantage Coordinated Care Plan members throughout Missouri and northwest Arkansas. The Company acquired MHP to expand its footprint in the Missouri market.

The PHS and MHP acquisitions are not material to the Company's consolidated financial statements, individually or in the aggregate. As a result of the PHS and MHP acquisitions the Company recorded \$21.9 million of goodwill as of December 31, 2010, none of which is expected to be deductible for tax purposes.

On February 13, 2008, the Company completed its acquisition of MHNet, a behavioral health company based in Austin, Texas. On May 14, 2008, the Company completed its acquisition of a majority ownership interest in Group Dental Service, Inc. ("GDS"), a dental company based in Rockville, Maryland. As a result of the MHNet and GDS acquisitions the Company has recorded \$110.6 million of goodwill as of December 31, 2010, none of which is expected to be deductible for tax purposes.

**D. DISCONTINUED OPERATIONS**

On July 31, 2009, the Company completed the sale of its fee-based Medicaid services subsidiary FHSC for \$117.5 million in cash, which included adjustments for changes in working capital. FHSC was a component of the Company's business operations within its Specialized Managed Care operating segment. In accordance with ASC 205-20 "Discontinued Operations," FHSC's operations and disposal costs are presented as (loss) income from discontinued operations, net of tax in the Company's consolidated statements of operations.

The following table presents select FHSC discontinued operations information (in thousands):

	<u>Years ended December 31,</u>	
	<u>2009</u>	<u>2008</u>
FHSC revenues	\$ 89,808	\$ 179,419
FHSC earnings before taxes	14,218	33,915
FHSC goodwill impairment, before taxes	(72,373)	-
Loss on disposal of FHSC, before taxes	(4,123)	-
(Loss) income from discontinued operations, including loss on disposal in 2009, before taxes	(62,278)	33,915
Provision for taxes on discontinued operations and disposal of FHSC	10,755	14,020
(Loss) income from discontinued operations, net of tax	<u>\$ (73,033)</u>	<u>\$ 19,895</u>

The Company considered the sale of FHSC a potential indicator of impairment and in accordance with ASC Topic 350, "Intangibles – Goodwill and Other," it was determined that the carrying value of the reporting unit was in excess of fair value. Accordingly, the Company performed an estimate of the probable impairment loss, determined that the goodwill allocated to the reporting unit was impaired, and recorded a gross impairment charge of \$72.4 million during the quarter ended June 30, 2009.

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The table below shows the carrying amounts of the major classes of assets and liabilities of FHSC as of December 31, 2008 that were included as part of the disposal group on the July 31, 2009 sale (in thousands):

<b><u>FHSC Assets</u></b>	
Accounts receivable, net	\$ 27,084
Prepaid expenses and other	2,180
Current assets	<u>29,264</u>
Property and equipment, net	4,192
Goodwill and other intangibles	161,930
Deferred tax asset	4,833
Other assets	102
Total Assets	<u>\$ 200,321</u>
<b><u>FHSC Liabilities</u></b>	
Accounts payable	\$ 6,625
Deferred revenue	3,337
Deferred tax liability	1,362
Total Liabilities	<u>\$ 11,324</u>

**E. GOODWILL AND OTHER INTANGIBLE ASSETS**

**Goodwill**

The changes in the carrying amount of goodwill for the years ended December 31, 2010 and 2009 were as follows (in thousands):

	<u>Total</u>
Balance, December 31, 2008	\$ 2,695,025
FHSC impairment charge	(72,373)
FHSC sale	(85,724)
Other adjustments	(7,644)
Balance, December 31, 2009	\$ 2,529,284
Acquisition of PHS	16,987
Acquisition of MHP	4,920
Other adjustments	(621)
Balance, December 31, 2010	<u>\$ 2,550,570</u>

The Company completed its 2010 annual impairment test of goodwill in accordance with ASC Topic 350 and determined that there were no impairments. In performing its impairment analysis the Company identified its reporting units in accordance with the provisions of ASC Topic 350 and ASC Topic 280, "Segment Reporting."

In accordance with ASC Topic 350, for the purpose of testing goodwill for impairment, acquired assets and assumed liabilities were assigned to a reporting unit as of the acquisition date if both of the following criteria were met: (1) the asset will be employed in or the liability relates to the operations of a reporting unit and (2) the asset or liability will be considered in determining the fair value of the reporting unit. Corporate assets or liabilities were also assigned to a reporting unit if both of these criteria were met.

In order to determine the fair value of its reporting units, the Company weighted the income approach and the market approach. Under the income approach, the Company assumed certain growth rates, capital expenditures, discount rates and terminal growth rates in its calculations. The key assumptions used to determine the fair value of the Company's reporting units included terminal values based upon long term growth rates and a discount rate based on the Company's weighted average cost of capital adjusted for the risks associated with the operations. The market approach estimates the Company's fair value by utilizing market multiples.

As an overall test of the reasonableness of the estimated fair values of the reporting units, the Company compared the aggregate fair values of its reporting units to its market capitalization. The comparison confirmed that the determined fair values were representative of market views when applying a reasonable control premium. The Company determined that its implied control premium was reasonable based on a review of such premiums identified in recent acquisitions for entities of similar size and/or in similar industries.

The Company will continue to monitor its market capitalization in relation to aggregate fair values of its reporting units to determine if events and circumstances warrant the performance of an interim impairment analysis.

**Other Intangible Assets**

The other intangible asset balances are as follows (in thousands):

	<b>Gross Carrying Amount</b>	<b>Accumulated Amortization</b>	<b>Net Carrying Amount</b>	<b>Amortization Period</b>
<b>As of December 31, 2010</b>				
Amortized other intangible assets				
Customer Lists	\$ 579,062	\$ 283,978	\$ 295,084	7-15 Years
HMO Licenses	12,600	7,717	4,883	20 Years
Provider Networks	63,200	17,605	45,595	15-20 Years
Trade Names	3,449	3,025	424	3-4 Years
<b>Total amortized other intangible assets</b>	<b>\$ 658,311</b>	<b>\$ 312,325</b>	<b>\$ 345,986</b>	
Unamortized other intangible assets				
Trade Name	\$ 85,900	\$ -	\$ 85,900	---
<b>Total unamortized other intangible assets</b>	<b>\$ 85,900</b>	<b>\$ -</b>	<b>\$ 85,900</b>	
<b>Total other intangible assets</b>	<b>\$ 744,211</b>	<b>\$ 312,325</b>	<b>\$ 431,886</b>	
<b>As of December 31, 2009</b>				
Amortized other intangible assets				
Customer Lists	\$ 555,962	\$ 224,789	\$ 331,173	7-15 Years
HMO Licenses	12,600	7,122	5,478	20 Years
Provider Networks	62,000	14,353	47,647	15-20 Years
Trade Names	3,449	1,954	1,495	3-4 Years
<b>Total amortized other intangible assets</b>	<b>\$ 634,011</b>	<b>\$ 248,218</b>	<b>\$ 385,793</b>	
Unamortized other intangible assets				
Trade Name	\$ 85,900	\$ -	\$ 85,900	---
<b>Total unamortized other intangible assets</b>	<b>\$ 85,900</b>	<b>\$ -</b>	<b>\$ 85,900</b>	
<b>Total other intangible assets</b>	<b>\$ 719,911</b>	<b>\$ 248,218</b>	<b>\$ 471,693</b>	

Other intangible asset amortization expense for the years ended December 31, 2010, 2009 and 2008 was \$64.1 million, \$71.0 million, and \$65.6 million, respectively.

In 2009, we recorded a \$5.5 million impairment charge to our customer list balances primarily as a result of lower than expected customer retention levels. The impairment charges, which are included in the line item depreciation and amortization in the Company's consolidated statements of operations, related to components of its Health Plan and Medical Services operating segment and its Specialized Managed Care operating segment, respectively. The fair values were based on present value calculations which are Level 3 in the fair value hierarchy.

The Company performed an impairment test of its unamortized other intangible asset (trade name) as of October 1, 2010, and determined that the asset was not impaired.

For the years ending December 31, 2011, 2012, 2013, 2014, and 2015, the Company's estimated intangible amortization expense is \$64.9 million, \$64.6 million, \$64.2 million, \$63.7 million and \$32.1 million, respectively. The weighted-average amortization period is approximately 10 years for other intangible assets.

**F. PROPERTY AND EQUIPMENT**

Property and equipment is comprised of the following (in thousands):

	<b>As of December 31,</b>		<b>Depreciation</b>
	<b>2010</b>	<b>2009</b>	<b>Period</b>
Land	\$ 24,779	\$ 24,779	---
Buildings and leasehold improvements	144,585	142,605	1-40 Years
Developed software	199,416	174,887	1-9 Years
Equipment	367,560	336,904	3-7 Years
Sub-total	<u>736,340</u>	<u>679,175</u>	
Less: accumulated depreciation	(474,058)	(407,244)	
Property and equipment, net	<u>\$ 262,282</u>	<u>\$ 271,931</u>	

Depreciation expense for the years ended December 31, 2010, 2009 and 2008 was \$76.6 million, \$80.8 million and \$84.6 million, respectively. Included in the depreciation expense for the years ended December 31, 2010, 2009 and 2008 was \$25.2 million, \$25.4 million and \$29.9 million, respectively, of amortization expense for developed software.

**G. INVESTMENTS AND FAIR VALUE MEASUREMENTS****Investments**

The Company considers all of its investments as available-for-sale securities. For debt securities, if the Company intends to either sell or determine that it will more-likely-than-not be required to sell a debt security before recovery of the entire amortized cost basis or maturity of the debt security, the Company recognizes the entire impairment in earnings. If the Company does not intend to sell the debt security and the Company determines that it will not more-likely-than-not be required to sell the debt security but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other cases, which are recognized in other comprehensive income. Realized gains and losses on the sale of investments are determined on a specific identification basis. Certain prior year investment balances have been reclassified in the tables below to conform to the 2010 presentation requirements.

The amortized cost, gross unrealized gain or loss and estimated fair value of short-term and long-term investments by security type were as follows at December 31, 2010 and 2009 (in thousands):

	<b>Amortized</b>	<b>Unrealized</b>	<b>Unrealized</b>	<b>Fair</b>
	<b>Cost</b>	<b>Gain</b>	<b>Loss</b>	<b>Value</b>
<b>As of December 31, 2010</b>				
State and municipal bonds	\$ 856,838	\$ 29,886	\$ (3,068)	\$ 883,656
U.S. Treasury securities	84,739	3,667	(7)	88,399
Government-sponsored enterprise securities <sup>(1)</sup>	332,421	7,477	(318)	339,580
Residential mortgage-backed securities <sup>(2)</sup>	308,250	10,421	(1,270)	317,401
Commercial mortgage-backed securities	22,025	952	-	22,977
Asset-backed securities <sup>(3)</sup>	29,143	1,192	-	30,335
Corporate debt and other securities	473,982	17,123	(588)	490,517
	<u>\$ 2,107,398</u>	<u>\$ 70,718</u>	<u>\$ (5,251)</u>	<u>\$ 2,172,865</u>
Equity method investments <sup>(4)</sup>				28,590
				<u>\$ 2,201,455</u>

	<b>Amortized Cost</b>	<b>Unrealized Gain</b>	<b>Unrealized Loss</b>	<b>Fair Value</b>
<b>As of December 31, 2009</b>				
State and municipal bonds	\$ 863,561	\$ 37,392	\$ (1,371)	\$ 899,582
U.S. Treasury securities	566,057	2,572	(32)	568,597
Government-sponsored enterprise securities <sup>(1)</sup>	231,645	4,225	(330)	235,540
Residential mortgage-backed securities <sup>(2)</sup>	229,665	10,581	(932)	239,314
Commercial mortgage-backed securities	26,891	344	(507)	26,728
Asset-backed securities <sup>(3)</sup>	48,434	4,441	(1,170)	51,705
Corporate debt and other securities	357,594	12,373	(1,091)	368,876
	<u>\$ 2,323,847</u>	<u>\$ 71,928</u>	<u>\$ (5,433)</u>	<u>\$ 2,390,342</u>
Equity method investments <sup>(4)</sup>				46,751
				<u>\$ 2,437,093</u>

(1) Includes FDIC-insured Temporary Liquidity Guarantee Program securities.

(2) Agency pass-through, with the timely payment of principal and interest guaranteed.

(3) Includes auto loans, credit card debt and rate reduction bonds.

(4) Includes investments in entities accounted for under the equity method of accounting and therefore are presented at their carrying value.

The Company adopted the provisions of ASC 320-10-65-1 related to its fixed maturity securities as of April 1, 2009. The portion of the Company's impairment charge recorded prior to 2009 that was not related to a belief that the entire amortized cost basis would not be recovered, credit deterioration of the specific security, or securities that the Company has made the decision to sell was insignificant. Accordingly, the Company did not record a cumulative effect transition adjustment upon adoption.

The Company acquired eight separate investments (tranches) in a limited liability company that invests in equipment leased to third parties, through its acquisition of First Health on January 28, 2005. The total investment as of December 31, 2010 was \$27.0 million and is accounted for using the equity method. The Company's proportionate share of the partnership's income is included in other income in the Company's statements of operations. The Company has between a 20% and 25% interest in the limited partners' share of each individual tranche of the partnership (approximately 10% of the total partnership). The Company determined that events and changes in circumstances have occurred indicating that the carrying value might not be fully recoverable. Accordingly, the investment was evaluated to determine fair value. As a result of this evaluation, the Company recorded an impairment charge of \$5.0 million and \$2.5 million for the year ended December 31, 2010 and 2009, respectively.

The amortized cost and estimated fair value of available for sale debt securities by contractual maturity were as follows at December 31, 2010 and 2009 (in thousands):

	<b>As of December 31, 2010</b>		<b>As of December 31, 2009</b>	
	<b>Amortized Cost</b>	<b>Fair Value</b>	<b>Amortized Cost</b>	<b>Fair Value</b>
Maturities:				
Within 1 year	\$ 174,639	\$ 176,400	\$ 612,960	\$ 616,177
1 to 5 years	889,990	922,696	753,697	780,908
5 to 10 years	499,632	519,296	440,552	459,092
Over 10 years	543,137	554,473	516,638	534,165
Total	<u>\$ 2,107,398</u>	<u>\$ 2,172,865</u>	<u>\$ 2,323,847</u>	<u>\$ 2,390,342</u>

Investments with long-term option adjusted maturities, such as residential and commercial mortgage-backed securities, are included in the "Over 10 years" category. Actual maturities may differ due to call or prepayment rights.

Gross investment gains of \$15.5 million and gross investment losses of \$4.5 million were realized on sales of investments for the year ended December 31, 2010. This compares to gross investment gains of \$14.0 million and gross investment losses of \$2.4 million realized on sales of investments for the year ended December 31, 2009, and gross investment gains of \$7.6 million and gross investment losses of \$37.0 million realized on sales and the other-than-temporary impairment of investments for the year ended December 31, 2008. The Company's other-than-temporary impairment charge and its realized gains and losses are recorded in other income, net in the Company's consolidated statements of operations.

The following table shows the Company's investments' gross unrealized losses and fair value at December 31, 2010 and December 31, 2009, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position (in thousands).

<b>At December 31, 2010</b>		<b>Less than 12 months</b>		<b>12 months or more</b>		<b>Total</b>	
<b>Description of Securities</b>	<b>Unrealized</b>		<b>Unrealized</b>		<b>Unrealized</b>		
	<b>Fair Value</b>	<b>Losses</b>	<b>Fair Value</b>	<b>Losses</b>	<b>Fair Value</b>	<b>Losses</b>	
State and municipal bonds	\$ 156,894	\$ (3,068)	\$ -	\$ -	\$ 156,894	\$ (3,068)	
U.S. Treasury securities	5,890	(7)	-	-	5,890	(7)	
Government sponsored enterprises	19,551	(318)	-	-	19,551	(318)	
Residential mortgage-backed securities	59,738	(1,269)	17	(1)	59,755	(1,270)	
Commercial mortgage-backed securities	-	-	-	-	-	-	
Asset-backed securities	-	-	-	-	-	-	
Corporate debt and other securities	34,405	(588)	-	-	34,405	(588)	
<b>Total</b>	<b>\$ 276,478</b>	<b>\$ (5,250)</b>	<b>\$ 17</b>	<b>\$ (1)</b>	<b>\$ 276,495</b>	<b>\$ (5,251)</b>	

<b>At December 31, 2009</b>		<b>Less than 12 months</b>		<b>12 months or more</b>		<b>Total</b>	
<b>Description of Securities</b>	<b>Unrealized</b>		<b>Unrealized</b>		<b>Unrealized</b>		
	<b>Fair Value</b>	<b>Losses</b>	<b>Fair Value</b>	<b>Losses</b>	<b>Fair Value</b>	<b>Losses</b>	
State and municipal bonds	\$ 49,963	\$ (833)	\$ 12,898	\$ (538)	\$ 62,861	\$ (1,371)	
U.S. Treasury securities	8,146	(32)	-	-	8,146	(32)	
Government sponsored enterprises	45,331	(330)	-	-	45,331	(330)	
Residential mortgage-backed securities	28,461	(645)	9,658	(287)	38,119	(932)	
Commercial mortgage-backed securities	2,505	(17)	5,580	(490)	8,085	(507)	
Asset-backed securities	-	-	2,255	(1,170)	2,255	(1,170)	
Corporate debt and other securities	119,594	(1,091)	-	-	119,594	(1,091)	
<b>Total</b>	<b>\$ 254,000</b>	<b>\$ (2,948)</b>	<b>\$ 30,391</b>	<b>\$ (2,485)</b>	<b>\$ 284,391</b>	<b>\$ (5,433)</b>	

The unrealized losses presented in this table do not meet the criteria for treatment as an other-than-temporary impairment. The unrealized losses are the result of interest rate movements. The Company has not decided to sell and it is not more-likely-than not that the Company will be required to sell before a recovery of the amortized cost basis of these securities.

The Company continues to review its investment portfolios under its impairment review policy. Given the current market conditions and the significant judgments involved, there is a continuing risk that declines in fair value may occur and that other-than-temporary impairments may be recorded in future periods.

**Fair Value Measurements**

ASC Topic 820, "Fair Value Measurements and Disclosures," defines fair value and requires a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value based on the quality and reliability of the inputs or assumptions used in fair value measurements.

The Company's Level 1 securities primarily consist of U.S. Treasury securities and cash. The Company determines the estimated fair value for its Level 1 securities using quoted (unadjusted) prices for identical assets or liabilities in active markets.

The Company's Level 2 securities primarily consist of government-sponsored enterprise securities, state and municipal bonds, mortgage-backed securities, asset-backed securities, corporate debt and money market funds. The Company determines the estimated fair value for its Level 2 securities using the following methods: quoted prices for similar assets/liabilities in active markets, quoted prices for identical or similar assets in non-active markets (few transactions, limited information, non-current prices and high variability over time), inputs other than quoted prices that are observable for the asset/liability (e.g. interest rates, yield curves volatilities and default rates, among others), and inputs that are derived principally from or corroborated by other observable market data.

The Company's Level 3 securities primarily consist of corporate financial holdings and mortgage-backed and asset-backed securities that were thinly traded due to market volatility and lack of liquidity. The Company determines the estimated fair value for its Level 3 securities using unobservable inputs that cannot be corroborated by observable market data including, but not limited to, broker quotes, default rates, benchmark yields, credit spreads and prepayment speeds.

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The following table presents the fair value hierarchy for the Company's financial assets measured at fair value on a recurring basis at December 31, 2010 and 2009 (in thousands):

	Total	Quoted Prices in	Significant Other	Significant
		Active Markets for Identical Assets	Observable Inputs	Unobservable Inputs
<u>At December 31, 2010</u>		Level 1	Level 2	Level 3
Cash and cash equivalents	\$ 1,853,988	\$ 326,258	\$ 1,527,730	\$ -
State and municipal bonds	883,656	-	883,656	-
U.S. Treasury securities	88,399	88,399	-	-
Government-sponsored enterprise securities	339,580	-	339,580	-
Residential mortgage-backed securities	317,401	-	317,181	220
Commercial mortgage-backed securities	22,977	-	22,977	-
Asset-backed securities	30,335	-	30,208	127
Corporate debt and other securities	490,517	-	489,787	730
Total	<u>\$ 4,026,853</u>	<u>\$ 414,657</u>	<u>\$ 3,611,119</u>	<u>\$ 1,077</u>

	Total	Quoted Prices in	Significant Other	Significant
		Active Markets for Identical Assets	Observable Inputs	Unobservable Inputs
<u>At December 31, 2009</u>		Level 1	Level 2	Level 3
Cash and cash equivalents	\$ 1,418,554	\$ 398,073	\$ 1,020,481	\$ -
State and municipal bonds	899,582	-	899,582	-
U.S. Treasury securities	568,597	568,597	-	-
Government-sponsored enterprise securities	235,540	-	235,540	-
Residential mortgage-backed securities	239,314	-	236,214	3,100
Commercial mortgage-backed securities	26,728	-	26,728	-
Asset-backed securities	51,705	-	47,267	4,438
Corporate debt and other securities	368,876	-	360,250	8,626
Total	<u>\$ 3,808,896</u>	<u>\$ 966,670</u>	<u>\$ 2,826,062</u>	<u>\$ 16,164</u>

During the year ended December 31, 2010, there were no transfers between Level 1 and Level 2. The following table provides a summary of changes in the fair value of the Company's Level 3 financial assets for the years ended December 31, 2010 and 2009 (in thousands):

Year Ended December 31, 2010

	Total Level 3	Municipal bonds	Mortgage-backed securities	Asset-backed securities	Corporate and other
Beginning Balance, January 1	\$ 16,164	\$ -	\$ 3,100	\$ 4,438	\$ 8,626
Transfers to (from) Level 3 <sup>(1)</sup>	(513)	-	(470)	470	(513)
Total gains or losses (realized / unrealized)					
Included in earnings	7,944	-	730	3,168	4,046
Included in other comprehensive income	(7,241)	-	(664)	(2,944)	(3,633)
Purchases, issuances and settlements	(15,277)	-	(2,476)	(5,005)	(7,796)
Ending Balance, December 31, 2010	<u>\$ 1,077</u>	<u>\$ -</u>	<u>\$ 220</u>	<u>\$ 127</u>	<u>\$ 730</u>

<sup>(1)</sup> During 2010, one investment previously classified as Level 3 was reclassified to Level 2 because observable market data became available to price this security.

**Year Ended December 31, 2009**

	<b>Total Level 3</b>	<b>Municipal bonds</b>	<b>Mortgage-backed securities</b>	<b>Asset-backed securities</b>	<b>Corporate and other</b>
Beginning Balance, January 1	\$ 23,155	\$ 7,980	\$ -	\$ 2,250	\$ 12,925
Transfers to (from) Level 3	-	-	-	-	-
Total gains or losses (realized / unrealized)					
Included in earnings	13,245	2,683	3,255	1,614	5,693
Included in other comprehensive income	7,866	-	1,355	2,534	3,977
Purchases, issuances and settlements	(28,102)	(10,663)	(1,510)	(1,960)	(13,969)
Ending Balance, December 31, 2009	<u>\$ 16,164</u>	<u>\$ -</u>	<u>\$ 3,100</u>	<u>\$ 4,438</u>	<u>\$ 8,626</u>

**H. STOCK-BASED COMPENSATION**

The Company has one stock incentive plan, the Amended and Restated 2004 Stock Incentive Plan (the “Stock Incentive Plan”) under which shares of the Company’s common stock are authorized for issuance to key employees, consultants and directors in the form of stock options, restricted stock and other stock-based awards. Shares available for issuance under the Stock Incentive Plan were 5.7 million as of December 31, 2010.

**Stock Options**

Under the Stock Incentive Plan, the terms and conditions of option grants are established on an individual basis with the exercise price of the options being equal to not less than 100% of the fair value of the underlying stock at the date of grant. Options generally become exercisable after one year in either 33% or 25% increments per year and expire ten years from the date of grant.

The Company continues to use the Black-Scholes-Merton option pricing model and amortizes compensation expense over the requisite service period of the grant. The methodology used in 2010 to derive the assumptions used in the valuation model is consistent with that used in prior years. The following average values and weighted-average assumptions were used for option grants.

	<b>2010</b>	<b>2009</b>	<b>2008</b>
Black-Scholes-Merton Value	\$ 7.45	\$ 7.11	\$ 13.16
Dividend yield	0.0%	0.0%	0.0%
Risk-free interest rate	1.4%	1.7%	2.9%
Expected volatility	47.4%	60.8%	32.3%
Expected life (in years)	3.5	3.8	4.2

The Company has not paid dividends in the past nor does it expect to pay dividends in the future. As such, the Company used a dividend yield percentage of zero. The Company uses a risk-free interest rate consistent with the yield available on a U.S. Treasury note with a term equal to the expected term of the underlying grants. The expected volatility was estimated based upon a blend of the implied volatility of the Company’s tradeable options and the historical volatility of the Company’s share price. The expected life was estimated based upon exercise experience of option grants made in the past to Company employees.

The Company recorded compensation expense related to stock options of approximately \$21.0 million, \$30.6 million and \$35.3 million, for the years ended December 31, 2010, 2009 and 2008, respectively. Cash received from stock option exercises was \$15.5 million, \$1.2 million and \$7.2 million, for the years ended December 31, 2010, 2009 and 2008, respectively.

The total intrinsic value of options exercised was \$11.3 million, \$1.5 million, and \$10.4 million for the years ended December 31, 2010, 2009 and 2008, respectively. The tax benefit realized from stock option exercises was \$4.1 million, \$0.5 million and \$3.7 million, for the years ended December 31, 2010, 2009 and 2008, respectively. As of December 31, 2010, there was \$21.4 million of total unrecognized compensation cost (net of expected forfeitures) related to nonvested stock option grants which is expected to be recognized over a weighted average period of 1.8 years.

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The following table summarizes stock option activity for the year ended December 31, 2010:

	<u>Shares</u> <u>(in thousands)</u>	<u>Weighted-Average</u> <u>Exercise Price</u>	<u>Aggregate</u> <u>Intrinsic Value</u> <u>(in thousands)</u>	<u>Weighted Average</u> <u>Remaining</u> <u>Contractual Life</u>
Outstanding at January 1, 2010	13,033	\$ 35.67		
Granted	1,721	\$ 20.95		
Exercised	(1,050)	\$ 14.75		
Cancelled and expired	<u>(1,444)</u>	\$ 40.03		
Outstanding at December 31, 2010	<u>12,260</u>	\$ 34.88	\$ 36,814	5.16
Exercisable at December 31, 2010	<u>8,611</u>	\$ 39.18	\$ 14,466	3.71

**Restricted Stock Awards**

Under the Stock Incentive Plan, restricted stock awards generally vest in 25% increments per year. The fair value of restricted stock awards is based on the market price of our common stock on the date of grant and is amortized over various vesting periods through 2014. Restricted stock awards may also include a performance measure that must be met for the restricted stock award to vest.

The Company recorded compensation expense related to restricted stock grants, including restricted stock granted in prior periods, of approximately \$19.5 million, \$16.5 million and \$25.3 million for the years ended December 31, 2010, 2009 and 2008, respectively. The total unrecognized compensation cost (net of expected forfeitures) related to the restricted stock was \$29.6 million at December 31, 2010, and is expected to be recognized over a weighted average period of 1.9 years. The weighted-average fair value of restricted stock granted was \$21.45, \$16.43 and \$39.06 per share for the years ended December 31, 2010, 2009 and 2008, respectively. The total fair value of shares vested during the years ended December 31, 2010, 2009 and 2008 was \$14.4 million, \$8.5 million and \$17.3 million, respectively.

The following table summarizes restricted stock award activity for the year ended December 31, 2010:

	<u>Shares</u> <u>(in thousands)</u>	<u>Weighted-Average</u> <u>Grant-Date Fair</u> <u>Value Per Share</u>
Nonvested, January 1, 2010	2,226	\$ 24.43
Granted	885	\$ 21.45
Vested	(665)	\$ 27.78
Forfeited	<u>(273)</u>	\$ 25.81
Nonvested, December 31, 2010	<u>2,173</u>	\$ 22.01

**Performance Share Units**

During the twelve months ended December 31, 2010, the Company granted performance share units ("PSUs") to key employees pursuant to the Stock Incentive Plan. The PSUs represent hypothetical shares of the Company's common stock. The holders of PSUs have no rights as shareholders with respect to the shares of the Company's common stock to which the awards relate. The PSUs will vest based upon the achievement of certain performance goals and vest over various periods through 2011. All PSUs that vest will be paid out in cash based upon the price of the Company's common stock and therefore are classified as a liability by the Company. The related liability on the Company's books at December 31, 2010 was \$23.1 million, of which \$18.2 million was paid out in February 2011. The liability on the Company's books at December 31, 2009 was \$13.8 million. During the twelve months ended December 31, 2010 the Company paid \$10.9 million for PSUs that vested December 31, 2009. The Company recorded compensation expense related to the PSUs of approximately \$20.2 million and \$13.8 million for the years ended December 31, 2010 and 2009, respectively.

The following table summarizes PSU activity for the twelve months ended December 31, 2010 (in thousands):

	<u>Units</u>
Outstanding, January 1, 2010	368
Granted	923
Vested	(661)
Cancelled/Forfeited	(45)
Outstanding, December 31, 2010	<u>585</u>

**I. INCOME TAXES**

The provision (benefit) for income taxes consisted of the following (in thousands):

	<b>Years ended December 31,</b>		
	<b>2010</b>	<b>2009</b>	<b>2008</b>
Current provision:			
Federal	\$ 350,451	\$ 233,951	\$ 210,877
State	28,216	42,002	32,210
Deferred benefit:			
Federal	(117,600)	(60,864)	(36,050)
State	(13,149)	(25,869)	2,824
<b>Income tax expense</b>	<b>\$ 247,918</b>	<b>\$ 189,220</b>	<b>\$ 209,861</b>

The Company's effective tax rate differs from the federal statutory rate of 35% as a result of the following:

	<b>Years ended December 31,</b>		
	<b>2010</b>	<b>2009</b>	<b>2008</b>
Statutory federal tax rate	35.00%	35.00%	35.00%
Effect of:			
State income taxes, net of federal benefit	1.56%	1.72%	2.42%
Tax exempt investment income	(1.34%)	(1.71%)	(1.55%)
Remuneration disallowed	0.55%	0.35%	0.00%
Other	0.34%	2.14%	0.83%
<b>Effective tax rate</b>	<b>36.11%</b>	<b>37.50%</b>	<b>36.70%</b>

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The effect of temporary differences that give rise to significant portions of the deferred tax assets and deferred tax liabilities at December 31, 2010 and 2009 are presented below (in thousands):

	<b>December 31,</b>	
	<b>2010</b>	<b>2009</b>
<u>Deferred tax assets:</u>		
Net operating loss carryforward	\$ 59,002	\$ 28,359
Deferred compensation	77,892	66,464
Deferred revenue	7,578	8,392
Medical liabilities	101,302	79,781
Accounts receivable	2,280	9,011
Other accrued liabilities	208,514	96,393
Unrealized capital losses	2,512	2,670
Capital loss carryforward	-	1,787
Internally developed software	-	1,221
Other assets	17,469	18,079
Gross deferred tax assets	476,549	312,157
Less valuation allowance	(3,632)	(3,101)
Deferred tax asset	\$ 472,917	\$ 309,056
<u>Deferred tax liabilities:</u>		
Unrealized gain on securities	\$ (24,386)	\$ (25,085)
Other liabilities	(19,734)	(9,959)
Depreciation	(8,614)	(35,502)
Intangibles	(189,160)	(187,527)
Internally developed software	(24,007)	-
Tax liability of limited partnership investment	(26,523)	(41,804)
Gross deferred tax liabilities	(292,424)	(299,877)
Net deferred tax asset <sup>(1)</sup>	\$ 180,493	\$ 9,179

<sup>(1)</sup> Includes \$339.6 million and \$207.1 million classified as current assets at December 31, 2010 and 2009, respectively, and \$(159.1) million and \$(198.0) million classified as noncurrent assets (liabilities) at December 31, 2010 and 2009, respectively.

At December 31, 2010, the Company had approximately \$151 million of federal and \$257 million of state tax net operating loss carryforwards. The Federal net operating losses were primarily acquired through various acquisitions and are subject to limitation under Internal Revenue Code Section 382. The net operating loss carryforwards can be used to reduce future taxable income and expire over varying periods through the year 2030. A valuation allowance of approximately \$3.6 million and \$3.1 million has been recorded as of December 31, 2010 and 2009, respectively, for certain net operating loss deferred tax assets as the Company believes it is not more-likely-than-not that these deferred tax assets will be realized before expiration of those net operating losses.

A reconciliation of the total amounts of unrecognized tax benefits for the years ended December 31, 2010, 2009 and 2008 is as follows (in thousands):

	<b>2010</b>	<b>2009</b>	<b>2008</b>
Gross unrecognized tax benefits - beginning balance	\$ 129,084	\$ 51,841	\$ 83,482
Gross increases to tax positions taken in the current period	100,426	98,254	25,469
Gross increases to tax positions taken in prior periods	7,128	17,865	14,456
Gross decreases to tax positions taken in prior periods	(94,712)	(34,777)	(68,585)
Decreases relating to settlements with tax authorities	-	-	(874)
Decreases due to a lapse of statute of limitations	(5,671)	(4,099)	(2,107)
Gross unrecognized tax benefits - ending balance	\$ 136,255	\$ 129,084	\$ 51,841

The total amount of unrecognized tax benefits, as of December 31, 2010 and 2009 that, if recognized, would affect the effective tax rate was \$43.3 million and \$40.4 million, respectively. Further, the Company is unaware of any positions for which it is reasonably possible that the total amounts of unrecognized tax benefits will significantly increase or decrease within the next twelve months.

Penalties and tax-related interest expense are reported as a component of income tax expense. As of December 31, 2010 and 2009, the total amount of income tax-related accrued interest and penalties, net of related tax benefit, recognized in the statement of financial position was \$9.2 million and \$6.5 million, respectively.

For the years ended December 31, 2010, 2009 and 2008, the total amount of income tax-related accrued interest and penalties, net of related tax benefit, recognized in the statement of operations was \$4.0 million, \$2.8 million and \$2.4 million, respectively.

The Company is regularly audited by federal, state and local tax authorities, and from time to time these audits result in proposed assessments. Tax years 2007-2009 remain open to examination by these tax jurisdictions. The Company believes appropriate provisions for all outstanding issues have been made for all jurisdictions and all open years.

During the year ended December 31, 2010, the Company settled certain income tax examinations with various state and local tax authorities. Tax assessed as a result of these examinations was not material. During the year ended December 31, 2009, the Internal Revenue Service ("IRS") completed its examination of the income tax returns for the Company for the years ended December 31, 2005 and 2006. Tax assessed as a result of this examination was not material. First Health Group Corporation ("FHGC") is also subject to ongoing examinations by certain state tax authorities for pre-acquisition years. The Company believes that adequate accruals have been provided for all FHGC open tax years.

## **J. EMPLOYEE BENEFIT PLANS**

### **Employee Retirement Plans**

The Company sponsors one defined contribution retirement plan qualifying under the Internal Revenue Code Section 401(k): the Coventry Health Care, Inc. Retirement Savings Plan (the "Savings Plan"). All employees of Coventry Health Care, Inc. and employees of its subsidiaries can elect to participate in the Savings Plan. T. Rowe Price is the custodial trustee of all Savings Plan assets, participant loans and the Coventry Health Care, Inc. common stock in the Savings Plan.

Under the Savings Plan, participants may defer up to 75% of their eligible compensation, limited by the maximum compensation deferral amount permitted by applicable law. The Company makes matching contributions in the Company's common stock equal to 100% of the participant's contribution on the first 3% of the participant's eligible compensation and equal to 50% of the participant's contribution on the second 3% of the participant's eligible compensation. Participants vest immediately in all safe harbor matching contributions. The Savings Plan permits all participants, regardless of service, to sell the employer match portion of the Coventry common stock in their accounts, during certain times of the year, and transfer the proceeds to other Coventry 401(k) funds of their choosing. All costs of the Savings Plan are funded by the Company and participants as they are incurred.

As a result of corporate acquisitions and transactions, the Company has acquired entities that have sponsored other qualified plans. All qualified plans sponsored by the acquired subsidiaries of the Company have either terminated or merged with and into the Savings Plan. The cost of the Savings Plan, including the acquired plans, for 2010, 2009 and 2008 was approximately \$27.4 million, \$30.3 million and \$31.5 million, respectively.

### **401(k) Restoration and Deferred Compensation Plan**

The Company is the sponsor of a 401(k) Restoration and Deferred Compensation Plan ("RESTORE"). Under RESTORE, participants may defer up to 75% of their base salary and up to 100% of any bonus awarded. The Company makes matching contributions equal to 100% of the participant's contribution on the first 3% of the participant's compensation and 50% of the participant's contribution on the second 3% of the participant's compensation. Participants vest in the Company's matching contributions ratably over two years. All costs of RESTORE are funded by the Company as they are incurred.

The cost, principally employer matching contributions, of RESTORE charged to operations for 2010, 2009 and 2008 was \$0.4 million, \$0.9 million and \$0.2 million, respectively.

### **Executive Retention Plans**

The Company was the sponsor of a deferred compensation plan that was designed to promote the retention of key senior management and to recognize their strategic importance to the Company. The fixed dollar and stock equivalent allocations charged to operations for this plan was \$1.6 million and \$1.1 million in 2009 and 2008, respectively. The liability for this plan was \$1.4 million at December 31, 2009 and, during 2010, this plan was settled and paid out.

**Stock Incentive Plan**

For information regarding the Company’s stock-based compensation, please refer to Note H, Stock-Based Compensation, to the consolidated financial statements.

**K. DEBT**

The Company’s outstanding debt was as follows at December 31, 2010 and 2009 (in thousands):

	December 31, 2010	December 31, 2009
5.875% Senior notes due 1/15/12, net of repurchases	\$ 233,903	\$ 233,903
6.125% Senior notes due 1/15/15, net of repurchases	228,845	228,845
5.95% Senior notes due 3/15/17, net of repurchases and unamortized discount of \$880 at December 31, 2010	382,355	382,213
6.30% Senior notes due 8/15/14, net of unamortized discount of \$834 at December 31, 2010	374,264	374,037
Revolving Credit Facility due 7/11/12, 0.81% weighted average interest rate for the period ended December 31, 2010	380,029	380,029
<b>Total Debt</b>	<b>\$ 1,599,396</b>	<b>\$ 1,599,027</b>

During 2010, the Company made no principal repayments on its outstanding senior notes or revolving credit facility.

During 2009, the Company repaid a total of \$68.9 million principal of outstanding senior notes for payments of \$59.9 million, resulting in a gain of \$8.4 million. These gains were net of the write off of deferred financing costs. The funds for the repayments were provided by cash from operations.

During 2009, the Company repaid \$235 million on its revolving credit facility. The remaining outstanding balance of \$380 million will be used to optimize the Company’s liquidity position and for other general corporate purposes.

During 2008, the Company repaid a principal total of \$10 million of its outstanding 5.95% Senior Notes due March 15, 2017.

During 2008, the Company drew down \$543.5 million from its Revolving Credit Facility and repaid \$103.5 million of this amount. The remaining outstanding balance of \$615.0 million was used to optimize the Company’s liquidity position during the current uncertain macroeconomic environment and for general corporate purposes. Also, from time to time throughout 2008 the Company drew down amounts as needed and repaid certain amounts on its Revolving Credit Facility for general corporate purposes.

The Company’s senior notes and credit facility contain certain covenants and restrictions regarding, among other things, additional debt, dividends or other restricted payments, transactions with affiliates, asset dispositions and consolidations or mergers. Additionally, the Company’s credit facility requires compliance with a leverage ratio of 3 to 1. The Company’s credit facility and certain of its senior notes also include, as an event of default, the entry of a judgment against the Company or a subsidiary in excess of a specified amount (\$50 million in the case of the credit agreement and \$20 million in the case of the applicable senior notes) if enforcement proceedings are commenced or if enforcement is not stayed for a period of 30 consecutive days. As described in Note L, Commitments and Contingencies, to the consolidated financial statements, the Company had filed an appeal with the State of Louisiana intermediate appellate court of the partial summary judgment against FHGC which was denied. FHGC has filed an application for a writ of appeal with the Louisiana Supreme Court with respect to the class decertification order and the partial summary judgment order. The decision to grant or deny the application for a writ of appeal is at the discretion of the Louisiana Supreme Court. The Louisiana Supreme Court has not yet issued a decision on either of these applications. On December 6, 2010, the Company entered into a Memorandum of Understanding setting forth settlement terms of a partial summary judgment. On February 2, 2011, FHGC, counsel for the class representatives and the class representatives executed a definitive settlement agreement which was acceptable to FHGC. As set forth in the settlement agreement, certain contingencies must be satisfied before the settlement becomes final. For additional information regarding this contingency, see Note L, Commitments and Contingencies, to the consolidated financial statements. As of December 31, 2010, the Company was in compliance with the applicable covenants and restrictions under its senior notes and credit facility.

Loans under the credit facilities bear interest at a margin or spread in excess of either (1) the one-, two-, three-, six-, nine-, or twelve- month rate for Eurodollar deposits (the “Eurodollar Rate”) or (2) the greater of the federal funds rate plus 0.5% or the base rate of the Administrative Agent (“Base Rate”), as selected by the Company. The margin or spread depends on the Company’s non-credit-enhanced long-term senior unsecured debt ratings and varies from 0.350% to 1.000% for Eurodollar Rate advances and from 0.000% to 0.500% for Base Rate advances.

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As of December 31, 2010, the aggregate maturities of debt based on their contractual terms, gross of unamortized discount, are as follows (in thousands):

<u>Year</u>	<u>Amount</u>
2011	\$ -
2012	613,932
2013	-
2014	375,098
2015	228,845
Thereafter	383,235
Total	<u>\$ 1,601,110</u>

**L. COMMITMENTS AND CONTINGENCIES**

As of December 31, 2010, the Company is contractually obligated to make the following minimum lease payments, including arrangements that may be noncancelable and may include escalation clauses, within the next five years and thereafter (in thousands):

	<u>Lease Payments</u>	<u>Sublease Income</u>	<u>Net Lease Payments</u>
2011	\$ 34,116	\$ (1,751)	\$ 32,365
2012	27,742	(1,497)	26,245
2013	19,333	(777)	18,556
2014	12,816	(426)	12,390
2015	9,513	(439)	9,074
Thereafter	21,964	(528)	21,436
Total	<u>\$ 125,484</u>	<u>\$ (5,418)</u>	<u>\$ 120,066</u>

The Company operates in leased facilities with original lease terms of up to thirteen years with options for renewal. Total rent expense was \$32.4 million, \$35.6 million and \$40.8 million, for the years ended December 31, 2010, 2009 and 2008, respectively.

**Legal Proceedings**

In the normal course of business, the Company has been named as a defendant in various legal actions such as actions seeking payments for claims denied by the Company, medical malpractice actions, employment related claims and other various claims seeking monetary damages. The claims are in various stages of proceedings and some may ultimately be brought to trial. Incidents occurring through December 31, 2010 may result in the assertion of additional claims. The Company maintains general liability, professional liability and employment practices liability insurances in amounts that it believes are appropriate, with varying deductibles for which it maintains reserves. The professional errors and omissions liability and employment practices liability insurances are carried through its captive subsidiary. Although the results of pending litigation are always uncertain, the Company does not believe the results of such actions currently threatened or pending, including those described below, will individually or in the aggregate, have a material adverse effect on its consolidated financial position or results of operations.

The Company has received a subpoena from the U.S. Attorney for the District of Maryland, Northern Division, requesting information regarding the operational process for confirming Medicare eligibility for its Workers' Compensation set-aside product. The Company is fully cooperating and is providing the requested information. The Company cannot predict what, if any, actions may be taken by the U.S. Attorney. However, based on the information known to date, the Company does not believe that the outcome of this investigation will have a material adverse effect on its financial position or results of operations.

FHGC, a subsidiary of the Company, is a party to various lawsuits filed in the state and federal courts of Louisiana involving disputes between providers and workers' compensation payors who access FHGC's contracts with these providers to reimburse them for services rendered to injured workers. FHGC has written contracts with providers in Louisiana which expressly state that the provider agrees to accept a specified discount off their billed charges for services rendered to injured workers. The discounted rate set forth in the FHGC provider contract is less than the reimbursement amount set forth in the Louisiana Workers' Compensation Fee Schedule. For this reason, workers' compensation insurers and third-party administrators ("TPAs") for employers who self insure workers' compensation benefits, contract with FHGC to access the FHGC provider contracts. Thus, when a FHGC contracted provider renders services to an injured worker, the workers' compensation insurer or the TPA reimburses the provider for those services in accordance with the discounted rate in the provider's contract with FHGC. These workers' compensation insurers and TPAs are referred to as "payors" in the FHGC provider contract and the contract expressly states that the discounted rate will apply to those payors who access the FHGC contract. Thus, the providers enter into these contracts with FHGC knowing that they will be paid the discounted rate by every payor who chooses to access the FHGC contract. So that its contracted providers know which payors are accessing their contract, FHGC sends regular written notices to its contracted providers and maintains a provider website which lists each and every payor who is accessing the FHGC contract.

Four providers who have contracts with FHGC filed a state court class action lawsuit against FHGC and certain payors alleging that FHGC violated Louisiana's Any Willing Provider Act (the "Act"), which requires a payor accessing a preferred provider network contract to give a one time notice 30 days before that payor uses the discounted rate in the preferred provider network contract to pay the provider for services rendered to a member insured under that payor's health benefit plan. These provider plaintiffs allege that the Act applies to medical bills for treatment rendered to injured workers and that the Act requires point of service written notice in the form of a benefit identification card. If a payor is found to have violated the Act's notice provision, the court may assess up to \$2,000 in damages for each instance when the provider was not given proper notice that a discounted rate would be used to pay for the services rendered. In response to the state court class action, FHGC and certain payors filed a suit in federal court against the same four provider plaintiffs in the state court class action seeking a declaratory judgment that FHGC's contracts are valid and enforceable, that its contracts are not subject to the Act since that Act does not apply to medical services rendered to injured workers and that FHGC is exempt from the notice requirements of the Act because it has contracted directly with each provider in its network. The federal district court ruled in favor of FHGC and declared that its contracts are not subject to the Act, that FHGC was exempt from the Act's notice provision because it contracted directly with the providers, and that FHGC's contracts were valid and enforceable, i.e., the four provider plaintiffs were required to accept the discounted rate in accordance with the terms of their written contracts with FHGC.

Despite the federal court's decision, the provider plaintiffs continued to pursue their state court class action against FHGC and filed a motion for partial summary judgment seeking damages of \$2,000 for each provider visit where the provider was not given a benefit identification card at the time the service was performed. In response to the motion for partial summary judgment filed in the state court action, FHGC obtained an order from the federal court which enjoined, barred and prevented any of the four provider plaintiffs or their counsel from pursuing any claim against FHGC before any court or tribunal arising under the Act. Despite the issuance of this federal court injunction, the provider plaintiffs and their counsel pursued their motion for partial summary judgment in the state court action. Before the state court held a hearing on the motion for partial summary judgment, FHGC moved to decertify the class on the basis that the four named provider plaintiffs had been enjoined by the federal court from pursuing their claims against FHGC. The state court denied the motion to decertify the class but did enter an order permitting FHGC to file an immediate appeal of the state court's denial of the motion. Even though FHGC had filed its appeal and there were no class representatives since all four named plaintiffs had been enjoined from pursuing their claims against FHGC, the state court held a hearing and granted the plaintiffs' motion for partial summary judgment. The amount of the partial summary judgment was \$262 million. FHGC appealed both the partial summary judgment order and the denial of class decertification order to the state's intermediate appellate court. Both appeals were denied by the intermediate appellate court. FHGC has filed an application for a writ of appeal with the Louisiana Supreme Court with respect to the class decertification order and the partial summary judgment order. The decision to grant or deny the application for a writ of appeal is at the discretion of the Louisiana Supreme Court. The Louisiana Supreme Court has not yet issued a decision on either of these applications. FHGC also filed a motion with the federal court to enforce the federal court's prior judgments and for sanctions against the provider plaintiffs for violating those judgments which barred and enjoined them from pursuing their claims against FHGC in the state courts. That motion also sought to enjoin the state courts from proceeding in order to protect and effectuate the federal court's judgments. FHGC's motion was denied by the federal court.

As a result of the Louisiana appellate court's decision on July 1, 2010 to affirm the state trial court's summary judgment order, the Company recorded a \$278 million pre-tax charge to earnings and a corresponding accrued liability during the quarter ended June 30, 2010. This amount represents the \$262 million judgment amount plus post judgment interest and is included in "accounts payable and other accrued liabilities" in the accompanying balance sheets. The Company has accrued for legal fees expected to be incurred related to this case as well as post judgment interest subsequent to the second quarter charge, which are included in "accounts payable and other accrued liabilities" in the accompanying balance sheets.

On December 6, 2010, FHGC entered into a Memorandum of Understanding with attorneys representing the four plaintiffs and the class setting forth the settlement terms of the \$262 million partial summary judgment entered in the class action lawsuit. The Memorandum of Understanding provides that subject to the execution of a settlement agreement acceptable to FHGC and final non-appealable approval of such settlement by the Louisiana state court, FHGC will pay \$150.5 million to satisfy in full the amount of the partial summary judgment and to resolve and settle all claims of the class, including claims for pre and post judgment interest, attorneys fees and costs. In addition, Coventry will assign to the class certain rights it has to the proceeds of FHGC's insurance policies relating to the claims asserted by the class. Pursuant to the Memorandum of Understanding, the parties have also agreed to request that the appropriate courts stay all related proceedings and consideration of any pending appellate writ applications, and to stay the effect of any outstanding judgments until the settlement agreement is prepared, executed and receives final court approval.

In exchange for the settlement payment by FHGC, class members will release FHGC and all of its affiliates and clients for any claims relating in any way to re-pricing, payment for, or reimbursement of a workers' compensation bill, including but not limited to claims under the Act. Plaintiffs have also agreed to a notice procedure that FHGC may follow in the future to comply with the Act. As noted, the Memorandum of Understanding is contingent upon the execution of a definitive settlement agreement acceptable to FHGC. Under Louisiana law, once the parties have executed such a settlement agreement, they must apply to the court for approval of the settlement following a court-supervised process of notice to the class and an opportunity for the class to be heard about the fairness of the settlement or exclude themselves from the settlement.

On February 2, 2011, FHGC, counsel for the class representatives and the class representatives executed a definitive settlement agreement which was acceptable to FHGC. The settlement agreement contains the same terms and conditions as was set forth in the Memorandum of Understanding. As noted above and as set forth in the settlement agreement, certain contingencies (preliminary court approval; resolutions of objections filed by class members challenging the fairness of the settlement; class members excluded from the settlement not exceeding a materiality threshold; and, final court approval) must be satisfied before the settlement becomes final. Given these various contingencies which must be satisfied before the settlement becomes final, no changes have been made to the previously recorded amounts.

In a related matter, FHGC has filed another lawsuit in Louisiana federal district court against 85 Louisiana providers seeking a declaratory judgment that its contracts are valid and enforceable, that its contracts are not subject to the Louisiana's Any Willing Provider Act because its contracts pertain to payment for services rendered to injured workers, and FHGC is exempt from the notice provision of the Any Willing Provider Act because it has contracted directly with the providers. As a result of the Memorandum of Understanding and the settlement agreement executed in connection with the provider class action lawsuit in Louisiana referenced above, this lawsuit will be stayed and dismissed if the settlement agreement of the class action lawsuit becomes final.

On September 3, 2009, a shareholder, who owned less than 5,000 shares, filed a putative securities class action against the Company and three of its current and former officers in the federal district court of Maryland. Subsequent to the filing of the complaint, three other shareholders and/or investor groups filed motions with the court for appointment as lead plaintiff and approval of selection of lead and liaison counsel. By agreement, the four shareholders submitted a stipulation to the court regarding appointment of lead plaintiff and approval of selection of lead and liaison counsel. In December, 2009, the court approved the stipulation and ordered the lead plaintiff to file a consolidated and amended complaint. To date, no consolidated and amended complaint has been filed. The purported class period is February 9, 2007 to October 22, 2008. The complaint alleges that the Company's public statements contained false, misleading and incomplete information regarding the Company's profitability, particularly the profit margins for its Medicare PFFS products. The Company will vigorously defend against the allegations in the lawsuit and has filed a motion to dismiss the complaint which is pending before the court. Although it cannot predict the outcome, the Company believes this lawsuit will not have a material adverse effect on its financial position or results of operations.

On October 13, 2009, two former employees and participants in the Coventry Health Care Retirement Savings Plan filed a putative ERISA class action lawsuit against the Company and several of its current and former officers, directors and employees in the U.S. District Court for the District of Maryland. Plaintiffs allege that defendants breached their fiduciary duties under ERISA by offering and maintaining Company stock in the Plan after it allegedly became imprudent to do so and by allegedly failing to provide complete and accurate information about the Company's financial condition to plan participants in SEC filings and public statements. Three similar actions by different plaintiffs were later filed in the same court and were consolidated on December 9, 2009. A consolidated complaint has not yet been filed. The Company intends to vigorously defend against the allegations in the consolidated lawsuit and has filed a motion to dismiss the complaint which is pending before the court. Although it cannot predict the outcome, the Company believes this lawsuit will not have a material adverse effect on its financial position or results of operations.

There were several lawsuits filed against our Florida health plan by non-participating providers seeking to be paid their full billed charges for services rendered to Florida members. The Florida health plan reimburses non-participating providers at rates which are usual and customary for similar services in the same geographical area. The Company has settled these lawsuits for amounts that did not have a material adverse effect on its financial position or results of operations.

### **Capitation Arrangements**

The Company has capitation arrangements for certain ancillary health care services, such as laboratory services and, in some cases, physician and radiology services. A small percentage of the Company's membership is covered by global capitation arrangements. Under the typical arrangement, the provider receives a fixed percentage of premium to cover costs of all medical care or of the specified ancillary services provided to the capitated members. Under some capitated and professional capitation arrangements, physicians may also receive additional compensation from risk sharing and other incentive arrangements. Capitation arrangements limit the Company's exposure to the risk of increasing medical costs, but expose the Company to risk as to the adequacy of the financial and medical care resources of the provider organization. The Company is ultimately responsible for the coverage of its members pursuant to the customer agreements. To the extent that a provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangements, the Company will be required to perform such obligations. Consequently, the Company may have to incur costs in excess of the amounts it would otherwise have to pay under the original global or ancillary capitation through our contracted network arrangements. Medical costs associated with capitation arrangements made up approximately 6.4%, 2.9% and 4.1% of the Company's total medical costs for the years ended December 31, 2010, 2009 and 2008, respectively.

## **CMS Audits**

CMS periodically performs audits and may seek return of premium payments made to the company if risk adjustment factors are not properly supported by medical record data. We estimate and record reserves for CMS audits based on information available at the time the estimates are made. The judgments and uncertainties affecting the application of these policies include significant estimates related to the amount of HCC revenue subject to audit and anticipated error rates. Although the Company maintains reserves for its exposure to the risk adjustment data validation (“RADV”) audits, actual results could differ materially from those estimates. Accordingly, CMS audit results could have a material adverse effect on our financial position, results of operations, and cash flows.

## **M. CONCENTRATIONS OF CREDIT RISK**

The Company’s financial instruments that are exposed to credit risk consist primarily of cash equivalents, investments in fixed income securities and accounts receivable. The Company invests its excess cash in state and municipal bonds, U.S. Treasury and agency securities, mortgage-backed securities, asset-backed securities, corporate debt and other securities. Investments in marketable securities are managed within guidelines established by the Board of Directors, which only allow for the purchase of investment-grade fixed income securities and limits exposure to any one issuer. The fair value of the Company’s financial instruments is equivalent to their carrying value. There is some credit risk associated with these instruments.

The Company is a provider of health insurance coverage to the State of Illinois employees and their dependents. In August 2009, the State of Illinois notified the Company of the State’s significant budget deficit and subsequently the State has limited payments to the Company based on available cash.

As of December 31, 2010, the Company has an outstanding premium receivable balance from the State of Illinois of approximately \$50.1 million which represents four months of health insurance premiums. As the receivable is from a governmental entity which has been making payments, including accrued interest on late payments, we believe that the full receivable balance will ultimately be realized and therefore we have not reserved against the outstanding balance. The Company’s regulated subsidiaries are required to submit statutory-basis financial statements to state regulatory agencies. For those financial statements, in accordance with state regulations, this receivable is being treated as an admitted asset in its entirety.

Concentration of credit risk with respect to receivables is limited due to the large number of customers comprising the Company’s customer base and their breakdown among geographical locations. The Company believes the allowance for doubtful accounts adequately provides for estimated losses as of December 31, 2010. The Company has a risk of incurring losses if such allowances are not adequate.

The Company contracts with a pharmacy benefit management (“PBM”) vendor to manage our pharmacy benefits for our members and to provide rebate administration services on behalf of the Company. As of December 31, 2010, the Company had pharmacy rebate receivables of \$310.7 million due from the PBM vendor resulting from the normal cycle of rebate processing, data submission and collection of rebates. The Company has credit risk due to the concentration of receivables with this single vendor although the Company does not consider the associated credit risk to be significant. The Company only records the pharmacy rebate receivables to the extent that the amounts are deemed probable of collection.

## **N. STATUTORY INFORMATION**

The Company’s regulated HMO and insurance company subsidiaries are required by state regulatory agencies to maintain minimum surplus balances, thereby limiting the dividends the parent may receive from its regulated entities. During 2010, the Company received \$319.4 million in dividends from its regulated subsidiaries and paid \$11.5 million in capital contributions to these subsidiaries.

The National Association of Insurance Commissioners (“NAIC”) has proposed that states adopt risk-based capital (“RBC”) standards which are a method of measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. The managed care organization’s RBC is calculated by applying factors to various assets, premiums and reserve items. The factor is higher for those items with greater underlying risk and lower for less risky items. The adequacy of a managed care organization’s actual capital can then be measured by a comparison to its RBC as determined by the formula. The Company’s health plans are required to submit an RBC report to the NAIC and their domiciled state’s department of insurance with their annual filing.

Regulators will use the RBC results to determine if any regulatory actions are required. Regulatory actions that could take place, if any, range from filing a financial action plan explaining how the plan will increase its statutory net worth to the approved levels, to the health plan being placed under regulatory control.

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The majority of states in which the Company operates health plans have adopted a RBC policy that recommends the health plans maintain statutory reserves at or above the "Company Action Level," which is currently equal to 200% of their RBC. Some states in which the Company's regulated subsidiaries operate require deposits to be maintained with the respective states' departments of insurance. The table below summarizes the Company's statutory reserve information as of December 31, 2010 and 2009 (in millions, except percentage data).

	<u>2010</u>	<u>2009</u>
	<i>(unaudited)</i>	
Regulated capital and surplus	\$ 1,908.7	\$ 1,636.2
200% of RBC <sup>(1, 2)</sup>	\$ 633.8	\$ 812.2
Excess capital and surplus above 200% of RBC <sup>(1, 2)</sup>	\$ 1,274.9	\$ 824.0
Capital and surplus as percentage of RBC <sup>(1, 2)</sup>	602%	403%
Statutory deposits	\$ 79.9	\$ 75.3

(1) RBC amounts are not audited.

(2) The State of Florida does not have a RBC requirement for its regulated HMOs. Accordingly, the statutory reserve information provided for the Company's health plans domiciled in Florida is based on the actual statutory minimum capital required by the State of Florida.

The increase in capital and surplus for our regulated subsidiaries primarily resulted from net earnings, acquisition of PHS and MHP, and capital contributions made by the parent company, partially offset by dividends paid to the parent company.

The Company believes that all subsidiaries which incur medical claims maintain more than adequate liquidity and capital resources to meet these short-term obligations as a matter of both Company policy and applicable department of insurance regulations.

Excluding funds held by entities subject to regulation and excluding our equity method investments, the Company had cash and investments of approximately \$1.1 billion and \$713.0 million at December 31, 2010 and 2009, respectively. The increase resulted from earnings from non-regulated businesses, and dividends from the Company's regulated subsidiaries. These were partially offset by capital infusions into the Company's subsidiaries.

## **O. OTHER INCOME, NET**

Other income, net for the years ended December 31, 2010, 2009 and 2008 includes interest income, net of fees, of approximately \$70.8 million, \$65.5 million and \$104.6 million, respectively. Other income, net includes gains of \$8.4 million and \$4.6 million on the repayment of outstanding debt for the years ended December 31, 2009 and 2008, respectively. Other income, net included a gain on disposal of investments of \$11.0 million and \$11.6 million for the years ended December 31, 2010 and 2009, respectively. For the year ended December 31, 2008, other income, net included a charge of \$33.5 million for the other-than-temporary impairment of investment securities. As discussed in Note G, Investments and Fair Value Measurements, to the consolidated financial statements, the Company recorded an impairment charge, related to the Company's equity method investments, of \$5.0 million and \$2.5 million for the years ended December 31, 2010 and 2009, respectively.

## **P. SHARE REPURCHASE PROGRAM**

The Company's Board of Directors has approved a program to repurchase its outstanding common shares. Share repurchases may be made from time to time at prevailing prices on the open market, by block purchase, or in private transactions. As a part of this program, the Company made no purchases of common stock during 2010. The Company purchased 1.5 million shares of its common stock during 2009 at an aggregate cost of \$30.0 million and 7.3 million shares of its common stock during 2008 at an aggregate cost of \$318.0 million. As of December 31, 2010, the total remaining common shares the Company is authorized to repurchase under this program is 5.2 million. Excluded from these amounts are shares purchased in exchange for employee payroll taxes on vesting of restricted stock awards as these purchases are not part of the program.

**Q. QUARTERLY FINANCIAL DATA (UNAUDITED)**

The following is a summary of unaudited quarterly results of operations (in thousands, except per share data) for the years ended December 31, 2010 and 2009. Due to rounding of quarterly results, total amounts for each year may differ immaterially from the annual results.

	<b>Quarters Ended</b>			
	<b>March 31, 2010</b>	<b>June 30, 2010 <sup>(1)</sup></b>	<b>September 30, 2010</b>	<b>December 31, 2010</b>
Operating revenues	\$ 2,858,978	\$ 2,868,141	\$ 2,835,781	\$ 3,025,016
Operating earnings	155,066	5,230	291,943	237,046
Earnings before income taxes	155,223	3,242	292,222	235,846
Income from continuing operations	97,325	1,021	189,945	150,326
Income from discontinued operations, net of tax	-	-	-	-
Net earnings	97,325	1,021	189,945	150,326
Basic earnings per share from continuing operations	0.67	0.01	1.30	1.02
Basic earnings per share from discontinued operations	-	-	-	-
Total basic earnings per share	0.67	0.01	1.30	1.02
Diluted earnings per share from continuing operations	0.66	0.01	1.29	1.01
Diluted earnings per share from discontinued operations	-	-	-	-
Total diluted earnings per share	0.66	0.01	1.29	1.01

	<b>Quarters Ended</b>			
	<b>March 31, 2009</b>	<b>June 30, 2009</b>	<b>September 30, 2009</b>	<b>December 31, 2009</b>
Operating revenues	\$ 3,532,895	\$ 3,498,374	\$ 3,444,110	\$ 3,428,147
Operating earnings	63,325	102,459	152,762	183,406
Earnings before income taxes	61,061	112,579	150,077	180,838
Income from continuing operations	38,108	67,708	100,439	109,080
Income (loss) from discontinued operations, net of tax	6,060	(49,283)	(29,810)	-
Net earnings	44,168	18,425	70,629	109,080
Basic earnings per share from continuing operations	0.26	0.46	0.68	0.75
Basic earnings (loss) per share from discontinued operations	0.04	(0.33)	(0.20)	-
Total basic earnings per share	0.30	0.13	0.48	0.75
Diluted earnings per share from continuing operations	0.26	0.46	0.68	0.74
Diluted earnings (loss) per share from discontinued operations	0.04	(0.34)	(0.20)	-
Total diluted earnings per share	0.30	0.12	0.48	0.74

<sup>(1)</sup> As a result of the Louisiana appellate court's decision on July 1, 2010 to affirm the state trial court's summary judgment order, the company recorded a \$278 million pre-tax charge to earnings and a corresponding accrued liability during the quarter ended June 30, 2010. See Note L, Commitments and Contingencies, to the consolidated financial statements for additional information.

**R. RELATED PARTY TRANSACTION**

Allen F. Wise, Chief Executive Officer and Director of the Company, owns a majority interest in Health Risk Partners ("HRP"), an organization that has entered into a written contract with the Company to provide various services relating to the Company's Medicare line of business. The contract was negotiated and entered into on an arms-length basis. Two other Directors of the Company own minority interests in HRP. Specifically, HRP provides operational consulting, data processing, data reporting, and chart review/coding services, premium reconciliation, and hierarchical condition categories ("HCC") revenue compliance related to the Company's Medicare business. For the years ended December 31, 2010, 2009 and 2008, the Company incurred expenses of approximately \$15.4 million, \$12.2 million and \$1.1 million, respectively, to HRP for services rendered under the contract. At December 31, 2010 and 2009, the Company had accrued amounts to HRP of approximately \$1.8 million and \$4.6 million. These amounts are recognized within accounts payable and other accrued liabilities in the Company's consolidated balance sheets.

**Item 9: Changes in and Disagreements with Accountants on Accounting and Financial Disclosure**

None.

**Item 9A: Controls and Procedures**

**Management's Annual Report on Internal Control over Financial Reporting**

Coventry's management, including the principal executive officer and principal financial officer, is responsible for establishing and maintaining adequate internal control over financial reporting. Internal control over financial reporting (as defined in Rule 13a-15(f) under the U.S. Securities Exchange Act of 1934, as amended) is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles.

Internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the Company's assets; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that the Company's receipts and expenditures are being made only in accordance with authorizations of the Company's management and directors; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions or that the degree of compliance with the policies and procedures may deteriorate.

Coventry's management has performed an assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2010 based on criteria established by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"), Internal Controls – Integrated Framework, and believes that the COSO framework is a suitable framework for such an evaluation. Management has concluded that the Company's internal control over financial reporting was effective as of December 31, 2010.

The effectiveness of the Company's internal control over financial reporting as of December 31, 2010 has been audited by Ernst & Young LLP, the independent registered public accounting firm that audited the Company's consolidated financial statements for the year ended December 31, 2010, and their opinion is included in this Annual Report on Form 10-K.

**Disclosure Controls and Procedures**

We have performed an evaluation as of the end of the period covered by this report of the effectiveness of our "disclosure controls and procedures" (as defined in Rule 13a-15(e) promulgated under the Securities Exchange Act of 1934, as amended), under the supervision and with the participation of our Chief Executive Officer and our Chief Financial Officer. Based upon our evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective.

**Changes in Internal Control over Financial Reporting**

There have been no significant changes in our internal control over financial reporting during the quarter ended December 31, 2010 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting. Changes to certain processes, information technology systems and other components of internal control over financial reporting resulting from the acquisitions may occur and will be evaluated by management as such integration activities are implemented.

**Report of Independent Registered Public Accounting Firm**

**The Board of Directors and Stockholders of Coventry Health Care, Inc.**

We have audited Coventry Health Care, Inc.'s internal control over financial reporting as of December 31, 2010, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). Coventry Health Care, Inc.'s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Annual Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Coventry Health Care, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2010, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Coventry Health Care, Inc.'s consolidated balance sheets as of December 31, 2010 and 2009 and the related consolidated statements of operations, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2010 of Coventry Health Care, Inc., and our report dated February 25, 2011 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Baltimore, Maryland  
February 25, 2011

**Item 9B: Other Information**

None.

**PART III**

**Item 10: Directors, Executive Officers and Corporate Governance**

The information set forth under the captions “Election of Directors,” “Section 16(a) Beneficial Ownership Reporting Compliance,” and “Corporate Governance” in our definitive Proxy Statement for our 2011 Annual Meeting of Stockholders to be held on May 19, 2011, which we intend to file within 120 days after our fiscal year-end, is incorporated herein by reference. As provided in General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding executive officers of our Company is provided in Part I of this Annual Report on Form 10-K under the caption, “Executive Officers of our Company.”

**Item 11: Executive Compensation**

The information set forth under the caption “Executive Compensation” in our definitive Proxy Statement for our 2011 Annual Meeting of Stockholders to be held on May 19, 2011, which we intend to file within 120 days after our fiscal year-end, is incorporated herein by reference.

**Item 12: Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters**

The information set forth under the captions “Voting Stock Ownership of Principal Stockholders, Directors and Executive Officers” in our definitive Proxy Statement for our 2011 Annual Meeting of Stockholders to be held on May 19, 2011, which we intend to file within 120 days after our fiscal year-end, is incorporated herein by reference.

**Equity Compensation Plan Information**

The following table sets forth certain information, as of December 31, 2010, concerning shares of common stock authorized for issuance under all of our equity compensation plans.

	(a)	(b)	(c)
<b>Plan Category</b>	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-Average exercise price of outstanding options, warrants, and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
Equity compensation plans approved by stockholders	12,358,945 <sup>(1)</sup>	\$ 34.88 <sup>(2)</sup>	5,699,255
Equity compensation plans not approved by stockholders	-	-	-
<b>Total</b>	<b>12,358,945</b>	<b>-</b>	<b>5,699,255</b>

<sup>(1)</sup> Includes stock options and restricted stock units convertible into stock under the Company’s Amended and Restated 2004 Incentive Plan, which was approved by the stockholders on May 21, 2009. Also includes stock options under the Amended and Restated 1998 Stock Incentive Plan, which was approved by the stockholders on June 8, 2000. Restricted stock awards were issued on the date of grant and are not included.

<sup>(2)</sup> Includes only outstanding stock options and stock units granted under the Amended and Restated 2004 Incentive Plan and the Amended and Restated 1998 Stock Incentive Plan. Restricted stock awards were issued on the date of grant and are not included.

**Item 13: Certain Relationships and Related Transactions, and Director Independence**

The information set forth under the captions “Transactions With Related Persons, Promoters and Certain Control Persons” and “Corporate Governance” in our definitive Proxy Statement for our 2011 Annual Meeting of Stockholders to be held on May 19, 2011, which we intend to file within 120 days after our fiscal year-end, is incorporated herein by reference.

**Item 14: Principal Accountant Fees and Services**

The information set forth under the captions “Fees Paid to Independent Auditors” and “Procedures for Pre-approval of Independent Auditor Services” in our definitive Proxy Statement for our 2011 Annual Meeting of Stockholders to be held on May 19, 2011, which we intend to file within 120 days after our fiscal year-end, is incorporated herein by reference.

**PART IV**

**Item 15: Exhibits, Financial Statement Schedules**

**(a) 1. Financial Statements**

	<b>Form 10-K Pages</b>
Report of Independent Registered Public Accounting Firm	47
Consolidated Balance Sheets, December 31, 2010 and 2009	48
Consolidated Statements of Operations for the Years Ended December 31, 2010, 2009 and 2008	49
Consolidated Statements of Stockholders' Equity for the Years Ended December 31, 2010, 2009 and 2008	50
Consolidated Statements of Cash Flows for the Years Ended December 31, 2010, 2009 and 2008	51
Notes to Consolidated Financial Statements, December 31, 2010, 2009 and 2008	52 – 77

**2. Financial Statement Schedules**

Schedule I, Condensed Financial Information of Parent Company	83
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**CONDENSED FINANCIAL INFORMATION OF REGISTRANT  
(PARENT COMPANY ONLY)  
COVENTRY HEALTH CARE, INC.  
CONDENSED BALANCE SHEETS  
(in thousands)**

	<b>December 31, 2010</b>	<b>December 31, 2009</b>
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents	\$ 814,811	\$ 344,025
Short-term investments	61	195,071
Other receivables, net	4,510	6,597
Other current assets	27,429	35,556
Total current assets	<u>846,811</u>	<u>581,249</u>
Long-term investments	30,125	28,830
Property and equipment, net	2,766	4,226
Investment in subsidiaries	5,187,346	4,914,948
Other long-term assets	91,852	81,117
Total assets	<u>\$ 6,158,900</u>	<u>\$ 5,610,370</u>
<b>LIABILITIES AND STOCKHOLDERS' EQUITY</b>		
Current liabilities:		
Accounts payable and other accrued liabilities	\$ 273,868	\$ 200,547
Total current liabilities	<u>273,868</u>	<u>200,547</u>
Long-term debt, net	1,599,396	1,599,026
Notes payable to subsidiary	65,000	69,235
Other long-term liabilities	21,470	29,008
Total liabilities	<u>1,959,734</u>	<u>1,897,816</u>
Stockholders' equity:		
Common stock, \$.01 par value; 570,000 authorized	1,915	1,905
191,512 issued and 149,427 outstanding in 2010		
190,462 issued and 147,990 outstanding in 2009		
Treasury stock, at cost; 42,085 in 2010; 42,472 in 2009	(1,268,456)	(1,282,054)
Additional paid-in capital	1,784,826	1,750,113
Accumulated other comprehensive income	41,081	41,406
Retained earnings	3,639,800	3,201,184
Total stockholders' equity	<u>4,199,166</u>	<u>3,712,554</u>
Total liabilities and stockholders' equity	<u>\$ 6,158,900</u>	<u>\$ 5,610,370</u>

See accompanying notes to the condensed financial statements.

**CONDENSED FINANCIAL INFORMATION OF REGISTRANT  
(PARENT COMPANY ONLY)  
COVENTRY HEALTH CARE, INC.  
CONDENSED STATEMENTS OF OPERATIONS  
(in thousands)**

	<b>For the years ended December 31,</b>		
	<b>2010</b>	<b>2009</b>	<b>2008</b>
Revenues:			
Management fees charged to operating subsidiaries	\$ 208,453	\$ 252,962	\$ 192,359
Expenses:			
Selling, general and administrative	170,524	214,733	133,008
Depreciation and amortization	939	2,208	1,034
Interest expense	82,590	88,250	104,811
Total expenses	<u>254,053</u>	<u>305,191</u>	<u>238,853</u>
Investment and other income, net	<u>629</u>	<u>8,456</u>	<u>8,139</u>
Loss before income taxes and equity in net earnings of subsidiaries	(44,971)	(43,773)	(38,355)
Benefit for income taxes	<u>16,239</u>	<u>16,415</u>	<u>14,076</u>
Income (loss) before equity in net earnings of subsidiaries	(28,732)	(27,358)	(24,279)
Equity in net earnings of subsidiaries	<u>467,348</u>	<u>269,659</u>	<u>406,174</u>
Net earnings	<u>\$ 438,616</u>	<u>\$ 242,301</u>	<u>\$ 381,895</u>

See accompanying notes to the condensed financial statements.

**CONDENSED FINANCIAL INFORMATION OF REGISTRANT  
(PARENT COMPANY ONLY)  
COVENTRY HEALTH CARE, INC.  
CONDENSED STATEMENTS OF CASH FLOWS  
(in thousands)**

	<b>For the years ended December 31,</b>		
	<b>2010</b>	<b>2009</b>	<b>2008</b>
Net cash from operating activities	\$ (21,032)	\$ 114,403	\$ (28,165)
Cash flows from investing activities:			
Capital expenditures, net	518	275	(1,472)
Proceeds from the sales and maturities of investments	196,052	308,742	147,764
Purchases of investments and other	---	(259,955)	(238,578)
Capital contributions to subsidiaries	(142,271)	(293,750)	(225,199)
Dividends from subsidiaries	530,589	635,137	639,050
(Payments) / Proceeds for acquisitions, net	(102,356)	10,197	(137,374)
Net cash from investing activities	<u>482,532</u>	<u>400,646</u>	<u>184,191</u>
Cash flows from financing activities:			
Proceeds from issuance of stock	15,484	1,224	7,233
Payments for repurchase of stock	(4,888)	(32,796)	(323,137)
Repayment of debt	---	(294,930)	(423,872)
Repayment of note to subsidiaries	(4,235)	(28,728)	(12,307)
Proceeds from issuance of debt	---	---	668,409
Excess tax benefit from stock compensation	2,925	604	387
Net cash from financing activities	<u>9,286</u>	<u>(354,626)</u>	<u>(83,287)</u>
Net change in cash and cash equivalents	470,786	160,423	72,739
Cash and cash equivalents at beginning of period	344,025	183,602	110,863
Cash and cash equivalents at end of period	<u>\$ 814,811</u>	<u>\$ 344,025</u>	<u>\$ 183,602</u>

See accompanying notes to the condensed financial statements.

**COVENTRY HEALTH CARE, INC.**  
**SCHEDULE I – PARENT COMPANY ONLY FINANCIAL INFORMATION**  
**NOTES TO THE CONDENSED FINANCIAL STATEMENTS**

**A. BASIS OF PRESENTATION**

Coventry Health Care, Inc. (“Coventry” or the “Company”) parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note A, Organization and Summary of Significant Accounting Policies, to the Company’s consolidated financial statements. The accounts of all subsidiaries are excluded from the parent company financial information.

For information regarding the Company’s debt, commitments and contingencies and income taxes, refer to the respective notes to the Company’s consolidated financial statements.

**B. SUBSIDIARY TRANSACTIONS**

Through intercompany service agreements approved, if required, by state regulatory authorities, our parent company charges a management fee for reimbursement of certain centralized services provided to its subsidiaries.

The captions “Capital contributions to subsidiaries” and “Dividends from subsidiaries” on the condensed statements of cash flows include amounts from our regulated and non-regulated subsidiaries. During 2010, 2009 and 2008 we received \$319.4 million, \$121.0 million and \$332.1 million in dividends from our regulated subsidiaries, respectively, and infused \$11.5 million, \$293.8 million and \$225.2 million in capital contributions into our regulated subsidiaries, respectively.

**3. Exhibits Required To Be Filed By Item 601 of Regulation S-K**

<b>Exhibit No.</b>	<b>Description of Exhibit</b>
2.1	Membership Interest Purchase Agreement among Steven M. Scott, M.D., and Rebecca J. Scott, as tenants by the entirety, Rebecca J. Scott FHPA Trust, Florida Health Plan Administrators, LLC and Coventry Health Care, Inc., dated as of July 6, 2007 (Incorporated by reference to Exhibit 2.1 to Coventry's Current Report on Form 8-K filed July 12, 2007).
3.1	Restated Certificate of Incorporation of Coventry Health Care, Inc. (Incorporated by reference to Exhibit 3.1 to Coventry's Quarterly Report on Form 10-Q for the quarter ended June 30, 2006, filed on August 9, 2006).
3.2	Amended and Restated Bylaws of Coventry Health Care, Inc. (Incorporated by reference to Exhibit 3.1 to Coventry's Current Report on Form 8-K filed on March 10, 2009).
4.1	Specimen Common Stock Certificate (Incorporated by reference to Exhibit 4.1 to Coventry's Annual Report on Form 10-K for the fiscal year ended December 31, 2005, filed on March 9, 2006).
4.2	Indenture for the 2012 Notes, dated as of January 28, 2005, between Coventry Health Care, Inc., as Issuer, and Wachovia Bank, National Association, a national banking association, as Trustee (Incorporated by reference to Exhibit 4.1 to Coventry's Current Report on Form 8-K filed on January 28, 2005).
4.3	Form of Note for the 2012 Notes issued pursuant to the Indenture, dated as of January 28, 2005, between Coventry Health Care, Inc., as Issuer, and Wachovia Bank, National Association, as Trustee (Incorporated by reference to Exhibit 4.1 to Coventry's Current Report on Form 8-K filed on January 28, 2005).
4.4	Indenture for the 2015 Notes, dated as of January 28, 2005, between Coventry Health Care, Inc., as Issuer, and Wachovia Bank, National Association, a national banking association, as Trustee (Incorporated by reference to Exhibit 4.2 to Coventry's Current Report on Form 8-K filed on January 28, 2005).
4.5	Form of Note for the 2015 Notes issued pursuant to the Indenture, dated as of January 28, 2005, between Coventry Health Care, Inc., as Issuer, and Wachovia Bank, National Association, as Trustee (Incorporated by reference to Exhibit 4.2 to Coventry's Current Report on Form 8-K filed on January 28, 2005).
4.6	Registration Rights Agreement for the 2012 Notes, dated as of January 28, 2005, by and among Coventry Health Care, Inc. and Lehman Brothers Inc., CIBC World Markets Corp., ABN AMRO Incorporated, Banc of America Securities LLC, Wachovia Securities, BNP Paribas, BNY Capital Markets, Inc. and Piper Jaffray & Co. (Incorporated by reference to Exhibit 4.4 to Coventry's Current Report on Form 8-K filed on January 28, 2005).
4.7	Registration Rights Agreement for the 2015 Notes, dated as of January 28, 2005, by and among Coventry Health Care, Inc. and Lehman Brothers Inc., CIBC World Markets Corp., ABN AMRO Incorporated, Banc of America Securities LLC, Wachovia Securities, BNP Paribas, BNY Capital Markets, Inc. and Piper Jaffray & Co. (Incorporated by reference to Exhibit 4.3 to Coventry's Current Report on Form 8-K filed on January 28, 2005).
4.8	Indenture, dated as of March 20, 2007, between Coventry Health Care, Inc., as Issuer, and The Bank of New York, as Trustee (Incorporated by reference to Exhibit 4.1 to Coventry's Current Report on Form 8-K filed on March 20, 2007).
4.9	Officers' Certificate pursuant to the Indenture, dated March 20, 2007 (Incorporated by reference to Exhibit 4.2 to Coventry's Current Report on Form 8-K filed March 20, 2007).
4.10	Global Note for the 2017 Notes, dated as of March 20, 2007, between Coventry Health Care, Inc., as Issuer, and The Bank of New York, as Trustee (Incorporated by reference to Exhibit 4.3 to Coventry's Current Report on Form 8-K filed March 20, 2007).
4.11	First Supplemental Indenture, dated as of August 27, 2007, among Coventry Health Care, Inc., as Issuer, and Union Bank of California, as Trustee (Incorporated by reference to Exhibit 4.1 to Coventry's Current Report on Form 8-K filed on August 27, 2007).
4.12	Officers' Certificate pursuant to the Indenture, dated August 27, 2007 (Incorporated by reference to Exhibit 4.2 to Coventry's Current Report on Form 8-K filed August 27, 2007).

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- 4.13 Global Note for the 2014 Notes, dated as of August 27, 2007, between Coventry Health Care, Inc., as Issuer, and Union Bank of California, as Trustee (Incorporated by reference to Exhibit 4.3 to Coventry's Current Report on Form 8-K filed March 20, 2007).
- 10.1 Amended and Restated Credit Agreement, dated July 11, 2007, by and among Coventry Health Care, Inc., as borrower, with several banks and other financial institutions or entities from time to time parties thereto, Citibank, N.A., as Administrative Agent, J.P. Morgan Chase Bank, N.A., as Syndication Agent, Deutsche Bank Securities Inc., Lehman Brothers Commercial Bank, and The Royal Bank of Scotland PLC, as Co-Documentation Agents, and Citigroup Global Markets Inc. and J.P. Morgan Securities Inc., as Joint Lead Arrangers and Joint Bookrunners (Incorporated by reference to Exhibit 10.1 to Coventry's Current Report on Form 8-K filed July 17, 2007).
- 10.2 \* Employment Agreement between Coventry Health Care, Inc. and Dale B. Wolf, dated as of December 19, 2007, effective January 1, 2008 (Incorporated by reference to Exhibit 10.1 to Coventry's Current Report on Form 8-K filed on December 20, 2007).
- 10.3 \* Separation of Employment Agreement and General Release, dated May 4, 2009, by and between Dale B. Wolf and Coventry Health Care, Inc. (Incorporated by reference to Exhibit 10.1 to Coventry's Current Report on Form 8-K filed May 7, 2009).
- 10.4 \* Employment Agreement between Coventry Health Care, Inc. and Shawn M. Guertin, dated as of December 19, 2007, effective January 1, 2008 (Incorporated by reference to Exhibit 10.2 to Coventry's Current Report on Form 8-K filed on December 20, 2007).
- 10.5 Separation and Consulting Agreement, dated November 16, 2009, by and between Coventry Health Care, Inc. and Shawn M. Guertin (Incorporated by reference to Exhibit 10.1 to Coventry's Current Report on Form 8-K filed on November 20, 2009).
- 10.6 \* Employment Agreement between Coventry Health Care, Inc. and Allen F. Wise, dated as of April 30, 2009, effective as of January 26, 2009 (Incorporated by reference to Exhibit 10.1 to Coventry's Current Report on Form 8-K filed on May 7, 2009).
- 10.7 \* Amendment No. 1 to Employment Agreement between Coventry Health Care, Inc. and Allen F. Wise, executed as of June 16, 2010 (Incorporated by reference to Exhibit 10.1 to Coventry's Current Report on Form 8-K filed on June 17, 2010).
- 10.8 \* Employment Agreement between Coventry Health Care, Inc. and Harvey C. DeMovick, dated as of May 17, 2009, effective as of February 2, 2009 (Incorporated by reference to Exhibit 10.7 to Coventry's Annual Report on Form 10-K filed on February 26, 2010, as amended on March 12, 2010).
- 10.9 \* Employment Agreement between Coventry Health Care, Inc. and Francis S. Soistman, dated as of December 19, 2007, effective January 1, 2008 (Incorporated by reference to Exhibit 10.4 to Coventry's Current Report on Form 8-K filed on December 20, 2007).
- 10.10 \* Employment Agreement between Coventry Health Care, Inc. and Thomas C. Zielinski, dated as of December 19, 2007, effective January 1, 2008 (Incorporated by reference to Exhibit 10.8 to Coventry's Form 10-K for the fiscal year ended December 31, 2007, filed on February 28, 2008).
- 10.11 \* Employment Agreement between Coventry Health Care, Inc. and Michael D. Bahr, dated May 18, 2010.
- 10.13 \* Employment Agreement effective as of June 17, 1999, executed by James E. McGarry and Coventry Health Care, Inc. (Incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1999, filed on August 16, 1999).
- 10.14 \* Summary of Coventry Health Care, Inc. 2011 Executive Management Incentive Plan.
- 10.15 \* 2011 Coventry Health Care, Inc. Executive Management Incentive Plan (Incorporated by reference to Exhibit 10.1 to Coventry's Current Report on Form 8-K filed on January 24, 2011).

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10.16	* 2006 Compensation Program for Non-Employee Directors, effective January 1, 2006 (Incorporated by reference to Exhibit 10.1 to Coventry's Current Report on Form 8-K filed on November 10, 2005).
10.17	* Deferred Compensation Plan for Non-Employee Directors, effective January 1, 2006 (Incorporated by reference to Exhibit 10.13 to Coventry's Annual Report on Form 10-K for the fiscal year ended December 31, 2005, filed on March 9, 2006).
10.18	* Summary of Non-Employee Directors' Compensation.
10.19	* Coventry Health Care, Inc. Amended and Restated 1998 Stock Incentive Plan, amended as of June 5, 2003 (Incorporated by reference to Exhibit 10.15 to Coventry's Annual Report on Form 10-K for the fiscal year ended December 31, 2003, filed on March 10, 2004).
10.20	* Coventry Health Care, Inc. Amended and Restated 2004 Incentive Plan (Incorporated by reference to Appendix A to Coventry's Definitive Proxy Statement filed on April 10, 2009).
10.21	* Form of Coventry Health Care, Inc. Non-Qualified Stock Option Agreement (Incorporated by reference to Exhibit 10.18 to Coventry's Annual Report on Form 10-K for the fiscal year ended December 31, 2004, filed on March 16, 2005).
10.22	* Form of Amendment to Coventry Health Care, Inc. Non-Qualified Stock Option Agreement (Incorporated by reference to Exhibit 10.2 to Coventry's Quarterly Report on Form 10-Q for the quarter ended September 30, 2006, filed on November 8, 2006).
10.23	* Form of Restrictive Covenants Agreement (Incorporated by reference to Exhibit 10.2 to Coventry's Current Report on Form 8-K, filed on October 2, 2008).
10.24	* Form of Coventry Health Care, Inc. non-performance based Restricted Stock Award Agreement (Incorporated by reference to Exhibit 10.2 to Coventry's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009, filed on August 7, 2009).
10.25	* Form of Performance Share Units Agreement (Incorporated by reference to Exhibit 10.1 to Coventry's Quarterly Report on Form 10-Q, for the quarter ended June 30, 2010, filed on August 6, 2010).
10.26	* Form of performance-based Restricted Stock Award Agreement (Incorporated by reference to Exhibit 10.2 to Coventry's Quarterly Report on Form 10-Q for the quarter ended June 30, 2010, filed on August 6, 2010).
10.27	* 2006 Coventry Health Care, Inc. Mid-Term Executive Retention Program (Incorporated by reference to Exhibit 10.1 to Coventry's Current Report on Form 8-K filed on May 25, 2006).
10.28	* Coventry Health Care, Inc. Supplemental Executive Retirement Plan, as amended and restated effective January 1, 2003, including the First Amendment effective as of January 1, 2004 (Incorporated by reference to Exhibit 10.31 to Coventry's Annual Report on Form 10-K for the fiscal year ended December 31, 2004, filed March 16, 2005).
10.29	* Second Amendment to the Coventry Health Care, Inc. Supplemental Executive Retirement Plan, as amended and restated effective January 1, 2003, including the First Amendment effective as of January 1, 2004, effective May 18, 2005 (Incorporated by reference to Exhibit 10 to Coventry's Quarterly Report on Form 10-Q for the quarter ended June 30, 2005, filed August 9, 2005).
10.30	* Third Amendment to the Coventry Health Care, Inc. Supplemental Executive Retirement Plan (now known as "The Coventry Health Care, Inc. 401(k) Restoration and Deferred Compensation Plan"), effective as of December 22, 2006 (Incorporated by reference to Exhibit 10.28.3 of Coventry's Annual Report on Form 10-K for the fiscal year ended December 31, 2006, filed on February 28, 2007).
10.31	Settlement Agreement in the matter of <u>Clark A. Gunderson, M.D., et al. vs. F. A. Richard &amp; Associates, Inc., et al.</u> , filed on February 2, 2011 in the 14th Judicial District Court, Parish of Calcasieu, State of Louisiana, Suit Number: 2004-2417, Division: "D".
12	Computation of Ratio of Earnings to Fixed Charges.
14	Code of Business Conduct and Ethics initially adopted by the Board of Directors of Coventry on February 20, 2003, as amended on March 3, 2005, November 1, 2006 and November 11, 2010 (Incorporated by reference to Exhibit 14.1 to Coventry's Current Report on Form 8-K filed on November 17, 2010).

Table of Contents

21	Subsidiaries of the Registrant.
23	Consent of Ernst & Young LLP.
31.1	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to section 302 of the Sarbanes-Oxley Act of 2002, made by Allen F. Wise, Chief Executive Officer and Director.
31.2	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to section 302 of the Sarbanes-Oxley Act of 2002, made by John J. Stelben, Interim Chief Financial Officer and Treasurer.
32	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to section 906 of the Sarbanes-Oxley Act of 2002, made by Allen F. Wise, Chief Executive Officer and Director, and John J. Stelben, Interim Chief Financial Officer and Treasurer.

\* Indicates management compensatory plan, contract or arrangement.

**SIGNATURES**

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized

**COVENTRY HEALTH CARE, INC.**

(Registrant)

Date: February 25, 2011

By: /s/ Allen F. Wise

Allen F. Wise  
Chief Executive Officer  
and Director

Date: February 25, 2011

By: /s/ John J. Stelben

John J. Stelben  
Interim Chief Financial Officer  
and Treasurer

Date: February 25, 2011

By: /s/ John J. Ruhlmann

John J. Ruhlmann  
Senior Vice President and Corporate Controller

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the date indicated.

<u>Signature</u>	<u>Title (Principal Function)</u>	<u>Date</u>
By: /s/ Allen F. Wise Allen F. Wise	Chief Executive Officer and Director	February 25, 2011
By: /s/ Joel Ackerman Joel Ackerman	Director	February 25, 2011
By: /s/ L. Dale Crandall L. Dale Crandall	Director	February 25, 2011
By: /s/ Lawrence N. Kugelman Lawrence N. Kugelman	Director	February 25, 2011
By: /s/ Daniel N. Mendelson Daniel N. Mendelson	Director	February 25, 2011
By: /s/ Rodman W. Moorhead, III Rodman W. Moorhead, III	Director	February 25, 2011
By: /s/ Michael A. Stocker, M.D. Michael A. Stocker, M.D.	Director	February 25, 2011
By: /s/ Joseph R. Swedish Joseph R. Swedish	Director	February 25, 2011
By: /s/ Elizabeth E. Tallett Elizabeth E. Tallett	Director	February 25, 2011
By: /s/ Timothy T. Weglicki Timothy T. Weglicki	Director	February 25, 2011

**INDEX TO EXHIBITS**

**Reg. S-K: Item 601**

<b>Exhibit No.</b>	<b>Description of Exhibit</b>
10.11	Employment Agreement between Coventry Health Care, Inc. and Michael D. Bahr, dated May 18, 2010.
10.14	Summary of Coventry Health Care, Inc. 2011 Executive Management Incentive Plan.
10.18	Summary of Non-Employee Directors' Compensation.
10.31	Settlement Agreement in the matter of <u>Clark A. Gunderson, M.D., et al. vs. F. A. Richard &amp; Associates, Inc., et al.</u> , filed on February 2, 2011 in the 14th Judicial District Court, Parish of Calcasieu, State of Louisiana, Suit Number: 2004-2417, Division: "D".
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32	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to section 906 of the Sarbanes-Oxley Act of 2002, made by Allen F. Wise, Chief Executive Officer and Director, and John J. Stelben, Interim Chief Financial Officer and Treasurer.

Note: This index only lists the exhibits included in this Form 10-K. A complete list of exhibits can be found in "Item 15. Exhibits, Financial Statement Schedules" of this Form 10-K.

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# QUARTERLY STATEMENT

AS OF SEPTEMBER 30, 2011  
OF THE CONDITION AND AFFAIRS OF THE

## HealthAmerica Pennsylvania, Inc.

NAIC Group Code 1137 , 1137 NAIC Company Code 95060 Employer's ID Number 25-1264318  
(Current Period) (Prior Period)

Organized under the Laws of Pennsylvania , State of Domicile or Port of Entry Pennsylvania

Country of Domicile United States

Licensed as business type: Life, Accident & Health [ ] Property/Casualty [ ] Hospital, Medical & Dental Service or Indemnity [ ]  
 Dental Service Corporation [ ] Vision Service Corporation [ ] Health Maintenance Organization [ X ]  
 Other [ ] Is HMO, Federally Qualified? Yes [ X ] No [ ]

Incorporated/Organized 04/04/1974 Commenced Business 01/13/1975

Statutory Home Office 600 North Second Street, Suite 500 , Harrisburg, PA 17101  
(Street and Number) (City or Town, State and Zip Code)

Main Administrative Office 3721 TecPort Drive, PO Box 67103 Harrisburg, PA 17106-7103 800-788-6445  
(Street and Number) (City or Town, State and Zip Code) (Area Code) (Telephone Number)

Mail Address 3721 TecPort Drive, PO Box 67103 Harrisburg, PA 17106-7103  
(Street and Number or P.O. Box) (City or Town, State and Zip Code)

Primary Location of Books and Records 3721 TecPort Drive, PO Box 67103 Harrisburg, PA 17106-7103 717-671-2411  
(Street and Number) (City or Town, State and Zip Code) (Area Code) (Telephone Number)

Internet Web Site Address www.healthamerica.cvty.com

Statutory Statement Contact Dane J. Kreiss 717-671-2411  
(Name) (Area Code) (Telephone Number) (Extension)

dkreiss@cvty.com 717-671-5297  
(E-mail Address) (FAX Number)

### OFFICERS

Name	Title	Name	Title
<u>David Wilson Fields #</u>	<u>Chief Executive Officer &amp; President</u>	<u>Evelyn Nedved Pendleton</u>	<u>Chief Financial Officer &amp; Treasurer</u>
<u>Nicholas Timothy Guarneschelli</u>	<u>Secretary &amp; Vice President</u>		

### OTHER OFFICERS

<u>Shirley Ann Roquemore Smith</u>	<u>Assistant Secretary</u>	<u>Melinda Lee Tuozzo</u>	<u>Assistant Treasurer</u>
<u>Micheal Joseph Ridler #</u>	<u>Actuary</u>	<u>Dane Jason Kreiss</u>	<u>Corporate Controller</u>
<u>Mary Louise Osborne</u>	<u>Executive Vice President</u>		

### DIRECTORS OR TRUSTEES

<u>Robert Addison Mathias Ph.D</u>	<u>Ronald Michael Robinson Ph.D</u>	<u>Douglas Bruce Templeton</u>	<u>John Charles Wallendjack M.D.</u>
<u>Frank Eugene Weaver</u>	<u>Timothy Edmund Nolan</u>		

State of .....Pennsylvania.....

ss

County of .....Dauphin.....

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC *Annual Statement Instructions and Accounting Practices and Procedures* manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

David Wilson Fields  
Chief Executive Officer & President

Evelyn Nedved Pendleton  
Chief Financial Officer & Treasurer

Nicholas Timothy Guarneschelli  
Secretary & Vice President

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_,

a. Is this an original filing? Yes [ X ] No [ ]

b. If no:

1. State the amendment number \_\_\_\_\_

2. Date filed \_\_\_\_\_

3. Number of pages attached \_\_\_\_\_

STATEMENT AS OF SEPTEMBER 30, 2011 OF THE HealthAmerica Pennsylvania, Inc.

**ASSETS**

	Current Statement Date			4 December 31 Prior Year Net Admitted Assets
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	
1. Bonds .....	120,234,215		120,234,215	119,950,378
2. Stocks:				
2.1 Preferred stocks .....			0	0
2.2 Common stocks .....			0	0
3. Mortgage loans on real estate:				
3.1 First liens .....			0	0
3.2 Other than first liens .....			0	0
4. Real estate:				
4.1 Properties occupied by the company (less \$ ..... encumbrances) .....			0	0
4.2 Properties held for the production of income (less \$ ..... encumbrances) .....			0	0
4.3 Properties held for sale (less \$ ..... encumbrances) .....			0	0
5. Cash (\$ .....45,495,139 ), cash equivalents (\$ .....10,033,360 ) and short-term investments (\$ .....4,469,616 ) .....	59,998,115		59,998,115	40,298,861
6. Contract loans (including \$ ..... premium notes) .....			0	0
7. Derivatives .....			0	0
8. Other invested assets .....	0		0	0
9. Receivables for securities .....			0	13,737
10. Securities lending reinvested collateral assets .....			0	0
11. Aggregate write-ins for invested assets .....	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11) .....	180,232,330	0	180,232,330	160,262,976
13. Title plants less \$ ..... charged off (for Title insurers only) .....			0	0
14. Investment income due and accrued .....	1,225,325		1,225,325	1,380,575
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection .....	3,490,352		3,490,352	4,267,733
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including \$ ..... earned but unbilled premiums) .....			0	0
15.3 Accrued retrospective premiums .....	5,278,091		5,278,091	7,242,720
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers .....	967,966		967,966	404,836
16.2 Funds held by or deposited with reinsured companies .....			0	0
16.3 Other amounts receivable under reinsurance contracts .....			0	0
17. Amounts receivable relating to uninsured plans .....			0	5,789
18.1 Current federal and foreign income tax recoverable and interest thereon .....			0	0
18.2 Net deferred tax asset .....	9,053,138	5,403,429	3,649,709	3,649,709
19. Guaranty funds receivable or on deposit .....			0	0
20. Electronic data processing equipment and software .....	17,949	17,949	0	0
21. Furniture and equipment, including health care delivery assets (\$ ..... ) .....	295,508	295,508	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates .....			0	0
23. Receivables from parent, subsidiaries and affiliates .....	3,635,645		3,635,645	6,791,914
24. Health care (\$ ..... ) and other amounts receivable .....	15,547,571	23,335	15,524,236	13,450,107
25. Aggregate write-ins for other than invested assets .....	3,854,390	3,854,390	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25) .....	223,598,265	9,594,611	214,003,654	197,456,359
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts .....			0	0
28. Total (Lines 26 and 27) .....	223,598,265	9,594,611	214,003,654	197,456,359
<b>DETAILS OF WRITE-INS</b>				
1101. ....			0	0
1102. ....			0	0
1103. ....			0	0
1198. Summary of remaining write-ins for Line 11 from overflow page .....	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above) .....	0	0	0	0
2501. Prepaid Expenses .....	1,256,316	1,256,316	0	0
2502. Intangible Assets .....	2,598,074	2,598,074	0	0
2503. Construction in Progress .....			0	0
2598. Summary of remaining write-ins for Line 25 from overflow page .....	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above) .....	3,854,390	3,854,390	0	0

## LIABILITIES, CAPITAL AND SURPLUS

	Current Period			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$ 1,335,549 reinsurance ceded)	57,274,455	1,224,398	58,498,853	56,931,058
2. Accrued medical incentive pool and bonus amounts	4,369		4,369	14,248
3. Unpaid claims adjustment expenses	936,914		936,914	929,820
4. Aggregate health policy reserves			0	0
5. Aggregate life policy reserves			0	0
6. Property/casualty unearned premium reserve			0	0
7. Aggregate health claim reserves			0	0
8. Premiums received in advance	25,154,249		25,154,249	826,600
9. General expenses due or accrued	16,177,208		16,177,208	13,766,261
10.1 Current federal and foreign income tax payable and interest thereon (including \$ 3 on realized gains (losses))	750,838		750,838	2,005,817
10.2 Net deferred tax liability			0	0
11. Ceded reinsurance premiums payable			0	0
12. Amounts withheld or retained for the account of others	132,150		132,150	477,581
13. Remittances and items not allocated	1,902,793		1,902,793	1,277,244
14. Borrowed money (including \$ current) and interest thereon \$ (including \$ current)			0	0
15. Amounts due to parent, subsidiaries and affiliates	2,257,286		2,257,286	2,327,348
16. Derivatives			0	0
17. Payable for securities	3,418,353		3,418,353	0
18. Payable for securities lending			0	0
19. Funds held under reinsurance treaties (with \$ authorized reinsurers and \$ unautho- rized reinsurers)			0	0
20. Reinsurance in unauthorized companies			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans	2,903,088		2,903,088	2,043,499
23. Aggregate write-ins for other liabilities (including \$ current)	26,913,772	0	26,913,772	29,345,640
24. Total liabilities (Lines 1 to 23)	137,825,475	1,224,398	139,049,873	109,945,116
25. Aggregate write-ins for special surplus funds	XXX	XXX	0	0
26. Common capital stock	XXX	XXX	5	5
27. Preferred capital stock	XXX	XXX	0	0
28. Gross paid in and contributed surplus	XXX	XXX	2,888,585	2,888,585
29. Surplus notes	XXX	XXX	0	0
30. Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	72,065,191	84,622,653
32. Less treasury stock, at cost:				
32.1 shares common (value included in Line 26 \$ )	XXX	XXX	0	0
32.2 shares preferred (value included in Line 27 \$ )	XXX	XXX	0	0
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	74,953,781	87,511,243
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	214,003,654	197,456,359
<b>DETAILS OF WRITE-INS</b>				
2301. Office of Personnel Management	2,266,101		2,266,101	7,331,913
2302. Medicare Payable Other	24,364,885		24,364,885	21,599,082
2303. Abandon Property Liability	282,786		282,786	414,645
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	26,913,772	0	26,913,772	29,345,640
2501.	XXX	XXX		0
2502.	XXX	XXX		0
2503.	XXX	XXX		0
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX	0	0
3001.	XXX	XXX		0
3002.	XXX	XXX		0
3003.	XXX	XXX		0
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX	0	0

## STATEMENT OF REVENUE AND EXPENSES

	Current Year To Date		Prior Year To Date	Prior Year Ended December 31
	1 Uncovered	2 Total	3 Total	4 Total
1. Member Months.....	XXX	500,730	466,077	733,293
2. Net premium income (including \$ non-health premium income).....	XXX	356,550,677	351,466,035	478,031,244
3. Change in unearned premium reserves and reserve for rate credits .....	XXX		0	0
4. Fee-for-service (net of \$ medical expenses) .....	XXX		0	0
5. Risk revenue .....	XXX		0	0
6. Aggregate write-ins for other health care related revenues .....	XXX	0	0	0
7. Aggregate write-ins for other non-health revenues .....	XXX	0	0	(1,145)
8. Total revenues (Lines 2 to 7) .....	XXX	356,550,677	351,466,035	478,030,099
<b>Hospital and Medical:</b>				
9. Hospital/medical benefits .....		250,806,191	247,962,612	334,679,605
10. Other professional services .....			0	0
11. Outside referrals .....			0	0
12. Emergency room and out-of-area .....			0	0
13. Prescription drugs .....		33,503,604	42,511,625	55,624,083
14. Aggregate write-ins for other hospital and medical.....	0	586,615	(31,435)	(12,904)
15. Incentive pool, withhold adjustments and bonus amounts.....		3,785	14,749	20,403
16. Subtotal (Lines 9 to 15) .....	0	284,900,195	290,457,551	390,311,187
<b>Less:</b>				
17. Net reinsurance recoveries .....		2,346,839	1,750,250	2,151,576
18. Total hospital and medical (Lines 16 minus 17) .....	0	282,553,356	288,707,301	388,159,611
19. Non-health claims (net).....			0	0
20. Claims adjustment expenses, including \$ cost containment expenses.....		15,464,226	13,341,533	20,307,310
21. General administrative expenses.....		23,731,455	20,076,776	20,989,970
22. Increase in reserves for life and accident and health contracts (including \$ increase in reserves for life only).....			0	0
23. Total underwriting deductions (Lines 18 through 22) .....	0	321,749,037	322,125,610	429,456,891
24. Net underwriting gain or (loss) (Lines 8 minus 23) .....	XXX	34,801,640	29,340,425	48,573,208
25. Net investment income earned .....		3,448,279	4,130,143	5,288,004
26. Net realized capital gains (losses) less capital gains tax of \$ 23,096 .....		42,893	601,170	601,170
27. Net investment gains (losses) (Lines 25 plus 26) .....	0	3,491,172	4,731,313	5,889,174
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$ ) (amount charged off \$ )] .....			0	0
29. Aggregate write-ins for other income or expenses .....	0	0	0	0
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29) .....	XXX	38,292,812	34,071,738	54,462,382
31. Federal and foreign income taxes incurred .....	XXX	15,182,417	13,156,909	18,316,197
32. Net income (loss) (Lines 30 minus 31) .....	XXX	23,110,395	20,914,829	36,146,185
<b>DETAILS OF WRITE-INS</b>				
0601. ....	XXX		0	0
0602. ....	XXX		0	0
0603. ....	XXX		0	0
0698. Summary of remaining write-ins for Line 6 from overflow page .....	XXX	0	0	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 6 above) .....	XXX	0	0	0
0701. ....	XXX		0	(1,145)
0702. ....	XXX		0	0
0703. ....	XXX		0	0
0798. Summary of remaining write-ins for Line 7 from overflow page .....	XXX	0	0	0
0799. Totals (Lines 0701 through 0703 plus 0798) (Line 7 above) .....	XXX	0	0	(1,145)
1401. Other medical expenses.....		586,615	(31,435)	(12,904)
1402. ....				
1403. ....				
1498. Summary of remaining write-ins for Line 14 from overflow page .....	0	0	0	0
1499. Totals (Lines 1401 through 1403 plus 1498) (Line 14 above) .....	0	586,615	(31,435)	(12,904)
2901. ....			0	0
2902. ....			0	0
2903. ....			0	0
2998. Summary of remaining write-ins for Line 29 from overflow page .....	0	0	0	0
2999. Totals (Lines 2901 through 2903 plus 2998) (Line 29 above) .....	0	0	0	0

**STATEMENT OF REVENUE AND EXPENSES (Continued)**

	1	2	3
	Current Year To Date	Prior Year To Date	Prior Year Ended December 31
<b>CAPITAL &amp; SURPLUS ACCOUNT</b>			
33. Capital and surplus prior reporting year.....	87,511,243	97,839,705	97,839,705
34. Net income or (loss) from Line 32 .....	23,110,395	20,914,829	36,146,185
35. Change in valuation basis of aggregate policy and claim reserves .....		0	0
36. Change in net unrealized capital gains (losses) less capital gains tax of \$ .....		0	0
37. Change in net unrealized foreign exchange capital gain or (loss) .....		0	0
38. Change in net deferred income tax .....		(656,573)	678,367
39. Change in nonadmitted assets .....	332,143	523,263	846,986
40. Change in unauthorized reinsurance .....	0	0	0
41. Change in treasury stock .....		0	0
42. Change in surplus notes .....	0	0	0
43. Cumulative effect of changes in accounting principles .....		0	0
44. Capital Changes:			
44.1 Paid in .....		0	0
44.2 Transferred from surplus (Stock Dividend) .....		0	0
44.3 Transferred to surplus .....		0	0
45. Surplus adjustments:			
45.1 Paid in .....		0	0
45.2 Transferred to capital (Stock Dividend) .....	0	0	0
45.3 Transferred from capital .....		0	0
46. Dividends to stockholders .....	(36,000,000)	(48,000,000)	(48,000,000)
47. Aggregate write-ins for gains or (losses) in surplus .....	0	0	0
48. Net change in capital and surplus (Lines 34 to 47) .....	(12,557,462)	(27,218,481)	(10,328,462)
49. Capital and surplus end of reporting period (Line 33 plus 48)	74,953,781	70,621,225	87,511,243
<b>DETAILS OF WRITE-INS</b>			
4701. ....		0	0
4702. ....		0	0
4703. ....		0	0
4798. Summary of remaining write-ins for Line 47 from overflow page .....	0	0	0
4799. Totals (Lines 4701 through 4703 plus 4798) (Line 47 above)	0	0	0

## CASH FLOW

	1 Current Year To Date	2 Prior Year To Date	3 Prior Year Ended December 31
<b>Cash from Operations</b>			
1. Premiums collected net of reinsurance.....	383,620,336	366,375,800	486,387,757
2. Net investment income .....	4,201,321	5,346,283	6,806,973
3. Miscellaneous income .....	0	0	(1,145)
4. Total (Lines 1 to 3) .....	387,821,657	371,722,083	493,193,585
5. Benefit and loss related payments .....	283,632,699	300,132,792	402,972,459
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts.....		0	0
7. Commissions, expenses paid and aggregate write-ins for deductions .....	35,912,262	34,202,106	41,933,160
8. Dividends paid to policyholders .....		0	0
9. Federal and foreign income taxes paid (recovered) net of \$ ..... tax on capital gains (losses).....	16,460,492	15,438,266	20,557,051
10. Total (Lines 5 through 9) .....	336,005,453	349,773,164	465,462,670
11. Net cash from operations (Line 4 minus Line 10) .....	51,816,204	21,948,919	27,730,915
<b>Cash from Investments</b>			
12. Proceeds from investments sold, matured or repaid:			
12.1 Bonds .....	44,792,578	62,800,002	68,776,789
12.2 Stocks .....	0	0	0
12.3 Mortgage loans .....	0	0	0
12.4 Real estate .....	0	0	0
12.5 Other invested assets .....	0	0	0
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments .....	2,595	0	0
12.7 Miscellaneous proceeds .....	3,432,337	0	0
12.8 Total investment proceeds (Lines 12.1 to 12.7) .....	48,227,510	62,800,002	68,776,789
13. Cost of investments acquired (long-term only):			
13.1 Bonds .....	45,611,058	23,306,969	28,262,491
13.2 Stocks .....	0	0	0
13.3 Mortgage loans .....	0	0	0
13.4 Real estate .....	0	0	0
13.5 Other invested assets .....	0	0	0
13.6 Miscellaneous applications .....	0	5,796	960
13.7 Total investments acquired (Lines 13.1 to 13.6) .....	45,611,058	23,312,765	28,263,451
14. Net increase (or decrease) in contract loans and premium notes .....	0	0	0
15. Net cash from investments (Line 12.8 minus Line 13.7 and Line 14) .....	2,616,452	39,487,237	40,513,338
<b>Cash from Financing and Miscellaneous Sources</b>			
16. Cash provided (applied):			
16.1 Surplus notes, capital notes .....	0	0	0
16.2 Capital and paid in surplus, less treasury stock.....	0	0	0
16.3 Borrowed funds .....	0	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities .....	0	0	0
16.5 Dividends to stockholders .....	36,000,000	48,000,000	48,000,000
16.6 Other cash provided (applied).....	1,266,598	2,196,306	4,273,784
17. Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6).....	(34,733,402)	(45,803,694)	(43,726,216)
<b>RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS</b>			
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17) .....	19,699,254	15,632,462	24,518,037
19. Cash, cash equivalents and short-term investments:			
19.1 Beginning of year.....	40,298,861	15,780,824	15,780,824
19.2 End of period (Line 18 plus Line 19.1) .....	59,998,115	31,413,286	40,298,861

STATEMENT AS OF SEPTEMBER 30, 2011 OF THE HealthAmerica Pennsylvania, Inc.

**EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION**

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		2	3							
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year .....	58,161	.0	8,120	.0	.0	.0	10,413	27,921	11,707	.0
2. First Quarter .....	55,651	.0	6,697	.0	.0	.0	9,434	26,600	12,920	.0
3. Second Quarter .....	56,390	.0	6,396	.0	.0	.0	9,346	26,350	14,298	.0
4. Third Quarter .....	57,255		6,144				9,299	26,172	15,640	
5. Current Year	0									
6. Current Year Member Months	500,730		58,437				84,052	237,990	120,251	
Total Member Ambulatory Encounters for Period:										
7. Physician .....	528,310		36,097				68,941	365,942	57,330	
8. Non-Physician .....	53,334		6,745				8,782	35,150	2,657	
9. Total	581,644	0	42,842	0	0	0	77,723	401,092	59,987	0
10. Hospital Patient Days Incurred	81,145		1,452				2,818	68,379	8,496	
11. Number of Inpatient Admissions	9,218		234				453	7,061	1,470	
12. Health Premiums Written (a).....	359,558,539		24,374,094				47,400,373	241,826,545	45,957,527	
13. Life Premiums Direct.....	.0									
14. Property/Casualty Premiums Written .....	.0									
15. Health Premiums Earned .....	359,558,539		24,374,094				47,400,373	241,826,545	45,957,527	
16. Property/Casualty Premiums Earned .....	.0									
17. Amount Paid for Provision of Health Care Services .....	283,256,636		18,628,592				34,461,964	190,200,957	39,965,123	
18. Amount Incurred for Provision of Health Care Services	284,900,195		17,209,677				33,407,019	192,328,667	41,954,832	

(a) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$



STATEMENT AS OF SEPTEMBER 30, 2011 OF THE HealthAmerica Pennsylvania, Inc.

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**ANALYSIS OF CLAIMS UNPAID-PRIOR YEAR-NET OF REINSURANCE**

Line of Business	Claims Paid Year to Date		Liability End of Current Quarter		5 Claims Incurred in Prior Years (Columns 1 + 3)	6 Estimated Claim Reserve and Claim Liability Dec. 31 of Prior Year
	1	2	3	4		
	On Claims Incurred Prior to January 1 of Current Year	On Claims Incurred During the Year	On Claims Unpaid Dec. 31 of Prior Year	On Claims Incurred During the Year		
1. Comprehensive (hospital and medical) .....	2,129,159	15,511,441	20,782	2,597,546	2,149,941	4,039,080
2. Medicare Supplement .....					.0	.0
3. Dental Only .....					.0	.0
4. Vision Only .....					.0	.0
5. Federal Employees Health Benefits Plan .....	4,133,073	30,110,444	40,341	5,042,295	4,173,414	6,186,439
6. Title XVIII - Medicare .....	23,770,754	164,959,596	2,355,855	29,442,002	26,126,609	29,553,665
7. Title XIX - Medicaid .....	10,572,384	29,794,924	1,029,797	17,970,235	11,602,181	17,151,874
8. Other health .....					.0	.0
9. Health subtotal (Lines 1 to 8).....	40,605,370	240,376,405	3,446,775	55,052,078	44,052,145	56,931,058
10. Health care receivables (a) .....					.0	.0
11. Other non-health .....					.0	.0
12. Medical incentive pools and bonus amounts .....	13,664			4,369	13,664	14,248
13. Totals (Lines 9-10+11+12)	40,619,034	240,376,405	3,446,775	55,056,447	44,065,809	56,945,306

(a) Excludes \$ ..... loans or advances to providers not yet expensed.

## NOTES TO FINANCIAL STATEMENTS

### 1. Significant Accounting Policies

#### A. Accounting Practices

The accompanying financial statements of HealthAmerica Pennsylvania, Inc. (“the Company”) have been prepared in accordance with the accounting practices prescribed or permitted by the Pennsylvania Department of Insurance (DOI). Such practices differ in certain respects from generally accepted accounting principles in determining financial position and results of operations. Certain assets designated as nonadmitted (e.g. receivables greater than 90 days old, prepaid assets, intangible assets, certain amounts of property and equipment, notes receivable and deferred taxes) are excluded from the balance sheet by a direct charge to surplus. Bonds generally are stated at amortized cost, except for bonds that are rated by the NAIC as class 3-6 which are reported at the lower of amortized cost or fair market value.

The Pennsylvania Department of Insurance recognizes only statutory accounting practices prescribed or permitted by the state of Pennsylvania for determining and reporting the financial condition and results of operations of an insurance company, for determining its solvency under Pennsylvania insurance laws. The National Association of Insurance Commissioners’ (NAIC) “Accounting Practices and Procedures Manual” (APPM), version effective [March 1, 2011](#), (NAIC SAP) has been adopted as a component of prescribed or permitted practices by the State of Pennsylvania. The State of Pennsylvania has not adopted any prescribed accounting practices that differ from those found in the NAIC SAP.

Net income for the nine months ended September 30, 2011 and statutory surplus as of September 30, 2011 as prescribed by the DOI and as prescribed by NAIC SAP is as follows:

DOI net income nine months ended September 30, 2011	\$23,110,395
NAIC net income nine months ended September 30, 2011	\$23,110,395
DOI statutory surplus as of September 30, 2011	\$74,953,781
NAIC statutory surplus as of September 30, 2011	\$74,953,781

#### 2. Accounting Changes and Corrections of Errors

No change

#### 3. Business Combinations and Goodwill

No change

#### 4. Discontinued Operations

No change

#### 5. Investments

##### d. Loan Backed Securities

- Carrying value for structured securities has been determined in accordance with the guidelines of the NAIC. Fair value is determined using a pricing hierarchy starting with a widely accepted pricing vendor, followed by external broker/dealers, Bloomberg analytic modeling and a benchmark to index model.
- The Company uses a proprietary model for loss assumptions and widely accepted models for prepayment assumptions in valuing mortgage-backed and asset-backed securities with inputs from major third party data providers. It combines the effects of interest rates, volatility, and pre-payment speeds based on various scenario (Monte Carlo) simulations with credit loss analysis and resulting effective analytics (spreads, duration, convexity) and cash-flows on a monthly basis. Model assumptions are specific to asset class and collateral types and are regularly evaluated and adjusted where appropriate.
- Credit risk concentrations are evaluated in our base security analysis through exposure stratification of the collateral attributes. The Company will then apply an appropriate credit default curve reflecting our forecasted expectations of future defaults and losses.
- None
- None
- The fair market value, amortized cost and unrealized losses for structured securities (fair value is less than amortized cost for which an other-than-temporary impairment has not been recognized in earnings as a realized loss) owned as of September 30, 2011 are as follows:

U.S. Government Mortgage	Less than	12 months
Mortgage Backed Securities	12 months	or more
Fair Market Value	\$ 0	\$ 0
Amortized Cost	\$ 0	\$ 0
Unrealized Losses	\$ 0	\$ 0

The structured securities have been in a continuous unrealized loss position for less than 12 months. There are no structured securities that that been in a continuous unrealized loss position for 12 months or longer.

- There are a number of factors that are considered in determining if there is not an other-than-temporary-impairment on an investment, including but not limited to, debt burden, credit ratings, sector, liquidity, financial flexibility, company management, expected earnings and cash flow stream and economic prospects associated with the investment.
- All investments in an unrealized loss position are evaluated for an other-than-temporary-impairment based on the severity level and length of time. As the magnitude of the loss increases so does the degree of analysis in determining if an other-than-temporary-loss exists.

## NOTES TO FINANCIAL STATEMENTS

**6.** Joint Ventures, Partnerships and Limited Liability Corporations

No change

**7.** Investment Income

No change

**8.** Derivative Instruments

No change

**9.** Income Taxes

No change

**10.** Information Concerning Parents, Subsidiaries and Affiliates

**11.**

a-c. No change

d. Amounts due from related parties and due to related parties are as follows:

Due from Related Parties

HealthAssurance Pennsylvania, Inc.	\$2,080,942
Coventry Healthcare Management Corp.	\$588,529
Coventry Health and Life Insurance Co.	\$632,001
Coventry Financial Management Services	\$330,903
Coventry Health Care of Pennsylvania, Inc	<u>\$3,270</u>
Total Due from Related Parties	\$3,635,645

Due to Related Parties

Coventry Health Care, Inc.	<u>\$2,257,286</u>
Total Due from Related Parties	\$2,257,286

**12.** Debt

No change

**13.** Retirement Plans, Deferred Compensation, Post-Employment Benefits and Compensated Absence and Other Post-Retirement Benefit Plans

No change

**14.** Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

9) The portion of unassigned funds (surplus) represented or reduced by each item below is as follows:

a. Unrealized gains and losses	\$ 0
b. Non-admitted asset value	\$ 9,594,611
c. Separate account business	\$ 0
d. Asset valuation reserve	\$ 0
e. Reinsurance in unauthorized companies	\$ 0

**15.** Contingencies

No change

**16.** Leases

No change

**17.** Information About Financials Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

No change

**18.** Sales, Transfers and Servicing of Financial Assets and Extinguishment of Liabilities Wash Sales – No change

C. Wash sales - None

## NOTES TO FINANCIAL STATEMENTS

19. Gain or Loss to Reporting Entity from Uninsured A&H Plans and the Uninsured Portion of Partially Insured Plans  
No change
20. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators  
No change
21. Other Items - No change  
G. Sub prime mortgage related risk exposure – No change
22. Events Subsequent  
None
23. Reinsurance  
No change
24. Retrospectively Rated Contracts and Contracts Subject to Redetermination  
No change
25. Change in Incurred Claims and Claims Adjustment Expense  
Reserves as of September 30, 2011 were \$58,503,222. As of September 30, 2011, \$40,619,034 has been paid for incurred losses and loss adjustment expenses attributable to insured events of prior years. Reserves remaining for prior years are now \$3,446,775 as a result of re-estimation of unpaid losses and loss adjustment expenses principally on Commercial, Medicare, and Medicaid lines of insurance. Therefore, there has been \$12,879,497 of favorable prior year development since December 31, 2010. This increase (decrease) is generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased, as additional information becomes known regarding individual claims. There are no retrospectively rated contracts that are subject to redetermination.
26. Intercompany Pooling Arrangements  
No change
27. Structured Settlements  
No change
28. Health Care Receivables  
No change
29. Participating Policies  
No change
30. Premium Deficiency Reserve  
No change
31. Anticipated Salvage and Subrogation  
No change

## GENERAL INTERROGATORIES

### PART 1 - COMMON INTERROGATORIES GENERAL

- 1.1 Did the reporting entity experience any material transactions requiring the filing of Disclosure of Material Transactions with the State of Domicile, as required by the Model Act? ..... Yes  No
- 1.2 If yes, has the report been filed with the domiciliary state? ..... Yes  No
- 2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? ..... Yes  No
- 2.2 If yes, date of change: .....
3. Have there been any substantial changes in the organizational chart since the prior quarter end? ..... Yes  No   
If yes, complete the Schedule Y - Part 1 - organizational chart.
- 4.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? ..... Yes  No
- 4.2 If yes, provide the name of entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

5. If the reporting entity is subject to a management agreement, including third-party administrator(s), managing general agent(s), attorney-in-fact, or similar agreement, have there been any significant changes regarding the terms of the agreement or principals involved? ..... Yes  No  NA   
If yes, attach an explanation.
- 6.1 State as of what date the latest financial examination of the reporting entity was made or is being made. .... 12/31/2010
- 6.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. .... 12/31/2005
- 6.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). .... 05/16/2007
- 6.4 By what department or departments?  
Pennsylvania Department of Insurance.....
- 6.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? ..... Yes  No  NA
- 6.6 Have all of the recommendations within the latest financial examination report been complied with? ..... Yes  No  NA
- 7.1 Has this reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? ..... Yes  No
- 7.2 If yes, give full information:  
.....
- 8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? ..... Yes  No
- 8.2 If response to 8.1 is yes, please identify the name of the bank holding company.  
.....
- 8.3 Is the company affiliated with one or more banks, thrifts or securities firms? ..... Yes  No
- 8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Office of Thrift Supervision (OTS), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.]

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 OTS	6 FDIC	7 SEC

## GENERAL INTERROGATORIES

- 9.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? ..... Yes  No
- (a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;  
 (b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;  
 (c) Compliance with applicable governmental laws, rules and regulations;  
 (d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and  
 (e) Accountability for adherence to the code.

9.11 If the response to 9.1 is No, please explain:  
 .....

- 9.2 Has the code of ethics for senior managers been amended? ..... Yes  No

9.21 If the response to 9.2 is Yes, provide information related to amendment(s).  
 .....

- 9.3 Have any provisions of the code of ethics been waived for any of the specified officers? ..... Yes  No

9.31 If the response to 9.3 is Yes, provide the nature of any waiver(s).  
 .....

### FINANCIAL

- 10.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? ..... Yes  No

10.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: ..... \$ .....330,903

### INVESTMENT

- 11.1 Were any of the stocks, bonds, or other assets of the reporting entity loaned, placed under option agreement, or otherwise made available for use by another person? (Exclude securities under securities lending agreements.) ..... Yes  No

11.2 If yes, give full and complete information relating thereto:  
 .....

12. Amount of real estate and mortgages held in other invested assets in Schedule BA: ..... \$ .....

13. Amount of real estate and mortgages held in short-term investments: ..... \$ .....

- 14.1 Does the reporting entity have any investments in parent, subsidiaries and affiliates? ..... Yes  No

14.2 If yes, please complete the following:

	1 Prior Year-End Book/Adjusted Carrying Value	2 Current Quarter Book/Adjusted Carrying Value
14.21 Bonds .....	\$ .....	\$ .....
14.22 Preferred Stock .....	\$ .....	\$ .....
14.23 Common Stock .....	\$ .....	\$ .....
14.24 Short-Term Investments .....	\$ .....	\$ .....
14.25 Mortgage Loans on Real Estate .....	\$ .....	\$ .....
14.26 All Other .....	\$ .....	\$ .....
14.27 Total Investment in Parent, Subsidiaries and Affiliates (Subtotal Lines 14.21 to 14.26).....	\$ .....0	\$ .....0
14.28 Total Investment in Parent included in Lines 14.21 to 14.26 above .....	\$ .....	\$ .....

- 15.1 Has the reporting entity entered into any hedging transactions reported on Schedule DB? ..... Yes  No

- 15.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? ..... Yes  No

If no, attach a description with this statement.

## GENERAL INTERROGATORIES

16. Excluding items in Schedule E – Part 3 – Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 3, III Conducting Examinations, F - Custodial or Safekeeping Agreements of the NAIC *Financial Condition Examiners Handbook*? .....

Yes  No

16.1 For all agreements that comply with the requirements of the NAIC *Financial Condition Examiners Handbook*, complete the following:

1 Name of Custodian(s)	2 Custodian Address
Wachovia Bank.....	1525 West WT Blvd., Charlotte, NC 28288-1162.....
CitiBank.....	3800 CitiGroup Center, Building 02/08, Tampa, FL 33610-9122.....

16.2 For all agreements that do not comply with the requirements of the NAIC *Financial Condition Examiners Handbook*, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

16.3 Have there been any changes, including name changes, in the custodian(s) identified in 16.1 during the current quarter? .....

Yes  No

16.4 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

16.5 Identify all investment advisors, broker/dealers or individuals acting on behalf of broker/dealers that have access to the investment accounts, handle securities and have authority to make investments on behalf of the reporting entity:

1 Central Registration Depository	2 Name(s)	3 Address
107423.....	Conning & Company.....	One Financial Plaza, Hartford, CT 06103..
110441.....	Western Asset Management Company.....	399 Park Ave., 4th Floor, New York, NY 10021.....

17.1 Have all the filing requirements of the *Purposes and Procedures Manual* of the NAIC Securities Valuation Office been followed? .....

Yes  No

17.2 If no, list exceptions:

.....

## GENERAL INTERROGATORIES

### PART 2 - HEALTH

1 Operating Percentages

1.1 A&H loss percent ..... 79.2 %

1.2 A&H cost containment percent ..... 0.0 %

1.3 A&H expense percent excluding cost containment expenses ..... %

2.1 Do you act as a custodian for health savings accounts? ..... Yes [ ] No [X]

2.2 If yes, please provide the amount of custodial funds held as of the reporting date..... \$

2.3 Do you act as an administrator for health savings accounts? ..... Yes [ ] No [X]

2.4 If yes, please provide the balance of the funds administered as of the reporting date..... \$

**SCHEDULE S - CEDED REINSURANCE**

Showing All New Reinsurance Treaties - Current Year to Date

1 NAIC Company Code	2 Federal ID Number	3 Effective Date	4 Name of Reinsurer	5 Domiciliary Jurisdiction	6 Type of Reinsurance Ceded	7 Is Insurer Authorized? (Yes or No)
			NONE			

STATEMENT AS OF SEPTEMBER 30, 2011 OF THE HealthAmerica Pennsylvania, Inc.

**SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS**

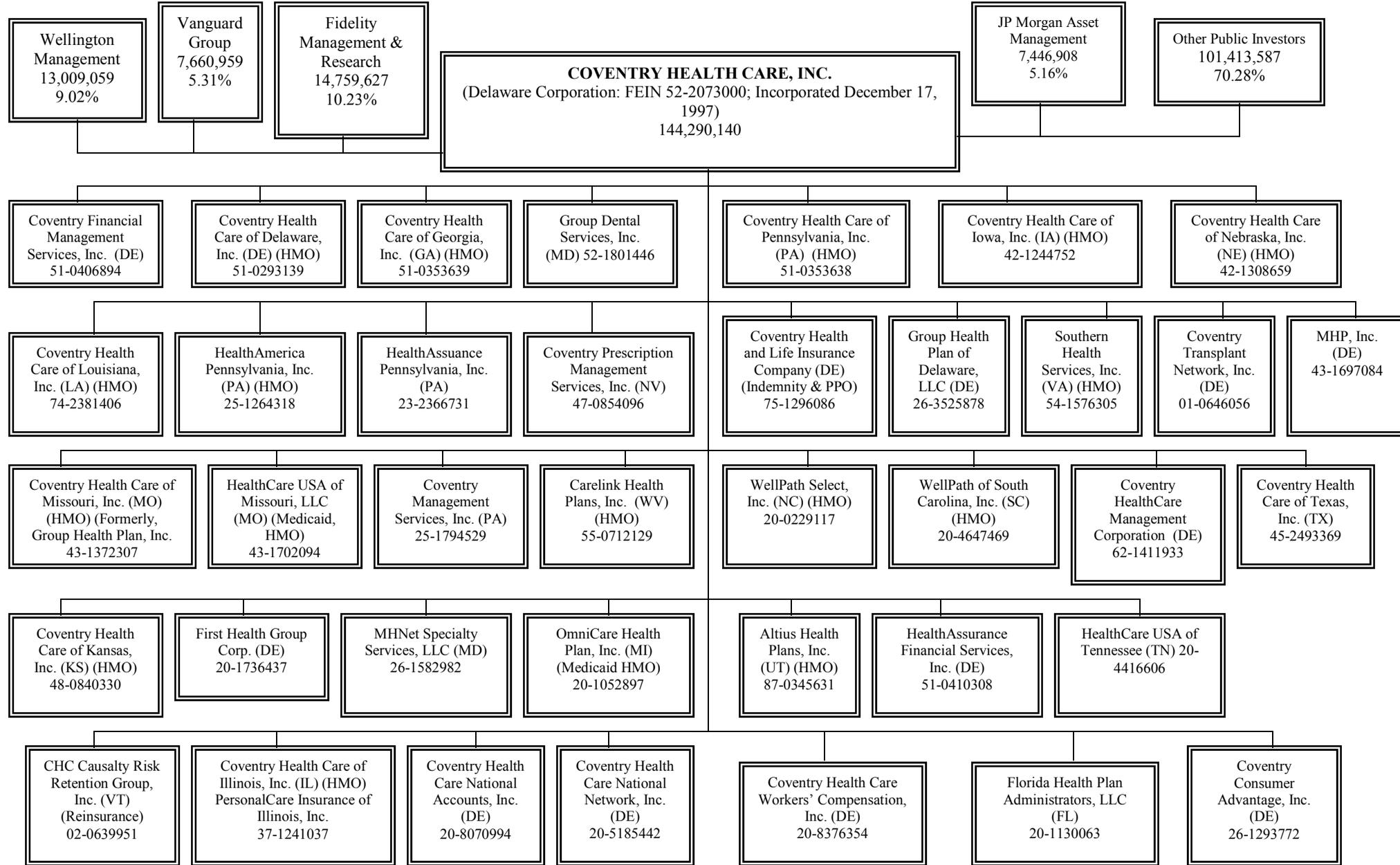
Current Year to Date - Allocated by States and Territories

States, Etc.	1 Active Status	Direct Business Only							9 Deposit-Type Contracts	
		2 Accident & Health Premiums	3 Medicare Title XVIII	4 Medicaid Title XIX	5 Federal Employees Health Benefits Program Premiums	6 Life & Annuity Premiums & Other Considerations	7 Property/Casualty Premiums	8 Total Columns 2 Through 7		
1. Alabama	AL	N							0	
2. Alaska	AK	N							0	
3. Arizona	AZ	N							0	
4. Arkansas	AR	N							0	
5. California	CA	N							0	
6. Colorado	CO	N							0	
7. Connecticut	CT	N							0	
8. Delaware	DE	N							0	
9. Dist. Columbia	DC	N							0	
10. Florida	FL	N							0	
11. Georgia	GA	N							0	
12. Hawaii	HI	N							0	
13. Idaho	ID	N							0	
14. Illinois	IL	N							0	
15. Indiana	IN	N							0	
16. Iowa	IA	N							0	
17. Kansas	KS	N							0	
18. Kentucky	KY	N							0	
19. Louisiana	LA	N							0	
20. Maine	ME	N							0	
21. Maryland	MD	N							0	
22. Massachusetts	MA	N							0	
23. Michigan	MI	N							0	
24. Minnesota	MN	N							0	
25. Mississippi	MS	N							0	
26. Missouri	MO	N							0	
27. Montana	MT	N							0	
28. Nebraska	NE	N							0	
29. Nevada	NV	N							0	
30. New Hampshire	NH	N							0	
31. New Jersey	NJ	N							0	
32. New Mexico	NM	N							0	
33. New York	NY	N							0	
34. North Carolina	NC	N							0	
35. North Dakota	ND	N							0	
36. Ohio	OH	L	37,440						37,440	
37. Oklahoma	OK	N							0	
38. Oregon	OR	N							0	
39. Pennsylvania	PA	L	24,336,654	241,826,545	45,957,527	47,400,373			359,521,099	
40. Rhode Island	RI	N							0	
41. South Carolina	SC	N							0	
42. South Dakota	SD	N							0	
43. Tennessee	TN	N							0	
44. Texas	TX	N							0	
45. Utah	UT	N							0	
46. Vermont	VT	N							0	
47. Virginia	VA	N							0	
48. Washington	WA	N							0	
49. West Virginia	WV	N							0	
50. Wisconsin	WI	N							0	
51. Wyoming	WY	N							0	
52. American Samoa	AS	N							0	
53. Guam	GU	N							0	
54. Puerto Rico	PR	N							0	
55. U.S. Virgin Islands	VI	N							0	
56. Northern Mariana Islands	MP	N							0	
57. Canada	CN	N							0	
58. Aggregate other alien	OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal	XXX		24,374,094	241,826,545	45,957,527	47,400,373	0	0	359,558,539	0
60. Reporting entity contributions for Employee Benefit Plans	XXX								0	
61. Total (Direct Business)	(a) 2		24,374,094	241,826,545	45,957,527	47,400,373	0	0	359,558,539	0
<b>DETAILS OF WRITE-INS</b>										
5801.	XXX								0	
5802.	XXX								0	
5803.	XXX								0	
5898. Summary of remaining write-ins for Line 58 from overflow page.	XXX		0	0	0	0	0	0	0	0
5899. Totals (Lines 5801 through 5803 plus 5898) (Line 58 above)	XXX		0	0	0	0	0	0	0	0

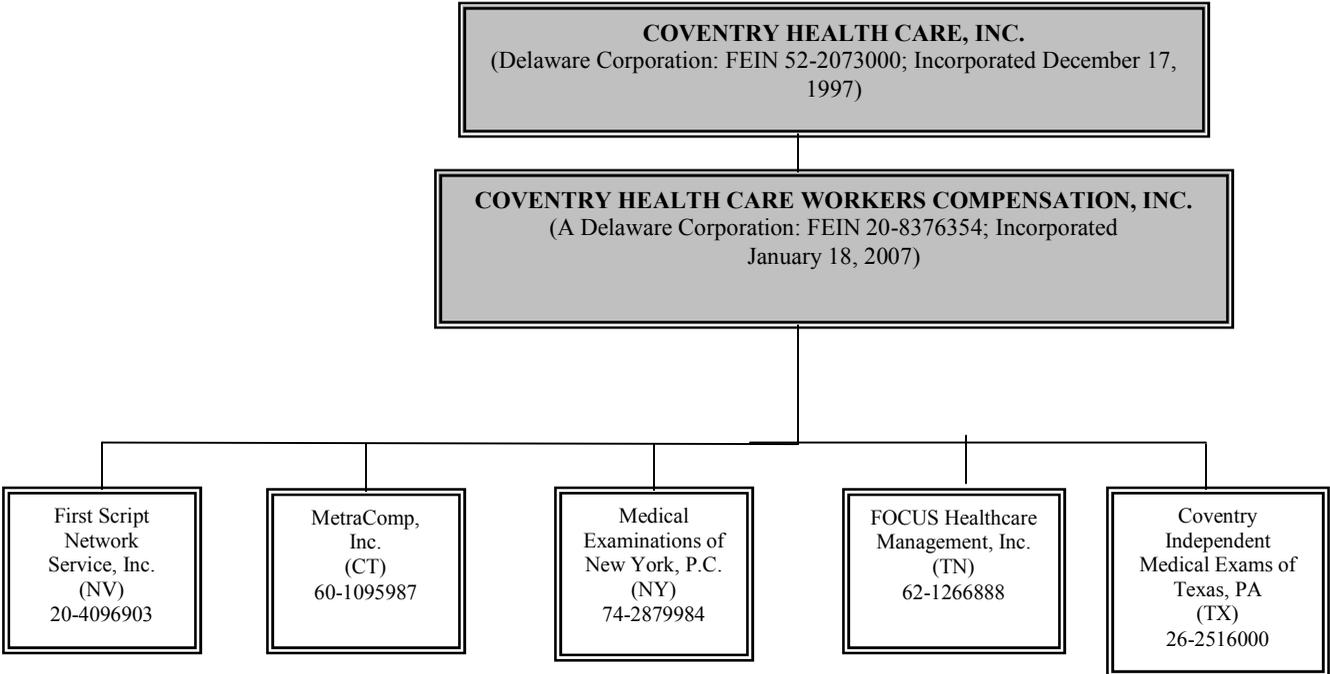
(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.

(a) Insert the number of L responses except for Canada and other Alien.

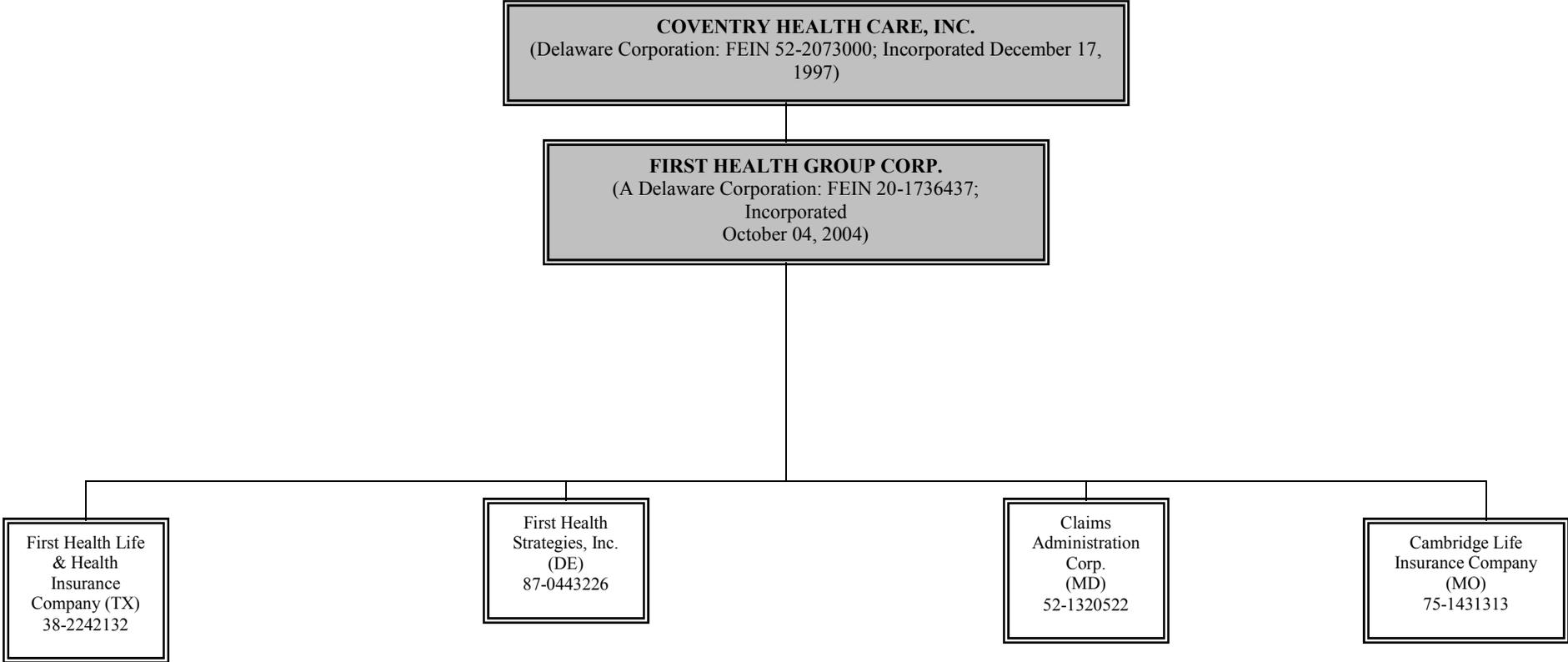
**COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (as of September 30, 2011)**



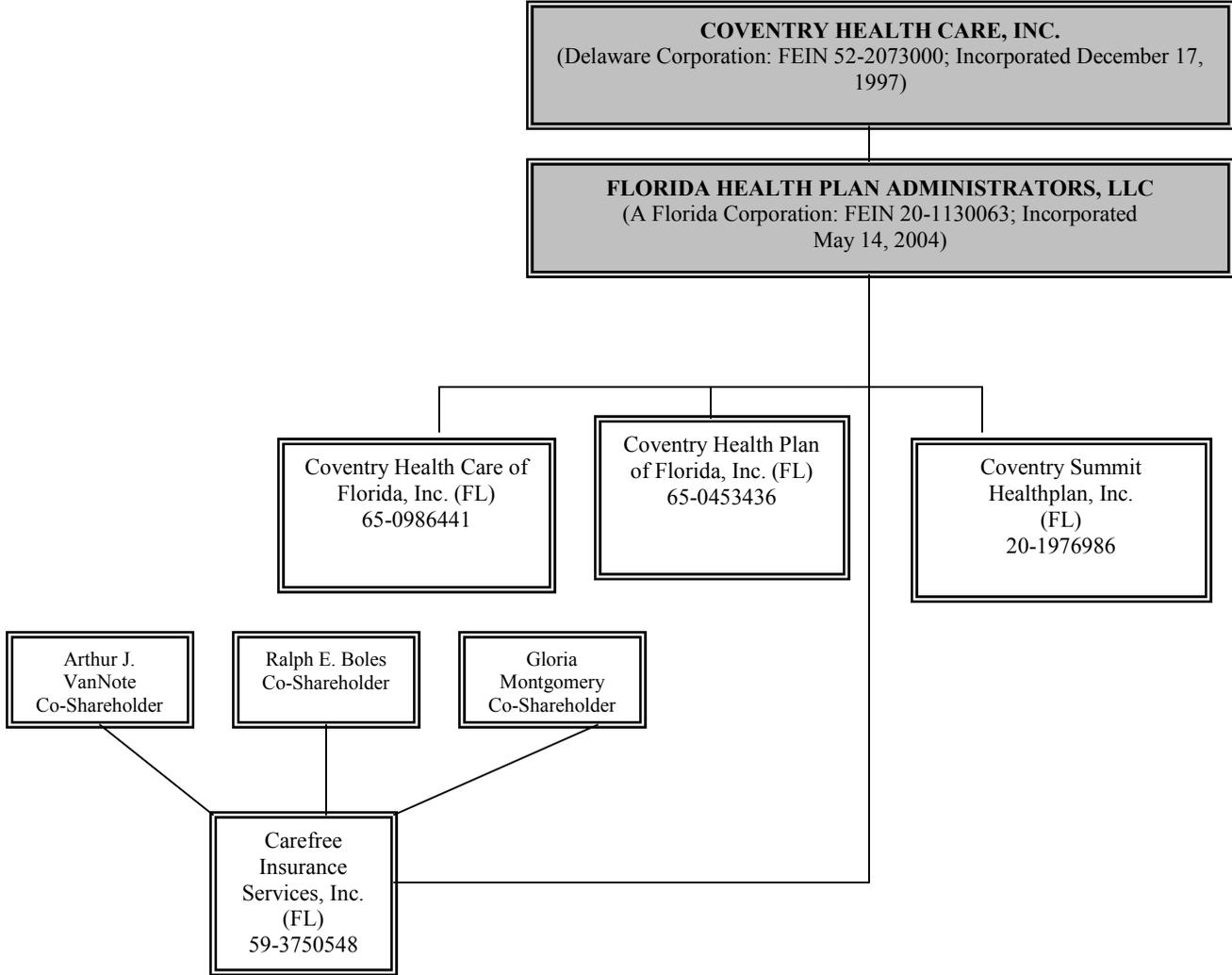
**COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (as of September 30, 2011)**



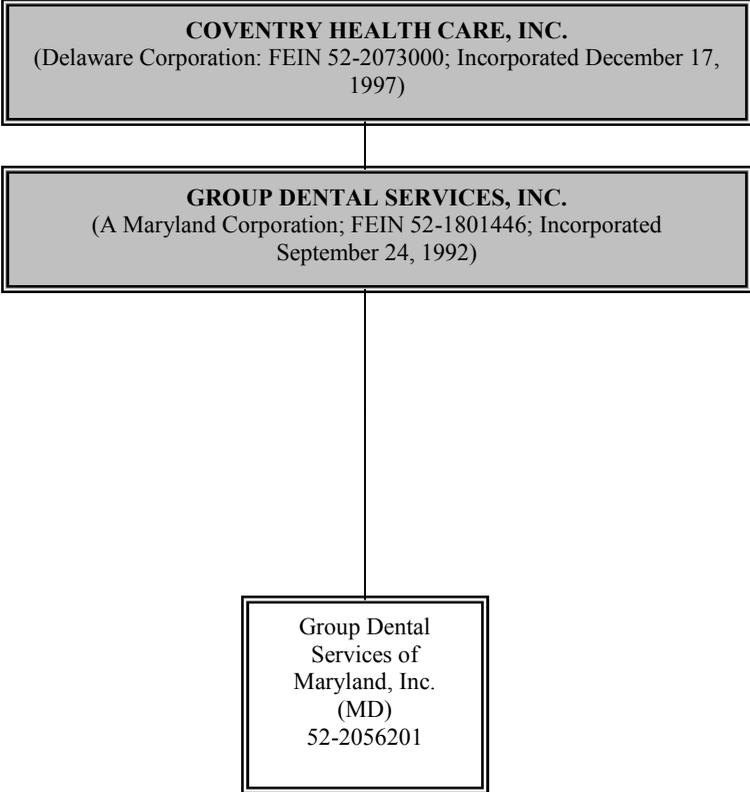
**COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (as of September 30, 2011)**



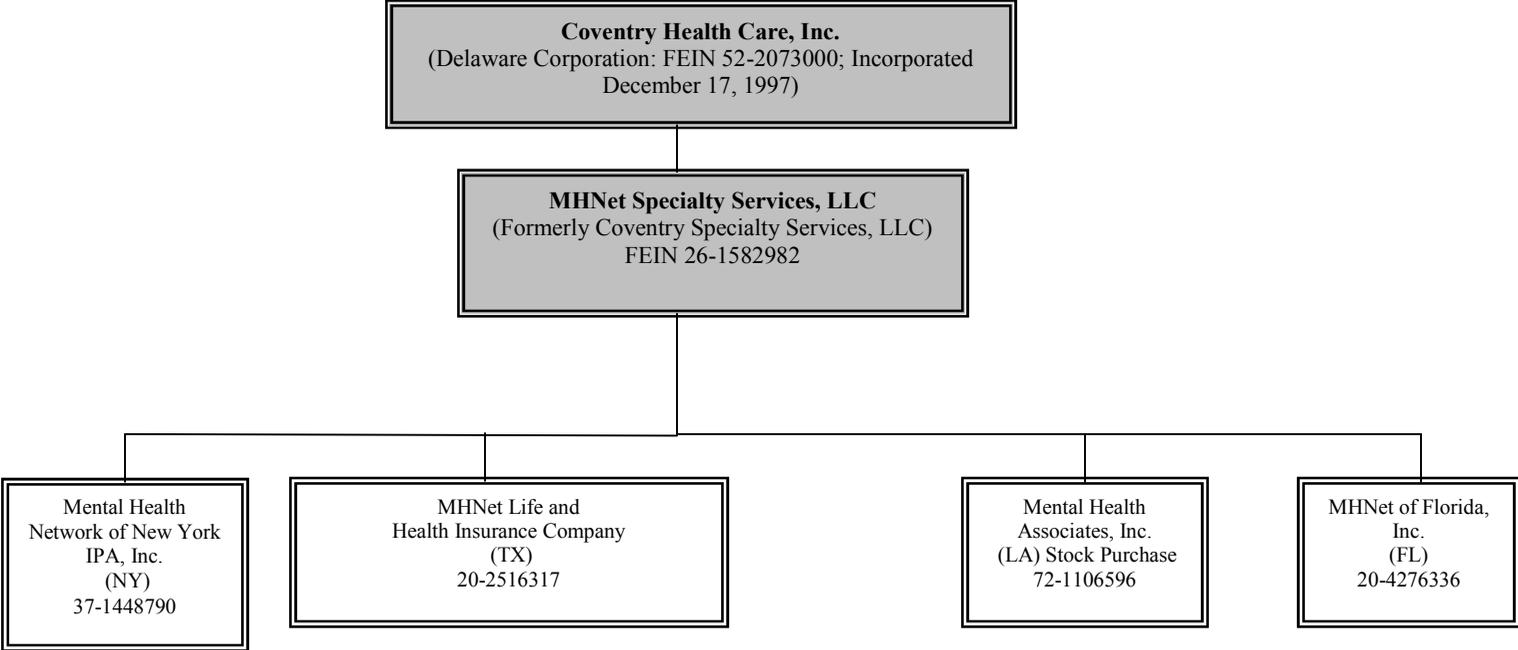
**COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (as of September 30, 2011)**



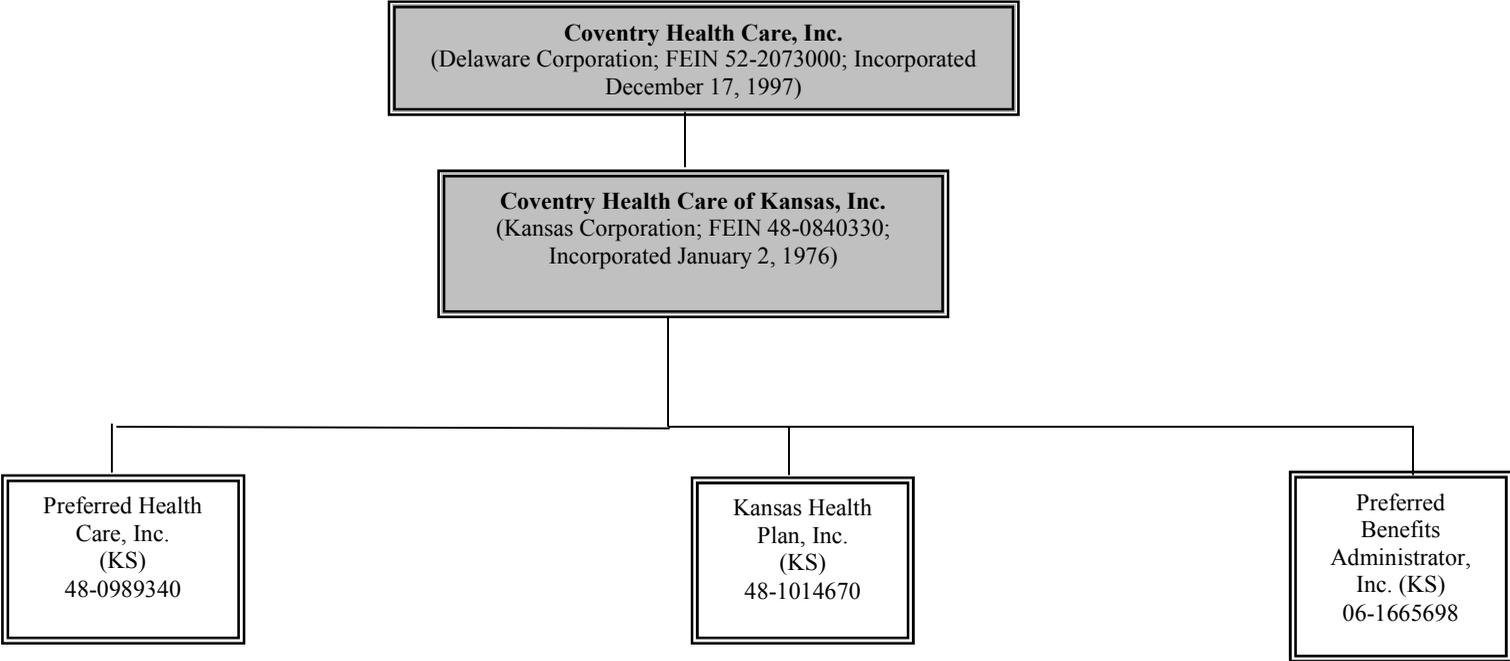
**COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (as of September 30, 2011)**



**COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (as of September 30, 2011)**



**COVENTRY HEALTH CARE, INC. ORGANIZATIONAL CHART (as of September 30, 2011)**



## SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of **NO** to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter **SEE EXPLANATION** and provide an explanation following the interrogatory questions.

RESPONSE

1. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC with this statement?

.....NO.....

**Explanation:**

1.

**Bar Code:**

1.



**OVERFLOW PAGE FOR WRITE-INS**

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## SCHEDULE A – VERIFICATION

### Real Estate

	1 Year To Date	2 Prior Year Ended December 31
1. Book/adjusted carrying value, December 31 of prior year .....	0	0
2. Cost of acquired:		
2.1 Actual cost at time of acquisition .....	0	0
2.2 Additional investment made after acquisition .....	0	0
3. Current year change in encumbrances .....	<b>NONE</b>	0
4. Total gain (loss) on disposals .....	0	0
5. Deduct amounts received on disposals .....	0	0
6. Total foreign exchange change in book/adjusted carrying value .....	0	0
7. Deduct current year's other than temporary impairment recognized .....	0	0
8. Deduct current year's depreciation .....	0	0
9. Book/adjusted carrying value at the end of current period (Lines 1+2+3+4-5+6-7-8) .....	0	0
10. Deduct total nonadmitted amounts .....	0	0
11. Statement value at end of current period (Line 9 minus Line 10)	0	0

## SCHEDULE B – VERIFICATION

### Mortgage Loans

	1 Year To Date	2 Prior Year Ended December 31
1. Book value/recorded investment excluding accrued interest, December 31 of prior year .....	0	0
2. Cost of acquired:		
2.1 Actual cost at time of acquisition .....	0	0
2.2 Additional investment made after acquisition .....	0	0
3. Capitalized deferred interest and other .....	0	0
4. Accrual of discount .....	0	0
5. Unrealized valuation increase (decrease) .....	<b>NONE</b>	0
6. Total gain (loss) on disposals .....	0	0
7. Deduct amounts received on disposals .....	0	0
8. Deduct amortization of premium and mortgage interest points and commitment fees .....	0	0
9. Total foreign exchange change in book value/recorded investment excluding accrued interest .....	0	0
10. Deduct current year's other than temporary impairment recognized .....	0	0
11. Book value/recorded investment excluding accrued interest at end of current period (Lines 1+2+3+4+5+6-7-8+9-10) .....	0	0
12. Total valuation allowance .....	0	0
13. Subtotal (Line 11 plus Line 12) .....	0	0
14. Deduct total nonadmitted amounts .....	0	0
15. Statement value at end of current period (Line 13 minus Line 14)	0	0

## SCHEDULE BA – VERIFICATION

### Other Long-Term Invested Assets

	1 Year To Date	2 Prior Year Ended December 31
1. Book/adjusted carrying value, December 31 of prior year .....	0	0
2. Cost of acquired:		
2.1 Actual cost at time of acquisition .....	0	0
2.2 Additional investment made after acquisition .....	0	0
3. Capitalized deferred interest and other .....	<b>NONE</b>	0
4. Accrual of discount .....	0	0
5. Unrealized valuation increase (decrease) .....	0	0
6. Total gain (loss) on disposals .....	0	0
7. Deduct amounts received on disposals .....	0	0
8. Deduct amortization of premium and depreciation .....	0	0
9. Total foreign exchange change in book/adjusted carrying value .....	0	0
10. Deduct current year's other than temporary impairment recognized .....	0	0
11. Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10) .....	0	0
12. Deduct total nonadmitted amounts .....	0	0
13. Statement value at end of current period (Line 11 minus Line 12)	0	0

## SCHEDULE D – VERIFICATION

### Bonds and Stocks

	1 Year To Date	2 Prior Year Ended December 31
1. Book/adjusted carrying value of bonds and stocks, December 31 of prior year .....	119,950,377	160,610,433
2. Cost of bonds and stocks acquired .....	45,611,058	28,262,491
3. Accrual of discount .....	17,410	34,889
4. Unrealized valuation increase (decrease) .....	0	0
5. Total gain (loss) on disposals .....	63,147	924,877
6. Deduct consideration for bonds and stocks disposed of .....	44,792,578	68,776,789
7. Deduct amortization of premium .....	615,202	1,105,524
8. Total foreign exchange change in book/adjusted carrying value .....	0	0
9. Deduct current year's other than temporary impairment recognized .....	0	0
10. Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9) .....	120,234,212	119,950,377
11. Deduct total nonadmitted amounts .....	0	0
12. Statement value at end of current period (Line 10 minus Line 11)	120,234,212	119,950,377

STATEMENT AS OF SEPTEMBER 30, 2011 OF THE HealthAmerica Pennsylvania, Inc.

**SCHEDULE D - PART 1B**

Showing the Acquisitions, Dispositions and Non-Trading Activity  
During the Current Quarter for all Bonds and Preferred Stock by Rating Class

	1 Book/Adjusted Carrying Value Beginning of Current Quarter	2 Acquisitions During Current Quarter	3 Dispositions During Current Quarter	4 Non-Trading Activity During Current Quarter	5 Book/Adjusted Carrying Value End of First Quarter	6 Book/Adjusted Carrying Value End of Second Quarter	7 Book/Adjusted Carrying Value End of Third Quarter	8 Book/Adjusted Carrying Value December 31 Prior Year
<b>BONDS</b>								
1. Class 1 (a).....	118,086,045	29,773,396	15,261,014	(189,788)	148,913,885	118,086,045	132,408,639	160,001,524
2. Class 2 (a).....	2,333,564	0	0	(5,012)	3,313,782	2,333,564	2,328,552	3,088,542
3. Class 3 (a).....	0	0	0	0	0	0	0	0
4. Class 4 (a).....	0	0	0	0	0	0	0	0
5. Class 5 (a).....	0	0	0	0	0	0	0	0
6. Class 6 (a).....	0	0	0	0	0	0	0	0
7. Total Bonds	120,419,609	29,773,396	15,261,014	(194,800)	152,227,667	120,419,609	134,737,191	163,090,066
<b>PREFERRED STOCK</b>								
8. Class 1.....	0	0	0	0	0	0	0	0
9. Class 2.....	0	0	0	0	0	0	0	0
10. Class 3.....	0	0	0	0	0	0	0	0
11. Class 4.....	0	0	0	0	0	0	0	0
12. Class 5.....	0	0	0	0	0	0	0	0
13. Class 6.....	0	0	0	0	0	0	0	0
14. Total Preferred Stock.....	0	0	0	0	0	0	0	0
15. Total Bonds & Preferred Stock	120,419,609	29,773,396	15,261,014	(194,800)	152,227,667	120,419,609	134,737,191	163,090,066

(a) Book/Adjusted Carrying Value column for the end of the current reporting period includes the following amount of non-rated short-term and cash equivalent bonds by NAIC designation: NAIC 1 \$ .....14,502,976 ; NAIC 2 \$ .....0 ;  
NAIC 3 \$ .....0 ; NAIC 4 \$ .....0 ; NAIC 5 \$ .....0 ; NAIC 6 \$ .....0

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**SCHEDULE DA - PART 1**

## Short-Term Investments

	1	2	3	4	5
	Book/Adjusted Carrying Value	Par Value	Actual Cost	Interest Collected Year To Date	Paid for Accrued Interest Year To Date
9199999	4,469,616	XXX	4,468,052	0	502

**SCHEDULE DA - VERIFICATION**

## Short-Term Investments

	1	2
	Year To Date	Prior Year Ended December 31
1. Book/adjusted carrying value, December 31 of prior year.....	35,120,359	14,751,104
2. Cost of short-term investments acquired .....	90,648,159	263,462,100
3. Accrual of discount .....	11,012	0
4. Unrealized valuation increase (decrease).....	0	0
5. Total gain (loss) on disposals .....	2,005	0
6. Deduct consideration received on disposals .....	121,297,144	243,092,845
7. Deduct amortization of premium.....	14,775	0
8. Total foreign exchange change in book/adjusted carrying value.....	0	0
9. Deduct current year's other than temporary impairment recognized.....	0	0
10. Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9).....	4,469,616	35,120,359
11. Deduct total nonadmitted amounts.....	0	0
12. Statement value at end of current period (Line 10 minus Line 11)	4,469,616	35,120,359

Schedule DB - Part A - Verification

**NONE**

Schedule DB - Part B - Verification

**NONE**

Schedule DB - Part C - Section 1

**NONE**

Schedule DB - Part C - Section 2

**NONE**

Schedule DB - Verification

**NONE**

**SCHEDULE E - VERIFICATION**

(Cash Equivalents)

	1 Year To Date	2 Prior Year Ended December 31
1. Book/adjusted carrying value, December 31 of prior year.....	8,019,328	9,610,642
2. Cost of cash equivalents acquired .....	80,103,313	60,009,147
3. Accrual of discount .....	3,702	45
4. Unrealized valuation increase (decrease) .....	0	0
5. Total gain (loss) on disposals.....	590	0
6. Deduct consideration received on disposals .....	78,090,194	61,598,146
7. Deduct amortization of premium .....	3,379	2,359
8. Total foreign exchange change in book/adjusted carrying value .....	0	0
9. Deduct current year's other than temporary impairment recognized .....	0	0
10. Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9) .....	10,033,360	8,019,329
11. Deduct total nonadmitted amounts .....	0	0
12. Statement value at end of current period (Line 10 minus Line 11)	10,033,360	8,019,329

Schedule A - Part 2

**NONE**

Schedule A - Part 3

**NONE**

Schedule B - Part 2

**NONE**

Schedule B - Part 3

**NONE**

Schedule BA - Part 2

**NONE**

Schedule BA - Part 3

**NONE**

STATEMENT AS OF SEPTEMBER 30, 2011 OF THE HealthAmerica Pennsylvania, Inc.

**SCHEDULE D - PART 3**

Show All Long-Term Bonds and Stock Acquired During the Current Quarter

1	2	3	4	5	6	7	8	9	10
CUSIP Identification	Description	Foreign	Date Acquired	Name of Vendor	Number of Shares of Stock	Actual Cost	Par Value	Paid for Accrued Interest and Dividends	NAIC Designation or Market Indicator (a)
<b>Bonds - U.S. Governments</b>									
313462-B9-2	FREDDIE MAC		.08/24/2011	BNP PARIBUS SECURITIES		165,000	165,000	0	1
313462-06-2	FREDDIE MAC		.09/27/2011	J.P. MORGAN		166,883	167,000	0	1
313462-UC-4	FREDDIE MAC		.08/03/2011	J.P. MORGAN		274,973	275,000	0	1
912828-LR-9	US TREASURY N/B		.08/02/2011	BNP PARIBUS SECURITIES		390,098	385,000	1,591	1
912828-RA-0	US TREASURY N/B		.07/06/2011	DIRECT		400,118	400,000	24	1
912828-RD-4	US TREASURY N/B		.09/15/2011	BARCLAYS AMERICAN		104,856	105,000	6	1
<b>0599999 - Bonds - U.S. Governments</b>						1,501,928	1,497,000	1,621	XXX
<b>Bonds - U.S. Political Subdivisions of States, Territories and Possessions</b>									
013595-KH-5	ALBUQUERQUE NM MUNT SCH DIST #		.07/13/2011	MORGAN KEEGAN & CO INC		557,560	500,000	11,597	1FE
215111-AY-1	COOK CNTY IL SCH DIST #150 SOU		.07/15/2011	BMO CAPITAL MARKETS - US		449,815	500,000	3,063	1FE
<b>2499999 - Bonds - U.S. Political Subdivisions of States, Territories and Possessions</b>						1,007,375	1,000,000	14,660	XXX
<b>Bonds - U.S. Special Revenue</b>									
31326F-CK-1	F6 001874		.07/01/2011	WELLS FARGO SECURITIES LLC		995,883	999,631	1,444	1
313375-R3-3	FEDERAL HOME LOAN BANK		.09/15/2011	BNP PARIBUS SECURITIES		275,000	275,000	0	1
64989K-HX-7	NEW YORK ST PWR AUTH REVENUE		.09/22/2011	RAMIREZ & CO		927,578	750,000	0	1FE
79575D-N7-1	SALT RIVER AZ PROJ AGRIC IMPT		.09/22/2011	CITIGROUP GLOBAL MARKETS		1,190,380	1,000,000	0	1FE
919061-FC-0	VALDEZ AK MARINE TERMINAL REVE		.09/21/2011	GOLDMAN SACHS		705,513	625,000	0	1FE
956704-XF-2	WEST VIRGINIA ST UNIV REVENUES		.09/22/2011	J.P. MORGAN		861,870	750,000	0	1FE
<b>3199999 - Bonds - U.S. Special Revenue and Special Assessment and all Non-Guaranteed Obligations of Agencies and Authorities of Government and Their Political Subdivisions</b>						4,956,224	4,399,631	1,444	XXX
<b>Bonds - Industrial and Miscellaneous (Unaffiliated)</b>									
06051G-DX-4	BANK OF AMERICA CORP		.09/01/2011	MIZUHO SECURITIES		515,480	500,000	9,888	1FE
06051G-EL-9	BANK OF AMERICA CORP		.07/07/2011	BANK AMERICA		160,000	160,000	0	1FE
084670-BA-5	BERKSHIRE HATHAWAY INC		.08/10/2011	GOLDMAN SACHS		165,000	165,000	0	1FE
36962G-3U-6	GENERAL ELEC CAP CORP		.09/01/2011	CITIGROUP GLOBAL MARKETS		559,880	500,000	9,844	1FE
38141G-FM-1	GOLDMAN SACHS GROUP INC		.09/19/2011	J.P. MORGAN		532,985	500,000	14,606	1FE
742718-DU-0	PROCTER & GAMBLE CO/THE		.08/10/2011	DEUTSCHE BANK		99,589	100,000	0	1FE
87612E-AX-4	TARGET CORP		.07/13/2011	BARCLAYS AMERICAN		151,000	151,000	0	1FE
89114Q-AC-2	TORONTO-DOMINION BANK	A	.07/07/2011	GOLDMAN SACHS		111,000	111,000	0	1FE
<b>3899999 - Bonds - Industrial and Miscellaneous (Unaffiliated)</b>						2,294,934	2,187,000	34,338	XXX
<b>8399997 - Subtotals - Bonds - Part 3</b>						9,760,461	9,083,631	52,063	XXX
<b>8399999 - Subtotals - Bonds</b>						9,760,461	9,083,631	52,063	XXX
<b>9999999 Totals</b>						9,760,461	XXX	52,063	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues .....0

STATEMENT AS OF SEPTEMBER 30, 2011 OF THE HealthAmerica Pennsylvania, Inc.

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change in Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Identification	Description	Foreign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consideration	Par Value	Actual Cost	Prior Year Book/Adjusted Carrying Value	Unrealized Valuation Increase/(Decrease)	Current Year's (Amortization)/Accretion	Current Year's Other Than Temporary Impairment Recognized	Total Change in B./A.C.V. (11+12-13)	Total Foreign Exchange Change in B./A.C.V.	Book/Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/Stock Dividends Received During Year	Maturity Date	NAIC Designation or Market Indicator (a)
<b>Bonds - U.S. Governments</b>																					
362905-UD-1	GN 616280		09/01/2011	MBS PAYMENT		6,536	6,536	6,589	6,545	0	(9)	0	(9)	0	6,536	0	0	0	195	07/01/2018	1
36297F-UJ-9	GN 710785		09/01/2011	MBS PAYMENT		12,427	12,427	13,106	12,500	0	(73)	0	(73)	0	12,427	0	0	0	502	05/01/2039	1
912828-LV-0	US TREASURY N/B		09/09/2011	VARIOUS		102,000	102,000	102,358	102,121	0	(121)	0	(121)	0	102,000	0	0	0	1,020	08/31/2011	1
<b>0599999 - Bonds - U.S. Governments</b>						120,963	120,963	122,053	121,166	0	(203)	0	(203)	0	120,963	0	0	0	1,717	XXX	XXX
<b>Bonds - U.S. Special Revenue and Special Assessment and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</b>																					
31281L-AL-2	FG N70011		09/01/2011	MBS PAYMENT		515	515	553	517	0	(2)	0	(2)	0	515	0	0	0	34	11/01/2018	1
312875-3F-2	FG 067098		09/01/2011	MBS PAYMENT		782	782	782	782	0	0	0	0	0	782	0	0	0	38	09/01/2011	1
3128JR-PW-2	FH 847628		09/15/2011	VARIOUS		4,577	4,577	4,569	4,575	0	2	0	2	0	4,577	0	0	0	158	01/01/2036	1
3128M7-PX-8	FG 605538		09/01/2011	MBS PAYMENT		48,331	48,331	49,388	48,341	0	(10)	0	(10)	0	48,331	0	0	0	1,613	05/01/2038	1
3128M7-WP-7	FG 605754		09/01/2011	MBS PAYMENT		14,020	14,020	14,563	14,046	0	(26)	0	(26)	0	14,020	0	0	0	462	01/01/2039	1
3128PT-QW-8	FG J14069		09/01/2011	MBS PAYMENT		31,384	31,384	31,587	31,046	0	(20)	0	(20)	0	31,384	0	0	0	629	11/01/2025	1
312905-L3-4	FHR 1078 GZ		09/01/2011	MBS PAYMENT		179	179	174	179	0	0	0	0	0	179	0	0	0	8	10/01/2018	1
312907-F6-0	FHR 1175 D		09/01/2011	MBS PAYMENT		741	741	746	741	0	0	0	0	0	741	0	0	0	38	11/01/2021	1
31290K-UJ-6	FH 555085		09/15/2011	VARIOUS		138	138	146	139	0	(1)	0	(1)	0	138	0	0	0	11	09/01/2014	1
31295M-HE-3	FH 788329		09/01/2011	VARIOUS		1	1	1	1	0	0	0	0	0	1	0	0	0	0	07/01/2031	1
31297P-Z2-0	FG A34361		09/01/2011	MBS PAYMENT		15,728	15,728	15,916	15,726	0	2	0	2	0	15,728	0	0	0	566	03/01/2034	1
31326F-CK-1	FG 001874		09/01/2011	MBS PAYMENT		2,670	2,670	2,660	2,670	0	0	0	0	0	2,670	0	0	0	13	06/01/2041	1
313401-2C-4	FH 360123		09/15/2011	VARIOUS		67	67	72	67	0	0	0	0	0	67	0	0	0	5	09/01/2020	1
31358F-ZB-8	FNR 1991-6 ZD		09/01/2011	MBS PAYMENT		852	852	886	857	0	(5)	0	(5)	0	852	0	0	0	53	11/01/2020	1
313602-NR-1	FNR 1989-14 Z		09/01/2011	MBS PAYMENT		370	370	396	373	0	(3)	0	(3)	0	370	0	0	0	25	03/01/2019	1
31364H-GL-5	FNS 66 1		09/01/2011	MBS PAYMENT		69	69	69	69	0	0	0	0	0	69	0	0	0	4	08/01/2019	1
31371K-AA-3	FN 253927		09/01/2011	MBS PAYMENT		497	497	494	496	0	1	0	1	0	497	0	0	0	22	01/01/2030	1
31371L-OY-8	FN 255271		09/01/2011	MBS PAYMENT		19,848	19,848	19,854	19,848	0	0	0	0	0	19,848	0	0	0	662	11/01/2023	1
31371L-WR-6	FN 255456		09/01/2011	MBS PAYMENT		16,878	16,878	17,295	16,891	0	(12)	0	(12)	0	16,878	0	0	0	615	03/01/2024	1
31386F-F7-5	FN 561890		09/01/2011	MBS PAYMENT		9	9	9	9	0	0	0	0	0	9	0	0	0	0	07/01/2030	1
31386T-6C-4	FN 573367		09/01/2011	MBS PAYMENT		82	82	80	82	0	0	0	0	0	82	0	0	0	3	04/01/2031	1
31387C-L4-1	FN 580047		09/01/2011	MBS PAYMENT		800	800	791	799	0	1	0	1	0	800	0	0	0	35	10/01/2029	1
31387D-3T-4	FN 581410		09/01/2011	MBS PAYMENT		623	623	620	622	0	1	0	1	0	623	0	0	0	27	06/01/2028	1
31387E-KT-3	FN 581806		09/01/2011	MBS PAYMENT		251	251	254	252	0	(1)	0	(1)	0	251	0	0	0	12	12/01/2030	1
31387F-ES-9	FN 582545		09/01/2011	MBS PAYMENT		3,262	3,262	3,244	3,259	0	3	0	3	0	3,262	0	0	0	158	05/01/2030	1
31387W-3N-5	FN 596705		09/01/2011	MBS PAYMENT		4,740	4,740	4,739	4,739	0	1	0	1	0	4,740	0	0	0	191	11/01/2030	1
31389D-OR-1	FN 622464		09/01/2011	MBS PAYMENT		232	232	230	232	0	0	0	0	0	232	0	0	0	9	11/01/2016	1
31389F-J6-0	FN 624085		09/01/2011	MBS PAYMENT		270	270	273	271	0	(1)	0	(1)	0	270	0	0	0	13	12/01/2030	1
31389S-TE-4	FN 634249		09/01/2011	MBS PAYMENT		292	292	288	291	0	1	0	1	0	292	0	0	0	12	07/01/2031	1
31389V-RU-3	FN 636899		09/01/2011	MBS PAYMENT		380	380	380	380	0	0	0	0	0	380	0	0	0	16	10/01/2031	1
31391E-AP-6	FN 664314		09/01/2011	MBS PAYMENT		7,808	7,808	7,938	7,827	0	(18)	0	(18)	0	7,808	0	0	0	265	03/01/2017	1
31402F-BX-2	FN 727354		09/01/2011	MBS PAYMENT		33,228	33,228	33,171	33,216	0	11	0	11	0	33,228	0	0	0	1,090	12/01/2017	1
31403C-6L-0	FN 745275		09/01/2011	MBS PAYMENT		24,756	24,756	23,870	24,740	0	16	0	16	0	24,756	0	0	0	829	02/01/2035	1
31403C-6U-0	FN 745283		09/01/2011	MBS PAYMENT		20,491	20,491	19,767	20,494	0	(3)	0	(3)	0	20,491	0	0	0	757	02/01/2035	1
31405E-63-3	FN 786918		09/01/2011	MBS PAYMENT		1,745	1,745	1,800	1,753	0	(8)	0	(8)	0	1,745	0	0	0	64	05/01/2019	1
31405V-2E-6	FN 800973		09/01/2011	MBS PAYMENT		22,227	22,227	22,693	22,265	0	(38)	0	(38)	0	22,227	0	0	0	751	03/01/2019	1
31406L-0D-3	FN 813252		09/01/2011	MBS PAYMENT		17,817	17,817	18,155	17,817	0	12	0	12	0	17,817	0	0	0	668	06/01/2034	1
31406P-QM-4	FN 815960		09/01/2011	MBS PAYMENT		4,442	4,442	4,488	4,439	0	3	0	3	0	4,442	0	0	0	171	05/01/2034	1
31407A-PZ-8	FN 824940		09/01/2011	MBS PAYMENT		10,947	10,947	11,005	10,941	0	6	0	6	0	10,947	0	0	0	419	11/01/2034	1
31407L-ZR-1	FN 834252		09/01/2011	MBS PAYMENT		16,800	16,800	17,189	16,807	0	(7)	0	(7)	0	16,800	0	0	0	748	10/01/2034	1
31410F-D7-7	FN 887626		09/01/2011	MBS PAYMENT		21,273	21,273	21,421	21,336	0	(64)	0	(64)	0	21,273	0	0	0	745	07/01/2036	1
31410Q-W4-4	FN 894269		09/01/2011	MBS PAYMENT		36,487	36,487	36,350	36,466	0	21	0	21	0	36,487	0	0	0	1,308	10/01/2036	1
31410S-YK-7	FN 896314		09/01/2011	MBS PAYMENT		18,674	18,674	18,339	18,674	0	23	0	23	0	18,674	0	0	0	721	07/01/2035	1
31410T-L7-8	FN 896850		09/01/2011	MBS PAYMENT		25,708	25,708	25,862	25,715	0	(7)	0	(7)	0	25,708	0	0	0	878	06/01/2021	1
31411D-SB-6	FN 905114		09/01/2011	MBS PAYMENT		31,963	31,963	32,130	31,953	0	8	0	8	0	31,963	0	0	0	1,362	05/01/2036	1
31411J-TX-4	FN 909666		09/01/2011	MBS PAYMENT		35,162	35,162	34,775	35,145	0	17	0	17	0	35,162	0	0	0	1,257	08/01/2036	1
31411L-YN-5	FN 911617		09/01/2011	MBS PAYMENT		23,996	23,996	24,067	23,986	0	10	0	10	0	23,996	0	0	0	993	09/01/2036	1
31413F-GL-0	FN 944003		09/01/2011	MBS PAYMENT		31,766	31,766	31,557	31,748	0	18	0	18	0	31,766	0	0	0	1,253	02/01/2037	1
31419J-SZ-2	FN AE7735		09/01/2011	MBS PAYMENT		32,679	32,679	34,359	32,679	0	(133)	0	(133)	0	32,679	0	0	0	908	04/01/2040	1
31419K-DZ-5	FN AE8219		09/01/2011	MBS PAYMENT		24,542	24,542	25,048	24,542	0	(31)	0	(31)	0	24,542	0	0	0	538	08/01/2038	1
<b>3199999 - Bonds - U.S. Special Revenue and Special Assessment and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions</b>						611,099	611,0														



Schedule DB - Part A - Section 1

**NONE**

Schedule DB - Part B - Section 1

**NONE**

Schedule DB - Part D

**NONE**

Schedule DL - Part 1

**NONE**

Schedule DL - Part 2

**NONE**





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**ANNUAL STATEMENT**

OF THE

HealthAmerica Pennsylvania, Inc.

of

Harrisburg

in the state of

Pennsylvania

TO THE

Insurance Department

OF THE

STATE OF Pennsylvania

FOR THE YEAR ENDED

DECEMBER 31, 2010

**2010**

HEALTH

**2010**



**ANNUAL STATEMENT**  
**FOR THE YEAR ENDING DECEMBER 31, 2010**  
 OF THE CONDITION AND AFFAIRS OF THE

**HealthAmerica Pennsylvania, Inc.**

NAIC Group Code 1137 , 1137 NAIC Company Code 95060 Employer's ID Number 25-1264318  
(Current Period) (Prior Period)

Organized under the Laws of Pennsylvania , State of Domicile or Port of Entry Pennsylvania

Country of Domicile United States

Licensed as business type: Life, Accident & Health [ ] Property/Casualty [ ] Hospital, Medical & Dental Service or Indemnity [ ]  
 Dental Service Corporation [ ] Vision Service Corporation [ ] Health Maintenance Organization [ X ]  
 Other [ ] Is HMO, Federally Qualified? Yes [ X ] No [ ]

Incorporated/Organized 04/04/1974 Commenced Business 01/13/1975

Statutory Home Office 600 North Second Street, Suite 500 , Harrisburg, PA 17101  
(Street and Number) (City, State and Zip Code)

Main Administrative Office 3721 TecPort Drive, PO Box 67103  
(Street and Number)  
Harrisburg, PA 17106-7103 800-788-6445  
(City, State and Zip Code) (Area Code) (Telephone Number)

Mail Address 3721 TecPort Drive, PO Box 67103 , Harrisburg, PA 17106-7103  
(Street and Number or P.O. Box) (City, State and Zip Code)

Primary Location of Books and Records 3721 TecPort Drive, PO Box 67103  
(Street and Number)  
Harrisburg, PA 17106-7103 717-671-2411  
(City, State and Zip Code) (Area Code) (Telephone Number) (Extension)

Internet Web Site Address www.healthamerica.cvty.com

Statutory Statement Contact Dane J. Kreiss , 717-671-2411  
(Name) (Area Code) (Telephone Number) (Extension)  
dkreiss@cvty.com 717-671-5297  
(E-Mail Address) (Fax Number)

**OFFICERS**

Name	Title	Name	Title
<u>Timothy Edmund Nolan</u>	<u>Chief Executive Officer &amp; President</u>	<u>Evelyn Nedved Pendleton</u>	<u>Chief Financial Officer &amp; Treasurer</u>
<u>Nicholas Timothy Guarneschelli</u>	<u>Secretary &amp; Vice President</u>		

**OTHER OFFICERS**

<u>Shirley Ann Roquemore Smith</u>	<u>Assistant Secretary</u>	<u>Melinda Lee Tuozzo</u>	<u>Assistant Treasurer</u>
<u>John Joseph Ruhlmann #</u>	<u>Vice President, Finance</u>	<u>Dane Jason Kreiss</u>	<u>Corporate Controller</u>
<u>Mary Louise Osborne</u>	<u>Executive Vice President</u>	<u>Kristen Sheekey #</u>	<u>Acting Chief Actuary</u>

**DIRECTORS OR TRUSTEES**

<u>Robert Addison Mathias Ph.D</u>	<u>Ronald Michael Robinson Ph.D</u>	<u>Douglas Bruce Templeton #</u>	<u>John Charles Wallendjack M.D.</u>
<u>Frank Eugene Weaver</u>	<u>Timothy Edmund Nolan #</u>		

State of Pennsylvania

**ss**

County of Dauphin

The officers of this reporting entity, being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC *Annual Statement Instructions and Accounting Practices and Procedures* manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Timothy Edmund Nolan  
 Chief Executive Officer & President

Evelyn Nedved Pendleton  
 Chief Financial Officer & Treasurer

Nicholas Timothy Guarneschelli  
 Secretary & Vice President

Subscribed and sworn to before me this  
 \_\_\_\_\_ day of \_\_\_\_\_,  
 \_\_\_\_\_

- a. Is this an original filing? Yes [ X ] No [ ]
- b. If no:
1. State the amendment number \_\_\_\_\_
  2. Date filed \_\_\_\_\_
  3. Number of pages attached \_\_\_\_\_

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**ASSETS**

	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1. Bonds (Schedule D).....	119,950,378		119,950,378	160,610,438
2. Stocks (Schedule D):				
2.1 Preferred stocks .....				
2.2 Common stocks .....				
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens .....				
3.2 Other than first liens .....				
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$ ..... encumbrances).....				
4.2 Properties held for the production of income (less \$ ..... encumbrances) .....				
4.3 Properties held for sale (less \$ ..... encumbrances) .....				
5. Cash (\$ ..... (2,840,827) , Schedule E-Part 1), cash equivalents (\$ .....8,019,328 , Schedule E-Part 2) and short-term investments (\$ .....35,120,360 , Schedule DA).....	40,298,861		40,298,861	15,780,824
6. Contract loans (including \$ .....premium notes)				
7. Derivatives .....				
8. Other invested assets (Schedule BA) .....				
9. Receivables for securities .....	13,737		13,737	12,777
10. Securities lending reinvested collateral assets.....				
11. Aggregate write-ins for invested assets .....				
12. Subtotals, cash and invested assets (Lines 1 to 11) .....	160,262,976		160,262,976	176,404,039
13. Title plants less \$ .....charged off (for Title insurers only).....				
14. Investment income due and accrued .....	1,380,575		1,380,575	1,828,909
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection .....	4,267,733		4,267,733	20,486,802
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including \$ .....earned but unbilled premiums).....				
15.3 Accrued retrospective premiums.....	7,242,720		7,242,720	
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers .....	404,836		404,836	51,804
16.2 Funds held by or deposited with reinsured companies .....				
16.3 Other amounts receivable under reinsurance contracts .....				
17. Amounts receivable relating to uninsured plans .....	5,789		5,789	
18.1 Current federal and foreign income tax recoverable and interest thereon .....				
18.2 Net deferred tax asset.....	9,053,138	5,403,429	3,649,709	2,249,918
19. Guaranty funds receivable or on deposit .....				
20. Electronic data processing equipment and software.....	24,140	24,140		
21. Furniture and equipment, including health care delivery assets (\$ ..... ) .....	115,007	115,007		
22. Net adjustment in assets and liabilities due to foreign exchange rates .....				
23. Receivables from parent, subsidiaries and affiliates .....	6,791,914		6,791,914	5,892,699
24. Health care (\$ .....13,450,107 ) and other amounts receivable.....	13,473,442	23,335	13,450,107	
25. Aggregate write-ins for other than invested assets .....	4,360,842	4,360,842		
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25).....	207,383,112	9,926,753	197,456,359	206,914,171
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts.....				
28. Total (Lines 26 and 27)	207,383,112	9,926,753	197,456,359	206,914,171
<b>DETAILS OF WRITE-INS</b>				
1101. ....				
1102. ....				
1103. ....				
1198. Summary of remaining write-ins for Line 11 from overflow page .....				
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501. Prepaid Expenses.....	1,709,926	1,709,926		
2502. Intangible Assets.....	2,650,916	2,650,916		
2503. Construction in Progress.....				
2598. Summary of remaining write-ins for Line 25 from overflow page .....				
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	4,360,842	4,360,842		

## LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$ .....1,249,906 reinsurance ceded)	55,669,539	1,261,519	56,931,058	57,915,499
2. Accrued medical incentive pool and bonus amounts	14,248		14,248	16,181
3. Unpaid claims adjustment expenses	929,820		929,820	1,071,672
4. Aggregate health policy reserves				112,243
5. Aggregate life policy reserves				
6. Property/casualty unearned premium reserves				
7. Aggregate health claim reserves				
8. Premiums received in advance	826,600		826,600	1,334,193
9. General expenses due or accrued	13,766,261		13,766,261	12,914,223
10.1 Current federal and foreign income tax payable and interest thereon (including \$ ..... on realized capital gains (losses))	2,005,817		2,005,817	3,922,964
10.2 Net deferred tax liability				
11. Ceded reinsurance premiums payable				
12. Amounts withheld or retained for the account of others	477,581		477,581	81,747
13. Remittances and items not allocated	1,277,244		1,277,244	862,964
14. Borrowed money (including \$ ..... current) and interest thereon \$ ..... (including \$ ..... current)				
15. Amounts due to parent, subsidiaries and affiliates	2,327,348		2,327,348	2,359,319
16. Derivatives				
17. Payable for securities				
18. Payable for securities lending				
19. Funds held under reinsurance treaties (with \$ ..... authorized reinsurers and \$ ..... unauthorized reinsurers)				
20. Reinsurance in unauthorized companies				
21. Net adjustments in assets and liabilities due to foreign exchange rates				
22. Liability for amounts held under uninsured plans	2,043,499		2,043,499	3,383,776
23. Aggregate write-ins for other liabilities (including \$ ..... current)	29,345,640		29,345,640	25,099,685
24. Total liabilities (Lines 1 to 23)	108,683,597	1,261,519	109,945,116	109,074,466
25. Aggregate write-ins for special surplus funds	XXX	XXX		
26. Common capital stock	XXX	XXX	5	5
27. Preferred capital stock	XXX	XXX		
28. Gross paid in and contributed surplus	XXX	XXX	2,888,585	2,888,585
29. Surplus notes	XXX	XXX		
30. Aggregate write-ins for other than special surplus funds	XXX	XXX		
31. Unassigned funds (surplus)	XXX	XXX	84,622,653	94,951,115
32. Less treasury stock, at cost:				
32.1 ..... shares common (value included in Line 26 \$ ..... )	XXX	XXX		
32.2 ..... shares preferred (value included in Line 27 \$ ..... )	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	87,511,243	97,839,705
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	197,456,359	206,914,171
<b>DETAILS OF WRITE-INS</b>				
2301. Office of Personnel Management	7,331,913		7,331,913	6,371,667
2302. Medicare Payable Other	21,599,082		21,599,082	
2303. Abandon Property Liability	414,645		414,645	307,696
2398. Summary of remaining write-ins for Line 23 from overflow page				18,420,322
2399. Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	29,345,640		29,345,640	25,099,685
2501. ....	XXX	XXX		
2502. ....	XXX	XXX		
2503. ....	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX		
3001. ....	XXX	XXX		
3002. ....	XXX	XXX		
3003. ....	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099. Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX		

## STATEMENT OF REVENUE AND EXPENSES

	Current Year		Prior Year
	1 Uncovered	2 Total	3 Total
1. Member Months.....	XXX	733,293	1,249,142
2. Net premium income (including \$ ..... non-health premium income).....	XXX	478,031,244	608,309,210
3. Change in unearned premium reserves and reserve for rate credits .....	XXX		
4. Fee-for-service (net of \$ ..... medical expenses) .....	XXX		
5. Risk revenue .....	XXX		
6. Aggregate write-ins for other health care related revenues .....	XXX		
7. Aggregate write-ins for other non-health revenues .....	XXX	(1,145)	
8. Total revenues (Lines 2 to 7) .....	XXX	478,030,099	608,309,210
<b>Hospital and Medical:</b>			
9. Hospital/medical benefits .....	5,046,075	334,679,605	457,596,657
10. Other professional services .....			
11. Outside referrals .....			
12. Emergency room and out-of-area .....			
13. Prescription drugs .....		55,624,083	71,627,961
14. Aggregate write-ins for other hospital and medical .....		(12,904)	527,279
15. Incentive pool, withhold adjustments and bonus amounts.....		20,403	31,716
16. Subtotal (Lines 9 to 15) .....	5,046,075	390,311,187	529,783,613
<b>Less:</b>			
17. Net reinsurance recoveries .....		2,151,576	3,367,256
18. Total hospital and medical (Lines 16 minus 17) .....	5,046,075	388,159,611	526,416,357
19. Non-health claims (net).....			
20. Claims adjustment expenses, including \$ .....7,818,281 cost containment expenses.....		20,307,310	17,637,434
21. General administrative expenses.....		20,989,970	28,744,351
22. Increase in reserves for life and accident and health contracts (including \$ ..... increase in reserves for life only).....			
23. Total underwriting deductions (Lines 18 through 22) .....	5,046,075	429,456,891	572,798,142
24. Net underwriting gain or (loss) (Lines 8 minus 23) .....	XXX	48,573,208	35,511,068
25. Net investment income earned (Exhibit of Net Investment Income, Line 17).....		5,288,004	5,507,196
26. Net realized capital gains (losses) less capital gains tax of \$ .....323,707 .....		601,170	1,906,332
27. Net investment gains (losses) (Lines 25 plus 26) .....		5,889,174	7,413,528
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$ ..... ) (amount charged off \$ ..... )] .....			
29. Aggregate write-ins for other income or expenses .....			
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29).....	XXX	54,462,382	42,924,596
31. Federal and foreign income taxes incurred .....	XXX	18,316,197	19,417,042
32. Net income (loss) (Lines 30 minus 31) .....	XXX	36,146,185	23,507,554
<b>DETAILS OF WRITE-INS</b>			
0601. ....	XXX		
0602. ....	XXX		
0603. ....	XXX		
0698. Summary of remaining write-ins for Line 6 from overflow page .....	XXX		
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 6 above) .....	XXX		
0701. Loss on Disposal of Fixed Assets.....	XXX	(1,145)	
0702. ....	XXX		
0703. ....	XXX		
0798. Summary of remaining write-ins for Line 7 from overflow page .....	XXX		
0799. Totals (Lines 0701 through 0703 plus 0798) (Line 7 above) .....	XXX	(1,145)	
1401. Other Medical Expenses.....		(12,904)	527,279
1402. ....			
1403. ....			
1498. Summary of remaining write-ins for Line 14 from overflow page .....			
1499. Totals (Lines 1401 through 1403 plus 1498) (Line 14 above) .....		(12,904)	527,279
2901. ....			
2902. ....			
2903. ....			
2998. Summary of remaining write-ins for Line 29 from overflow page .....			
2999. Totals (Lines 2901 through 2903 plus 2998) (Line 29 above) .....			

**STATEMENT OF REVENUE AND EXPENSES (Continued)**

	1 Current Year	2 Prior Year
<b>CAPITAL &amp; SURPLUS ACCOUNT</b>		
33. Capital and surplus prior reporting year .....	97,839,705	90,214,615
34. Net income or (loss) from Line 32 .....	36,146,185	23,507,554
35. Change in valuation basis of aggregate policy and claim reserves .....		
36. Change in net unrealized capital gains (losses) less capital gains tax of \$ .....		
37. Change in net unrealized foreign exchange capital gain or (loss) .....		
38. Change in net deferred income tax .....	678,367	5,008,498
39. Change in nonadmitted assets .....	846,986	(4,890,962)
40. Change in unauthorized reinsurance .....		
41. Change in treasury stock .....		
42. Change in surplus notes .....		
43. Cumulative effect of changes in accounting principles .....		
44. Capital Changes:		
44.1 Paid in .....		
44.2 Transferred from surplus (Stock Dividend) .....		
44.3 Transferred to surplus .....		
45. Surplus adjustments:		
45.1 Paid in .....		
45.2 Transferred to capital (Stock Dividend) .....		
45.3 Transferred from capital .....		
46. Dividends to stockholders .....	(48,000,000)	(16,000,000)
47. Aggregate write-ins for gains or (losses) in surplus .....		
48. Net change in capital & surplus (Lines 34 to 47) .....	(10,328,462)	7,625,090
49. Capital and surplus end of reporting year (Line 33 plus 48)	87,511,243	97,839,705
<b>DETAILS OF WRITE-INS</b>		
4701. ....		
4702. ....		
4703. ....		
4798. Summary of remaining write-ins for Line 47 from overflow page .....		
4799. Totals (Lines 4701 through 4703 plus 4798) (Line 47 above)		

## CASH FLOW

	1 Current Year	2 Prior Year
<b>Cash from Operations</b>		
1. Premiums collected net of reinsurance.....	486,387,757	602,311,896
2. Net investment income.....	6,806,973	6,213,956
3. Miscellaneous income.....	(1,145)	
4. Total (Lines 1 through 3).....	493,193,585	608,525,852
5. Benefit and loss related payments.....	402,972,459	533,279,636
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts.....		
7. Commissions, expenses paid and aggregate write-ins for deductions.....	41,933,160	41,108,029
8. Dividends paid to policyholders.....		
9. Federal and foreign income taxes paid (recovered) net of \$..... tax on capital gains (losses)	20,557,051	12,711,920
10. Total (Lines 5 through 9).....	465,462,670	587,099,585
11. Net cash from operations (Line 4 minus Line 10).....	27,730,915	21,426,267
<b>Cash from Investments</b>		
12. Proceeds from investments sold, matured or repaid:		
12.1 Bonds.....	68,776,789	18,727,520
12.2 Stocks.....		
12.3 Mortgage loans.....		
12.4 Real estate.....		
12.5 Other invested assets.....		
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments.....		676
12.7 Miscellaneous proceeds.....		1
12.8 Total investment proceeds (Lines 12.1 to 12.7).....	68,776,789	18,728,197
13. Cost of investments acquired (long-term only):		
13.1 Bonds.....	28,262,491	49,078,893
13.2 Stocks.....		
13.3 Mortgage loans.....		
13.4 Real estate.....		
13.5 Other invested assets.....		
13.6 Miscellaneous applications.....	960	4,991
13.7 Total investments acquired (Lines 13.1 to 13.6).....	28,263,451	49,083,884
14. Net increase (decrease) in contract loans and premium notes.....		
15. Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14).....	40,513,338	(30,355,687)
<b>Cash from Financing and Miscellaneous Sources</b>		
16. Cash provided (applied):		
16.1 Surplus notes, capital notes.....		
16.2 Capital and paid in surplus, less treasury stock.....		
16.3 Borrowed funds.....		
16.4 Net deposits on deposit-type contracts and other insurance liabilities.....		
16.5 Dividends to stockholders.....	48,000,000	16,000,000
16.6 Other cash provided (applied).....	4,273,784	11,694,873
17. Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6).....	(43,726,216)	(4,305,127)
<b>RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS</b>		
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17).....	24,518,037	(13,234,547)
19. Cash, cash equivalents and short-term investments:		
19.1 Beginning of year.....	15,780,824	29,015,371
19.2 End of year (Line 18 plus Line 19.1).....	40,298,861	15,780,824

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**ANALYSIS OF OPERATIONS BY LINES OF BUSINESS**

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Net premium income	478,031,244	40,585,762				62,230,175	345,035,732	30,179,575		
2. Change in unearned premium reserves and reserve for rate credit										
3. Fee-for-service (net of \$ medical expenses)										XXX
4. Risk revenue										XXX
5. Aggregate write-ins for other health care related revenues										XXX
6. Aggregate write-ins for other non-health care related revenues	(1,141)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	(1,141)
7. Total revenues (Lines 1 to 6)	478,030,103	40,585,762				62,230,175	345,035,732	30,179,575		(1,141)
8. Hospital/medical benefits	334,679,605	26,129,402				40,020,984	235,593,058	32,936,161		XXX
9. Other professional services										XXX
10. Outside referrals										XXX
11. Emergency room and out-of-area										XXX
12. Prescription drugs	55,624,083	6,870,847				10,523,702	35,981,824	2,247,710		XXX
13. Aggregate write-ins for other hospital and medical	(12,904)	(30,167)				(46,206)	63,469			XXX
14. Incentive pool, withhold adjustments and bonus amounts	20,403	659				1,010	18,734			XXX
15. Subtotal (Lines 8 to 14)	390,311,187	32,970,741				50,499,490	271,657,085	35,183,871		XXX
16. Net reinsurance recoveries	2,151,575	269,409				412,640	1,182,323	287,203		XXX
17. Total hospital and medical (Lines 15 minus 16)	388,159,612	32,701,332				50,086,850	270,474,762	34,896,668		XXX
18. Non-health claims (net)		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
19. Claims adjustment expenses including \$ 7,818,281 cost containment expenses	20,307,310	1,728,005				2,476,851	10,908,506	1,737,851		3,456,097
20. General administrative expenses	20,989,973	2,423,039				3,370,018	13,871,969	2,243,716		(918,769)
21. Increase in reserves for accident and health contracts										XXX
22. Increase in reserves for life contracts		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
23. Total underwriting deductions (Lines 17 to 22)	429,456,895	36,852,376				55,933,719	295,255,237	38,878,235		2,537,328
24. Net underwriting gain or (loss) (Line 7 minus Line 23)	48,573,208	3,733,386				6,296,456	49,780,495	(8,698,660)		(2,538,469)
<b>DETAILS OF WRITE-INS</b>										
0501.										XXX
0502.										XXX
0503.										XXX
0598. Summary of remaining write-ins for Line 5 from overflow page										XXX
0599. Totals (Lines 0501 through 0503 plus 0598) (Line 5 above)										XXX
0601. Loss on Disposal of Fixed Assets	(1,141)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	(1,141)
0602.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698. Summary of remaining write-ins for Line 6 from overflow page		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 6 above)	(1,141)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	(1,141)
1301. Other Medical Expenses	(12,904)	(30,167)				(46,206)	63,469			XXX
1302.										XXX
1303.										XXX
1398. Summary of remaining write-ins for Line 13 from overflow page										XXX
1399. Totals (Lines 1301 through 1303 plus 1398) (Line 13 above)	(12,904)	(30,167)				(46,206)	63,469			XXX

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 1 - PREMIUMS**

Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Cols. 1+2-3)
1. Comprehensive (hospital and medical) .....	41,012,322		426,560	40,585,762
2. Medicare Supplement .....				
3. Dental only.....				
4. Vision only.....				
5. Federal Employees Health Benefits Plan .....	62,883,513		653,338	62,230,175
6. Title XVIII - Medicare .....	347,310,441		2,274,709	345,035,732
7. Title XIX - Medicaid.....	30,635,453		455,878	30,179,575
8. Other health.....				
9. Health subtotal (Lines 1 through 8) .....	481,841,729		3,810,485	478,031,244
10. Life .....				
11. Property/casualty.....				
12. Totals (Lines 9 to 11)	481,841,729		3,810,485	478,031,244

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**UNDERWRITING AND INVESTMENT EXHIBIT**

**PART 2 – CLAIMS INCURRED DURING THE YEAR**

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non- Health
1. Payments during the year:										
1.1 Direct .....	390,853,510	36,592,443				53,304,209	283,212,064	17,744,794		
1.2 Reinsurance assumed .....										
1.3 Reinsurance ceded .....	1,376,825	277,747				359,546	739,532			
1.4 Net .....	389,476,685	36,314,696				52,944,663	282,472,532	17,744,794		
2. Paid medical incentive pools and bonuses .....	22,336	1,458				1,010	19,868			
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct .....	58,180,964	4,146,676				6,351,239	30,243,972	17,439,077		
3.2 Reinsurance assumed .....										
3.3 Reinsurance ceded .....	1,249,906	107,596				164,800	690,307	287,203		
3.4 Net .....	56,931,058	4,039,080				6,186,439	29,553,665	17,151,874		
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct .....										
4.2 Reinsurance assumed .....										
4.3 Reinsurance ceded .....										
4.4 Net .....							13,217			
5. Accrued medical incentive pools and bonuses, current year .....	14,248	1,031								
6. Net healthcare receivables (a) .....										
7. Amounts recoverable from reinsurers December 31, current year .....	404,836	70,648				108,209	225,979			
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct .....	58,743,690	7,769,037				9,156,968	41,817,685			
8.2 Reinsurance assumed .....										
8.3 Reinsurance ceded .....	828,190	170,587				201,062	456,541			
8.4 Net .....	57,915,500	7,598,450				8,955,906	41,361,144			
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct .....										
9.2 Reinsurance assumed .....										
9.3 Reinsurance ceded .....										
9.4 Net .....										
10. Accrued medical incentive pools and bonuses, prior year .....	16,181	1,830					14,351			
11. Amounts recoverable from reinsurers December 31, prior year .....	51,804	15,995				18,853	16,956			
12. Incurred benefits:										
12.1 Direct .....	390,290,784	32,970,082				50,498,480	271,638,351	35,183,871		
12.2 Reinsurance assumed .....										
12.3 Reinsurance ceded .....	2,151,573	269,409				412,640	1,182,321	287,203		
12.4 Net .....	388,139,211	32,700,673				50,085,840	270,456,030	34,896,668		
13. Incurred medical incentive pools and bonuses .....	20,403	659				1,010	18,734			

(a) Excludes \$ ..... loans or advances to providers not yet expensed.

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**UNDERWRITING AND INVESTMENT EXHIBIT  
PART 2A - CLAIMS LIABILITY END OF CURRENT YEAR**

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital and Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Reported in Process of Adjustment:										
1.1. Direct .....	458,000	(221,200)				(338,800)	954,000	64,000		
1.2. Reinsurance assumed .....										
1.3. Reinsurance ceded .....										
1.4. Net .....	458,000	(221,200)				(338,800)	954,000	64,000		
2. Incurred but Unreported:										
2.1. Direct .....	57,722,964	4,367,876				6,690,039	29,289,972	17,375,077		
2.2. Reinsurance assumed .....										
2.3. Reinsurance ceded .....	1,249,906	107,596				164,800	690,307	287,203		
2.4. Net .....	56,473,058	4,260,280				6,525,239	28,599,665	17,087,874		
3. Amounts Withheld from Paid Claims and Capitations:										
3.1. Direct .....										
3.2. Reinsurance assumed .....										
3.3. Reinsurance ceded .....										
3.4. Net .....										
4. TOTALS:										
4.1. Direct .....	58,180,964	4,146,676				6,351,239	30,243,972	17,439,077		
4.2. Reinsurance assumed .....										
4.3. Reinsurance ceded .....	1,249,906	107,596				164,800	690,307	287,203		
4.4. Net .....	56,931,058	4,039,080				6,186,439	29,553,665	17,151,874		

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 2B - ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR-NET OF REINSURANCE**

Line of Business	Claims Paid During the Year		Claim Reserve and Claim Liability Dec. 31 of Current Year		5 Claims Incurred in Prior Years (Columns 1 + 3)	6 Estimated Claim Reserve and Claim Liability December 31 of Prior Year
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid December 31 of Prior Year	4 On Claims Incurred During the Year		
1. Comprehensive (hospital and medical) .....	4,344,436	30,863,168		4,039,080	4,344,436	7,598,450
2. Medicare Supplement .....						
3. Dental Only.....						
4. Vision Only.....						
5. Federal Employees Health Benefits Plan .....	6,654,137	47,271,395		6,186,439	6,654,137	8,955,906
6. Title XVIII - Medicare .....	34,429,542	247,816,177	3,124,696	26,428,969	37,554,238	41,361,144
7. Title XIX - Medicaid.....		17,744,794		17,151,874		
8. Other health .....						
9. Health subtotal (Lines 1 to 8).....	45,428,115	343,695,534	3,124,696	53,806,362	48,552,811	57,915,500
10. Healthcare receivables (a).....						
11. Other non-health.....						
12. Medical incentive pools and bonus amounts .....	22,336			14,248	22,336	16,181
13. Totals (Lines 9-10+11+12)	45,450,451	343,695,534	3,124,696	53,820,610	48,575,147	57,931,681

(a) Excludes \$ ..... loans or advances to providers not yet expensed.

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**UNDERWRITING AND INVESTMENT EXHIBIT  
PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS  
(000 Omitted)**

**Section A – Paid Health Claims - Hospital and Medical**

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2006	2 2007	3 2008	4 2009	5 2010
1. Prior .....	1,143,043	1,143,043	1,143,043	1,143,043	1,143,043
2. 2006 .....	176,988	190,381	190,381	190,381	190,381
3. 2007 .....	XXX	119,777	126,493	126,493	126,493
4. 2008 .....	XXX	XXX	90,087	96,573	96,573
5. 2009 .....	XXX	XXX	XXX	65,685	70,030
6. 2010 .....	XXX	XXX	XXX	XXX	30,863

**Section B – Incurred Health Claims - Hospital and Medical**

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2006	2 2007	3 2008	4 2009	5 2010
1. Prior .....	1,118,808	1,118,808	1,118,808	1,118,808	1,118,808
2. 2006 .....	198,421	190,458	190,458	190,458	190,458
3. 2007 .....	XXX	134,001	137,523	137,523	137,523
4. 2008 .....	XXX	XXX	101,117	101,135	101,135
5. 2009 .....	XXX	XXX	XXX	73,266	73,266
6. 2010 .....	XXX	XXX	XXX	XXX	34,902

**Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio – Hospital and Medical**

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2+3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2006.....	246,497	190,381	6,817	3.6	197,198	80.0			197,198	80.0
2. 2007.....	155,522	126,493	6,458	5.1	132,951	85.5			132,951	85.5
3. 2008.....	108,229	96,573	2,853	3.0	99,426	91.9			99,426	91.9
4. 2009.....	83,218	70,030	2,317	3.3	72,347	86.9		10	72,357	86.9
5. 2010.....	41,012	30,863	1,538	5.0	32,401	79.0	4,040	74	36,515	89.0

Pt 2C - Sn A - Paid Claims - MS

**NONE**

Pt 2C - Sn A - Paid Claims - DO

**NONE**

Pt 2C - Sn A - Paid Claims - VO

**NONE**

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS**  
**(000 Omitted)**

**Section A – Paid Health Claims - Federal Employees Health Benefits Plan Premium**

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2006	2 2007	3 2008	4 2009	5 2010
1. Prior .....	445,636	445,636	445,636	445,636	445,636
2. 2006 .....	111,736	122,917	122,917	122,917	122,917
3. 2007 .....	XXX	99,997	107,662	107,662	107,662
4. 2008 .....	XXX	XXX	98,436	106,081	106,081
5. 2009 .....	XXX	XXX	XXX	77,415	84,069
6. 2010 .....	XXX	XXX	XXX	XXX	47,271

**Section B - Incurred Health Claims - Federal Employees Health Benefits Plan Premium**

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2006	2 2007	3 2008	4 2009	5 2010
1. Prior .....	436,810	436,810	436,810	436,810	125,267
2. 2006 .....	125,267	122,981	122,981	122,981	122,981
3. 2007 .....	XXX	111,872	107,679	107,679	107,679
4. 2008 .....	XXX	XXX	111,024	111,045	111,045
5. 2009 .....	XXX	XXX	XXX	86,350	86,350
6. 2010 .....	XXX	XXX	XXX	XXX	53,458

**Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio – Federal Employees Health Benefits Plan Premium**

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2+3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2006.....	155,802	122,917	3,611	2.9	126,528	81.2			126,528	81.2
2. 2007.....	129,670	107,662	4,134	3.8	111,796	86.2			111,796	86.2
3. 2008.....	123,480	106,081	3,158	3.0	109,239	88.5			109,239	88.5
4. 2009.....	98,132	84,069	2,850	3.4	86,919	88.6		15	86,934	88.6
5. 2010.....	62,884	47,271	2,375	5.0	49,646	78.9	6,186	114	55,947	89.0

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS**  
**(000 Omitted)**

**Section A - Paid Health Claims - Medicare**

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2006	2 2007	3 2008	4 2009	5 2010
1. Prior .....	899,498	899,498	899,498	899,498	899,498
2. 2006 .....	265,864	291,429	291,429	291,429	291,429
3. 2007 .....	XXX	289,840	319,406	319,406	319,406
4. 2008 .....	XXX	XXX	315,289	352,746	352,746
5. 2009 .....	XXX	XXX	XXX	338,896	373,326
6. 2010 .....	XXX	XXX	XXX	XXX	247,816

**Section B - Incurred Health Claims - Medicare**

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2006	2 2007	3 2008	4 2009	5 2010
1. Prior .....	896,082	896,082	896,082	896,082	896,082
2. 2006 .....	295,898	294,813	294,813	294,813	294,813
3. 2007 .....	XXX	322,111	321,647	321,647	321,647
4. 2008 .....	XXX	XXX	354,514	357,282	357,282
5. 2009 .....	XXX	XXX	XXX	377,490	376,451
6. 2010 .....	XXX	XXX	XXX	XXX	274,245

**Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio – Medicare**

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2+3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2006.....	362,122	291,429	8,536	2.9	299,965	82.8			299,965	82.8
2. 2007.....	398,614	319,406	10,963	3.4	330,369	82.9			330,369	82.9
3. 2008.....	411,527	352,746	10,727	3.0	363,473	88.3			363,473	88.3
4. 2009.....	432,262	373,326	13,070	3.5	386,396	89.4	3,125	79	389,599	90.1
5. 2010.....	347,310	247,816	12,389	5.0	260,205	74.9	26,442	595	287,243	82.7

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS**  
 (000 Omitted)

**Section A - Paid Health Claims - Title XIX Medicaid**

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2006	2 2007	3 2008	4 2009	5 2010
1. Prior .....					
2. 2006 .....					
3. 2007 .....	XXX				
4. 2008 .....	XXX	XXX			
5. 2009 .....	XXX	XXX	XXX		
6. 2010 .....	XXX	XXX	XXX	XXX	17,745

**Section B – Incurred Health Claims - Title XIX Medicaid**

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2006	2 2007	3 2008	4 2009	5 2010
1. Prior .....					
2. 2006 .....					
3. 2007 .....	XXX				
4. 2008 .....	XXX	XXX			
5. 2009 .....	XXX	XXX	XXX		
6. 2010 .....	XXX	XXX	XXX	XXX	34,897

**Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio – Title XIX Medicaid**

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claim Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2+3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2006.....										
2. 2007.....										
3. 2008.....										
4. 2009.....										
5. 2010.....	30,635	17,745	786	4.4	18,531	60.5	17,152	43	35,726	116.6

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**UNDERWRITING AND INVESTMENT EXHIBIT  
PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS  
(000 Omitted)**

**Section A - Paid Health Claims - Grand Total**

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2006	2 2007	3 2008	4 2009	5 2010
1. Prior .....	2,488,177	2,488,177	2,488,177	2,488,177	2,488,177
2. 2006 .....	554,588	604,727	604,727	604,727	604,727
3. 2007 .....	XXX	509,614	553,561	553,561	553,561
4. 2008 .....	XXX	XXX	503,812	555,400	555,400
5. 2009 .....	XXX	XXX	XXX	481,996	527,425
6. 2010 .....	XXX	XXX	XXX	XXX	343,695

**Section B - Incurred Health Claims - Grand Total**

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2006	2 2007	3 2008	4 2009	5 2010
1. Prior .....	2,451,700	2,451,700	2,451,700	2,451,700	2,140,157
2. 2006 .....	619,586	608,252	608,252	608,252	608,252
3. 2007 .....	XXX	567,984	566,849	566,849	566,849
4. 2008 .....	XXX	XXX	566,655	569,462	569,462
5. 2009 .....	XXX	XXX	XXX	537,106	536,067
6. 2010 .....	XXX	XXX	XXX	XXX	397,502

**Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Grand Total**

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2+3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2006 .....	764,421	604,727	18,965	3.1	623,692	81.6			623,692	81.6
2. 2007 .....	683,806	553,561	21,555	3.9	575,116	84.1			575,116	84.1
3. 2008 .....	643,236	555,400	16,738	3.0	572,138	88.9			572,138	88.9
4. 2009 .....	613,612	527,425	18,237	3.5	545,662	88.9	3,125	104	548,890	89.5
5. 2010 .....	481,842	343,695	17,089	5.0	360,784	74.9	53,821	826	415,430	86.2

Pt 2C - Sn B - Incurred Claims - MS

**NONE**

Pt 2C - Sn B - Incurred Claims - DO

**NONE**

Pt 2C - Sn B - Incurred Claims - VO

**NONE**

Part 2C - Sn C - Claims Expense Ratio MS

**NONE**

Part 2C - Sn C - Claims Expense Ratio DO

**NONE**

Part 2C - Sn C - Claims Expense Ratio VO

**NONE**

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

**UNDERWRITING AND INVESTMENT EXHIBIT**

**PART 2D - AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY**

	1	2	3	4	5	6	7	8	9
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
1. Unearned premium reserves.....									
2. Additional policy reserves (a).....									
3. Reserve for future contingent benefits.....									
4. Reserve for rate credits or experience rating refunds (including \$ ..... for investment income).....									
5. Aggregate write-ins for other policy reserves .....									
6. Totals (gross) .....									
7. Reinsurance ceded .....									
8. Totals (Net) (Page 3, Line 4)									
9. Present value of amounts not yet due on claims .....									
10. Reserve for future contingent benefits .....									
11. Aggregate write-ins for other claim reserves .....									
12. Totals (gross) .....									
13. Reinsurance ceded .....									
14. Totals (Net) (Page 3, Line 7)									
<b>DETAILS OF WRITE-INS</b>									
0501. ....									
0502. ....									
0503. ....									
0598. Summary of remaining write-ins for Line 5 from overflow page .....									
0599. Totals (Lines 0501 through 0503 plus 0598) (Line 5 above)									
1101. ....									
1102. ....									
1103. ....									
1198. Summary of remaining write-ins for Line 11 from overflow page .....									
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)									

NONE

(a) Includes \$ ..... premium deficiency reserve.

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 3 - ANALYSIS OF EXPENSES**

	Claim Adjustment Expenses		3 General Administrative Expenses	4 Investment Expenses	5 Total
	1 Cost Containment Expenses	2 Other Claim Adjustment Expenses			
1. Rent (\$ .....for occupancy of own building).....	187,639	299,737	1,465,283		1,952,659
2. Salaries, wages and other benefits.....	4,838,734	7,729,460	8,898,644		21,466,838
3. Commissions (less \$ .....ceded plus \$ .....assumed).....					
4. Legal fees and expenses.....	32,837	52,454	7,090,590		7,175,881
5. Certifications and accreditation fees.....			76,875		76,875
6. Auditing, actuarial and other consulting services.....	442,515	706,879	(688,751)		460,643
7. Traveling expenses.....	114,929	183,589	407,930		706,448
8. Marketing and advertising.....	14,855	23,729	2,099,568		2,138,152
9. Postage, express and telephone.....	247,058	394,653	1,282,573		1,924,284
10. Printing and office supplies.....	294,749	470,836	1,731,316		2,496,901
11. Occupancy, depreciation and amortization.....			225,220		225,220
12. Equipment.....	11,727	18,734	346,964		377,425
13. Cost or depreciation of EDP equipment and software.....	891,284	1,423,749	(1,822,287)		492,746
14. Outsourced services including EDP, claims, and other services.....			(489,280)		(489,280)
15. Boards, bureaus and association fees.....			164,424		164,424
16. Insurance, except on real estate.....	63,328	101,161	(130,149)		34,340
17. Collection and bank service charges.....					
18. Group service and administration fees.....					
19. Reimbursements by uninsured plans.....			(6,534,883)		(6,534,883)
20. Reimbursements from fiscal intermediaries.....					
21. Real estate expenses.....					
22. Real estate taxes.....					
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes.....	26,582	42,463	5,341,515		5,410,560
23.2 State premium taxes.....			10,435		10,435
23.3 Regulatory authority licenses and fees.....					
23.4 Payroll taxes.....	329,931	527,037	1,761,032		2,618,000
23.5 Other (excluding federal income and real estate taxes).....			413,360		413,360
24. Investment expenses not included elsewhere.....				286,741	286,741
25. Aggregate write-ins for expenses.....	322,113	514,548	(660,409)		176,252
26. Total expenses incurred (Lines 1 to 25).....	7,818,281	12,489,029	20,989,970	286,741 (a)	41,584,021
27. Less expenses unpaid December 31, current year.....		929,820	13,766,261		14,696,081
28. Add expenses unpaid December 31, prior year.....		1,071,672	12,914,223		13,985,895
29. Amounts receivable relating to uninsured plans, prior year.....					
30. Amounts receivable relating to uninsured plans, current year.....					
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	7,818,281	12,630,881	20,137,932	286,741	40,873,835
<b>DETAILS OF WRITE-INS</b>					
2501. Other Expenses.....	322,113	514,548	(660,409)		176,252
2502. ....					
2503. ....					
2598. Summary of remaining write-ins for Line 25 from overflow page.....					
2599. Totals (Line 2501 through 2503 + 2598) (Line 25 above)	322,113	514,548	(660,409)		176,252

(a) Includes management fees of \$ .....15,781,030 to affiliates and \$ .....to non-affiliates.

**EXHIBIT OF NET INVESTMENT INCOME**

	1 Collected During Year	2 Earned During Year
1. U.S. Government bonds	(a).....232,794	.....227,138
1.1 Bonds exempt from U.S. tax	(a).....	.....
1.2 Other bonds (unaffiliated)	(a).....5,715,614	.....5,267,557
1.3 Bonds of affiliates	(a).....	.....
2.1 Preferred stocks (unaffiliated)	(b).....	.....
2.11 Preferred stocks of affiliates	(b).....	.....
2.2 Common stocks (unaffiliated)	.....	.....
2.21 Common stocks of affiliates	.....	.....
3. Mortgage loans	(c).....	.....
4. Real estate	(d).....	.....
5. Contract loans	.....	.....
6. Cash, cash equivalents and short-term investments	(e).....74,670	.....80,050
7. Derivative instruments	(f).....	.....
8. Other invested assets	.....	.....
9. Aggregate write-ins for investment income	.....	.....
10. Total gross investment income	6,023,078	5,574,745
11. Investment expenses		(g).....286,741
12. Investment taxes, licenses and fees, excluding federal income taxes		(g).....
13. Interest expense		(h).....
14. Depreciation on real estate and other invested assets		(i).....
15. Aggregate write-ins for deductions from investment income		.....
16. Total deductions (Lines 11 through 15)		.....286,741
17. Net investment income (Line 10 minus Line 16)		5,288,004
<b>DETAILS OF WRITE-INS</b>		
0901. ....		
0902. ....		
0903. ....		
0998. Summary of remaining write-ins for Line 9 from overflow page		
0999. Totals (Lines 0901 through 0903) plus 0998 (Line 9 above)		
1501. ....		
1502. ....		
1503. ....		
1598. Summary of remaining write-ins for Line 15 from overflow page		
1599. Totals (Lines 1501 through 1503) plus 1598 (Line 15 above)		

- (a) Includes \$ 34,889 accrual of discount less \$ 1,105,524 amortization of premium and less \$ 129,636 paid for accrued interest on purchases.
- (b) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued dividends on purchases.
- (c) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued interest on purchases.
- (d) Includes \$ for company's occupancy of its own buildings; and excludes \$ interest on encumbrances.
- (e) Includes \$ 45 accrual of discount less \$ 2,359 amortization of premium and less \$ 16,691 paid for accrued interest on purchases.
- (f) Includes \$ accrual of discount less \$ amortization of premium.
- (g) Includes \$ investment expenses and \$ investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.
- (h) Includes \$ interest on surplus notes and \$ interest on capital notes.
- (i) Includes \$ depreciation on real estate and \$ depreciation on other invested assets.

**EXHIBIT OF CAPITAL GAINS (LOSSES)**

	1 Realized Gain (Loss) On Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1. U.S. Government bonds					
1.1 Bonds exempt from U.S. tax					
1.2 Other bonds (unaffiliated)	.....924,877		.....924,877		
1.3 Bonds of affiliates					
2.1 Preferred stocks (unaffiliated)					
2.11 Preferred stocks of affiliates					
2.2 Common stocks (unaffiliated)					
2.21 Common stocks of affiliates					
3. Mortgage loans					
4. Real estate					
5. Contract loans					
6. Cash, cash equivalents and short-term investments					
7. Derivative instruments					
8. Other invested assets					
9. Aggregate write-ins for capital gains (losses)					
10. Total capital gains (losses)	924,877		924,877		
<b>DETAILS OF WRITE-INS</b>					
0901. ....					
0902. ....					
0903. ....					
0998. Summary of remaining write-ins for Line 9 from overflow page					
0999. Totals (Lines 0901 through 0903) plus 0998 (Line 9 above)					

**EXHIBIT OF NONADMITTED ASSETS**

	1	2	3
	Current Year Total Nonadmitted Assets	Prior Year Total Nonadmitted Assets	Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D).....			
2. Stocks (Schedule D):			
2.1 Preferred stocks .....			
2.2 Common stocks .....			
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens .....			
3.2 Other than first liens .....			
4. Real estate (Schedule A):			
4.1 Properties occupied by the company .....			
4.2 Properties held for the production of income.....			
4.3 Properties held for sale .....			
5. Cash (Schedule E-Part 1), cash equivalents (Schedule E-Part 2) and short-term investments (Schedule DA).....			
6. Contract loans .....			
7. Derivatives .....			
8. Other invested assets (Schedule BA) .....			
9. Receivables for securities .....			
10. Securities lending reinvested collateral assets.....			
11. Aggregate write-ins for invested assets .....			
12. Subtotals, cash and invested assets (Lines 1 to 11) .....			
13. Title plants (for Title insurers only).....			
14. Investment income due and accrued .....			
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection .....			
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due. ....			
15.3 Accrued retrospective premiums.....			
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers .....			
16.2 Funds held by or deposited with reinsured companies .....			
16.3 Other amounts receivable under reinsurance contracts .....			
17. Amounts receivable relating to uninsured plans .....			
18.1 Current federal and foreign income tax recoverable and interest thereon .....			
18.2 Net deferred tax asset.....	5,403,429	6,124,853	721,424
19. Guaranty funds receivable or on deposit .....			
20. Electronic data processing equipment and software.....	24,140	440	(23,700)
21. Furniture and equipment, including health care delivery assets.....	115,007	71,105	(43,902)
22. Net adjustment in assets and liabilities due to foreign exchange rates .....			
23. Receivables from parent, subsidiaries and affiliates .....			
24. Health care and other amounts receivable.....	23,335		(23,335)
25. Aggregate write-ins for other than invested assets .....	4,360,842	4,577,341	216,499
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25).....	9,926,753	10,773,739	846,986
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts.....			
28. Total (Lines 26 and 27)	9,926,753	10,773,739	846,986
<b>DETAILS OF WRITE-INS</b>			
1101. ....			
1102. ....			
1103. ....			
1198. Summary of remaining write-ins for Line 11 from overflow page .....			
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)			
2501. Prepaid Expenses.....	1,709,926	1,829,334	119,408
2502. Intangible Assets.....	2,650,916	2,721,372	70,456
2503. Construction in Progress.....		26,635	26,635
2598. Summary of remaining write-ins for Line 25 from overflow page .....			
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	4,360,842	4,577,341	216,499

**EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY**

Source of Enrollment	Total Members at End of					6 Current Year Member Months
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	
1. Health Maintenance Organizations.....	101,544	81,237	52,998	56,335	58,161	733,293
2. Provider Service Organizations.....						
3. Preferred Provider Organizations.....						
4. Point of Service.....						
5. Indemnity Only.....						
6. Aggregate write-ins for other lines of business.....						
7. Total	101,544	81,237	52,998	56,335	58,161	733,293
<b>DETAILS OF WRITE-INS</b>						
0601. ....						
0602. ....						
0603. ....						
0698. Summary of remaining write-ins for Line 6 from overflow page .....						
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 6 above)						





ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

**EXHIBIT 4 – CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)**

Aging Analysis of Unpaid Claims

1 Account	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 91 - 120 Days	6 Over 120 Days	7 Total
Claims Unpaid (Reported)						
0199999 Individually listed claims unpaid						
0299999 Aggregate accounts not individually listed-uncovered						
0399999 Aggregate accounts not individually listed-covered						
0499999 Subtotals	267,720	151,796	29,932	8,552		458,000
0599999 Unreported claims and other claim reserves	267,720	151,796	29,932	8,552		57,722,964
0699999 Total amounts withheld						
0799999 Total claims unpaid						58,180,964
0899999 Accrued medical incentive pool and bonus amounts						14,248







**EXHIBIT 8 – FURNITURE, EQUIPMENT AND SUPPLIES OWNED**

Description	1 Cost	2 Improvements	3 Accumulated Depreciation	4 Book Value Less Encumbrances	5 Assets Not Admitted	6 Net Admitted Assets
1. Administrative furniture and equipment .....	4,767,092		4,724,968		42,124	
2. Medical furniture, equipment and fixtures .....						
3. Pharmaceuticals and surgical supplies .....						
4. Durable medical equipment .....						
5. Other property and equipment	482,437		409,554		72,883	
6. Total	5,249,529		5,134,522		115,007	

## NOTES TO FINANCIAL STATEMENTS

### 1. Summary of Significant Accounting Policies

#### A. Accounting Practices

The accompanying financial statements of HealthAmerica Pennsylvania, Inc. ("the Company") have been prepared in accordance with the accounting practices prescribed or permitted by the Pennsylvania Department of Insurance (DOI). Such practices differ in certain respects from generally accepted accounting principles in determining financial position and results of operations. Certain assets designated as non-admitted (e.g. receivables greater than 90 days old, prepaid assets, intangible assets, certain amounts of property and equipment, notes receivable and deferred taxes) are excluded from the balance sheet by a direct charge to surplus. Bonds generally are stated at amortized cost, except for bonds that are rated by the NAIC as class 3-6 which are reported at the lower of amortized cost or fair market value.

The Pennsylvania Department of Insurance recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Pennsylvania for determining and reporting the financial condition and results of operations of an insurance company, for determining its solvency under Pennsylvania Insurance Laws. The National Association of Insurance Commissioners' (NAIC) "Accounting Practices and Procedures Manual" (APPM), version effective March 1, 2010, (NAIC SAP) has been adopted as a component of prescribed or permitted practices by the Commonwealth of Pennsylvania. The State of Pennsylvania has not adopted any prescribed accounting practices that differ from those found in the NAIC SAP

Below is a reconciliation of the Company's net income and capital and surplus between NAIC SAP and practices prescribed and permitted by the Pennsylvania Department of Insurance as of December 31, 2010:

PA DOI Net Income	\$36,146,185
NAIC SAP Net Income	\$36,146,185
PA DOI Statutory Surplus	\$87,511,243
NAIC SAP Statutory Surplus	\$87,511,243

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

The preparation of financial statements in conformity with the Statutory Accounting Principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. It also requires disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the period. Actual results could differ from those estimates.

#### C. Accounting Policy

Health premiums are earned ratably over the terms of the related insurance and reinsurance contracts or policies. Expenses incurred in connection with acquiring new insurance business, including acquisition costs such as sales commissions, are charged to operations as incurred.

In addition, the company uses the following accounting policies:

1. Short-term investments are stated at amortized cost.
2. Bonds not backed by other loans are stated at amortized cost, except for bonds that are rated 3 or below by the NAIC, which are reported at the lower of amortized cost or fair value. Amortization is calculated using the specific to worst constant yield method.
3. The Company has no common stocks.
4. The Company has no preferred stocks.
5. The Company has no mortgage loans on real estate.
6. Loan-backed securities are stated at either amortized cost or the lower of amortized cost or fair value. The Company applies the retrospective method of valuing loan-backed and asset backed securities.
7. The Company has no investments in subsidiaries, controlled and affiliated companies.
8. The Company has no investments in joint ventures, partnerships and limited liability companies.
9. The Companies has no derivatives.
10. Premium deficiency calculations do not utilize anticipated investment income as a factor.
11. Unpaid losses and loss adjustment expenses include an amount determined from individual case estimates and loss reports and an amount, based on past experience, for losses incurred but not reported. Such liabilities are necessary based on assumptions and estimates and, while management believes that amount is adequate, the ultimate liability may be in excess of or less

## NOTES TO FINANCIAL STATEMENTS

than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and any adjustments are reflected in the period determined.

12. The Company has not modified its capitalization policy from the prior period.

2. Accounting Changes and Corrections of Errors

A. Material Changes in Accounting Principles and/or Correction of Errors

NONE

3. Business Combinations and Goodwill

A. Statutory Purchased Method

NONE

B. Statutory Merger Method

NONE

C. Assumption Reinsurance

NONE

D. Impairment Losses

NONE

4. Discontinued Operations

NONE

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

NONE

B. Debt Restructuring

NONE

C. Reverse Mortgages

NONE

D. Loan-Backed Securities

1. The carrying value for structured securities has been determined in accordance with the guidelines of the NAIC. Fair value is determined using a pricing hierarchy starting with a widely accepted pricing vendor, followed by external broker/dealers, Bloomberg analytic modeling and a benchmark to index model.

2. The Company uses a proprietary model for loss assumptions and widely accepted models for repayment assumptions in valuing mortgage-backed and asset-backed securities with inputs from major third party data providers. The model combines the effects of interest rates, volatility, and pre-payment speeds based on various scenarios and simulations (Monte Carlo) with credit loss analysis and resulting effective analytics (spreads, duration, convexity) and cash flows on a monthly basis. Model assumptions are specific to asset class and collateral types and are regularly evaluated and adjusted where appropriate.

3. Credit risk concentrations are evaluated in our base security analysis through exposure stratification of the collateral attributes. The Company will then apply an appropriate credit default curve reflecting forecasted expectations of future defaults and losses.

4. NONE

5. Not applicable as there was no OTTI recognized in 2010 because the Company did not expect to hold the security to recovery (i.e.: there were no write-downs to projected cash flows)

6. The fair market value, amortized cost and unrealized losses for structured securities (fair value is less than amortized cost for which an other-than-temporary impairment has not been recognized in earnings as a realized loss) owned as of December 31, 2010 are as follows:

U.S. Government Mortgage Backed Securities

## NOTES TO FINANCIAL STATEMENTS

	Less than 12 months	12 months or more
Fair Market Value	\$1,971,030	\$0
Amortized Cost	\$1,999,102	\$0
Unrealized Losses	(\$28,072)	\$0

The structured securities have been in a continuous unrealized loss position for less than 12 months. There are no structured securities that that been in a continuous unrealized loss position for 12 months or longer.

7. There are a number of factors that are considered in determining if there is an other-than-temporary impairment on an investment, including but not limited to, debt burden, credit ratings, sector, liquidity, financial flexibility, company management, expected earnings and cash flow stream, and economic prospects associated with the investment.

8. All investments in an unrealized loss position are evaluated for other-than-temporary impairment based on the severity level and length of time the investment has been in an unrealized loss position. As the magnitude of the loss increases so does the degree of analysis required in determining if an other-than-temporary loss exists.

### E. Repurchase Agreements

1. Money Market Instruments used primarily for overnight sweep activity may contain repurchase agreements within the portfolio. Such investments will be limited to a percent of admitted assets.

### F. Real Estate

NONE

### G. Investments in low-income housing credits

NONE

### 6. Joint Ventures, Partnerships and Limited Liability Companies

NONE

### 7. Investment Income

A. The Company had no investment income accrued with amounts over 90 days old.

B. NONE

### 8. Derivative Instruments

NONE

### 9. Income Taxes

The components of the net deferred tax asset (DTA) and net deferred tax liability (DTL) as of as of December 31, 2010 and 2009 are as follows:

	December 31, 2010			December 31, 2009		
	Capital	Ordinary	Total	Capital	Ordinary	Total
Gross deferred tax assets	0	11,160,743	11,160,743	0	9,719,568	9,719,568
Statutory valuation allowance				0	0	0
Adjusted gross deferred tax assets	0	11,160,743	11,160,743	0	9,719,568	9,719,568
Gross deferred tax liabilities	0	2,107,605	2,107,605		2,001,370	2,001,370
Net deferred tax asset before admissibility test	0	9,053,138	9,053,138	0	7,718,198	7,718,198
Less: Deferred tax asset nonadmitted	0	5,403,429	5,403,429	0	5,468,279	5,468,279
Net deferred tax asset	0	3,649,709	3,649,709	0	2,249,919	2,249,918
Increase(decrease) in DTA nonadmitted			(64,850)			4,126,197

The amount of admitted adjusted gross deferred tax asset under each component of SSAP10R during 2010 and 2009 is as follows:

December 31, 2010	December 31, 2009
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NOTES TO FINANCIAL STATEMENTS

		Capital	Ordinary	Total	Capital	Ordinary	Total
Federal income taxes recoverable through loss carryback	10.a	-	3,649,709	3,649,709	-	-	-
Adjusted gross DTA expected to be realized in one year	10.b.i			-	2,249,918		2,249,918
10% adjusted capital and surplus limit Admitted pursuant to Paragraph 10.b (lesser of i. or ii.)	10 b ii			6,837,131			9,726,883
		-	-	-	2,249,918		2,249,918
Additional admitted pursuant to Paragraph 10.c		-	2,107,605	2,107,605	2,001,370		2,001,370
Risk-based capital: Total adjusted capital Authorized control level							
Additional admitted pursuant to 10.e.i	10.e.i	-	-	-	-	-	-
Adjusted gross DTA expected to be realized in three years	10.eii.a	-	-	-	-	-	-
15% adjusted statutory capital and surplus limit	10.e.ii.b	-	-	-	-	-	-
Additional permitted pursuant to 10.e.ii (lesser of a or b)		-	-	-	-	-	-
Additional admitted pursuant to 10.e.iii	10.e.iii	-	-	-	-	-	-
		-	-	-	-	-	-
Total Admitted DTA		-	5,757,314	5,757,314	4,251,289		4,251,289
Total DTL		-	(2,107,605)	(2,107,605)	(2,001,370)		(2,001,370)
Net admitted DTA		-	3,649,709	3,649,709	2,249,918		2,249,918
Nonadmitted DTA		-	5,403,429	5,403,429	-	5,468,279	5,468,279

The company has elected not to admit additional deferred tax assets pursuant to SSAP10R paragraph 10.e. The current period election does not differ from prior reporting period.

The tax effects of temporary differences that give rise to significant portions of deferred tax assets and liabilities as of December 31, 2010 and 2009 are as follows:

	December 31, 2010	December 31, 2009	Change	Character
Deferred tax assets:				
Unpaid claims	399,090	406,869	(7,780)	Ordinary
Unearned premiums	57,862	93,394	(35,532)	Ordinary
Allowance for doubtful accounts	14,320	21,288	(6,969)	Ordinary
Depreciation	712,382	1,105,056	(392,674)	Ordinary
Intangible amortization	187,928	379,354	(191,427)	Ordinary
Capital gain/loss	-	-	-	Capital
Other accrued liabilities	6,754,055	5,202,158	1,551,898	Ordinary
Non admitted assets	1,583,163	1,627,110	(43,947)	Ordinary
Net operating loss carryforward	-	-	-	Ordinary
Other	1,451,943	884,339	567,604	Ordinary
Total deferred tax assets	11,160,743	9,719,568	1,441,175	
Non admitted deferred tax assets	(5,403,429)	(5,468,279)	64,850	
Admitted deferred tax assets	5,757,314	4,251,289	1,506,025	
Deferred tax liabilities				
Unrealized gain	-	-	-	Ordinary
Other	(2,107,605)	(2,001,370)	(106,234)	Ordinary
Total Deferred tax liabilities	(2,107,605)	(2,001,370)	(106,234)	
Net admitted deferred tax assets	3,649,709	2,249,918	1,399,791	

## NOTES TO FINANCIAL STATEMENTS

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The provision for income taxes on earnings for years ended December 31, 2010 and 2009 are:

	December 31, 2010	December 31, 2009
Federal	18,841,129	17,622,877
Tax on capital gains	323,707	667,216
Foreign		-
Change in estimate	(524,932)	1,126,949
Federal and foreign income taxes incurred	<u>18,639,904</u>	<u>19,417,042</u>

The Company had no net operating loss carryforwards.

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before taxes. These differences for the years ended December 31, 2010 and 2009 may be summarized as follows:

	December 31, 2010	December 31, 2009
Provision computed at statutory rate	19,175,131	15,023,609
Tax-exempt interest, net	(879,087)	(1,017,065)
State taxes	-	154,986
Change in Estimate	(524,932)	1,126,949
Unpaid claims	(7,780)	(48,563)
Unearned premiums	(35,532)	(14,633)
Allowance for doubtful accounts	(6,969)	6,050
Depreciation and amortization	(326,918)	(292,042)
Capital gains/(losses)	-	(429,233)
Other accrued liabilities	867,395	4,797,847
Net operating loss utilization	-	-
Other permanent	(165,047)	(145,698)
Other temporary	543,642	254,837
Income tax provision per accompanying statements of operations-statutory basis	<u>18,639,904</u>	<u>19,417,042</u>

The amount of federal income taxes incurred in the current year and the preceding year that are available for recoupment in the event of future losses is as follows:

2010	\$ 18,639,904
2009	\$ 19,417,042

The Company does not have any deposits under Section 6603 of the Internal Revenue Code.

#### 10. Information Concerning Parent, Subsidiaries and Affiliates

A-C. The Company has management service agreements with its Parent company and certain affiliates, in which the Parent and affiliates provide information technology, service center and general administrative support services. The Company also provides certain administrative services to various wholly owned subsidiaries of the Parent.

The Company paid a cash dividend to the parent company, Coventry Health Care, Inc. on June 28, 2010, totaling \$48,000,000.

D. Amounts due from related parties and due to related parties are as follows:  
Due from Related Parties

HealthAssurance Pennsylvania, Inc.	4,024,843
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## NOTES TO FINANCIAL STATEMENTS

Coventry Healthcare Management Corp.	2,298,569
Coventry Health and Life Insurance Co.	264,391
Coventry Financial Management Services	<u>203,111</u>

Total Due from Related Parties	6,791,914
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Due to Related Parties	
Coventry Health Care, Inc.	<u>2,043,499</u>

Total Due to Related Parties	2,043,499
------------------------------	-----------

E. NONE

F. The Company provides certain management services to certain affiliated companies. These management

fees are reflected as a reduction of general and administrative expenses. Refer to page 39 of this Annual

Statement (Schedule Y) for the amounts of any significant transactions with affiliates.

The Parent Company provides certain management, consulting, computer and administrative services to the Company. The Company also reimburses the Parent for certain expenses paid by the Parent on behalf of the Company. The management fee to the Parent is based on monthly membership and the current year expense is included in Schedule Y, Part 2.

The terms of settlement require that these amounts are settled within 30 days.

G. All outstanding shares of the Company are owed by the Parent Company, which is domiciled in the state of

Delaware.

H.– L. NONE

### 11. Debt

NONE

### 12. Retirement Plans, Deferred Compensation, Post-employment Benefits and Compensated Absences and Other Post-retirement Benefit Plans

A. The Company does not sponsor a Defined Benefit Plan.

B. The Company's employees are eligible to participate in a 401(k) defined contribution plan sponsored by the Parent. Employees become eligible to participate in the plan upon their first day of employment. Subject to certain limitations, employees may contribute 75% of their salary to the plan which the Company matches at a rate of 100% up to the first 3% and 50% of the next 3% of each employee's contributions to a maximum of 4.5% of their total salary. The Company contributed \$1,027,000 to the 401(k) plan in 2010 (current year) and \$991,000 in 2009 (prior year).

The Company offers certain executives a 401(k) restoration and deferred compensation plan sponsored by the Parent. This is a non-qualified plan offering participants various investment fund options.

C. The Company does not offer multiple-employer plans.

D. The Company does not offer consolidated / holding company plans.

E. The Company does not have an obligation for any post-employment benefits or compensated absences.

### 13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

1) The Company has no shares of common capital stock authorized, issued and outstanding by the Company.

2) The Company has no preferred stock authorized or outstanding

3) Dividends on the Company's common capital stock are paid as declared by its Board of Directors, from earned surplus of the Company, not including surplus arising from the sale of stock. Dividends or other distributions may be paid only to the extent of net worth in excess of \$1,000,000 reported in the most recent financial statements filed with the Department of

## NOTES TO FINANCIAL STATEMENTS

Insurance and may be paid only out of positive retained earnings. In addition, Department of Insurance approval is generally required for any dividend or other distribution exceeding the greater of: (i) 10% of net worth (as of the preceding December 31) or (ii) net income for the prior year.

- 4) An extra-ordinary dividend in the amount of \$48,000,000 on June 28, 2010 was paid by the Company to its Parent.
- 5) Within the limitations of 3) above, there are no other restrictions placed on the portion of Company profits that may be paid as ordinary dividends to the stockholder.
- 6) There are no other restrictions on the Company's surplus.
- 7) The Company does not have any advances to surplus not repaid.
- 8) There are no amounts of the Company's common capital stock being held for special purposes.
- 9) NONE.
- 10) The portion of unassigned funds (surplus) represented or reduced by each item below is as follows:
 

a. Unrealized gains and losses	\$ 0
b. Non-admitted asset value	\$ 9,926,753
c. Separate account business	\$ 0
d. Asset valuation reserve	\$ 0
e. Reinsurance in unauthorized companies	\$ 0
- 11) The Company has no surplus debentures or similar obligations outstanding.
- 12) The Company has no prior quasi-reorganizations.
- 13) The Company has no quasi-reorganizations.

### 14. Contingencies

#### A. Contingent Commitments

NONE

#### B. Assessments

The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary association consisting of the state life and health insurance guaranty organizations located throughout the U.S. State life and health insurance guaranty organizations, working together with NOLHGA, provide a safety net for their state's policyholders, ensuring that they continue to receive coverage even if their insurer is declared insolvent. We are aware that the Pennsylvania Insurance Commissioner, or Insurance Commissioner, has placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. The Insurance Commissioner has petitioned the state court for liquidation, however, we do not know when a decision will be made, although we believe it is likely the state court will rule within the next twelve months. In the event that Penn Treaty is declared insolvent and placed in liquidation, we and other insurers may be required to pay a portion of their policyholder claims through NOLHGA guaranty association assessments in future periods. Given the uncertainty around whether Penn Treaty will ultimately be declared insolvent and, if so, the amount of the insolvency, the amount and timing of any associated future guaranty fund assessments and the availability and amount of any potential premium tax and other offsets, we currently cannot estimate our net exposure, if any, to this potential insolvency. We will continue to monitor the situation and may record a liability and expense in future reporting periods, which could be material to our operating results.

#### C. Gain Contingencies

NONE

#### D. Claims related extra contractual obligation and bad faith losses stemming from lawsuits

The Company paid \$69,620 during the reporting period to settle claims related to extra contractual obligation or bad faith claims stemming from lawsuits.

#### E. All Other Contingencies

## NOTES TO FINANCIAL STATEMENTS

The Company is involved in various legal actions arising in the normal course of business. After review, including consultation with legal counsel, management believes any ultimate liability that could arise from these actions would not materially affect the Company's financial position. The Company has no assets that it considers to be impaired.

The Company is contingently liable for certain costs in the event that a capitated provider is unable to meet its contractual obligations. The Company has committed no additional reserves to cover any material contingent liabilities.

### 15. Leases

#### A. Lessee Operating Lease

The Company leases its office facilities and certain office equipment under non-cancelable operating leases expiring in various years through 2015. Rent expense for the years ended December 31, 2010 and 2009 was \$1,388,000 and \$1,628,000, respectively. Future minimum lease payments under non-cancelable operating leases with initial lease terms over one year are as follows:

2011	1,020,377
2012	1,046,753
2013	1,066,580
2014	723,465
2015	<u>69,110</u>
Total	<u>\$3,926,285</u>

The Company is not involved in any sales leaseback transactions.

#### B. Lessor Leases

NONE

### 16. Information About Financial Instruments With off-Balance Sheet Risk And Financial Instruments With Concentrations of Credit Risk

NONE

### 17. Sale, Transfers and Servicing of Financial Assets and Extinguishment of Liabilities

NONE

### 18. Gain or Loss to the Reporting Entity from Uninsured A&H Plans and the Uninsured Portion of Partially Insured Plans

#### A. Administrative Service Only (ASO) Plans

The gain from operation of ASO uninsured plans was as follows for 2010:

a. Net reimbursement for administrative expenses in excess of actual expenses	(\$2,538,469)
b. Other income or expenses (including interest paid or received from the plans)	<u>\$0</u>
c. Net gain from operations	(\$2,538,469)
d. The claim payment volume for ASO plans is not readily available.	

#### B. Administrative Service Contract (ASC) Plans

NONE

#### C. Medicare or Similarly Structured Cost Based Reimbursement Contract

Centers for Medicare & Medicaid Services ("CMS") periodically performs audits of Medicare revenue and may seek return of premium payments made to the Company if risk adjustment factors are not properly supported by medical record data. We estimate and record reserves for CMS audits based on information available at the time the estimates are made. Although we believe the Company maintains appropriate reserves for its exposure to the CMS audits, actual results could differ materially from those estimates.

### 19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

## NOTES TO FINANCIAL STATEMENTS

NONE

### 20. Fair Value Measurements

#### A. Assets / Liabilities Measured at Fair Value on a Recurring Basis

None

#### B. Assets Measured at Fair Value on a Nonrecurring Basis

None

### 21. Other Items

#### A. Extraordinary Items

NONE

#### B. Troubled Debt Restructuring: Debtors

NONE

#### C. Other Disclosures

NONE

#### D. Uncollectible Balances

The Company establishes and routinely monitors the allowance for uncollectible accounts. Management considers the allowance to be adequate.

#### E. Business Interruption Insurance Recoveries

NONE

#### F. State Transferable Tax Credits

NONE

#### G. Sub-prime mortgage related risk exposure

1. The Company has no subprime mortgage related risk exposure.
2. NONE
3. NONE

### 22. Events Subsequent

Subsequent events have been considered through December 31, 2010 for the statutory annual statement filed on March 1, 2011.

The Company recognized no material subsequent events.

### 23. Reinsurance

#### A. Ceded Reinsurance Report

##### Section 1 – General Interrogatories

1. Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the company or by any representative, officer, trustee, or director of the company?  
Yes( ) No( X )  
If yes, give full details.
2. Have any policies issued by the company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?  
Yes( ) No( X )  
If yes, give full details.

## NOTES TO FINANCIAL STATEMENTS

### Section 2 – Ceded Reinsurance Report – Part A

1. Does the company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Yes(  )      No(  )

- a. If yes, what is the estimated amount of the aggregate reduction in surplus of a unilateral cancellation by the reinsurer as of the date of this statement, for those agreements in which cancellation results in a net obligation of the reporting entity to the reinsurer, and for which such obligation is not presently accrued? Where necessary, the reporting entity may consider the current or anticipated experience of the business reinsured in making this estimate.

The current reinsurance contract may be canceled due to:

1. acquisition of the reinsured entity
2. change in management or ownership of reinsured entity
3. change in provider contracts of reinsured entity.

- b. What is the total amount of reinsurance credit taken, whether as an asset or as a reduction of liability for this agreement in this statement?

\$1,654,742

2. Does the reporting entity have any reinsurance agreement in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collect under the reinsured policies?

Yes(  )      No(  )

If yes, give full details.

### Section 3 – Ceded Reinsurance Report – Part B

1. What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the company may consider the current or anticipated experience of the business reinsured in making these estimates. \$1,654,742

2. Have any new agreement been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the company as of the effective date of the agreement?

Yes(  )      No(  )

If yes, what is the amount of reinsurance credits, whether an asset or a reduction of liability, taken for such new agreement or amendments?

#### B. Uncollectible Reinsurance

NONE

#### C. Commutation of Ceded Reinsurance

NONE

### 24. Respectively Rated Contracts and Contracts Subject to Redetermination

A major customer maintains the rights to retrospectively adjust its premiums based on audits that may be performed several years in arrears. The Company provides reserves, on an estimated basis, based on the appropriate guidelines and management's review of current information. Management believes that the resolution of any adjustments to billed premiums will not be materially different from amounts recorded in the accompanying statutory financial statements.

### 25. Change in Incurred Losses and Loss Adjustment Expenses

Reserves as of December 31, 2009 were \$57.9 million. As of December 31, 2010, \$45.4 million has been paid for incurred losses and loss adjustment expenses attributable to insured events of prior years. Reserves remaining for prior year are now \$3.1 million as a result of re-estimation of unpaid losses and loss adjustment expenses principally Medicare lines of business. Therefore, there has

## NOTES TO FINANCIAL STATEMENTS

been \$9.4 million favorable prior year development since December 31, 2009. This decrease is generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. There are no retrospectively rated contracts subject to redetermination.

26. Intercompany Pooling Arrangements

NONE

27. Structured Settlements

NONE

28. Health Care Receivables

In accordance with SSAP No. 84 – “Certain Health Care Receivable and Receivables Under Government Insured Plans”, the following disclosures are made regarding pharmaceutical rebate receivables and risk sharing receivables:

A. Pharmaceutical Rebates Receivables  
None

B. Risk Sharing Receivables  
None

29. Participating Policies

NONE

30. Premium Deficiency Reserves

NONE

31. Anticipated Salvage and Subrogation

NONE

# GENERAL INTERROGATORIES

## PART 1 - COMMON INTERROGATORIES

### GENERAL

- 1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes  No
- 1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? Yes  No  N/A
- 1.3 State Regulating?..... Pennsylvania.....
- 2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes  No
- 2.2 If yes, date of change: .....
- 3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. ....12/31/2010
- 3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. ....12/31/2005
- 3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). ....05/16/2007
- 3.4 By what department or departments? Pennsylvania Department of Insurance.....
- 3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? Yes  No  N/A
- 3.6 Have all of the recommendations within the latest financial examination report been complied with? Yes  No  N/A
- 4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
- 4.11 sales of new business? Yes  No
- 4.12 renewals? Yes  No
- 4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
- 4.21 sales of new business? Yes  No
- 4.22 renewals? Yes  No
- 5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes  No
- 5.2 If yes, provide the name of the entity, NAIC company code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

- 6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes  No
- 6.2 If yes, give full information
- 7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? Yes  No
- 7.2 If yes,
- 7.21 State the percentage of foreign control .....
- 7.22 State the nationality(s) of the foreign person(s) or entity(s); or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact and identify the type of entity(s) (e.g., individual, corporation, government, manager or attorney-in-fact).

1 Nationality	2 Type of Entity
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

## GENERAL INTERROGATORIES

- 8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [ ] No [ X ]
- 8.2 If response to 8.1 is yes, please identify the name of the bank holding company.
- 8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [ ] No [ X ]
- 8.4 If response to 8.3 is yes, please provide the names and locations (city and state of the main office) of any affiliates regulated by a federal financial regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Office of Thrift Supervision (OTS), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 OTS	6 FDIC	7 SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?.....  
Ernst & Young, 621 East Pratt Street, Baltimore, MD 21202.....
- 10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes [ ] No [ X ]
- 10.2 If the response to 10.1 is yes, provide information related to this exemption:.....
- 10.3 Has the insurer been granted any exemptions to the audit committee requirements as allowed in Section 14H of the Annual Financial Reporting Model Regulation, or substantially similar state law or regulation? Yes [ ] No [ X ]
- 10.4 If the response to 10.3 is yes, provide information related to this exemption:.....
- 10.5 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 17A of the Model Regulation, or substantially similar state law or regulation? Yes [ ] No [ X ]
- 10.6 If the response to 10.5 is yes, provide information related to this exemption:.....
- 10.7 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [ X ] No [ ] N/A [ ]
- 10.8 If the response to 10.7 is no or n/a, please explain:.....
11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?.....  
Michael Ridler (Employee), PO Box 67103, 3721 TecPort Drive, Harrisburg, PA 17106-7103.....
- 12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly?..... Yes [ ] No [ X ]
- 12.11 Name of real estate holding company .....
- 12.12 Number of parcels involved.....
- 12.13 Total book/adjusted carrying value..... \$.....
- 12.2 If yes, provide explanation.....
13. FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:
- 13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?.....
- 13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [ ] No [ ]
- 13.3 Have there been any changes made to any of the trust indentures during the year? Yes [ ] No [ ]
- 13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [ ] No [ ] N/A [ ]
- 14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [ X ] No [ ]
- a. Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
- b. Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
- c. Compliance with applicable governmental laws, rules and regulations;
- d. The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
- e. Accountability for adherence to the code.
- 14.11 If the response to 14.1 is no, please explain:.....
- 14.2 Has the code of ethics for senior managers been amended? Yes [ X ] No [ ]
- 14.21 If the response to 14.2 is yes, provide information related to amendment(s).....  
The Code of Ethics was amended, for all employees, to reflect current practices and make minor corrections.....
- 14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [ ] No [ X ]
- 14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).....

## GENERAL INTERROGATORIES

### BOARD OF DIRECTORS

15. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? ..... Yes [ X ] No [ ]
16. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? ..... Yes [ X ] No [ ]
17. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person? ..... Yes [ X ] No [ ]

### FINANCIAL

18. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? ..... Yes [ ] No [ X ]
- 19.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):
- 19.11 To directors or other officers ..... \$.....
- 19.12 To stockholders not officers .. \$.....
- 19.13 Trustees, supreme or grand (Fraternal only) ..... \$.....
- 19.2 Total amount of loans outstanding at end of year (inclusive of Separate Accounts, exclusive of policy loans):
- 19.21 To directors or other officers .. \$.....
- 19.22 To stockholders not officers ... \$.....
- 19.23 Trustees, supreme or grand (Fraternal only) ..... \$.....
- 20.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? ..... Yes [ ] No [ X ]
- 20.2 If yes, state the amount thereof at December 31 of the current year:
- 20.21 Rented from others ..... \$.....
- 20.22 Borrowed from others ..... \$.....
- 20.23 Leased from others ..... \$.....
- 20.24 Other ..... \$.....
- 21.1 Does this statement include payments for assessments as described in the *Annual Statement Instructions* other than guaranty fund or guaranty association assessments? ..... Yes [ ] No [ X ]
- 21.2 If answer is yes:
- 21.21 Amount paid as losses or risk adjustment ..... \$.....
- 21.22 Amount paid as expenses ..... \$.....
- 21.23 Other amounts paid ..... \$.....
- 22.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? ..... Yes [ X ] No [ ]
- 22.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: ..... \$.....203,111

### INVESTMENT

- 23.1 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 23.3)..... Yes [ X ] No [ ]
- 23.2 If no, give full and complete information, relating thereto
- 23.3 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)
- 23.4 Does the company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions?.....Yes [ ] No [ ] NA [ X ]
- 23.5 If answer to 23.4 is yes, report amount of collateral for conforming programs. .... \$.....
- 23.6 If answer to 23.4 is no, report amount of collateral for other programs. .... \$.....
- 23.7 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract?.....Yes [ ] No [ ] NA [ X ]
- 23.8 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%?.....Yes [ ] No [ ] NA [ X ]
- 23.9 Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending?.....Yes [ ] No [ ] NA [ X ]

## GENERAL INTERROGATORIES

24.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 20.1 and 23.3). Yes [ ] No [ X ]

24.2 If yes, state the amount thereof at December 31 of the current year:

24.21	Subject to repurchase agreements	\$ .....
24.22	Subject to reverse repurchase agreements	\$ .....
24.23	Subject to dollar repurchase agreements	\$ .....
24.24	Subject to reverse dollar repurchase agreements	\$ .....
24.25	Pledged as collateral	\$ .....
24.26	Placed under option agreements	\$ .....
24.27	Letter stock or securities restricted as to sale	\$ .....
24.28	On deposit with state or other regulatory body	\$ .....
24.29	Other	\$ .....

24.3 For category (24.27) provide the following:

1 Nature of Restriction	2 Description	3 Amount

25.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [ ] No [ X ]

25.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [ ] No [ ] N/A [ X ]  
If no, attach a description with this statement.

26.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [ ] No [ X ]

26.2 If yes, state the amount thereof at December 31 of the current year. \$ .....

27. Excluding items in Schedule E – Part 3 – Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III – General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping agreements of the NAIC *Financial Condition Examiners Handbook*? Yes [ X ] No [ ]

27.01 For agreements that comply with the requirements of the NAIC *Financial Condition Examiners Handbook*, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
Wachovia Bank.....	1525 West WT Blvd. Charlotte, NC 28288-1162.....
CitiBank.....	3800 Citigroup Center Building B 02/08 Tampa, FL 33610-9122.....

27.02 For all agreements that do not comply with the requirements of the NAIC *Financial Condition Examiners Handbook*, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

27.03 Have there been any changes, including name changes, in the custodian(s) identified in 27.01 during the current year? Yes [ ] No [ X ]

27.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

27.05 Identify all investment advisors, brokers/dealers or individuals acting on behalf of broker/dealers that have access to the investment accounts, handle securities and have authority to make investments on behalf of the reporting entity:

1 Central Registration Depository Number(s)	2 Name	3 Address
107423.....	Conning & Company.....	One Financial Plaza Hartford, CT 06103.....
110441.....	Western Asset Management Co.....	399 Park Ave., 4th Floor New York, NY 10021.....

## GENERAL INTERROGATORIES

28.1 Does the reporting entity have any diversified mutual funds reported in Schedule D - Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5 (b) (1)])? Yes [ ] No [ X ]

28.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
28.2999 TOTAL		

28.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation

29. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
29.1 Bonds.....	163,090,067	168,038,978	4,948,911
29.2 Preferred Stocks.....			
29.3 Totals	163,090,067	168,038,978	4,948,911

29.4 Describe the sources or methods utilized in determining the fair values:.....

30.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D?..... Yes [ ] No [ X ]

30.2 If the answer to 30.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source?..... Yes [ ] No [ ]

30.3 If the answer to 30.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:.....

31.1 Have all the filing requirements of the *Purposes and Procedures Manual* of the NAIC Securities Valuation Office been followed?..... Yes [ X ] No [ ]

31.2 If no, list exceptions:.....

## GENERAL INTERROGATORIES

### OTHER

- 32.1 Amount of payments to Trade associations, service organizations and statistical or rating bureaus, if any? \$ .....88,225
- 32.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid
Insurance Federation of PA.....	\$.....75,000
Ohio Association of Health Plans, Inc.....	\$.....13,225

- 33.1 Amount of payments for legal expenses, if any? \$ .....96,382
- 33.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
Tucker Arensberg Attorneys.....	\$.....62,593
Morgan, Lewis & Bockius LLP.....	\$.....29,232

- 34.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any? \$ .....
- 34.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
.....	\$ .....
.....	\$ .....
.....	\$ .....

# GENERAL INTERROGATORIES

## PART 2 - HEALTH INTERROGATORIES

- 1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes [ ] No [ X ]
- 1.2 If yes, indicate premium earned on U. S. business only \$.....
- 1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? \$.....
- 1.31 Reason for excluding .....
- 1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above. \$.....
- 1.5 Indicate total incurred claims on all Medicare Supplement Insurance. \$.....
- 1.6 Individual policies:
- Most current three years:
- 1.61 Total premium earned \$.....
- 1.62 Total incurred claims \$.....
- 1.63 Number of covered lives .....
- All years prior to most current three years:
- 1.64 Total premium earned \$.....
- 1.65 Total incurred claims \$.....
- 1.66 Number of covered lives .....
- 1.7 Group policies:
- Most current three years:
- 1.71 Total premium earned \$.....
- 1.72 Total incurred claims \$.....
- 1.73 Number of covered lives .....
- All years prior to most current three years:
- 1.74 Total premium earned \$.....
- 1.75 Total incurred claims \$.....
- 1.76 Number of covered lives .....

2. Health Test:

		1		2
		Current Year		Prior Year
2.1	Premium Numerator	\$ 478,031,244	\$	608,309,210
2.2	Premium Denominator	\$ 478,031,244	\$	608,309,210
2.3	Premium Ratio (2.1/2.2)	1.000		1.000
2.4	Reserve Numerator	\$ 56,945,306	\$	58,043,923
2.5	Reserve Denominator	\$ 56,945,306	\$	58,043,923
2.6	Reserve Ratio (2.4/2.5)	1.000		1.000

- 3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes [ ] No [ X ]
- 3.2 If yes, give particulars:
- 4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes [ X ] No [ ]
- 4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes [ ] No [ X ]
- 5.1 Does the reporting entity have stop-loss reinsurance? Yes [ X ] No [ ]
- 5.2 If no, explain:
- 5.3 Maximum retained risk (see instructions)
- 5.31 Comprehensive Medical \$.....392,500
- 5.32 Medical Only \$.....
- 5.33 Medicare Supplement \$.....
- 5.34 Dental and Vision \$.....
- 5.35 Other Limited Benefit Plan \$.....
- 5.36 Other \$.....
6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:
- 7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes [ X ] No [ ]
- 7.2 If no, give details:
8. Provide the following information regarding participating providers:
- 8.1 Number of providers at start of reporting year .....37,293
- 8.2 Number of providers at end of reporting year .....38,885
- 9.1 Does the reporting entity have business subject to premium rate guarantees? Yes [ ] No [ X ]
- 9.2 If yes, direct premium earned:
- 9.21 Business with rate guarantees between 15-36 months .....
- 9.22 Business with rate guarantees over 36 months .....

# GENERAL INTERROGATORIES

## PART 2 - HEALTH INTERROGATORIES

- 10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes [ ] No [ X ]
- 10.2 If yes:
- 10.21 Maximum amount payable bonuses \$.....
- 10.22 Amount actually paid for year bonuses \$.....
- 10.23 Maximum amount payable withholds \$.....
- 10.24 Amount actually paid for year withholds \$.....
- 11.1 Is the reporting entity organized as:
- 11.12 A Medical Group/Staff Model, Yes [ ] No [ X ]
- 11.13 An Individual Practice Association (IPA), or, Yes [ ] No [ X ]
- 11.14 A Mixed Model (combination of above) ? Yes [ ] No [ X ]
- 11.2 Is the reporting entity subject to Minimum Net Worth Requirements? Yes [ X ] No [ ]
- 11.3 If yes, show the name of the state requiring such net worth. Pennsylvania.....
- 11.4 If yes, show the amount required. \$.....1,261,519
- 11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes [ ] No [ X ]
- 11.6 If the amount is calculated, show the calculation.  
 Year to Date Uncovered Medical Page 4, Line 18, Column 2 (4388,159,611) divided by 12 months and multiplied by 3 months outstanding.
12. List service areas in which reporting entity is licensed to operate:

1 Name of Service Area
HealthAmerica is licensed in every Pennsylvania County except for Fulton. In Ohio HealthAmerica is licensed in the Counties of Jefferson, Harrison, Belmont, Columbiana, Trumbull, and Mahoning.....
.....
.....
.....

- 13.1 Do you act as a custodian for health savings accounts? Yes [ ] No [ X ]
- 13.2 If yes, please provide the amount of custodial funds held as of the reporting date. \$.....
- 13.3 Do you act as an administrator for health savings accounts? Yes [ ] No [ X ]
- 13.4 If yes, please provide the balance of the funds administered as of the reporting date. \$.....

## FIVE - YEAR HISTORICAL DATA

	1 2010	2 2009	3 2008	4 2007	5 2006
<b>Balance Sheet</b> (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28) .....	197,456,359	206,914,171	184,084,833	211,139,815	253,929,182
2. Total liabilities (Page 3, Line 24) .....	109,945,116	109,074,466	93,870,218	97,037,213	129,034,449
3. Statutory surplus .....	1,261,519	1,710,853	1,788,735	2,078,566	2,738,170
4. Total capital and surplus (Page 3, Line 33) .....	87,511,243	97,839,705	90,214,615	114,102,602	124,894,733
<b>Income Statement</b> (Page 4)					
5. Total revenues (Line 8) .....	478,030,099	608,309,210	636,491,258	675,391,235	754,349,706
6. Total medical and hospital expenses (Line 18) .....	388,159,611	526,416,357	550,380,150	554,284,347	608,482,317
7. Claims adjustment expenses (Line 20) .....	20,307,310	17,637,434	16,416,858	22,522,552	18,501,900
8. Total administrative expenses (Line 21) .....	20,989,970	28,744,351	28,210,282	29,536,381	39,871,456
9. Net underwriting gain (loss) (Line 24) .....	48,573,208	35,511,068	41,483,968	69,047,955	87,494,033
10. Net investment gain (loss) (Line 27) .....	5,889,174	7,413,528	5,875,524	9,744,493	9,530,756
11. Total other income (Lines 28 plus 29) .....					
12. Net income or (loss) (Line 32) .....	36,146,185	23,507,554	32,642,012	55,623,220	67,157,379
<b>Cash Flow</b> (Page 6)					
13. Net cash from operations (Line 11) .....	27,730,915	21,426,267	38,528,615	18,278,856	81,471,416
<b>Risk-Based Capital Analysis</b>					
14. Total adjusted capital .....	87,511,243	97,839,705	90,214,615	114,102,602	124,894,733
15. Authorized control level risk-based capital .....	13,671,648	18,347,112	18,526,685	18,641,585	20,022,843
<b>Enrollment</b> (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7) .....	58,161	101,544	118,326	163,712	192,615
17. Total members months (Column 6, Line 7) .....	733,293	1,249,142	1,440,300	2,016,452	2,455,307
<b>Operating Percentage</b> (Page 4)					
(Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5) .....	100.0	100.0	100.0	100.0	100.0
19. Total hospital and medical plus other non-health (Lines 18 plus Line 19) .....	81.2	86.5	86.5	82.1	80.7
20. Cost containment expenses .....	1.6	1.4	1.3	1.5	1.2
21. Other claims adjustment expenses .....	2.6	1.5	1.3	1.8	1.2
22. Total underwriting deductions (Line 23) .....	89.8	94.2	93.5	89.8	88.4
23. Total underwriting gain (loss) (Line 24) .....	10.2	5.8	6.5	10.2	11.6
<b>Unpaid Claims Analysis</b>					
(U&I Exhibit, Part 2B)					
24. Total claims incurred for prior years (Line 13, Col. 5) .....	48,575,147	54,432,325	46,281,641	53,665,388	66,926,836
25. Estimated liability of unpaid claims – [prior year (Line 13, Col. 6)] .....	57,931,681	65,137,795	62,556,535	68,053,395	78,031,887
<b>Investments In Parent, Subsidiaries and Affiliates</b>					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1) .....					
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1) .....					
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1) .....					
29. Affiliated short-term investments (subtotal included in Sch. DA Verification, Col. 5, Line 10) .....					
30. Affiliated mortgage loans on real estate .....					
31. All other affiliated .....					
32. Total of above Lines 26 to 31 .....					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors?..... Yes [ ] No [ ]

If no, please explain:



ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

**EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)**

REPORT FOR: 1. CORPORATION

HealthAmerica Pennsylvania, Inc.

2.

(LOCATION)

NAIC Group Code 1137

BUSINESS IN THE STATE OF .....

DURING THE YEAR 2010

NAIC Company Code 95060

	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefit Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Other
		2 Individual	3 Group							
Total Members at end of:										
1. Prior Year .....										
2. First Quarter .....										
3. Second Quarter .....										
4. Third Quarter .....										
5. Current Year										
6. Current Year Member Months										
Total Member Ambulatory Encounters for Year:										
7. Physician .....										
8. Non-Physician .....										
9. Total										
10. Hospital Patient Days Incurred										
11. Number of Inpatient Admissions										
12. Health Premiums Written (b) .....										
13. Life Premiums Direct .....										
14. Property/Casualty Premiums Written .....										
15. Health Premiums Earned .....										
16. Property/Casualty Premiums Earned .....										
17. Amount Paid for Provision of Health Care Services .....										
18. Amount Incurred for Provision of Health Care Services										

(a) For health business: number of persons insured under PPO managed care products \_\_\_\_\_ and number of persons insured under indemnity only products \_\_\_\_\_

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$ .....



ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

**EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)**

REPORT FOR: 1. CORPORATION

HealthAmerica Pennsylvania, Inc.

2.

(LOCATION)

NAIC Group Code	1137	BUSINESS IN THE STATE OF Ohio		DURING THE YEAR 2010						NAIC Company Code	95060
	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10	
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other	
Total Members at end of:											
1. Prior Year .....	231		231								
2. First Quarter .....	10		10								
3. Second Quarter .....	10		10								
4. Third Quarter .....	10		10								
5. Current Year	10		10								
6. Current Year Member Months	120		120								
Total Member Ambulatory Encounters for Year:											
7. Physician .....	258		258								
8. Non-Physician .....	67		67								
9. Total	325		325								
10. Hospital Patient Days Incurred	6		6								
11. Number of Inpatient Admissions	2		2								
12. Health Premiums Written (b).....	32,651		32,651								
13. Life Premiums Direct.....											
14. Property/Casualty Premiums Written.....											
15. Health Premiums Earned.....	32,651		32,651								
16. Property/Casualty Premiums Earned.....											
17. Amount Paid for Provision of Health Care Services .....	103,281		103,281								
18. Amount Incurred for Provision of Health Care Services	27,281		27,281								

(a) For health business: number of persons insured under PPO managed care products \_\_\_\_\_ and number of persons insured under indemnity only products \_\_\_\_\_

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$ .....

29.OH



ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION

HealthAmerica Pennsylvania, Inc.

2.

(LOCATION)

NAIC Group Code	1137	BUSINESS IN THE STATE OF Pennsylvania		DURING THE YEAR 2010						NAIC Company Code		95060
	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefit Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Other		
		2 Individual	3 Group									
Total Members at end of:												
1. Prior Year .....	101,313		18,697				15,165	37,245		30,206		
2. First Quarter .....	81,227		9,169				10,823	29,450		31,785		
3. Second Quarter .....	52,988		8,658				10,613	28,627	5,090			
4. Third Quarter .....	56,325		8,502				10,501	28,352	8,970			
5. Current Year .....	58,151		8,110				10,413	27,921	11,707			
6. Current Year Member Months .....	733,173		104,055				126,675	344,728	62,335	95,380		
Total Member Ambulatory Encounters for Year:												
7. Physician .....	734,928		63,792				104,827	542,460	23,849			
8. Non-Physician .....	78,485		11,924				13,511	52,139	911			
9. Total .....	813,413		75,716				118,338	594,599	24,760			
10. Hospital Patient Days Incurred .....	116,324		2,913				4,424	102,356	6,631			
11. Number of Inpatient Admissions .....	13,021		470				714	10,825	1,012			
12. Health Premiums Written (b) .....	481,809,078		40,979,671				62,883,513	347,310,441	30,635,453			
13. Life Premiums Direct .....												
14. Property/Casualty Premiums Written .....												
15. Health Premiums Earned .....	481,809,078		40,979,671				62,883,513	347,310,441	30,635,453			
16. Property/Casualty Premiums Earned .....												
17. Amount Paid for Provision of Health Care Services .....	390,772,566		36,490,620				53,305,219	283,231,933	17,744,794			
18. Amount Incurred for Provision of Health Care Services .....	390,283,906		32,943,460				50,499,490	271,657,085	35,183,871			

(a) For health business: number of persons insured under PPO managed care products \_\_\_\_\_ and number of persons insured under indemnity only products \_\_\_\_\_

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$ .....

29.PA



ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

**EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)**

REPORT FOR: 1. CORPORATION

HealthAmerica Pennsylvania, Inc.

2.

(LOCATION)

NAIC Group Code	1137	BUSINESS IN THE STATE OF Consolidated		DURING THE YEAR 2010						NAIC Company Code	95060
	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefit Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Other	
		2 Individual	3 Group								
Total Members at end of:											
1. Prior Year .....	101,544		18,928				15,165	37,245		30,206	
2. First Quarter .....	81,237		9,179				10,823	29,450		31,785	
3. Second Quarter .....	52,998		8,668				10,613	28,627	5,090		
4. Third Quarter .....	56,335		8,512				10,501	28,352	8,970		
5. Current Year	58,161		8,120				10,413	27,921	11,707		
6. Current Year Member Months	733,293		104,175				126,675	344,728	62,335	95,380	
Total Member Ambulatory Encounters for Year:											
7. Physician .....	735,186		64,050				104,827	542,460	23,849		
8. Non-Physician .....	78,552		11,991				13,511	52,139	911		
9. Total	813,738		76,041				118,338	594,599	24,760		
10. Hospital Patient Days Incurred	116,330		2,919				4,424	102,356	6,631		
11. Number of Inpatient Admissions	13,023		472				714	10,825	1,012		
12. Health Premiums Written (b) .....	481,841,729		41,012,322				62,883,513	347,310,441	30,635,453		
13. Life Premiums Direct .....											
14. Property/Casualty Premiums Written .....											
15. Health Premiums Earned .....	481,841,729		41,012,322				62,883,513	347,310,441	30,635,453		
16. Property/Casualty Premiums Earned .....											
17. Amount Paid for Provision of Health Care Services .....	390,875,847		36,593,901				53,305,219	283,231,933	17,744,794		
18. Amount Incurred for Provision of Health Care Services	390,311,187		32,970,741				50,499,490	271,657,085	35,183,871		

(a) For health business: number of persons insured under PPO managed care products \_\_\_\_\_ and number of persons insured under indemnity only products \_\_\_\_\_

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$ .....

29.GT









**Schedule S - Part 5**

Five-Year Exhibit of Reinsurance Ceded Business  
(000 Omitted)

	1 2010	2 2009	3 2008	4 2007	5 2006
<b>A. OPERATIONS ITEMS</b>					
1. Premiums.....	1,080	1,997	2,633	3,599	5,371
2. Title XVIII-Medicare.....	2,275	3,305	4,112	4,816	4,700
3. Title XIX-Medicaid.....	456				
4. Commissions and reinsurance expense allowance.....					
5. Total hospital and medical expenses.....	2,152	3,367	2,764	889	8,168
<b>B. BALANCE SHEET ITEMS</b>					
6. Premiums receivable.....					
7. Claims payable.....	1,250	828	1,609	2,522	3,601
8. Reinsurance recoverable on paid losses.....	405	52	395	256	375
9. Experience rating refunds due or unpaid.....					
10. Commissions and reinsurance expense allowances unpaid.....					
11. Unauthorized reinsurance offset.....					
<b>C. UNAUTHORIZED REINSURANCE (DEPOSITS BY AND FUNDS WITHHELD FROM)</b>					
12. Funds deposited by and withheld from (F).....					
13. Letters of credit (L).....					
14. Trust agreements (T).....					
15. Other (O).....					

**SCHEDULE S - PART 6**

Restatement of Balance Sheet to Identify Net Credit For Ceded Reinsurance

	1	2	3
	As Reported (net of ceded)	Restatement Adjustments	Restated (gross of ceded)
<b>ASSETS (Page 2, Col. 3)</b>			
1. Cash and invested assets (Line 12).....	160,262,976		160,262,976
2. Accident and health premiums due and unpaid (Line 15).....	11,510,453		11,510,453
3. Amounts recoverable from reinsurers (Line 16.1).....	404,836		404,836
4. Net credit for ceded reinsurance.....	XXX	1,654,742	1,654,742
5. All other admitted assets (Balance).....	25,278,094		25,278,094
6. Total assets (Line 28)	197,456,359	1,654,742	199,111,101
<b>LIABILITIES, CAPITAL AND SURPLUS (Page 3)</b>			
7. Claims unpaid (Line 1).....	56,931,058	1,249,906	58,180,964
8. Accrued medical incentive pool and bonus payments (Line 2).....	14,248		14,248
9. Premiums received in advance (Line 8).....	826,600		826,600
10. Funds held under reinsurance treaties with authorized and unauthorized reinsurers (Line 19).....			
11. Reinsurance in unauthorized companies (Line 20).....			
12. All other liabilities (Balance).....	52,173,210		52,173,210
13. Total liabilities (Line 24).....	109,945,116	1,249,906	111,195,022
14. Total capital and surplus (Line 33).....	87,511,243	XXX	87,511,243
15. Total liabilities, capital and surplus (Line 34)	197,456,359	1,249,906	198,706,265
<b>NET CREDIT FOR CEDED REINSURANCE</b>			
16. Claims unpaid.....	1,249,906		
17. Accrued medical incentive pool.....			
18. Premiums received in advance.....			
19. Reinsurance recoverable on paid losses.....	404,836		
20. Other ceded reinsurance recoverables.....			
21. Total ceded reinsurance recoverables.....	1,654,742		
22. Premiums receivable.....			
23. Funds held under reinsurance treaties with authorized and unauthorized reinsurers.....			
24. Unauthorized reinsurance.....			
25. Other ceded reinsurance payables/offsets.....			
26. Total ceded reinsurance payables/offsets.....			
27. Total net credit for ceded reinsurance	1,654,742		

**SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS**

Allocated by States and Territories

State, Etc.	1 Active Status	Direct Business Only							9 Deposit-Type Contracts
		2 Accident & Health Premiums	3 Medicare Title XVIII	4 Medicaid Title XIX	5 Federal Employees Health Benefits Program Premiums	6 Life & Annuity Premiums & Other Considerations	7 Property/Casualty Premiums	8 Total Columns 2 Through 7	
1. Alabama	AL	N							
2. Alaska	AK	N							
3. Arizona	AZ	N							
4. Arkansas	AR	N							
5. California	CA	N							
6. Colorado	CO	N							
7. Connecticut	CT	N							
8. Delaware	DE	N							
9. District of Columbia	DC	N							
10. Florida	FL	N							
11. Georgia	GA	N							
12. Hawaii	HI	N							
13. Idaho	ID	N							
14. Illinois	IL	N							
15. Indiana	IN	N							
16. Iowa	IA	N							
17. Kansas	KS	N							
18. Kentucky	KY	N							
19. Louisiana	LA	N							
20. Maine	ME	N							
21. Maryland	MD	N							
22. Massachusetts	MA	N							
23. Michigan	MI	N							
24. Minnesota	MN	N							
25. Mississippi	MS	N							
26. Missouri	MO	N							
27. Montana	MT	N							
28. Nebraska	NE	N							
29. Nevada	NV	N							
30. New Hampshire	NH	N							
31. New Jersey	NJ	N							
32. New Mexico	NM	N							
33. New York	NY	N							
34. North Carolina	NC	N							
35. North Dakota	ND	N							
36. Ohio	OH	L	32,651					32,651	
37. Oklahoma	OK	N							
38. Oregon	OR	N							
39. Pennsylvania	PA	L	40,979,671	347,310,441	30,635,453	62,883,513		481,809,078	
40. Rhode Island	RI	N							
41. South Carolina	SC	N							
42. South Dakota	SD	N							
43. Tennessee	TN	N							
44. Texas	TX	N							
45. Utah	UT	N							
46. Vermont	VT	N							
47. Virginia	VA	N							
48. Washington	WA	N							
49. West Virginia	WV	N							
50. Wisconsin	WI	N							
51. Wyoming	WY	N							
52. American Samoa	AS	N							
53. Guam	GU	N							
54. Puerto Rico	PR	N							
55. U.S. Virgin Islands	VI	N							
56. Northern Mariana Islands	MP	N							
57. Canada	CN	N							
58. Aggregate Other Alien	OT	XXX							
59. Subtotal	XXX		41,012,322	347,310,441	30,635,453	62,883,513		481,841,729	
60. Reporting entity contributions for Employee Benefit Plans	XXX								
61. Total (Direct Business)	(a) 2		41,012,322	347,310,441	30,635,453	62,883,513		481,841,729	
<b>DETAILS OF WRITE-INS</b>									
5801.	XXX								
5802.	XXX								
5803.	XXX								
5898. Summary of remaining write-ins for Line 58 from overflow page	XXX								
5899. Totals (Lines 5801 through 5803 plus 5898) (Line 58 above)	XXX								

(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.

Explanation of basis of allocation by states, premiums by state, etc.: Allocated by state based on group location

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

(a) Insert the number of L responses except for Canada and other Alien.

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

**SCHEDULE T – PART 2  
INTERSTATE COMPACT – EXHIBIT OF PREMIUMS WRITTEN**

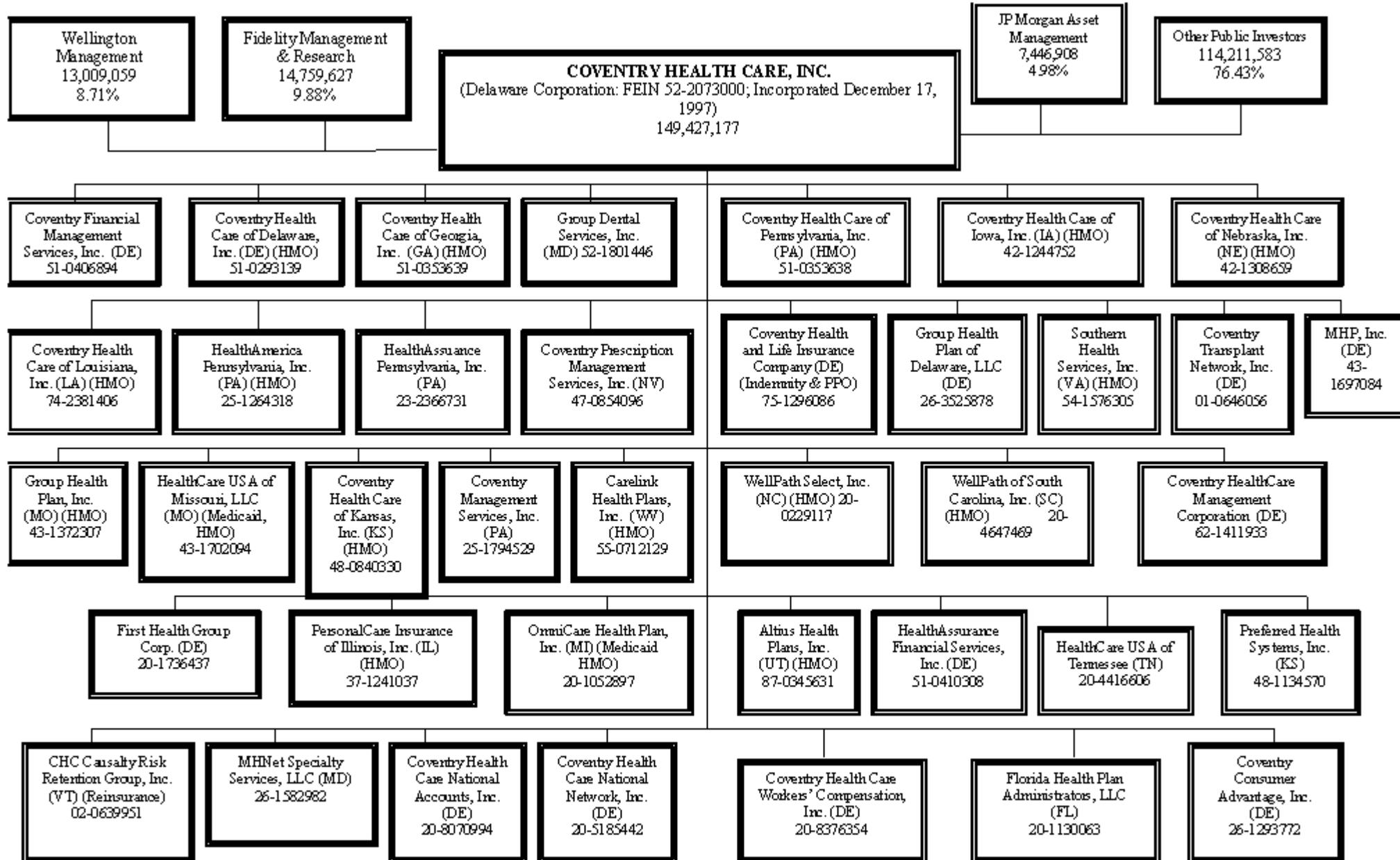
Allocated By States and Territories

States, Etc.		Direct Business Only					Totals
		1 Life (Group and individual)	2 Annuities (Group and individual)	3 Disability Income (Group and individual)	4 Long-Term Care (Group and individual)	5 Deposit-Type Contracts	
1. Alabama	AL						
2. Alaska	AK						
3. Arizona	AZ						
4. Arkansas	AR						
5. California	CA						
6. Colorado	CO						
7. Connecticut	CT						
8. Delaware	DE						
9. District of Columbia	DC						
10. Florida	FL						
11. Georgia	GA						
12. Hawaii	HI						
13. Idaho	ID						
14. Illinois	IL						
15. Indiana	IN						
16. Iowa	IA						
17. Kansas	KS						
18. Kentucky	KY						
19. Louisiana	LA						
20. Maine	ME						
21. Maryland	MD						
22. Massachusetts	MA						
23. Michigan	MI						
24. Minnesota	MN						
25. Mississippi	MS						
26. Missouri	MO						
27. Montana	MT						
28. Nebraska	NE						
29. Nevada	NV						
30. New Hampshire	NH						
31. New Jersey	NJ						
32. New Mexico	NM						
33. New York	NY						
34. North Carolina	NC						
35. North Dakota	ND						
36. Ohio	OH						
37. Oklahoma	OK						
38. Oregon	OR						
39. Pennsylvania	PA						
40. Rhode Island	RI						
41. South Carolina	SC						
42. South Dakota	SD						
43. Tennessee	TN						
44. Texas	TX						
45. Utah	UT						
46. Vermont	VT						
47. Virginia	VA						
48. Washington	WA						
49. West Virginia	WV						
50. Wisconsin	WI						
51. Wyoming	WY						
52. American Samoa	AS						
53. Guam	GU						
54. Puerto Rico	PR						
55. U.S. Virgin Islands	VI						
56. Northern Mariana Islands	MP						
57. Canada	CN						
58. Aggregate Other Alien	OT						
59. Totals							

NONE

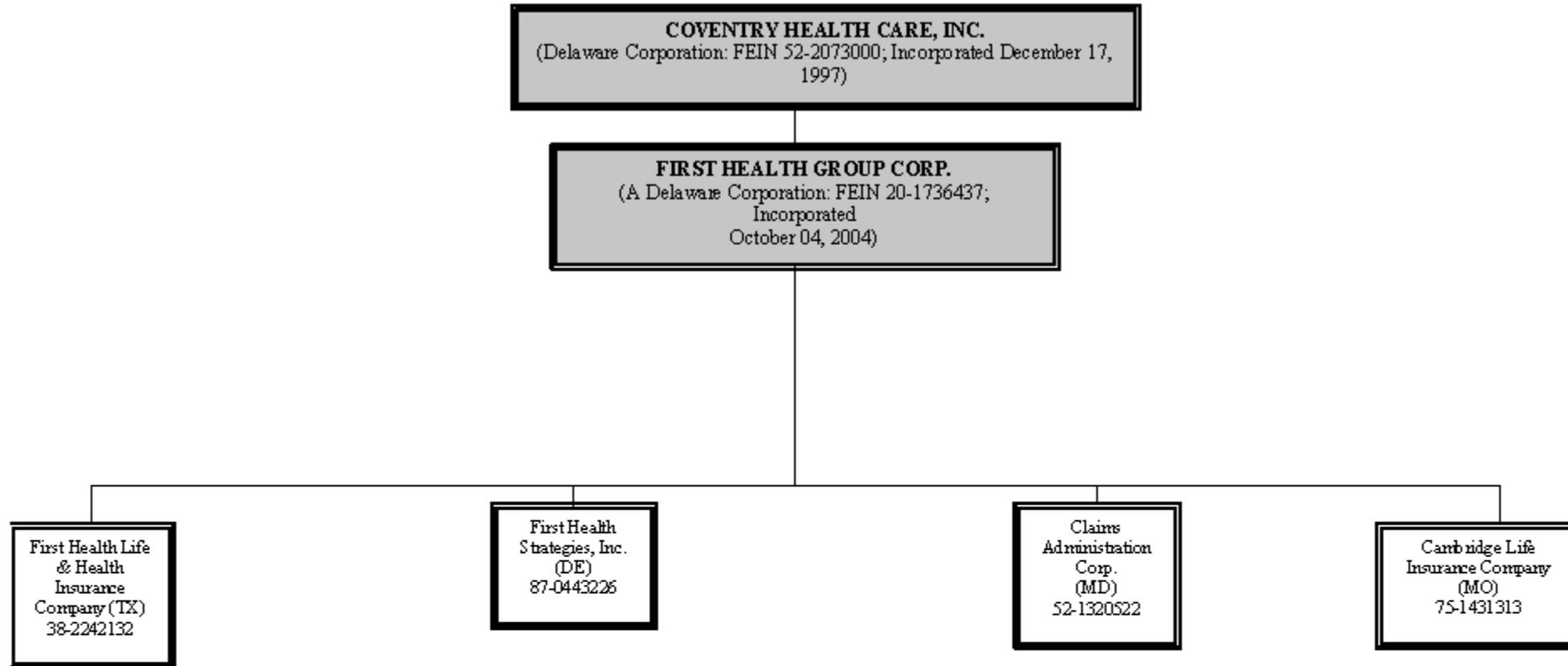
**SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP**

**PART 1 - ORGANIZATIONAL CHART**



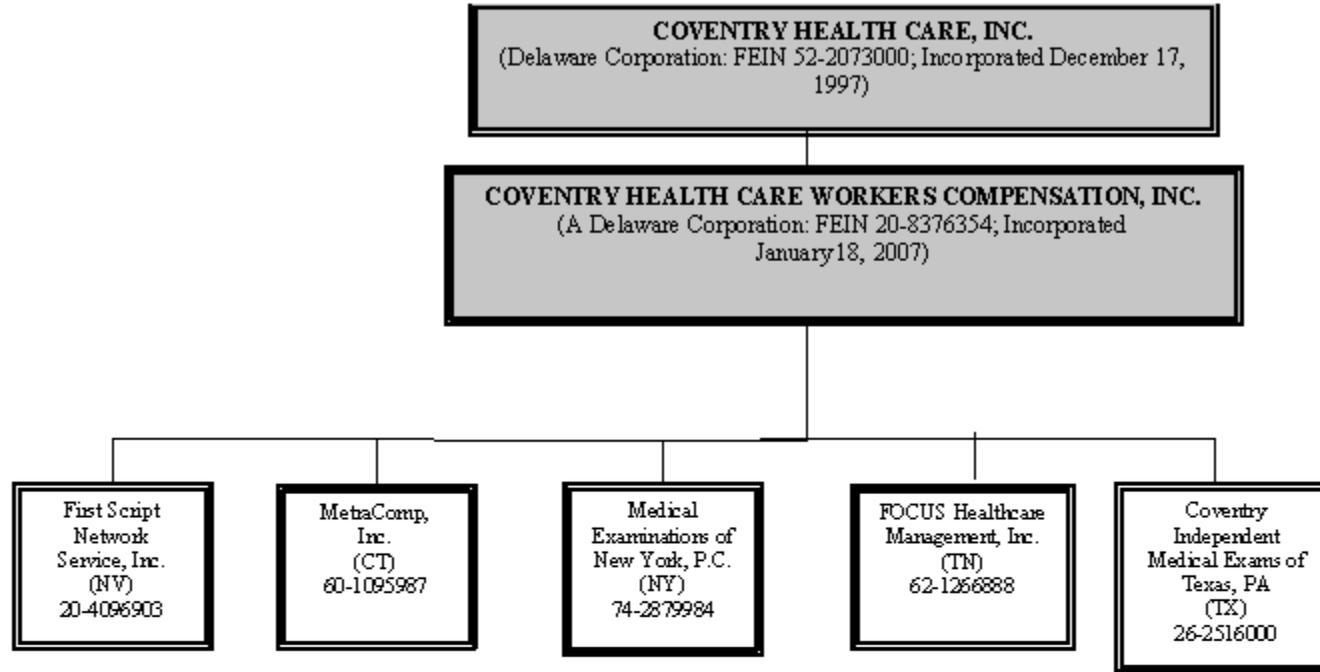
**SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP**

**PART 1 - ORGANIZATIONAL CHART**

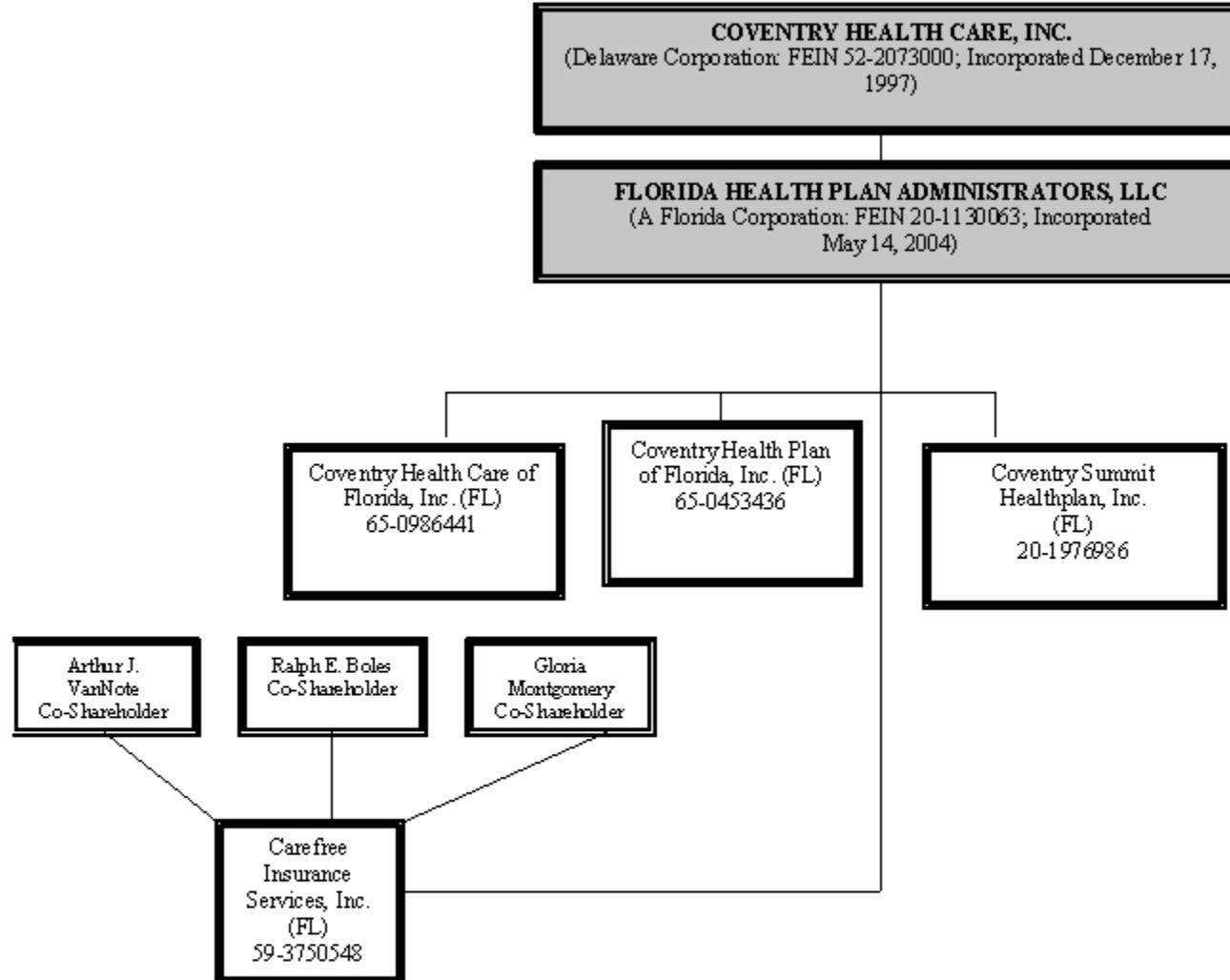


**SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP**

**PART 1 - ORGANIZATIONAL CHART**

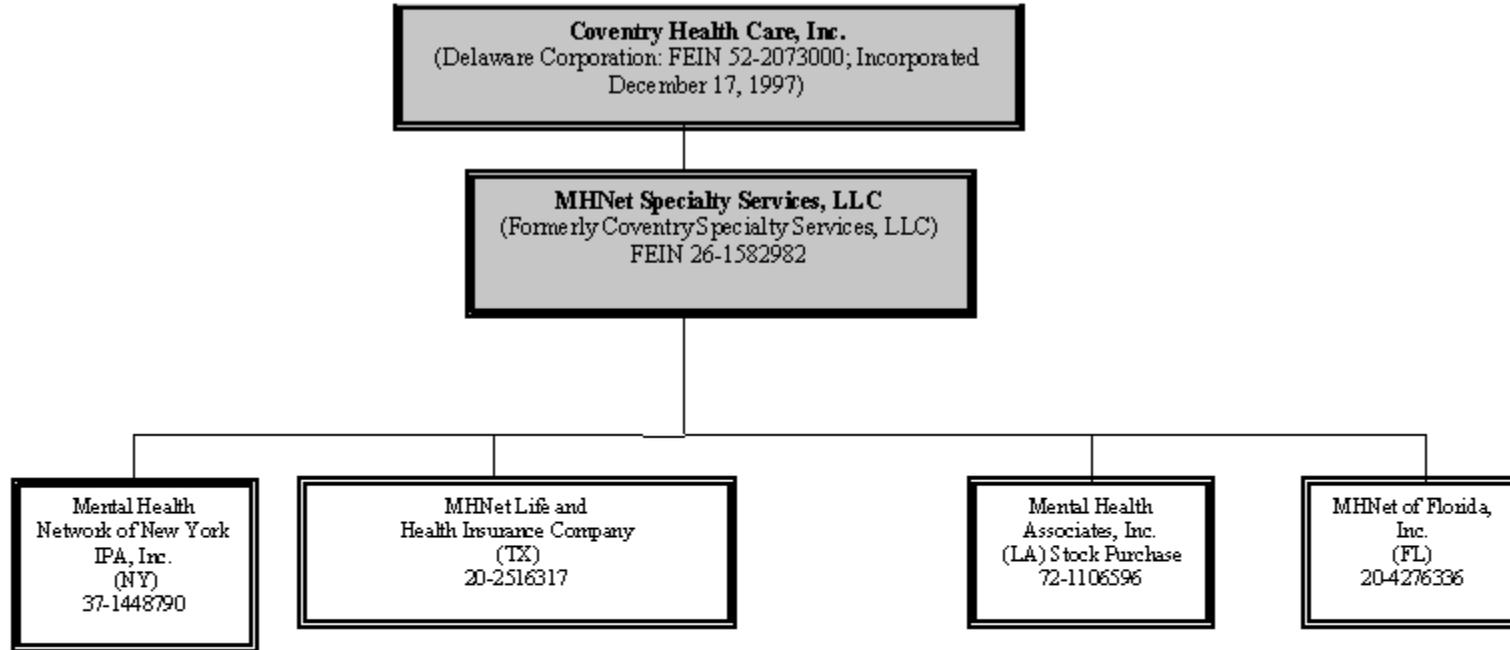


**SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP**  
**PART 1 - ORGANIZATIONAL CHART**

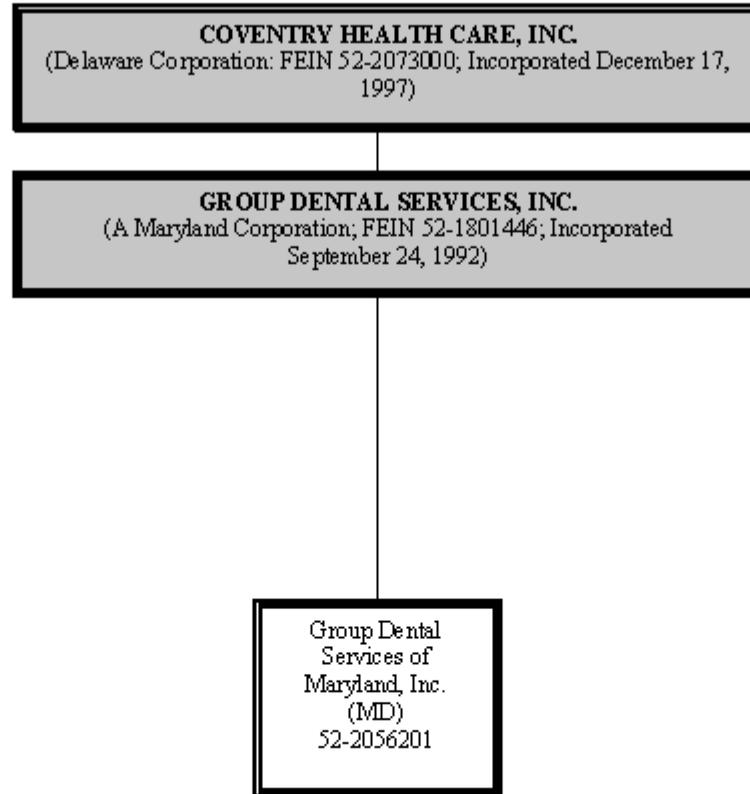


**SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP**

**PART 1 - ORGANIZATIONAL CHART**

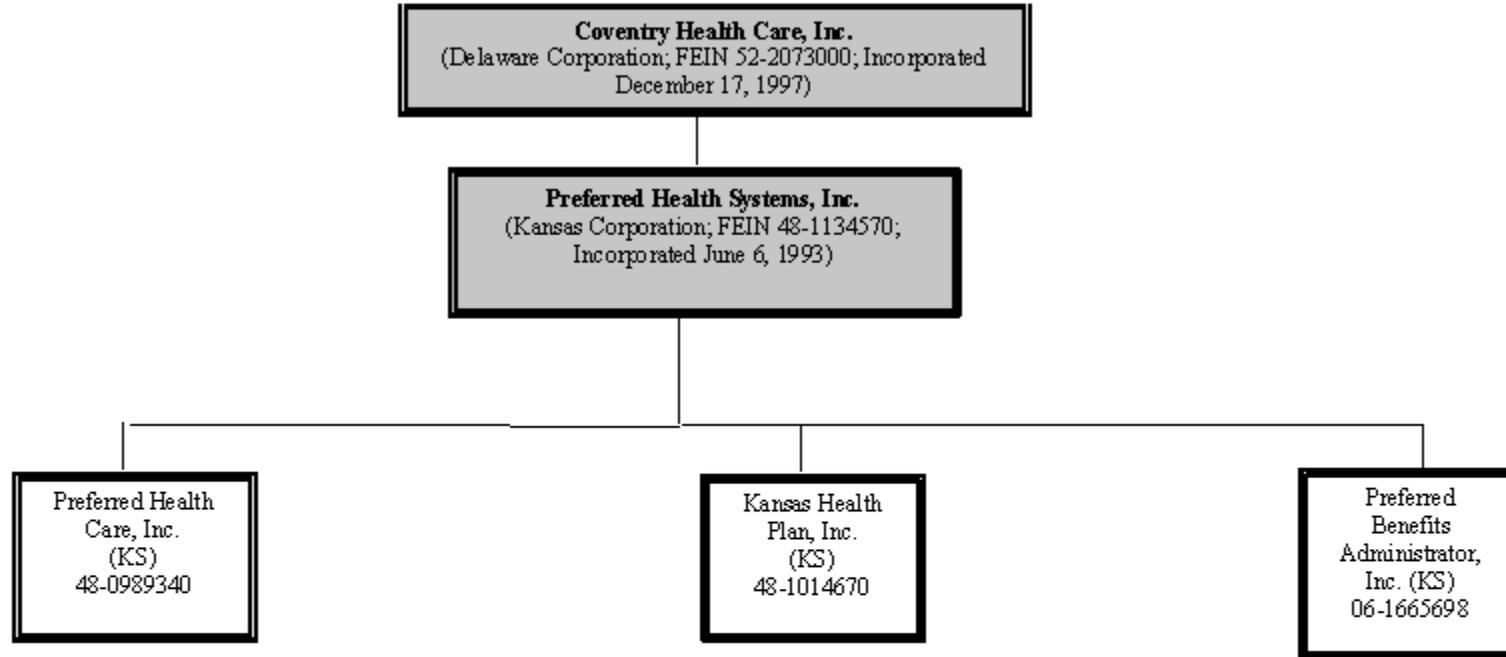


**SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP**  
**PART 1 - ORGANIZATIONAL CHART**



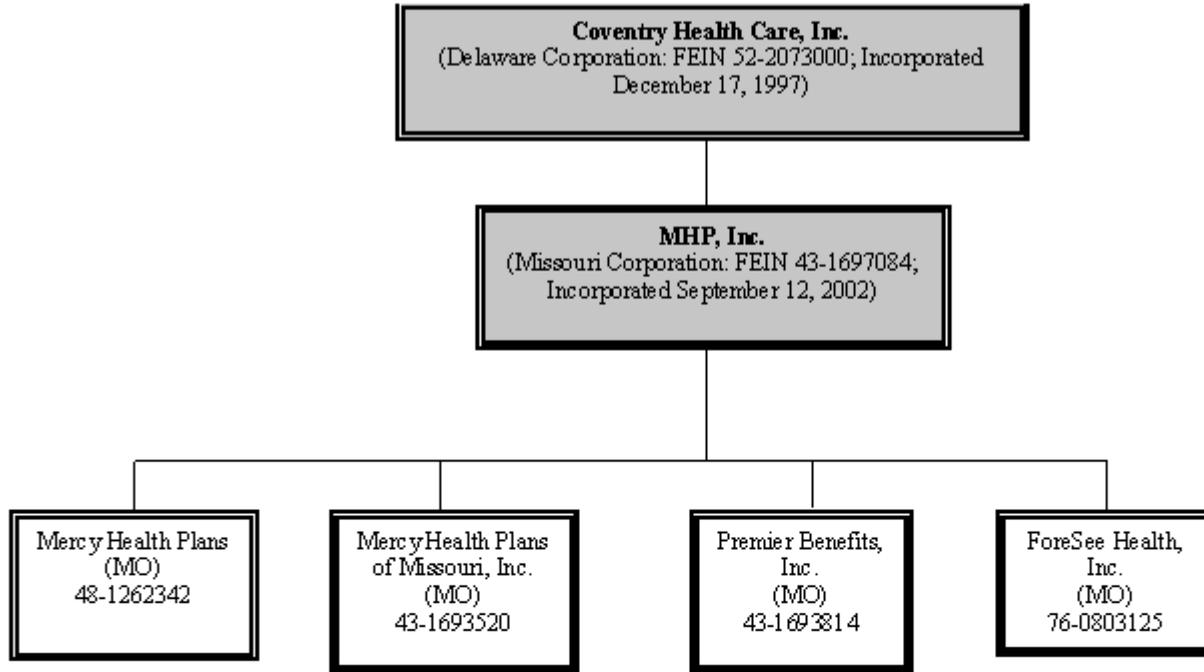
**SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP**

**PART 1 - ORGANIZATIONAL CHART**



**SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP**

**PART 1 - ORGANIZATIONAL CHART**



SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	Federal ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	52-2073000	Coventry Health Care Inc	319,367,343	(49,432,360)	(1,400,000)		580,065,135			(54,090)	848,546,028	
	51-0406894	Coventry Financial Mgmt Services, Inc					3,853,951				3,853,951	
96460	51-0293139	Coventry Health Care of Delaware, Inc					(25,250,866)	(2,690,687)			(27,941,554)	3,091,237
95282	51-0353639	Coventry Health Care of Georgia, Inc	(6,000,000)				(40,180,302)	(2,570,851)			(48,751,153)	1,422,639
	52-1801446	Group Dental Services, Inc			1,400,000		11,549,008				12,949,008	
95241	42-1244752	Coventry Health Care of Iowa, Inc					(11,389,804)	(1,764,101)			(13,153,905)	1,053,839
95925	42-1308659	Coventry Health Care of Nebraska, Inc		6,000,000			(11,103,639)	(1,898,647)			(7,002,286)	1,775,334
95283	51-0353638	Coventry Health Care of Pennsylvania, Inc					(27,566)				(27,566)	
95173	74-2381406	Coventry Health Care of Louisiana, Inc	(4,853,729)				(10,374,364)	(52,824)			(15,280,917)	1,156,902
95060	25-1264318	HealthAmerica Pennsylvania Inc	(48,000,000)				(8,983,584)	(1,658,909)			(58,642,493)	1,654,742
11102	23-2366731	HealthAssurance Pennsylvania, Inc					(137,941,020)	(8,702,200)			(146,643,220)	5,012,481
	47-0854096	Coventry Prescription Mgmt Services, Inc					(104,281,881)				(104,281,881)	
81973	75-1296086	Coventry Health & Life Insurance Company	(140,000,000)				(257,740,418)	44,543,997			(353,196,421)	(31,943,335)
	26-3525878	Group Health Plan of Delaware, LLC										
96555	54-1576305	Southern Health Services, Inc	(14,492,000)				(28,545,478)	(1,389,141)			(44,426,619)	1,268,744
	01-0646056	Coventry Transplant Network, Inc					(103,510)				(103,510)	
	43-1697084	MHP, Inc."					30,170,440				30,170,440	
96377	43-1372307	Group Health Plan, Inc	(48,925,764)				(45,973,170)	(92,459)			(94,991,393)	666,856
95318	43-1702094	HealthCare USA of Missouri, LLC	(10,172,753)				(57,919,700)	(7,548,555)			(75,641,009)	4,583,177
95489	48-0840330	Coventry Health Care of Kansas, Inc	(37,167,800)				(32,642,637)	(1,634,850)			(71,445,287)	922,457
	25-1794529	Coventry Management Services, Inc					614,819,914				614,819,914	
95408	55-0712129	Carelink Health Plans, Inc	(6,639,016)				(16,714,974)	(1,392,957)			(24,746,947)	977,761
95321	20-0229117	WellPath Select, Inc		2,600,000			(24,606,351)	(2,561,109)			(24,567,461)	1,192,119
12604	20-4647469	WellPath of South Carolina, Inc					(136,205)	(97,160)			(233,365)	
	62-1411933	Coventry Health Care Mgmt Corp		1,150,000			(24,199,897)				(23,049,897)	
	20-1736437	First Health Group Corp					(77,192,573)				(77,192,573)	
74160	37-1241037	PersonalCare Insurance of Illinois, Inc					(28,872,190)	(2,193,848)			(31,066,037)	1,440,291
12193	20-1052897	OmniCare Health Plan, Inc	(1,616,000)				(8,841,814)	(1,054,607)			(11,512,421)	492,982
95407	87-0345631	Altius Health Plans, Inc	(5,208,281)				(45,500,882)	(1,782,778)			(52,491,941)	272,366
	51-0410308	HealthAssurance Financial Services, Inc					9,708,642				9,708,642	
	20-4416606	HealthCare USA of Tennessee, LLC					53				53	
	48-1134570	Preferred Health Systems, Inc	3,708,000	500,000			18,590,021				22,798,021	
11531	02-0639951	CHC Casualty Risk Retention Group, Inc					7,812,051				7,812,051	
	26-1582982	MHNet Specialty Services, LLC					70,008,177				70,008,177	
	20-8070994	CHC National Accounts, Inc					(13)				(13)	
	20-5185442	CHC National Network, Inc					388				388	
	20-8376354	CHC Workers' Compensation, Inc		34,182,360			(52,965,603)				(18,783,243)	
	20-1130063	Florida Health Plan Administrators, LLC					66,967,497				66,967,497	
	26-1293772	Coventry Consumer Advantage, Inc					521				521	
90328	38-2242132	First Health Life & Health Ins Co					(116,714,653)	(146,498)			(116,861,151)	52,849
	87-0443226	First Health Strategies, Inc					402				402	
	52-1320522	Claims Administration Corp					(44,043,325)				(44,043,325)	

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	Federal ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
81000	75-1431313	Cambridge Life Insurance Co.					(306,966)			54,090	(252,876)	
	20-4096903	First Script Network Services, Inc.					(42,711,531)				(42,711,531)	
	06-1095987	MetraComp, Inc.					460				460	
	74-2879984	Medical Examinations of NY, P.C.					(2,246,319)				(2,246,319)	
	62-1266888	FOCUS Healthcare Management, Inc.					1,723,853				1,723,853	
	26-2516000	Coventry Ind. Medical Exam of TX, PA.					(457,708)				(457,708)	
95114	65-0986441	Coventry Health Care of Florida, Inc.					(76,480,753)	(4,203,024)			(80,683,777)	3,329,829
95266	65-0453436	Coventry Health Plan of Florida, Inc.					(36,958,069)	72,371			(36,885,699)	923,853
10771	20-1976986	Coventry Summit Healthplan, Inc.					(12,161,998)	(1,181,163)			(13,343,162)	652,878
	59-3750548	Carefree Insurance Services, Inc.										
	37-1448790	Mental Health Network of New York, IPA.					(41,614)				(41,614)	
12509	20-2516317	MHNet Life and Health Insurance Company					(50,193)				(50,193)	
	72-1106596	Mental Health Associates, Inc.					2,211,881				2,211,881	
	20-4276336	MHNet of Florida, Inc. "					(426,519)				(426,519)	
95846	52-2056201	Group Dental Services of Maryland, Inc.					(4,635,845)				(4,635,845)	
	48-0989340	Preferred Health Care, Inc.					(238,375)				(238,375)	
	48-1014670	Kansas Health Plan, Inc.					493,209				493,209	
	06-1665698	Preferred Benefits Administrator, Inc.					(2,447,725)				(2,447,725)	
11529	48-1262342	Mercy Health Plans		5,000,000			(19,267,621)				(14,267,621)	
95309	43-1693520	Mercy health Plans of Missouri, Inc.					1,703,101				1,703,101	
	43-1693814	Premier Benefits, Inc.					(2,401,676)				(2,401,676)	
	76-0803125	ForeSee Heath, Inc.					(6,599,371)				(6,599,371)	
9999999 Control Totals												
										XXX		

39.1

# SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of **WAIVED** to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter **SEE EXPLANATION** and provide an explanation following the interrogatory questions.

**MARCH FILING**

**Responses**

- 1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1? .....YES.....
- 2. Will an actuarial opinion be filed by March 1? .....YES.....
- 3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1? .....YES.....
- 4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required by March 1? .....YES.....

**APRIL FILING**

- 5. Will Management's Discussion and Analysis be filed by April 1? .....YES.....
- 6. Will the Supplemental Investment Risks Interrogatories be filed by April 1? .....YES.....
- 7. Will the Accident and Health Policy Experience Exhibit be filed by April 1? .....YES.....

**JUNE FILING**

- 8. Will an audited financial report be filed by June 1? .....YES.....
- 9. Will Accountants Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1? .....YES.....

**AUGUST FILING**

- 10. Will Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile by August 1? .....YES.....

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of **NO** to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter **SEE EXPLANATION** and provide an explanation following the interrogatory questions.

**MARCH FILING**

- 11. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1? .....NO.....
- 12. Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC? .....NO.....
- 13. Will the Supplemental Property/Casualty data due March 1 be filed with the state of domicile and the NAIC? .....NO.....
- 14. Will the Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1? .....NO.....
- 15. Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1? .....NO.....
- 16. Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1? .....NO.....
- 17. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1? .....NO.....

**APRIL FILING**

- 18. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1? .....NO.....
- 19. Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC? .....NO.....
- 20. Will the Supplemental Property/Casualty Insurance Expense Exhibit due April 1 be filed with any state that requires it, and, if so, the NAIC? .....NO.....
- 21. Will the Supplemental Health Care Exhibit be filed the state of domicile and the NAIC by April 1? .....YES.....
- 22. Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the sate of domicile and the NAIC by April 1? .....YES.....

**AUGUST FILING**

- 23. Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1? .....YES.....

**Explanation:**

- 11.
- 12.
- 13.
- 14.
- 15.
- 16.
- 17.
- 18.
- 19.
- 20.

**Bar code:**



- 11. 1195060201036059000
- 12.

# SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

- 9 5 0 6 0 2 0 1 0 2 0 5 0 0 0 0 0
- 13. 9 5 0 6 0 2 0 1 0 2 0 7 0 0 0 0 0
- 14. 9 5 0 6 0 2 0 1 0 4 2 0 0 0 0 0 0
- 15. 9 5 0 6 0 2 0 1 0 3 7 1 0 0 0 0 0
- 16. 9 5 0 6 0 2 0 1 0 3 7 0 0 0 0 0 0
- 17. 9 5 0 6 0 2 0 1 0 3 6 5 0 0 0 0 0
- 18. 9 5 0 6 0 2 0 1 0 3 0 6 0 0 0 0 0
- 19. 9 5 0 6 0 2 0 1 0 2 1 1 5 9 0 0 0
- 20. 9 5 0 6 0 2 0 1 0 2 1 3 0 0 0 0 0

**OVERFLOW PAGE FOR WRITE-INS**

M003 Additional Aggregate Lines for Page 03 Line 23.

\*LIAB - Liabilities

	1 Covered	2 Uncovered	3 Total	4 Total
2304. CMS Allowance.....				18,420,322
2397. Summary of remaining write-ins for Line 23 from Page 03				18,420,322

## SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
	1 Amount	2 Percentage	3 Amount	4 Percentage
1. Bonds:				
1.1 U.S. treasury securities .....	4,598,289	2.819	4,598,289	2.819
1.2 U.S. government agency obligations (excluding mortgage-backed securities):				
1.21 Issued by U.S. government agencies .....				
1.22 Issued by U.S. government sponsored agencies .....	1,458,618	0.894	1,458,618	0.894
1.3 Non-U.S. government (including Canada, excluding mortgage-backed securities) .....				
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S.:				
1.41 States, territories and possessions general obligations .....	3,793,283	2.326	3,793,283	2.326
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations .....	34,227,675	20.987	34,227,675	20.987
1.43 Revenue and assessment obligations .....	21,685,956	13.297	21,685,956	13.297
1.44 Industrial development and similar obligations .....				
1.5 Mortgage-backed securities (includes residential and commercial MBS):				
1.51 Pass-through securities:				
1.511 Issued or guaranteed by GNMA .....	927,590	0.569	927,590	0.569
1.512 Issued or guaranteed by FNMA and FHLMC .....	10,931,842	6.703	10,931,842	6.703
1.513 All other .....	2,974	0.002	2,974	0.002
1.52 CMOs and REMICs:				
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA .....	55,968	0.034	55,968	0.034
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521 .....				
1.523 All other .....	1,057,556	0.648	1,057,556	0.648
2. Other debt and other fixed income securities (excluding short term):				
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities) .....	39,662,209	24.319	39,662,209	24.319
2.2 Unaffiliated non-U.S. securities (including Canada) .....	1,548,418	0.949	1,548,418	0.949
2.3 Affiliated securities .....				
3. Equity interests:				
3.1 Investments in mutual funds .....				
3.2 Preferred stocks:				
3.21 Affiliated .....				
3.22 Unaffiliated .....				
3.3 Publicly traded equity securities (excluding preferred stocks):				
3.31 Affiliated .....				
3.32 Unaffiliated .....				
3.4 Other equity securities:				
3.41 Affiliated .....				
3.42 Unaffiliated .....				
3.5 Other equity interests including tangible personal property under lease:				
3.51 Affiliated .....				
3.52 Unaffiliated .....				
4. Mortgage loans:				
4.1 Construction and land development .....				
4.2 Agricultural .....				
4.3 Single family residential properties .....				
4.4 Multifamily residential properties .....				
4.5 Commercial loans .....				
4.6 Mezzanine real estate loans .....				
5. Real estate investments:				
5.1 Property occupied by company .....				
5.2 Property held for production of income (including \$ ..... of property acquired in satisfaction of debt) .....				
5.3 Property held for sale (including \$ ..... property acquired in satisfaction of debt) .....				
6. Contract loans .....				
7. Receivables for securities .....	13,737	0.009	13,737	0.009
8. Cash, cash equivalents and short-term investments .....	40,298,862	25.145	40,298,862	25.145
9. Other invested assets .....				
10. Total invested assets	160,262,977	100.000	160,262,977	100.000

## SCHEDULE A – VERIFICATION BETWEEN YEARS

### Real Estate

1. Book/adjusted carrying value, December 31 of prior year.....
2. Cost of acquired:
  - 2.1 Actual cost at time of acquisition (Part 2, Column 6).....
  - 2.2 Additional investment made after acquisition (Part 2, Column 9).....
3. Current year change in encumbrances:
  - 3.1 Totals, Part 1, Column 13.....
  - 3.2 Totals, Part 3, Column 11.....
4. Total gain (loss) on disposals, Part 3, Column 18.....
5. Deduct amounts received on disposals, Part 3, Column 15.....
6. Total foreign exchange change in book/adjusted carrying value: **NONE**
  - 6.1 Totals, Part 1, Column 15.....
  - 6.2 Totals, Part 3, Column 13.....
7. Deduct current year's other than temporary impairment recognized:
  - 7.1 Totals, Part 1, Column 12.....
  - 7.2 Totals, Part 3, Column 10.....
8. Deduct current year's depreciation:
  - 8.1 Totals, Part 1, Column 11.....
  - 8.2 Totals, Part 3, Column 9.....
9. Book/adjusted carrying value at the end of current period (Lines 1+2+3+4-5+6-7-8).....
10. Deduct total nonadmitted amounts.....
11. Statement value at end of current period (Line 9 minus Line 10).....

## SCHEDULE B – VERIFICATION BETWEEN YEARS

### Mortgage Loans

1. Book value/recorded investment excluding accrued interest, December 31 of prior year.....
2. Cost of acquired:
  - 2.1 Actual cost at time of acquisition (Part 2, Column 7).....
  - 2.2 Additional investment made after acquisition (Part 2, Column 8).....
3. Capitalized deferred interest and other:
  - 3.1 Totals, Part 1, Column 12.....
  - 3.2 Totals, Part 3, Column 11.....
4. Accrual of discount.....
5. Unrealized valuation increase (decrease):
  - 5.1 Totals, Part 1, Column 9.....
  - 5.2 Totals, Part 3, Column 8.....
6. Total gain (loss) on disposals, Part 3, Column 18..... **NONE**
7. Deduct amounts received on disposals, Part 3, Column 15.....
8. Deduct amortization of premium and mortgage interest points and commitment fees.....
9. Total foreign exchange change in book value/recorded investment excluding accrued interest:
  - 9.1 Totals, Part 1, Column 13.....
  - 9.2 Totals, Part 3, Column 13.....
10. Deduct current year's other than temporary impairment recognized:
  - 10.1 Totals, Part 1, Column 11.....
  - 10.2 Totals, Part 3, Column 10.....
11. Book value/recorded investment excluding accrued interest at end of current period (Lines 1+2+3+4+5+6-7-8+9-10).....
12. Total valuation allowance.....
13. Subtotal (Line 11 plus Line 12).....
14. Deduct total nonadmitted amounts.....
15. Statement value of mortgages owned at end of current period (Line 13 minus Line 14).....

## SCHEDULE BA – VERIFICATION BETWEEN YEARS

### Other Long-Term Invested Assets

1. Book/adjusted carrying value, December 31 of prior year.....	
2. Cost of acquired:	
2.1 Actual cost at time of acquisition (Part 2, Column 8).....	
2.2 Additional investment made after acquisition (Part 2, Column 9).....	
3. Capitalized deferred interest and other:	
3.1 Totals, Part 1, Column 16.....	
3.2 Totals, Part 3, Column 12.....	
4. Accrual of discount.....	
5. Unrealized valuation increase (decrease):	
5.1 Totals, Part 1, Column 13.....	
5.2 Totals, Part 3, Column 9.....	
6. Total gain (loss) on disposals, Part 3, Column 19.....	
7. Deduct amounts received on disposals, Part 3, Column 16.....	
8. Deduct amortization of premium and depreciation.....	
9. Total foreign exchange change in book/adjusted carrying value:	
9.1 Totals, Part 1, Column 17.....	
9.2 Totals, Part 3, Column 14.....	
10. Deduct current year's other than temporary impairment recognized:	
10.1 Totals, Part 1, Column 15.....	
10.2 Totals, Part 3, Column 11.....	
11. Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10).....	
12. Deduct total nonadmitted amounts.....	
13. Statement value at end of current period (Line 11 minus Line 12)	

NONE

## SCHEDULE D – VERIFICATION BETWEEN YEARS

### Bonds and Stocks

1. Book/adjusted carrying value, December 31 of prior year.....	160,610,441
2. Cost of bonds and stocks acquired, Part 3, Column 7.....	28,262,491
3. Accrual of discount.....	34,889
4. Unrealized valuation increase (decrease):	
4.1 Part 1, Column 12.....	
4.2 Part 2, Section 1, Column 15.....	
4.3 Part 2, Section 2, Column 13.....	
4.4 Part 4, Column 11.....	
5. Total gain (loss) on disposals, Part 4, Column 19.....	924,877
6. Deduction consideration for bonds and stocks disposed of, Part 4, Column 7.....	68,776,789
7. Deduct amortization of premium.....	1,105,524
8. Total foreign exchange change in book/adjusted carrying value:	
8.1 Part 1, Column 15.....	
8.2 Part 2, Section 1, Column 19.....	
8.3 Part 2, Section 2, Column 16.....	
8.4 Part 4, Column 15.....	
9. Deduct current year's other than temporary impairment recognized:	
9.1 Part 1, Column 14.....	
9.2 Part 2, Section 1, Column 17.....	
9.3 Part 2, Section 2, Column 14.....	
9.4 Part 4, Column 13.....	
10. Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9).....	119,950,378
11. Deduct total nonadmitted amounts.....	
12. Statement value at end of current period (Line 10 minus Line 11)	119,950,378

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE D - SUMMARY BY COUNTRY**

Long-Term Bonds and Stocks **OWNED** December 31 of Current Year

Description		1 Book/Adjusted Carrying Value	2 Fair Value	3 Actual Cost	4 Par Value of Bonds
<b>BONDS</b>					
Governments (Including all obligations guaranteed by governments)	1. United States .....	6,984,497	7,304,163	7,053,073	6,846,863
	2. Canada .....				
	3. Other Countries .....				
	4. Totals	6,984,497	7,304,163	7,053,073	6,846,863
U.S. States, Territories and Possessions (Direct and guaranteed)	5. Totals	3,793,283	3,955,536	4,012,478	3,680,000
U.S. Political Subdivisions of States, Territories and Possessions (Direct and guaranteed)	6. Totals	34,227,675	36,014,725	35,672,551	33,090,000
U.S. Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	7. Totals	32,676,740	33,796,472	33,380,981	32,027,339
Industrial and Miscellaneous, Credit Tenant Loans and Hybrid Securities (unaffiliated)	8. United States .....	40,719,765	42,218,006	41,001,538	39,726,687
	9. Canada .....	1,548,418	1,610,388	1,548,226	1,550,000
	10. Other Countries .....				
	11. Totals	42,268,183	43,828,394	42,549,764	41,276,687
Parent, Subsidiaries and Affiliates	12. Totals				
	<b>13. Total Bonds</b>	119,950,378	124,899,290	122,668,848	116,920,888
<b>PREFERRED STOCKS</b>					
Industrial and Miscellaneous (unaffiliated)	14. United States .....				
	15. Canada .....				
	16. Other Countries .....				
	17. Totals				
Parent, Subsidiaries and Affiliates	18. Totals				
	<b>19. Total Preferred Stocks</b>				
<b>COMMON STOCKS</b>					
Industrial and Miscellaneous (unaffiliated)	20. United States .....				
	21. Canada .....				
	22. Other Countries .....				
	23. Totals				
Parent, Subsidiaries and Affiliates	24. Totals				
	<b>25. Total Common Stocks</b>				
	26. Total Stocks				
	<b>27. Total Bonds and Stocks</b>	119,950,378	124,899,290	122,668,848	

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE D - PART 1A - SECTION 1**

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

Quality Rating per the NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 10.7	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed (a)
<b>1. U.S. Governments</b>											
1.1 Class 1 .....	816,461	5,971,615	135,518	55,320	5,583	6,984,497	4.3	12,493,696	6.8	6,984,497	
1.2 Class 2 .....											
1.3 Class 3 .....											
1.4 Class 4 .....											
1.5 Class 5 .....											
1.6 Class 6 .....											
1.7 Totals	816,461	5,971,615	135,518	55,320	5,583	6,984,497	4.3	12,493,696	6.8	6,984,497	
<b>2. All Other Governments</b>											
2.1 Class 1 .....											
2.2 Class 2 .....											
2.3 Class 3 .....											
2.4 Class 4 .....											
2.5 Class 5 .....											
2.6 Class 6 .....											
2.7 Totals											
<b>3. U.S. States, Territories and Possessions, etc., Guaranteed</b>											
3.1 Class 1 .....	1,006,354	1,019,972	1,262,573	504,385		3,793,283	2.3	11,841,336	6.4	3,793,283	
3.2 Class 2 .....											
3.3 Class 3 .....											
3.4 Class 4 .....											
3.5 Class 5 .....											
3.6 Class 6 .....											
3.7 Totals	1,006,354	1,019,972	1,262,573	504,385		3,793,283	2.3	11,841,336	6.4	3,793,283	
<b>4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed</b>											
4.1 Class 1 .....	2,009,161	21,856,268	6,169,262	1,104,442		31,139,132	19.1	39,541,453	21.4	31,139,132	
4.2 Class 2 .....		3,088,542				3,088,542	1.9	7,308,073	4.0	3,088,542	
4.3 Class 3 .....											
4.4 Class 4 .....											
4.5 Class 5 .....											
4.6 Class 6 .....											
4.7 Totals	2,009,161	24,944,810	6,169,262	1,104,442		34,227,675	21.0	46,849,526	25.3	34,227,675	
<b>5. U.S. Special Revenue &amp; Special Assessment Obligations, etc., Non-Guaranteed</b>											
5.1 Class 1 .....	11,264,709	9,567,400	9,017,448	2,787,263	39,920	32,676,740	20.0	42,298,355	22.9	32,676,740	
5.2 Class 2 .....								1,998,197	1.1		
5.3 Class 3 .....											
5.4 Class 4 .....											
5.5 Class 5 .....											
5.6 Class 6 .....											
5.7 Totals	11,264,709	9,567,400	9,017,448	2,787,263	39,920	32,676,740	20.0	44,296,552	23.9	32,676,740	

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**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE D - PART 1A - SECTION 1 (Continued)**

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

Quality Rating per the NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 10.7	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed (a)
<b>6. Industrial and Miscellaneous (unaffiliated)</b>											
6.1 Class 1 .....	45,706,714	30,934,751	8,766,406			85,407,871	52.4	69,491,072	37.6	85,407,871	
6.2 Class 2 .....											
6.3 Class 3 .....											
6.4 Class 4 .....											
6.5 Class 5 .....											
6.6 Class 6 .....											
6.7 Totals	45,706,714	30,934,751	8,766,406			85,407,871	52.4	69,491,072	37.6	85,407,871	
<b>7. Credit Tenant Loans</b>											
7.1 Class 1 .....											
7.2 Class 2 .....											
7.3 Class 3 .....											
7.4 Class 4 .....											
7.5 Class 5 .....											
7.6 Class 6 .....											
7.7 Totals											
<b>8. Hybrid Securities</b>											
8.1 Class 1 .....											
8.2 Class 2 .....											
8.3 Class 3 .....											
8.4 Class 4 .....											
8.5 Class 5 .....											
8.6 Class 6 .....											
8.7 Totals											
<b>9. Parent, Subsidiaries and Affiliates</b>											
9.1 Class 1 .....											
9.2 Class 2 .....											
9.3 Class 3 .....											
9.4 Class 4 .....											
9.5 Class 5 .....											
9.6 Class 6 .....											
9.7 Totals											

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**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE D - PART 1A - SECTION 1 (Continued)**

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

Quality Rating per the NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 10.7	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed (a)
<b>10. Total Bonds Current Year</b>											
10.1 Class 1	(d) 60,803,398	69,350,006	25,351,207	4,451,410	45,503	160,001,524	98.1	XXX	XXX	160,001,524	
10.2 Class 2	(d)	3,088,542				3,088,542	1.9	XXX	XXX	3,088,542	
10.3 Class 3	(d)							XXX	XXX		
10.4 Class 4	(d)							XXX	XXX		
10.5 Class 5	(d)							XXX	XXX		
10.6 Class 6	(d)							XXX	XXX		
10.7 Totals	60,803,398	72,438,549	25,351,207	4,451,410	45,503	(b) 163,090,067	100.0	XXX	XXX	163,090,067	
10.8 Line 10.7 as a % of Col. 6	37.3	44.4	15.5	2.7	0.0	100.0	XXX	XXX	XXX	100.0	
<b>11. Total Bonds Prior Year</b>											
11.1 Class 1	38,823,719	79,385,127	46,595,896	10,779,819	81,351	XXX	XXX	175,665,912	95.0	175,665,910	
11.2 Class 2	3,112,930	3,132,164	3,061,176			XXX	XXX	9,306,270	5.0	9,306,269	
11.3 Class 3						XXX	XXX				
11.4 Class 4						XXX	XXX				
11.5 Class 5						XXX	XXX				
11.6 Class 6						XXX	XXX				
11.7 Totals	41,936,649	82,517,291	49,657,072	10,779,819	81,351	XXX	XXX	(b) 184,972,182	100.0	184,972,179	
11.8 Line 11.7 as a % of Col. 8	22.7	44.6	26.8	5.8	0.0	XXX	XXX	100.0	XXX	100.0	
<b>12. Total Publicly Traded Bonds</b>											
12.1 Class 1	60,803,398	69,350,006	25,351,207	4,451,410	45,503	160,001,524	98.1	175,665,910	95.0	160,001,524	XXX
12.2 Class 2		3,088,542				3,088,542	1.9	9,306,270	5.0	3,088,542	XXX
12.3 Class 3											XXX
12.4 Class 4											XXX
12.5 Class 5											XXX
12.6 Class 6											XXX
12.7 Totals	60,803,398	72,438,549	25,351,207	4,451,410	45,503	163,090,067	100.0	184,972,180	100.0	163,090,067	XXX
12.8 Line 12.7 as a % of Col. 6	37.3	44.4	15.5	2.7	0.0	100.0	XXX	XXX	XXX	100.0	XXX
12.9 Line 12.7 as a % of Line 10.7, Col. 6, Section 10	37.3	44.4	15.5	2.7	0.0	100.0	XXX	XXX	XXX	100.0	XXX
<b>13. Total Privately Placed Bonds</b>											
13.1 Class 1										XXX	
13.2 Class 2										XXX	
13.3 Class 3										XXX	
13.4 Class 4										XXX	
13.5 Class 5										XXX	
13.6 Class 6										XXX	
13.7 Totals										XXX	
13.8 Line 13.7 as a % of Col. 6								XXX	XXX	XXX	
13.9 Line 13.7 as a % of Line 10.7, Col. 6, Section 10								XXX	XXX	XXX	

(a) Includes \$ ..... freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.  
 (b) Includes \$ 1,033,971 current year, \$ ..... prior year of bonds with Z designations and \$ 1,057,556 current year, \$ ..... prior year of bonds with Z\* designations. The letter "Z" means the NAIC designation was not assigned by the Securities Valuation Office (SVO) at the date of the statement. "Z\*" means the SVO could not evaluate the obligation because valuation procedures for the security class is under regulatory review.  
 (c) Includes \$ ..... current year, \$ ..... prior year of bonds with 5\* designations and \$ ..... current year, \$ ..... prior year of bonds with 6\* designations. "5\*" means the NAIC designation was assigned by the SVO in reliance on the insurer's certification that the issuer is current in all principal and interest payments. "6\*" means the NAIC designation was assigned by the SVO due to inadequate certification of principal and interest payments.  
 (d) Includes the following amount of non-rated short-term and cash equivalent bonds by NAIC designation: NAIC 1 \$ 43,139,688 ; NAIC 2 \$ ..... ; NAIC 3 \$ ..... ; NAIC 4 \$ ..... ; NAIC 5 \$ ..... ; NAIC 6 \$ .....

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**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE D - PART 1A - SECTION 2**

Maturity Distribution of All Bonds Owned December 31, At Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 10.7	8 Total from Col 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed
<b>1. U.S. Governments</b>											
1.1 Issuer Obligations	532,091	5,508,237		16,579		6,056,907	3.7	11,173,579	6.0	6,056,907	
1.2 Single Class Mortgage-Backed/Asset-Backed Securities	284,370	463,378	135,518	38,741	5,583	927,590	0.6	1,320,117	0.7	927,590	
1.7 Totals	816,461	5,971,615	135,518	55,320	5,583	6,984,497	4.3	12,493,696	6.8	6,984,497	
<b>2. All Other Governments</b>											
2.1 Issuer Obligations											
2.2 Single Class Mortgage-Backed/Asset-Backed Securities											
MULTI-CLASS RESIDENTIAL MORTGAGE-BACKED SECURITIES											
2.3 Defined											
2.4 Other											
MULTI-CLASS COMMERCIAL MORTGAGE-BACKED/ASSET-BACKED SECURITIES											
2.5 Defined											
2.6 Other											
2.7 Totals											
<b>3. U.S. States, Territories and Possessions, Guaranteed</b>											
3.1 Issuer Obligations	1,006,354	1,019,972	1,262,573	504,385		3,793,283	2.3	11,841,336	6.4	3,793,283	
3.2 Single Class Mortgage-Backed/Asset-Backed Securities											
MULTI-CLASS RESIDENTIAL MORTGAGE-BACKED SECURITIES											
3.3 Defined											
3.4 Other											
MULTI-CLASS COMMERCIAL MORTGAGE-BACKED/ASSET-BACKED SECURITIES											
3.5 Defined											
3.6 Other											
3.7 Totals	1,006,354	1,019,972	1,262,573	504,385		3,793,283	2.3	11,841,336	6.4	3,793,283	
<b>4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed</b>											
4.1 Issuer Obligations	2,009,161	24,944,810	6,169,262	1,104,442		34,227,675	21.0	46,849,525	25.3	34,227,675	
4.2 Single Class Mortgage-Backed/Asset-Backed Securities											
MULTI-CLASS RESIDENTIAL MORTGAGE-BACKED SECURITIES											
4.3 Defined											
4.4 Other											
MULTI-CLASS COMMERCIAL MORTGAGE-BACKED/ASSET-BACKED SECURITIES											
4.5 Defined											
4.6 Other											
4.7 Totals	2,009,161	24,944,810	6,169,262	1,104,442		34,227,675	21.0	46,849,525	25.3	34,227,675	
<b>5. U.S. Special Revenue &amp; Special Assessment Obligations, etc., Non-Guaranteed</b>											
5.1 Issuer Obligations	8,063,469	4,239,892	7,181,016	2,201,579		21,685,956	13.3	32,394,302	17.5	21,685,956	
5.2 Single Class Mortgage-Backed/Asset-Backed Securities	3,186,114	5,295,160	1,827,952	585,671	39,920	10,934,816	6.7	11,830,859	6.4	10,934,816	
MULTI-CLASS RESIDENTIAL MORTGAGE-BACKED SECURITIES											
5.3 Defined	15,126	32,349	8,480	13		55,968	0.0	71,391	0.0	55,968	
5.4 Other											
MULTI-CLASS COMMERCIAL MORTGAGE-BACKED/ASSET-BACKED SECURITIES											
5.5 Defined											
5.6 Other											
5.7 Totals	11,264,709	9,567,400	9,017,448	2,787,263	39,920	32,676,740	20.0	44,296,552	23.9	32,676,740	

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**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE D - PART 1A - SECTION 2 (Continued)**

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 10.7	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed
<b>6. Industrial and Miscellaneous</b>											
6.1 Issuer Obligations .....	45,596,715	29,987,194	8,766,406			84,350,315	51.7	68,422,402	37.0	84,350,315	
6.2 Single Class Mortgage-Backed/Asset-Backed Securities .....											
MULTI-CLASS RESIDENTIAL MORTGAGE- BACKED SECURITIES:											
6.3 Defined .....											
6.4 Other .....											
MULTI-CLASS COMMERCIAL MORTGAGE- BACKED/ASSET-BACKED SECURITIES:											
6.5 Defined .....	109,998	947,558				1,057,556	0.6	1,068,670	0.6	1,057,556	
6.6 Other .....											
6.7 Totals	45,706,714	30,934,751	8,766,406			85,407,871	52.4	69,491,072	37.6	85,407,871	
<b>7. Credit Tenant Loans</b>											
7.1 Issuer Obligations .....											
7.2 Single Class Mortgage-Backed/Asset-Backed Securities .....											
7.7 Totals											
<b>8. Hybrid Securities</b>											
8.1 Issuer Obligations .....											
8.2 Single Class Mortgage-Backed/Asset-Backed Securities .....											
MULTI-CLASS RESIDENTIAL MORTGAGE- BACKED SECURITIES:											
8.3 Defined .....											
8.4 Other .....											
MULTI-CLASS COMMERCIAL MORTGAGE- BACKED/ASSET-BACKED SECURITIES:											
8.5 Defined .....											
8.6 Other .....											
8.7 Totals											
<b>9. Parent, Subsidiaries and Affiliates</b>											
9.1 Issuer Obligations .....											
9.2 Single Class Mortgage-Backed/Asset-Backed Securities .....											
MULTI-CLASS RESIDENTIAL MORTGAGE- BACKED SECURITIES:											
9.3 Defined .....											
9.4 Other .....											
MULTI-CLASS COMMERCIAL MORTGAGE- BACKED/ASSET-BACKED SECURITIES:											
9.5 Defined .....											
9.6 Other .....											
9.7 Totals											

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**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE D - PART 1A - SECTION 2 (Continued)**

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 10.7	8 Total From Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed
<b>10. Total Bonds Current Year</b>											
10.1 Issuer Obligations	57,207,790	65,700,105	23,379,257	3,826,985		150,114,136	92.0	XXX	XXX	150,114,136	
10.2 Single Class Mortgage-Backed/Asset-Backed Securities	3,470,484	5,758,538	1,963,470	624,412	45,503	11,862,407	7.3	XXX	XXX	11,862,407	
MULTI-CLASS RESIDENTIAL MORTGAGE-BACKED SECURITIES:											
10.3 Defined	15,126	32,349	8,480	13		55,968	0.0	XXX	XXX	55,968	
10.4 Other								XXX	XXX		
MULTI-CLASS COMMERCIAL MORTGAGE-BACKED/ASSET-BACKED SECURITIES:											
10.5 Defined	109,998	947,558				1,057,556	0.6	XXX	XXX	1,057,556	
10.6 Other								XXX	XXX		
10.7 Totals	60,803,398	72,438,549	25,351,207	4,451,410	45,503	163,090,067	100.0	XXX	XXX	163,090,067	
10.8 Lines 10.7 as a % of Col. 6	37.3	44.4	15.5	2.7	0.0	100.0	XXX	XXX	XXX	100.0	
<b>11. Total Bonds Prior Year</b>											
11.1 Issuer Obligations	38,785,388	74,992,415	46,954,395	9,932,326	16,620	XXX	XXX	170,681,144	92.3	170,681,142	
11.2 Single Class Mortgage-Backed/Asset-Backed Securities	3,124,730	6,615,033	2,499,166	847,316	64,731	XXX	XXX	13,150,976	7.1	13,150,976	
MULTI-CLASS RESIDENTIAL MORTGAGE-BACKED SECURITIES:											
11.3 Defined	22,015	39,530	9,669	177		XXX	XXX	71,391	0.0	71,391	
11.4 Other						XXX	XXX				
MULTI-CLASS COMMERCIAL MORTGAGE-BACKED/ASSET-BACKED SECURITIES:											
11.5 Defined	4,516	870,313	193,841			XXX	XXX	1,068,670	0.6	1,068,670	
11.6 Other						XXX	XXX				
11.7 Totals	41,936,649	82,517,291	49,657,071	10,779,819	81,351	XXX	XXX	184,972,181	100.0	184,972,179	
11.8 Line 11.7 as a % of Col. 8	22.7	44.6	26.8	5.8	0.0	XXX	XXX	100.0	XXX	100.0	
<b>12. Total Publicly Traded Bonds</b>											
12.1 Issuer Obligations	57,207,790	65,700,105	23,379,257	3,826,985		150,114,136	92.0	170,681,143	92.3	150,114,136	XXX
12.2 Single Class Mortgage-Backed/Asset-Backed Securities	3,470,484	5,758,538	1,963,470	624,412	45,503	11,862,407	7.3	13,150,976	7.1	11,862,407	XXX
MULTI-CLASS RESIDENTIAL MORTGAGE-BACKED SECURITIES:											
12.3 Defined	15,126	32,349	8,480	13		55,968	0.0	71,391	0.0	55,968	XXX
12.4 Other											XXX
MULTI-CLASS COMMERCIAL MORTGAGE-BACKED/ASSET-BACKED SECURITIES:											
12.5 Defined	109,998	947,558				1,057,556	0.6	1,068,670	0.6	1,057,556	XXX
12.6 Other											XXX
12.7 Totals	60,803,398	72,438,549	25,351,207	4,451,410	45,503	163,090,067	100.0	184,972,180	100.0	163,090,067	XXX
12.8 Line 12.7 as a % of Col. 6	37.3	44.4	15.5	2.7	0.0	100.0	XXX	XXX	XXX	100.0	XXX
12.9 Line 12.7 as a % of Line 10.7, Col. 6, Section 10	37.3	44.4	15.5	2.7	0.0	100.0	XXX	XXX	XXX	100.0	XXX
<b>13. Total Privately Placed Bonds</b>											
13.1 Issuer Obligations										XXX	
13.2 Single Class Mortgage-Backed/Asset-Backed Securities										XXX	
MULTI-CLASS RESIDENTIAL MORTGAGE-BACKED SECURITIES:											
13.3 Defined										XXX	
13.4 Other										XXX	
MULTI-CLASS COMMERCIAL MORTGAGE-BACKED/ASSET-BACKED SECURITIES:											
13.5 Defined										XXX	
13.6 Other										XXX	
13.7 Totals										XXX	
13.8 Line 13.7 as a % of Col. 6								XXX	XXX	XXX	
13.9 Line 13.7 as a % of Line 10.7, Col. 6, Section 10								XXX	XXX	XXX	

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**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE DA - VERIFICATION BETWEEN YEARS**

Short-Term Investments

	1	2	3	4	5
	Total	Bonds	Mortgage Loans	Other Short-term Investment Assets(a)	Investments in Parent, Subsidiaries and Affiliates
1. Book/adjusted carrying value, December 31 of prior year .....	14,751,104	14,751,104			
2. Cost of short-term investments acquired .....	263,462,101	263,462,101			
3. Accrual of discount .....					
4. Unrealized valuation increase (decrease) .....					
5. Total gain (loss) on disposals .....					
6. Deduct consideration received on disposals .....	243,092,845	243,092,845			
7. Deduct amortization of premium .....					
8. Total foreign exchange change in book/adjusted carrying value .....					
9. Deduct current year's other than temporary impairment recognized .....					
10. Book adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9) .....	35,120,360	35,120,360			
11. Deduct total nonadmitted amounts .....					
12. Statement value at end of current period (Line 10 minus Line 11)	35,120,360	35,120,360			

(a) Indicate the category of such assets, for example, joint ventures, transportation equipment: .....

Schedule DB - Part A - Verification

**NONE**

Schedule DB - Part B - Verification

**NONE**

Schedule DB - Part C - Section 1

**NONE**

Schedule DB - Part C - Section 2

**NONE**

Schedule DB - Verification

**NONE**

**SCHEDULE E - VERIFICATION BETWEEN YEARS**

(Cash Equivalents)

	1	2	3
	Total	Bonds	Other (a)
1. Book/adjusted carrying value, December 31 of prior year.....	9,610,642	9,610,640	
2. Cost of cash equivalents acquired.....	60,009,147	60,009,147	
3. Accrual of discount.....	45	45	
4. Unrealized valuation increase (decrease).....			
5. Total gain (loss) on disposals.....			
6. Deduct consideration received on disposals.....	61,598,146	61,598,146	
7. Deduct amortization of premium.....	2,359	2,359	
8. Total foreign exchange change in book/adjusted carrying value.....			
9. Deduct current year's other than temporary impairment recognized.....			
10. Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9).....	8,019,329	8,019,329	
11. Deduct total nonadmitted amounts.....			
12. Statement value at end of current period (Line 10 minus Line 11)	8,019,329	8,019,329	

(a) Indicate the category of such investments, for example, joint ventures, transportation equipment

Schedule A - Part 1

**NONE**

Schedule A - Part 2

**NONE**

Schedule A - Part 3

**NONE**

Schedule B - Part 1

**NONE**

Schedule B - Part 2

**NONE**

Schedule B - Part 3

**NONE**

Schedule BA - Part 1

**NONE**

Schedule BA - Part 2

**NONE**

Schedule BA - Part 3

**NONE**

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE D - PART 1**

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest				Dates		
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	For e i g n	Bond CHAR	NAIC Designation	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other Than Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of	When Paid	Admitted Amount Due & Accrued	Amount Rec. During Year	Acquired	Maturity
Bonds: U.S. Governments - Issuer Obligations																					
3133XM-L6-6	FEDERAL HOME LOAN BANK				1	1,006,625		1,071,460	1,000,000	1,002,574		(1,365)			4.625	4.470	AO	10,406	46,250	11/08/2007	10/10/2012
31344A-JT-2	FREDDIE MAC				1	351,313		368,897	350,000	350,182		(165)			5.750	5.690	JJ	9,280	20,125	05/01/2002	01/15/2012
31359M-FP-3	FANNIE MAE				1	16,861		20,199	15,000	16,579		(41)			7.250	6.300	MN	139	1,088	05/01/2002	05/15/2030
779382-AH-3	ROWAN COMPANIES INC.			1	1	89,283		100,238	89,495	89,283					2.800	2.800	AO	493	2,500	06/24/2003	10/20/2013
912828-EE-6	US TREASURY N/B				1	1,050,082		1,107,270	1,000,000	1,035,336		(6,945)			4.250	3.410	FA	16,053	42,500	10/29/2008	08/15/2015
912828-JM-3	US TREASURY N/B				1	3,107,119		3,182,580	3,000,000	3,060,625		(21,143)			3.125	2.360	MS	23,953	93,750	10/08/2008	09/30/2013
912828-LF-5	US TREASURY N/B			SD	1	400,794		401,844	400,000	400,208		(415)			1.125	1.020	JD	12	4,500	07/31/2009	06/30/2011
912828-LV-0	US TREASURY N/B			SD	1	102,358		102,514	102,000	102,121		(181)			1.000	0.820	FA	347	1,020	09/11/2009	08/31/2011
0199999	Bonds: U.S. Governments - Issuer Obligations					6,124,435	xxx	6,344,259	5,956,283	6,056,907		(30,254)			xxx	xxx	xxx	60,683	211,732	xxx	xxx
Bonds: U.S. Government - Single Class Mortgage-Backed/Asset-Backed Securities																					
36215S-ZC-0	GN 143939			2	1	16,226		112,405	15,445	15,772		(253)			9.000	7.390	MON	116	1,390	09/03/1999	11/01/2014
36290S-JD-1	GN 616280			2	1	228,007		106,359	240,552	227,413		(437)			4.500	4.230	MON	848	10,178	10/18/2004	06/01/2018
36297F-UJ-9	GN 710785			2	1	684,405		108,171	648,965	684,405		(12,573)			5.500	3.400	MON	2,974	35,693	10/20/2009	06/01/2039
0299999	Bonds: U.S. Governments - Single Class Mortgage-Backed/Asset-Backed Securities					928,639	xxx	959,905	890,580	927,590		(13,263)			xxx	xxx	xxx	3,938	47,261	xxx	xxx
0399999	Bonds: Subtotals - U.S. Governments					7,053,073	xxx	7,304,163	6,846,863	6,984,497		(43,518)			xxx	xxx	xxx	64,621	258,993	xxx	xxx
Bonds: All Other Governments - Issuer Obligations																					
Bonds: All Other Governments - Single Class Mortgage-Backed/Asset-Backed Securities																					
Bonds: All Other Governments - Defined Multi-Class Residential Mortgage-Backed Securities																					
Bonds: All Other Governments - Other Multi-Class Residential Mortgage-Backed Securities																					
Bonds: All Other Governments - Defined Multi-Class Commercial Mortgage-Backed Securities																					
Bonds: All Other Governments - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities																					
Bonds: U.S. States, Territories, Possessions (Direct and Guaranteed) - Issuer Obligations																					
419791-YP-7	HAWAII ST				JFE	504,655		101,270	506,350	500,000		(270)			4.800	4.690	FA	10,000	10,867	02/10/2010	02/01/2022
709141-C9-4	PENNSYLVANIA ST				JFE	1,065,670		1,064,500	1,000,000	1,019,972		(12,730)			5.000	3.620	JJ	25,000	50,000	03/19/2007	07/01/2012
709141-VZ-5	PENNSYLVANIA ST				JFE	1,143,410		1,016,700	1,000,000	1,006,354		(18,674)			5.500	3.560	MN	9,167	55,000	08/29/2002	05/01/2011
70914P-AJ-1	PENNSYLVANIA ST				JFE	1,298,743		1,159,910	1,180,000	1,262,573		(12,487)			5.000	3.650	MN	9,833	59,000	12/14/2007	11/01/2016
1199999	Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Issuer Obligations					4,012,478	xxx	3,955,536	3,680,000	3,793,283		(44,160)			xxx	xxx	xxx	54,000	174,867	xxx	xxx
Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Single Class Mortgage-Backed/Asset-Backed Securities																					
Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Residential Mortgage-Backed Securities																					
Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Residential Mortgage-Backed Securities																					
Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Commercial Mortgage-Backed Securities																					
Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Commercial Mortgage-Backed Securities																					
1799999	Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed)					4,012,478	xxx	3,955,536	3,680,000	3,793,283		(44,160)			xxx	xxx	xxx	54,000	174,867	xxx	xxx
U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Issuer Obligations																					
092833-GT-3	BLAIR CNTY PA				2Z	1,100,360		1,099,980	1,000,000	1,033,971		(8,586)			5.375	4.340	FA	22,396	53,750	10/12/2001	08/01/2014
142508-EN-6	CARLISLE PA AREA SCH DIST				1	1,039,170		1,054,180	1,000,000	1,005,628		(4,590)			5.250	4.740	MS	17,500	52,500	03/22/2002	03/01/2013
152735-PR-1	CENTRAL BUCKS PA SCH DIST			1	JFE	1,102,000		1,099,480	1,000,000	1,049,999		(10,341)			5.000	3.740	MN	6,389	50,000	07/08/2005	05/15/2015
153300-PZ-5	CENTRAL DAUPHIN PA SCH DIST			1	JFE	1,044,667		1,064,309	1,030,000	1,040,123		(2,974)			4.500	4.300	FA	19,313	46,350	12/11/2007	08/01/2016
153300-QS-0	CENTRAL DAUPHIN PA SCH DIST			2	JFE	1,098,500		1,139,780	1,000,000	1,057,463		(10,579)			5.000	3.700	MN	6,389	50,000	11/20/2006	11/15/2015
156101-GZ-4	CENTRAL YORK PA SCH DIST			1	JFE	1,082,700		1,100,980	1,000,000	1,043,380		(10,091)			5.000	3.790	JD	4,167	50,000	11/09/2006	12/01/2014
190684-LZ-1	COATESVILLE PA SCH DIST			1	JFE	1,052,600		1,060,230	1,000,000	1,038,016		(9,487)			5.000	4.330	FA	20,833	50,000	11/08/2007	08/01/2017
294223-ML-3	EPHRATA PA AREA SCH DIST				JFE	1,067,220		1,112,820	1,000,000	1,035,456		(7,421)			5.000	4.090	AO	10,556	50,000	05/19/2006	04/15/2015
366268-JL-5	GARNET VALLEY PA SCH DIST			1	JFE	1,082,220		1,117,930	1,000,000	1,040,698		(8,635)			5.000	3.950	AO	12,500	50,000	10/11/2005	04/01/2015
383770-FC-3	GOVERNOR MIFFLIN PA SCH DIST			1	JFE	1,094,860		1,116,720	1,000,000	1,059,385		(9,149)			5.000	3.830	MS	14,722	50,000	11/20/2006	09/15/2016
391358-JE-9	GREAT VY SCH DIST PA CHESTER				JFE	2,155,400		2,252,480	2,000,000	2,078,816		(17,289)			5.000	3.950	FA	37,778	100,000	05/16/2006	02/15/2015
41473H-CD-4	HARRISBURG PA AUTH SCH REV				JFE	1,178,640		1,061,150	1,000,000	1,028,561		(22,077)			5.500	3.150	AO	13,750	55,000	06/24/2003	04/01/2013
514383-QJ-0	LANCASTER PA SCH DIST			1	JFE	1,075,480		1,106,390	1,000,000	1,055,299		(7,418)			5.000	4.010	JD	4,167	50,000	02/27/2008	06/01/2017
524786-WB-2	LEHIGH CNTY PA			1	JFE	1,079,400		1,135,100	1,000,000	1,058,276		(8,805)			5.000	4.020	MN	6,389	50,000	11/14/2007	11/15/2017
548246-AK-3	LOWER MERION PA SCH DIST				JFE	1,100,500		1,058,730	1,000,000	1,016,542		(11,542)			5.000	3.750	MN	6,389	50,000	08/23/2002	05/15/2012
600293-MX-9	MILLCREEK TWP PA SCH DIST				JFE	1,107,900		1,120,480	1,000,000	1,054,709		(10,885)			5.000	3.680	JJ	23,056	50,000	09/15/2005	07/15/2015
613579-SP-7	MONTGOMERY CNTY PA				JFE	1,126,950		1,163,760	1,000,000	1,104,442		(7,587)			5.250	4.040	AO	11,083	52,500	11/20/2007	10/15/2021
615401-JW-7	MOON AREA SCH DIST PA			1	JFE	1,081,680		1,099,560	1,000,000	1,044,764		(16,494)			5.000	3.980	MN	6,389	50,000	02/13/2006	11/15/2015
661684-HC-7	NORTH POCONO SCH DIST PA				JFE	996,880		1,031,540	1,000,000	999,726		373			4.850	4.890	MS	14,281	48,500	06/13/2001	09/15/2015
691789-FH-9	OXFORD PENN AREA SCH DIST				JFE	1,106,320		1,055,440	1,000,000	1,014,642		(12,502)			5.500	4.150	FA	20,778	55,000	06/19/2002	02/15/2013

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ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest				Dates		
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	For eig n	Bond CHAR	NAIC Designation	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other Than Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of	When Paid	Admitted Amount Due & Accrued	Amount Rec. During Year	Acquired	Maturity
717883-AP-7	PHILADELPHIA PA SCH DIST				JFE	1,071,250	113.1160	1,131,160	1,000,000	1,037,599		(10,065)			5.250	4.060	JD	4,375	52,500	06/20/2007	06/01/2034
725209-OP-9	PITTSBURGH PA				JFE	1,030,140	105.2740	1,021,158	970,000	983,632		(11,219)			5.125	3.880	MS	16,571	49,713	07/25/2006	09/01/2018
725276-Y6-0	PITTSBURGH PA SCH DIST				JFE	1,140,470	110.0430	1,100,430	1,000,000	1,050,222		(17,670)			5.500	3.510	MS	18,333	55,000	06/21/2005	09/01/2013
730436-WK-4	POCONO MOUNTAIN PA SCH DIST				JFE	1,073,360	108.5980	1,085,980	1,000,000	1,026,907		(11,981)			5.000	3.670	FA	18,889	50,000	11/20/2006	02/15/2015
730436-YA-4	POCONO MOUNTAIN PA SCH DIST				JFE	1,103,470	110.9050	1,109,050	1,000,000	1,046,546		(11,383)			5.000	3.660	AO	12,500	50,000	07/28/2005	10/01/2014
756638-SD-6	READING PA SCH DIST			1	JFE	922,285	103.7780	944,380	910,000	918,164		(1,422)			4.500	4.300	JJ	18,883	40,950	12/11/2007	01/15/2016
810827-MJ-1	SCRANTON PENN SCH DIST			1	2FE	992,500	100.7310	1,007,310	1,000,000	997,109		600			4.750	4.820	AO	11,875	47,500	08/03/2001	04/01/2015
836030-LE-4	SOUDERTON PA AREA SCH DIST			1	JFE	1,098,790	111.4000	1,114,000	1,000,000	1,047,909		(12,297)			5.000	3.800	MN	6,389	50,000	05/09/2005	05/15/2015
863475-KE-8	STROUDSBURG PENN AREA SCH DIST			1	JFE	1,251,119	104.1820	1,229,348	1,180,000	1,190,349		(7,903)			5.000	4.270	AO	14,750	59,000	11/14/2001	04/01/2012
916507-JX-5	UPPER ST CLAIR TWP PA SCH DIST				JFE	1,061,800	106.5550	1,065,550	1,000,000	1,016,869		(10,444)			5.000	3.860	JJ	23,056	50,000	05/17/2006	07/15/2032
936685-CT-1	WARWICK SCH DIST PA LANCASTER				JFE	1,072,300	103.0200	1,030,200	1,000,000	1,009,435		(14,740)			5.250	3.700	FA	19,833	52,500	06/08/2006	02/15/2019
979595-HJ-7	WOODLAND HILLS SCH DIST PA				JFE	1,081,620	112.5120	1,125,120	1,000,000	1,043,041		(8,240)			5.000	3.980	MS	16,667	50,000	11/30/2005	09/01/2015
1899999 - Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Issuer Obligations						35,672,551	xxx	36,014,725	33,090,000	34,227,675		(312,843)			xxx	xxx	xxx	460,942	1,670,763	xxx	xxx
Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Single Class Mortgage-Backed/Asset-Backed Securities																					
Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Residential Mortgage-Backed Securities																					
Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Residential Mortgage-Backed Securities																					
Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Commercial Mortgage-Backed Securities																					
Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities																					
2499999 - Bonds: Subtotals - U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)						35,672,551	xxx	36,014,725	33,090,000	34,227,675		(312,843)			xxx	xxx	xxx	460,942	1,670,763	xxx	xxx
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions - Issuer Obligations																					
118673-3P-5	BUCKS CNTY PA WTR & SWR AUTH				JFE	1,041,020	104.5200	1,045,200	1,000,000	1,004,643		(4,842)			5.375	4.850	JD	4,479	53,750	12/06/2001	06/01/2015
118674-BK-5	BUCKS CNTY PA WTR & SWR AUTH				JFE	349,655	113.2940	356,876	315,000	332,092		(4,627)			5.250	3.540	JD	1,378	16,538	01/01/2007	06/01/2014
118674-BT-6	BUCKS CNTY PA WTR & SWR AUTH				JFE	760,361	111.1350	761,275	685,000	722,169		(10,062)			5.250	3.540	JD	2,997	35,963	01/01/2007	06/01/2014
20281P-AZ-5	COMMONWEALTH FING AUTH PA REV			1	JFE	1,038,710	102.8550	1,028,550	1,000,000	1,026,208		(9,321)			5.000	4.450	JD	4,167	50,000	11/09/2007	06/01/2016
246045-JV-1	DELAWARE CNTY PA REGL WTR QJAL				JFE	1,050,900	104.0610	1,040,610	1,000,000	1,005,073		(5,847)			5.250	4.620	MN	8,750	52,500	07/26/2001	05/01/2013
246045-LK-2	DELAWARE CNTY PA REGL WTR QJAL				JFE	1,221,081	106.2090	1,152,368	1,085,000	1,201,579		(6,415)			5.250	4.180	MN	9,494	56,963	10/23/2007	05/01/2024
546398-WE-4	LOUISIANA PUB FACS AUTH REV			1	JFE	1,030,770	103.9360	1,039,360	1,000,000	1,022,948		(3,013)			5.000	4.580	JD	4,167	50,000	04/09/2008	06/01/2017
59259Y-C6-2	METROPOLITAN TRANSN AUTH N Y				JFE	350,000	100.9900	353,465	350,000	350,000					5.404	5.400	MN	2,417	14,396	02/05/2010	11/15/2020
59333P-XZ-6	MIAMI-DADE CNTY FLA AVIATION			1	JFE	568,585	102.8330	565,582	550,000	567,395		(1,190)			5.250	4.830	AO	7,219	19,490	01/14/2010	10/01/2020
59334D-GV-0	MIAMI-DADE CNTY FLA WTR & SWR			1	JFE	604,389	104.7040	581,107	555,000	601,309		(3,081)			5.000	3.960	AO	6,938	15,416	02/24/2010	10/01/2020
649905-F3-5	NEW YORK ST DORM AUTH REVS NON			1	JFE	548,905	106.1700	530,850	500,000	546,829		(2,076)			5.000	3.830	AO	13,611	50,000	05/21/2010	10/01/2020
708796-TN-7	PENNSYLVANIA HSG FIN AGY			1	JFE	1,000,000	96.9130	969,130	1,000,000	1,000,000					4.500	4.500	AO	11,250	34,750	12/03/2009	10/01/2024
70917N-KP-8	PENNSYLVANIA ST HIGHER EDL				JFE	988,710	101.8640	1,018,640	1,000,000	999,362		3,289			4.500	4.640	JD	2,000	45,000	06/26/2001	06/15/2013
70917N-R7-1	PENNSYLVANIA ST HIGHER EDL FAC				JFE	1,082,140	110.6360	1,106,360	1,000,000	1,033,606		(11,739)			5.250	3.910	MS	17,500	52,500	07/28/2006	09/01/2013
70917R-EL-5	PENNSYLVANIA ST HIGHER EDL			1	JFE	1,060,330	108.9660	1,089,660	1,000,000	1,035,365		(9,889)			5.000	4.240	AO	12,500	50,000	06/01/2006	04/01/2016
70917R-WS-0	PENNSYLVANIA ST HIGHER EDL			1	JFE	1,038,380	107.2950	1,072,950	1,000,000	1,033,912		(3,153)			5.000	4.520	FA	18,889	50,000	07/16/2009	08/15/2019
709193-JN-7	PENNSYLVANIA ST INDL DEV AUTH				JFE	1,122,840	101.9680	1,019,680	1,000,000	1,008,203		(15,976)			5.250	3.580	JJ	26,250	52,500	11/14/2002	07/01/2011
709208-DB-5	PENNSYLVANIA ST PUB SCH BLDG A				JFE	1,150,426	109.5060	1,188,140	1,085,000	1,112,879		(11,637)			5.125	3.920	AO	13,902	55,606	08/09/2007	10/01/2028
709222-BN-2	PENNSYLVANIA ST TPK COMMN				JFE	1,090,370	103.7110	1,037,110	1,000,000	1,015,666		(10,178)			5.500	4.380	JJ	25,361	55,000	05/15/2002	07/15/2012
709222-BP-7	PENNSYLVANIA ST TPK COMMN				JFE	1,074,210	103.6450	1,036,450	1,000,000	1,014,263		(7,649)			5.375	4.510	JJ	24,785	53,750	07/26/2001	07/15/2013
709222-CD-3	PENNSYLVANIA ST TPK COMMN				JFE	1,057,530	102.2340	1,022,340	1,000,000	1,006,496		(11,722)			5.000	3.770	JJ	23,056	50,000	04/28/2006	07/15/2011
717823-F2-9	PHILADELPHIA PA GAS WKS REV				JFE	1,076,940	102.9410	1,029,410	1,000,000	1,009,763		(16,266)			5.500	3.790	FA	22,917	55,000	08/03/2006	08/01/2016
717893-PG-0	PHILADELPHIA PA WTR & WASTEWTR				JFE	1,075,380	111.3620	1,113,620	1,000,000	1,039,145		(7,783)			5.000	4.030	JJ	25,000	50,000	12/08/2005	07/01/2015
914054-CH-2	UNIVERSITY AREA JT AUTH PA			1	JFE	993,580	102.2130	1,022,130	1,000,000	997,051		426			4.900	4.950	MN	8,167	49,000	07/18/2001	11/01/2016
2599999 - Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions - Issuer Obligations						22,375,212	xxx	22,180,862	21,125,000	21,685,956		(152,749)			xxx	xxx	xxx	297,191	1,018,121	xxx	xxx
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions - Single Class Mortgage-Backed/Asset-Backed Securities																					
31281L-AL-2	FG N70011			2	1	24,842	114.4880	26,457	23,109	24,351		(596)			10.000	7.490	MON	193	2,311	08/11/1999	11/01/2018
31287S-3F-2	FG C67098			2	1	802	112.4420	902	802	802					6.500	6.290	MON	4	52	05/09/2002	04/01/2027
3128JR-PM-2	FH 847628			2	1	244,802	105.5140	258,735	245,214	244,802		200			4.776	5.100	MON	2,174	13,077	11/15/2006	03/01/2036
3128M7-PX-8	FG G05538			2	1	833,180	105.5670	860,735	815,344	829,814		(5,512)			5.000	4.310	MON	3,397	40,767	08/11/2009	07/01/2038
3128M7-WP-7	FG G05754			2	1	459,228	105.5670	466,709	442,097	457,490		(3,523)			5.000	3.800	MON	1,842	18,421	01/21/2010	02/01/2039
31290K-UJ-6	FH 555085			2	1	836	115.6720	913	789	808		(10)			11.500	8.850	MON	15	91	04/07/2000	07/01/2014
312939-3L-3	FG A91703			2	1	455,168	102.5690	454,366	442,986	455,105		(1,441)			4.500	3.390	MON	1,661	9,966	06/07/2010	01/01/2040

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**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE D - PART 1**

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest				Dates			
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22	
CUSIP Identification	Description	Code	Foreign	Bond CHAR	NAIC Designation	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/Adjusted Carrying Value	Unrealized Valuation Increase/(Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other Than Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of	When Paid	Admitted Amount Due & Accrued	Amount Rec. During Year	Acquired	Maturity	
312940-4Y-2	FG A92639			2	1	1,021,671		102,8810	968,899	968,983		(3,148)			4.500	3.020	MON	3,634	10,901	09/01/2010	02/01/2040	
312942-XS-9	FG A94289			2	1	498,660		99,3770	494,202	497,300					4.000	3.900	MON	1,658		12/02/2010	10/01/2040	
31295M-HE-3	FH 788329			2	1	281		104,7670	285	272					2.686	4.220	MON	1	8	05/01/2002	07/01/2031	
31295W-XZ-6	FG A01596			2	1	27,207		103,8220	25,563	24,622		(417)		12.000	8.300	MON	246	2,955	02/07/2000	04/01/2014		
31297P-ZZ-0	FG A34361			2	1	253,347		107,3370	268,723	250,354		(673)		5.500	5.210	MON	1,147	13,769	05/06/2005	03/01/2034		
313401-2C-4	FH 360123			2	1	4,548		115,8140	4,923	4,250		(98)		10.000	6.550	MON	71	425	12/27/2000	10/01/2020		
31364H-GL-5	FNS 66 1			2	1	2,974		113,0740	3,375	2,985		2		7.500	7.440	MON	19	224	08/24/1999	10/01/2019		
31371K-AA-3	FN 253927			2	1	43,474		110,5450	48,372	43,758		123		6.500	6.570	MON	237	2,844	07/17/2001	04/01/2030		
31371L-QY-8	FN 255271			2	1	334,395		106,5010	356,022	334,290				5.000	4.910	MON	1,393	16,715	10/01/2004	11/01/2023		
31371L-WR-6	FN 255456			2	1	299,839		108,0780	316,252	292,615		(1,789)		5.500	4.780	MON	1,341	16,094	01/19/2005	03/01/2024		
31386F-F7-5	FN 561890			2	1	1,736		114,7570	1,922	1,675		(54)		7.500	4.400	MON	10	126	05/12/2002	07/01/2030		
31386T-6C-4	FN 573367			2	1	12,907		110,1600	14,637	13,287		516		6.000	6.920	MON	66	797	06/13/2001	03/01/2031		
31387C-L4-1	FN 580047			2	1	21,349		110,1600	23,786	21,592		73		6.000	6.370	MON	108	1,296	09/18/2001	08/01/2029		
31387D-3T-4	FN 581410			2	1	21,523		112,4420	24,338	21,645		55		6.500	6.550	MON	117	1,407	06/13/2001	08/01/2028		
31387E-KT-3	FN 581806			2	1	7,851		113,9240	8,831	7,752		(33)		7.000	5.470	MON	45	543	05/09/2002	10/01/2030		
31387F-ES-9	FN 582545			2	1	17,527		112,4420	19,813	17,621		31		6.500	6.540	MON	95	1,145	06/13/2001	12/01/2029		
31387W-3N-5	FN 596705			2	1	102,056		108,5760	110,860	102,104		21		6.000	5.900	MON	511	6,126	06/19/2002	02/01/2031		
31389D-QR-1	FN 622464			2	1	4,706		107,7030	5,103	4,738		11		5.500	5.640	MON	22	261	05/01/2002	06/01/2016		
31389F-J6-0	FN 624085			2	1	5,086		112,4420	5,646	5,021		(22)		6.500	5.580	MON	27	326	05/01/2002	03/01/2031		
31389S-TE-4	FN 634249			2	1	7,450		110,1600	8,305	7,539		16		6.000	6.360	MON	38	452	05/01/2002	06/01/2031		
31389V-RU-3	FN 636899			2	1	8,526		112,4420	9,578	8,526		(2)		6.500	6.230	MON	46	554	05/09/2002	07/01/2031		
31391E-AP-6	FN 664314			2	1	113,550		106,9530	119,466	111,700		(667)		5.000	4.340	MON	465	5,585	09/25/2002	03/01/2017		
31402F-BX-2	FN 727354			2	1	291,784		107,0780	312,974	292,286		145		5.000	4.960	MON	1,218	14,614	09/03/2003	12/01/2017		
31403C-6L-0	FN 745275			2	1	464,797		105,5780	508,934	482,045		5,081		5.000	5.780	MON	2,009	24,102	10/04/2006	03/01/2035		
31403C-6U-0	FN 745283			2	1	450,090		107,7590	502,787	466,585		4,631		5.500	6.270	MON	2,139	25,662	05/15/2006	02/01/2035		
31405E-G3-3	FN 786918			2	1	87,900		107,9530	92,001	85,223		(1,075)		5.500	4.390	MON	391	4,687	11/30/2004	05/01/2019		
31405V-2E-6	FN 800973			2	1	321,618		106,9530	336,925	315,022		(2,035)		5.000	4.400	MON	1,313	15,751	11/04/2004	03/01/2019		
31406L-QD-3	FN 813252			2	1	386,125		107,6340	407,858	378,931		(1,931)		5.500	4.970	MON	1,737	20,841	02/15/2005	07/01/2034		
31406P-QM-4	FN 815960			2	1	288,145		107,6340	285,669	265,408		(705)		5.500	5.160	MON	1,216	14,597	04/20/2005	06/01/2034		
31407A-PZ-8	FN 824940			2	1	187,687		107,5400	200,772	186,695		(227)		5.500	5.280	MON	856	10,268	08/03/2005	11/01/2034		
31407L-ZR-1	FN 834252			2	1	365,698		109,1290	390,062	357,432		(1,264)		6.000	5.280	MON	1,787	21,446	09/13/2005	12/01/2034		
31410F-D7-7	FN 887626			2	1	320,543		105,0780	334,482	318,318		(784)		5.721	5.410	MON	1,517	18,261	01/19/2007	07/01/2036		
31410Q-QW-4	FN 894269			2	1	301,764		105,0600	318,226	302,900		940		5.316	5.340	MON	1,338	16,148	10/19/2006	10/01/2036		
31410S-YK-7	FN 896314			2	1	386,858		109,6290	431,869	393,937		1,804		6.000	6.380	MON	1,970	23,636	07/06/2006	07/01/2035		
31410T-L7-8	FN 896850			2	1	485,791		108,3280	523,101	482,886		(415)		5.500	5.220	MON	2,213	26,559	03/22/2007	08/01/2021		
31411D-SB-6	FN 905114			2	1	515,652		109,6290	562,360	512,967		(448)		6.000	5.770	MON	2,565	30,778	11/24/2007	06/01/2036		
31411J-TX-4	FN 909666			2	1	513,712		107,6870	559,363	519,434		1,649		5.500	5.690	MON	2,381	28,569	04/30/2007	09/01/2036		
31411L-YN-5	FN 911617			2	1	222,116		108,8170	240,985	221,459		(141)		6.000	5.790	MON	1,107	13,288	05/18/2007	11/01/2036		
31413F-6L-0	FN 944003			2	1	549,808		109,6290	606,730	553,440		1,042		6.000	6.060	MON	2,767	33,206	08/08/2007	02/01/2037		
2699999 - Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions - Single Class Mortgage-Backed/Asset-Backed Securities						10,949,608	xxx	11,550,819	10,847,930	10,934,816		(10,671)			xxx	xxx	xxx	49,108	509,652	xxx	xxx	
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions - Defined Multi-Class Residential Mortgage-Backed Securities																						
312905-L3-4	FHR 1078 GZ			2	1	4,315		110,9230	4,920	4,436				6.500	6.500	MON		24	288	02/10/2000	08/01/2018	
312907-F6-0	FHR 1175 D			2	1	14,540		114,8080	16,578	14,440				8.000	6.680	MON	96	1,155	11/30/2000	11/01/2021		
31358F-ZB-8	FNR 1991-6 ZD			2	1	24,235		124,2500	28,954	23,303		(119)		9.000	7.210	MON	175	2,097	12/15/1999	12/01/2020		
313602-NR-1	FNR 1989-14 Z			2	1	13,071		117,2450	14,339	12,230		(107)		10.000	7.080	MON	102	1,223	08/26/1999	03/01/2019		
2799999 - Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions - Defined Multi-Class Residential Mortgage-Backed Securities						56,162	xxx	64,792	54,409	55,968		(227)			xxx	xxx	xxx	397	4,764	xxx	xxx	
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions - Other Multi-Class Residential Mortgage-Backed Securities																						
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions - Defined Multi-Class Commercial Mortgage-Backed Securities																						
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities																						
3199999 - Bonds: Subtotals - U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies of Governments and Their Political Subdivisions						33,380,981	xxx	33,796,472	32,027,339	32,676,740		(163,647)				xxx	xxx	xxx	346,695	1,532,536	xxx	xxx

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ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book Adjusted Carrying Value				Interest				Dates		
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	Foreign	Bond CHAR	NAIC Designation	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/Adjusted Carrying Value	Unrealized Valuation Increase/(Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other Than Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of	When Paid	Admitted Amount Due & Accrued	Amount Rec. During Year	Acquired	Maturity
Bonds: Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations																					
00206R-AF-9	AT&T INC.			1	JFE	997,730		1,071,870	1,000,000	999,061		427			4.950	4.990	JJ	22,825	49,500	12/12/2007	01/15/2013
002824-AX-8	ABBOTT LABORATORIES			1	JFE	199,796		203,910	200,000	199,819		23			2.700	2.720	MN	510	2,700	05/24/2010	05/27/2015
031162-AV-2	AMGEN INC.			1	JFE	552,670		570,750	500,000	547,011	(5,659)				5.850	4.160	JD	2,438	29,250	02/02/2010	06/01/2017
06050B-AA-9	BANK OF AMERICA CORP			1	JFE	1,000,160		1,035,720	1,000,000	1,000,072	(47)				3.125	3.110	JD	1,389	31,250	12/02/2008	06/15/2012
067383-AB-5	CR BARD INC.			1	JFE	999,138		1,007,320	1,000,000	999,138		1			2.875	2.890	JJ	878		12/15/2010	01/15/2016
07385T-AJ-5	BEAR STEARNS COS LLC			1	JFE	979,050		1,098,750	1,000,000	986,189	3,075				5.700	6.100	MN	7,283	57,000	08/11/2008	11/15/2014
084670-AV-0	BERKSHIRE HATHAWAY INC.			1	JFE	499,585		515,940	500,000	499,654	69				3.200	3.210	FA	6,222	8,000	02/04/2010	02/11/2015
097014-AK-0	BOEING CAPITAL CORP.			1	JFE	997,800		1,042,060	1,000,000	998,287	414				3.250	3.290	AO	5,778	32,500	10/22/2009	10/27/2014
144141-CZ-9	PROGRESS ENERGY CAROLINA			1	JFE	537,040		555,010	500,000	533,260	(3,389)				5.300	4.310	JJ	12,219	26,500	11/10/2009	01/15/2019
14912L-3S-8	CATERPILLAR FIN SERV CRP			1	JFE	499,355		531,155	500,000	499,712	128				4.250	4.270	FA	8,441	21,250	02/04/2008	02/08/2013
166751-AH-0	CHEVRON CORP.			1	JFE	532,470		533,780	500,000	524,422	(7,328)				3.950	2.340	MS	6,474	19,750	11/24/2009	03/03/2014
17275R-AC-6	CISCO SYSTEMS INC.			1	JFE	547,435		570,555	500,000	539,646	(6,851)				5.500	3.780	FA	9,854	27,500	11/05/2009	02/22/2016
191216-AL-4	COCA-COLA CO/THE			1	JFE	1,034,460		1,058,390	1,000,000	1,025,024	(7,362)				3.625	2.800	MS	10,674	36,250	09/15/2009	03/15/2014
191219-BV-5	COCA-COLA REFRESH USA			1	JFE	1,055,470		1,077,610	1,000,000	1,044,104	(9,755)				4.250	3.110	MS	14,167	42,500	10/27/2009	03/01/2015
194160-DO-0	COLGATE-PALMOLIVE CO			1	JFE	992,480		956,910	1,000,000	992,714	234				1.375	1.530	MN	2,215		10/29/2010	11/01/2015
20825R-AB-7	CONOCOPHIL AU			1	JFE	1,015,920		1,096,510	1,000,000	1,006,329	(2,542)				5.500	5.200	AO	11,611	55,000	11/20/2006	04/15/2013
216871-AD-5	COOPER US INC.			1	JFE	1,099,270		1,112,300	1,000,000	1,080,013	(17,198)				5.450	3.410	AO	13,625	54,500	11/12/2009	04/01/2015
24422E-QM-4	JOHN DEERE CAPITAL CORP.			1	JFE	998,990		1,078,620	1,000,000	999,574	202				4.950	4.970	JD	1,925	49,500	12/12/2007	12/17/2012
24702R-AH-4	DELL INC.			1	JFE	99,932		103,475	100,000	99,966	22				3.375	3.390	JD	150	3,375	06/10/2009	06/15/2012
24702R-AL-5	DELL INC.			1	JFE	399,908		389,908	400,000	399,913	5				2.300	2.300	MS	2,837		09/07/2010	09/10/2015
25468P-CE-4	WALT DISNEY COMPANY/THE			1	JFE	1,096,910		1,151,820	1,000,000	1,082,523	(12,618)				5.625	3.990	MS	16,563	56,250	11/04/2009	09/15/2016
263534-BY-4	E. I. DU PONT DE NEMOURS			1	JFE	723,238		752,463	725,000	723,640	373				3.250	3.300	JJ	10,865	16,101	11/04/2009	09/15/2016
26875P-AD-3	EOG RESOURCES INC.			1	JFE	546,890		552,125	500,000	542,220	(4,062)				5.625	4.410	JD	2,344	28,125	10/30/2009	06/01/2019
278642-AB-9	EBAY INC.			1	JFE	547,965		527,742	550,000	548,034	69				1.625	1.700	AO	1,564		10/21/2010	10/15/2015
377372-AC-1	GLAXOSMITHKLINE CAP INC.			1	JFE	542,920		542,900	500,000	531,161	(11,759)				4.850	2.140	MN	3,099	24,250	01/22/2010	05/15/2013
428236-AT-0	HEWLETT-PACKARD CO.			1	JFE	1,107,900		1,132,420	1,000,000	1,074,260	(21,758)				6.125	3.620	MS	20,417	61,250	06/03/2009	03/01/2014
478160-AU-8	JOHNSON & JOHNSON			1	JFE	548,710		569,010	500,000	545,530	(3,180)				5.150	3.750	JJ	11,874	12,875	05/13/2010	07/15/2018
548661-CS-4	LOWES COMPANIES INC.			1	JFE	399,800		391,184	400,000	399,803	3				2.125	2.130	AO	921		11/17/2010	04/15/2016
585055-AP-1	MEDTRONIC INC.			1	JFE	1,068,760		1,085,460	1,000,000	1,050,036	(14,704)				4.500	2.850	MS	13,250	45,000	09/16/2009	03/15/2014
589331-AP-2	MERCK & CO INC.			1	JFE	1,043,370		1,072,900	1,000,000	1,034,071	(6,941)				4.000	3.180	JD	1,111	40,000	08/19/2009	06/30/2015
594918-AB-0	MICROSOFT CORP.			1	JFE	1,019,110		1,040,980	1,000,000	1,014,484	(4,012)				2.950	2.500	JD	2,458	29,500	10/30/2009	06/01/2014
61166W-AF-8	MONSANTO CO.			1	JFE	535,665		544,340	500,000	532,231	(3,434)				5.125	4.090	AO	5,410	25,625	01/22/2010	04/15/2018
637432-HT-5	NATIONAL RURAL UTIL COOP			1	JFE	535,010		551,340	500,000	531,126	(3,884)				5.450	4.300	AO	6,131	27,250	01/26/2010	04/10/2017
637432-LT-0	NATIONAL RURAL UTIL COOP			1	JFE	374,441		385,433	375,000	374,677	183				2.625	2.670	MS	2,871	9,844	09/09/2009	09/16/2012
665772-CD-9	NORTHERN STATES PWR-MINN.			1	JFE	1,080,374		1,103,020	1,000,000	1,070,652	(8,302)				5.250	4.100	MS	17,500	52,500	10/22/2009	03/01/2018
67019E-AB-3	NSTAR			1	JFE	173,542		181,428	175,000	173,675	118				4.500	4.600	MN	1,006	7,831	11/12/2009	11/15/2019
670346-AF-2	NUCOR CORP.			1	JFE	995,430		1,071,970	1,000,000	998,108	917				5.000	5.100	JD	4,167	50,000	11/28/2007	12/01/2012
68389X-AF-2	ORACLE CORP.			1	JFE	1,031,940		1,062,880	1,000,000	1,023,594	(6,259)				3.750	3.030	JJ	18,021	37,500	08/24/2009	07/08/2014
693476-BD-4	PNC FUNDING CORP.			1	JFE	999,700		1,066,820	1,000,000	999,886	61				5.500	5.500	MS	14,208	55,000	09/25/2007	09/28/2012
74005P-AV-6	PRAXAIR INC.			1	JFE	997,430		1,031,010	1,000,000	997,964	398				3.250	3.290	MS	9,569	33,764	08/27/2009	09/15/2015
742718-DM-8	PROCTER & GAMBLE CO/THE			1	JFE	512,560		524,960	500,000	509,759	(2,191)				3.500	2.990	FA	6,611	17,500	09/15/2009	02/15/2015
742718-DO-9	PROCTER & GAMBLE CO/THE			1	JFE	324,259		337,552	325,000	324,413	115				3.150	3.190	MS	3,413	10,323	08/25/2009	09/01/2015
742718-DS-5	PROCTER & GAMBLE CO/THE			1	JFE	247,955		245,090	250,000	248,002	47				1.800	1.970	MN	538		11/15/2010	11/15/2015
74451P-AA-1	PUB SERV NC INC.			1	JFE	989,740		1,006,570	1,000,000	999,829	1,368				6.625	6.760	FA	25,028	66,250	06/19/2001	02/15/2011
744560-AW-6	PUB SVC ELEC & GAS			1	JFE	149,733		151,335	150,000	149,763	30				2.700	2.730	MN	675	1,811	05/17/2010	05/01/2015
748356-AA-0	QUESTAR CORP.			1	JFE	772,230		769,017	775,000	772,249	19				2.750	2.820	FA	1,006		12/09/2010	02/01/2016
863667-AB-7	STRYKER CORP.			1	JFE	497,120		515,995	500,000	497,344	224				4.375	4.440	JJ	10,087	10,938	02/03/2010	01/15/2020
88579E-AE-5	3M COMPANY			1	JFE	499,120		543,960	500,000	499,511	172				4.375	4.410	FA	8,264	21,875	08/18/2008	08/15/2013
90333W-AA-6	US BANK NA			1	JFE	787,118		774,930	750,000	757,463	(12,357)				6.375	4.620	FA	19,922	47,813	07/01/2008	08/01/2011
913017-BH-1	UNITED TECHNOLOGIES CORP.			1	JFE	1,087,930		1,107,010	1,000,000	1,068,556	(14,541)				4.875	3.160	MN	8,125	48,750	08/25/2009	05/01/2015
92344S-AP-5	CELLCO PART/VERI WIRELESS			1	JFE	1,085,728		1,102,710	1,000,000	1,063,846	(19,330)				5.550	3.350	FA	23,125	55,500	11/12/2009	02/01/2014
931142-CX-9	WAL-MART STORES INC.			1	JFE	497,295		95,7850	500,0												



Schedule D - Part 2 - Section 1

**NONE**

Schedule D - Part 2 - Section 2

**NONE**

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE D - PART 3**

Showing All Long-Term Bonds and Stocks **ACQUIRED** During Current Year

1	2	3	4	5	6	7	8	9	
CUSIP Identification	Description	Foreign	Date Acquired	Name of Vendor	Number of Shares of Stock	Actual Cost	Par Value	Paid for Accrued Interest and Dividends	
Bonds - U.S. Governments									
Bonds - All Other Governments									
Bonds - U.S. States, Territories and Possessions (Direct and Guaranteed)									
419791-YP-7	HAWAII ST.		02/10/2010	CITIGROUP GLOBAL MARKETS		504,655	500,000		
1799999 - Bonds - U.S. States, Territories and Possessions (Direct and Guaranteed)									
Bonds - U.S. Political Subdivisions of States (Direct and Guaranteed)									
Bonds - U.S. Special Revenue									
3128M7-WP-7	FG 605754		01/21/2010	MORGAN STANLEY		512,543	493,423	685	
312939-3L-3	FG A91703		06/07/2010	BANK AMERICA		510,417	496,756	807	
312940-4Y-2	FG A92639		09/01/2010	MORGAN STANLEY		1,044,169	990,321	1,609	
312942-XS-9	FG A94289		12/02/2010	MORGAN STANLEY		498,660	497,300	663	
59259Y-CG-2	METROPOLITAN TRANSN AUTH N Y		02/05/2010	BARCLAYS AMERICAN		350,000	350,000		
59333P-XZ-6	MIAMI-DADE CNTY FLA AVIATION		01/14/2010	CITIGROUP GLOBAL MARKETS		568,585	550,000		
59334D-GV-0	MIAMI-DADE CNTY FLA WTR & SWR		02/24/2010	RAYMOND JAMES		604,389	555,000		
649905-F3-5	NEW YORK ST DORM AUTH REVS NON		05/21/2010	JEFFERIES & CO.		548,905	500,000		
3199999 - Bonds - U.S. Special Revenue and Special Assessment and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions									
Bonds - Industrial and Miscellaneous (Unaffiliated)									
002824-AX-8	ABBOTT LABORATORIES		05/24/2010	J.P. MORGAN		199,796	200,000		
031162-AV-2	AMGEN INC.		02/02/2010	DEUTSCHE BANK		552,670	500,000	5,200	
067383-AB-5	CR BARD INC.		12/15/2010	VARIOUS		999,138	1,000,000		
084670-AV-0	BERKSHIRE HATHAWAY INC.		02/04/2010	J.P. MORGAN		499,585	500,000		
194160-DQ-0	COLGATE-PALMOLIVE CO.		10/29/2010	CITIGROUP GLOBAL MARKETS		992,480	1,000,000		
24702R-AL-5	DELL INC.		09/07/2010	BARCLAYS AMERICAN		399,908	400,000		
278642-AB-9	EBAY INC.		10/21/2010	BANK AMERICA		547,965	550,000		
377372-AC-1	GLAXOSMITHKLINE CAP INC.		01/22/2010	RBC CAPITAL MARKETS SECURITIES - US		542,920	500,000	4,850	
478160-AU-8	JOHNSON & JOHNSON		05/13/2010	CREDIT SUISSE		548,710	500,000	8,798	
548661-CS-4	LOWES COMPANIES INC.		11/17/2010	WELLS FARGO SECURITIES LLC		399,800	400,000		
61166W-AF-8	MONSANTO CO.		01/22/2010	CREDIT SUISSE		535,665	500,000	7,260	
637432-HT-5	NATIONAL RURAL UTIL COOP		01/26/2010	CREDIT SUISSE		535,010	500,000	8,251	
742718-DS-5	PROCTER & GAMBLE CO/THE		11/15/2010	MORGAN STANLEY		247,955	250,000		
744560-AW-6	PUB SVC ELEC & GAS		05/17/2010	BARCLAYS AMERICAN		149,733	150,000		
748356-AA-0	QUESTAR CORP.		12/09/2010	BARCLAYS AMERICAN		772,230	775,000		
863667-AB-7	STRYKER CORP.		02/03/2010	CREDIT SUISSE		497,120	500,000	1,398	
931142-CX-9	WAL-MART STORES INC.		10/18/2010	BARCLAYS AMERICAN		497,295	500,000		
893526-DH-3	TRANS-CANADA PIPELINES	A	05/27/2010	DEUTSCHE BANK		1,548,226	1,550,000	132	
3899999 - Bonds - Industrial and Miscellaneous (Unaffiliated)									
Bonds - Credit Tenant Loans									
Bonds - Hybrid Securities									
Bonds - Parent, Subsidiaries and Affiliates									
8399997	Subtotals - Bonds - Part 3					15,608,528	15,207,800	39,654	
8399998	Summary item from Part 5 for Bonds					12,653,963	11,940,000	89,983	
8399999	Subtotals - Bonds					28,262,491	27,147,800	129,636	
Preferred Stocks - Industrial and Miscellaneous (Unaffiliated)									
Preferred Stocks - Parent, Subsidiaries, and Affiliates									
Common Stocks - Industrial and Miscellaneous (Unaffiliated)									
Common Stocks - Parent, Subsidiaries, and Affiliates									
Common Stocks - Mutual Funds									
Common Stocks - Money Market Mutual Funds									
<b>9999999 Totals</b>							28,262,491	XXX	129,636

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ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

SCHEDULE D - PART 4

Showing all Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change in Book/Adjusted Carrying Value					16	17	18	19	20	21											
										11	12	13	14	15																	
CUSIP Identification	Description	Foreign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consideration	Par Value	Actual Cost	Prior Year Book/Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year (Amortization)/ Accretion	Current Year's Other Than Temporary Impairment Recognized	Total Change in B/A. C.V. (11+12-13)	Total Foreign Exchange Change in B/A. C.V.	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/Stock Dividends Received During Year	Maturity Date											
Bonds - U.S. Governments																															
362155-ZC-0	GN 143939		12/01/2010	MBS PAYMENT		12,743	12,743.00	13,388	12,806		(63)		(63)		12,743				543	11/01/2014											
362905-UD-1	GN 616280		12/01/2010	MBS PAYMENT		88,620	88,620.00	89,340	88,684		(64)		(64)		88,620				1,856	06/01/2018											
36297F-UJ-9	GN 710785		12/01/2010	MBS PAYMENT		275,606	275,606.00	290,657	277,773		(2,167)		(2,167)		275,606				7,272	06/01/2039											
779382-AH-3	ROWAN COMPANIES INC.		11/05/2010	SINK		29,764	29,764.00	29,764	29,764						29,764				625	10/20/2013											
912827-6J-6	US TREASURY N/B		08/15/2010	MATURITY		175,000	175,000.00	183,258	175,745		(745)		(745)		175,000				10,063	08/15/2010											
0399999	Bonds - U.S. Governments																			581,733				581,733				20,358	XXX		
Bonds - All Other Governments																															
Bonds - U.S. States, Territories and Possessions (Direct and Guaranteed)																															
373384-6Y-2	GEORGIA ST		06/17/2010	CANTOR FITZGERALD		1,152,470	1,000,000.00	1,105,000	1,094,654		(5,829)		(5,829)		1,088,826		63,644	63,644	48,750	07/01/2019											
57582P-CC-2	MASSACHUSETTS ST		06/17/2010	CITIGROUP GLOBAL MARKETS		1,156,050	1,000,000.00	1,086,170	1,070,806		(5,996)		(5,996)		1,064,810		91,240	91,240	40,417	03/01/2015											
57582P-LF-5	MASSACHUSETTS ST		06/18/2010	UBS SECURITIES		1,131,400	1,000,000.00	1,092,930	1,082,537		(3,919)		(3,919)		1,078,619		52,781	52,781	44,722	08/01/2019											
709141-MH-5	PENNSYLVANIA ST		01/15/2010	CALL BY ISSUER at 101.000		1,010,000	1,000,000.00	1,085,680	1,010,852		(852)		(852)		1,010,000				30,000	01/15/2010											
709141-PA-7	PENNSYLVANIA ST		10/15/2010	CALL BY ISSUER at 101.000		1,010,000	1,000,000.00	1,047,490	1,013,844		(3,844)		(3,844)		1,010,000				52,500	10/15/2010											
917542-MJ-8	UTAH ST		06/21/2010	J.P. MORGAN		1,164,400	1,000,000.00	1,071,390	1,061,443		(4,033)		(4,033)		1,057,410		106,990	106,990	49,028	07/01/2016											
93974B-WH-1	WASHINGTON ST		06/21/2010	PIPER JAFFREY & CO.		1,081,110	1,000,000.00	1,077,450	1,076,329		(4,631)		(4,631)		1,071,698		9,412	9,412	49,028	01/01/2023											
93974C-AH-3	WASHINGTON ST		06/21/2010	GOLDMAN SACHS		1,149,750	1,000,000.00	1,115,180	1,098,082		(6,559)		(6,559)		1,091,523		58,227	58,227	49,028	07/01/2016											
1799999	Bonds - U.S. States, Territories and Possessions (Direct and Guaranteed)																			8,855,180				8,855,180				382,295	382,295	363,472	XXX
Bonds - U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)																															
018479-JE-6	ALLENTOWN PA WTR REV GTO		08/12/2010	JEFFERIES & CO.		1,106,735	1,060,000.00	1,197,291	1,094,757		(11,951)		(11,951)		1,082,805		23,930	23,930	48,907	10/15/2013											
179090-KB-0	CLACKAMAS CNTY ORE SCH DIST NO		06/17/2010	CABRERA CAPITAL MARKETS		1,170,660	1,000,000.00	1,224,980	1,221,329		(7,006)		(7,006)		1,214,323		(43,663)	(43,663)	29,313	06/01/2022											
414018-3H-2	HARRIS CNTY TEX FLOOD CTL DIST		06/17/2010	HUTCHINSON SHOCKEY ERLEY & CO.		1,174,040	1,000,000.00	1,195,830	1,191,866		(6,422)		(6,422)		1,185,445		(11,405)	(11,405)	38,063	10/01/2021											
418780-JJ-2	HATBORO HORSHAM PA SCH DIST		06/22/2010	BMO CAPITAL MARKETS - US		525,930	500,000.00	536,670	511,555		(3,206)		(3,206)		508,349		17,581	17,581	19,444	09/15/2011											
549050-CS-9	LOYALSOCK TOWNSHIP PA SCH DIST		08/06/2010	EXCHANGE		1,267,359	1,265,000.00	1,339,319	1,273,259		(5,900)		(5,900)		1,267,359				48,316	11/01/2010											
64966H-AS-9	NEW YORK N Y		06/18/2010	STONE & YOUNGBERG		1,143,290	1,000,000.00	1,103,360	1,088,915		(5,671)		(5,671)		1,083,244		60,046	60,046	42,583	09/01/2016											
717880-4E-5	PHILADELPHIA PA SCH DIST		03/01/2010	CALL BY ISSUER at 100.000		1,000,000	1,000,000.00	1,132,840	1,004,266		(4,266)		(4,266)		1,000,000				28,750	03/01/2010											
725209-GF-1	PITTSBURGH PA		09/01/2010	MATURITY		835,000	835,000.00	868,759	838,098		(3,098)		(3,098)		835,000				41,750	09/01/2010											
812626-XB-0	SEATTLE WASH		06/21/2010	COMPANY		1,129,950	1,000,000.00	1,079,730	1,072,978		(4,966)		(4,966)		1,068,012		61,938	61,938	28,194	12/01/2020											
840659-LL-8	SOUTH WESTERN SCH DIST PA YORK		06/15/2010	MATURITY		750,000	750,000.00	743,213	749,570		430		430		750,000				15,000	06/15/2010											
915633-H6-9	UPPER DARBY PA SCH DIST		02/15/2010	MATURITY		1,260,000	1,260,000.00	1,320,581	1,261,070		(1,070)		(1,070)		1,260,000				31,500	02/15/2010											
972352-FN-3	WILSON PA AREA SCH DIST		02/15/2010	MATURITY		1,000,000	1,000,000.00	1,073,200	1,001,343		(1,343)		(1,343)		1,000,000				25,000	02/15/2010											
2499999	Bonds - U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)																			12,362,965				12,362,965				108,427	108,427	396,820	XXX
Bonds - U.S. Special Revenue and Special Assessment and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions																															
161045-HB-8	CHARLOTTE N C WTR & SWR SYS RE		06/17/2010	SOUTHWEST SECURITIES INC.		1,145,140	1,000,000.00	1,095,720	1,086,096		(5,294)		(5,294)		1,080,803		64,337	64,337	48,750	07/01/2019											
31281L-AL-2	FG N70011		12/01/2010	MBS PAYMENT		12,111	12,111.00	13,020	12,094		17		17		12,111				604	11/01/2018											
31287S-3F-2	FG C67098		12/01/2010	MBS PAYMENT		820	820.00	820	820						820				47	04/01/2027											
3128JR-PM-2	FH 847628		12/15/2010	VARIOUS		244,623	244,623.00	244,212	244,605		18		18		244,623				8,273	03/01/2036											
3128MT-PX-8	FG 605538		12/01/2010	MBS PAYMENT		160,518	160,518.00	164,029	161,119		(601)		(601)		160,518				5,813	07/01/2038											
3128MT-WP-7	FG 605754		12/01/2010	MBS PAYMENT		51,326	51,326.00	53,315	51,326		(203)		(203)		51,326				1,442	02/01/2039											
312905-L3-4	FHR 1078 GZ		12/01/2010	MBS PAYMENT		856	856.00	856	856						856				41	08/01/2018											
312907-F6-0	FHR 1175 D		12/01/2010	MBS PAYMENT		2,945	2,945.00	2,965	2,945						2,945				122	11/01/2021											
31290J-HZ-8	FH 553848		08/16/2010	VARIOUS		3,213	3,213.00	3,406	3,213						3,213				135	07/01/2010											
31290K-UJ-6	FH 555085		12/15/2010	VARIOUS		330	330.00	349	331		(1)		(1)		330				24	07/01/2014											
312939-3L-3	FG A91703		12/01/2010	MBS PAYMENT		53,770	53,770.00	55,249	53,770		(100)		(100)		53,770				838	01/01/2040											
312940-4Y-2	FG A92639		12/01/2010	MBS PAYMENT		21,338	21,338.00	22,498	21,338		(32)		(32)		21,338				187	02/01/2040											
31295M-HE-3	FH 788329		12/01/2010	MBS PAYMENT		12	12.00	12	12						12				32	10/01/2019											
31295W-XZ-6	FG A01596		12/01/2010	MBS PAYMENT		5,760	5,760.00	6,365	5,801		(41)		(41)		5,760				381	04/01/2014											
31297P-ZZ-0	FG A34361		12/01/2010	MBS PAYMENT		77,697	77,697.00	78,625	77,781		(85)		(85)		77,697				2,460	03/01/2034											
313401-2C-4	FH 360123		12/15/2010	VARIOUS		1,665	1,665.00	1,782	1,665		(4)		(4)		1,665				116	10/01/2020											
31340L-JH-1	FH 180264		10/15/2010	VARIOUS		442	442.00	469	442						442				22	09/01/2010											
31340M-VV-4	FH 181528		02/16/2010	VARIOUS		203	203.00	215	203						203				5	01/01/2010											
31358F-ZB-8	FNR 1991-6 ZD		12/01/2010	MBS PAYMENT		5,841	5,841.00	6,075	5,851		(9)		(9)		5,841				248	12/01/2020											
313602-NR-1	FNR 1989-14 Z		12/01/2010	MBS PAYMENT		1,957	1,957.00	2,092	1,957		(6)		(6)		1,957				104	03/01/2019											
31364H-GL-5	FNS 66 1		12/01/2010	MBS PAYMENT		610	610.00	607	609						610				32	10/01/2019											
31371K-AA-3	FN 253927		12/01/2010	MBS PAYMENT		24,110	24,110.00	23,954	24,084		26		26		24,110				665	04/01/2030											
31371L-OY-8	FN 255271		12/01/2010	MBS PAYMENT		120,692	120,692.00	120,730	120,692						120,692				3,416	11/01/2023											
31371L-WR-6	FN 255456		12/01/2010	MBS PAYMENT		112,503	112,503.00	115,280	112,747		(245)		(245)		112,503				3,373	03/01/2024											
31386F-F7-5	FN 561890		12/01/2010	MBS PAYMENT		1,718	1,718.00	1,781	1,727		(9)		(9)		1,718				34	07/01/2030											
31386T-6C-4	FN 573367		12/01/2010	MBS PAYMENT		17,541	17,541.00	17,529	17,529		12		12		17,541				438	03/01/2031											
31387C-L4-1	FN 580047		12/01/2010</																												

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

SCHEDULE D - PART 4

Showing all Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change in Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identification	Description	Foreign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consideration	Par Value	Actual Cost	Prior Year Book/Adjusted Carrying Value	Unrealized Valuation Increase/(Decrease)	Current Year (Amortization)/Accretion	Current Year's Other Than Temporary Impairment Recognized	Total Change in B/A. C.V. (11+12-13)	Total Foreign Exchange Change in B/A. C.V.	Book/Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/Stock Dividends Received During Year	Maturity Date
31387D-3T-4	FN 581410		12/01/2010	MBS PAYMENT		11,548.00	11,548.00	11,483.00	11,539.00		10		10		11,548.00				298	08/01/2028
31387E-KT-3	FN 581806		12/01/2010	MBS PAYMENT		3,016.00	3,016.00	3,055.00	3,022.00		(5)		(5)		3,016.00				139	10/01/2030
31387F-ES-9	FN 582545		12/01/2010	MBS PAYMENT		6,749.00	6,749.00	6,713.00	6,744.00		5		5		6,749.00				231	12/01/2029
31387W-3N-5	FN 596705		12/01/2010	MBS PAYMENT		58,046.00	58,046.00	58,019.00	58,040.00		6		6		58,046.00				2,082	02/01/2031
31389D-QR-1	FN 622464		12/01/2010	MBS PAYMENT		1,494.00	1,494.00	1,483.00	1,492.00		1		1		1,494.00				44	06/01/2016
31389F-J6-0	FN 624085		12/01/2010	MBS PAYMENT		1,963.00	1,963.00	1,988.00	1,966.00		(3)		(3)		1,963.00				58	03/01/2031
31389S-TE-4	FN 634249		12/01/2010	MBS PAYMENT		1,417.00	1,417.00	1,400.00	1,416.00		1		1		1,417.00				53	06/01/2031
31389V-RU-3	FN 636899		12/01/2010	MBS PAYMENT		2,258.00	2,258.00	2,261.00	2,259.00						2,258.00				75	07/01/2031
31391E-AP-6	FN 664314		12/01/2010	MBS PAYMENT		44,538.00	44,538.00	45,276.00	44,647.00		(109)		(109)		44,538.00				1,183	03/01/2017
31402F-BX-2	FN 727354		12/01/2010	MBS PAYMENT		96,281.00	96,281.00	96,116.00	96,261.00		20		20		96,281.00				2,631	12/01/2017
31403C-6L-0	FN 745275		12/01/2010	MBS PAYMENT		172,975.00	172,975.00	166,786.00	172,245.00		730		730		172,975.00				5,058	03/01/2035
31403C-6U-0	FN 745283		12/01/2010	MBS PAYMENT		147,916.00	147,916.00	142,686.00	147,348.00		568		568		147,916.00				4,842	02/01/2035
31405E-G3-3	FN 786918		12/01/2010	MBS PAYMENT		55,734.00	55,734.00	57,484.00	55,938.00		(204)		(204)		55,734.00				1,278	05/01/2019
31405V-2E-6	FN 800973		12/01/2010	MBS PAYMENT		124,093.00	124,093.00	126,691.00	124,412.00		(320)		(320)		124,093.00				3,512	03/01/2019
31406L-0D-3	FN 813252		12/01/2010	MBS PAYMENT		138,477.00	138,477.00	141,106.00	138,751.00		(274)		(274)		138,477.00				4,475	07/01/2034
31406P-QM-4	FN 815960		12/01/2010	MBS PAYMENT		103,652.00	103,652.00	104,721.00	103,760.00		(109)		(109)		103,652.00				3,060	06/01/2034
31407A-PZ-8	FN 824940		12/01/2010	MBS PAYMENT		75,293.00	75,293.00	75,693.00	75,319.00		(25)		(25)		75,293.00				2,336	11/01/2034
31407L-ZR-1	FN 834252		12/01/2010	MBS PAYMENT		98,000.00	98,000.00	100,266.00	98,095.00		(95)		(95)		98,000.00				1,681	12/01/2034
31410F-D7-7	FN 887626		12/01/2010	MBS PAYMENT		133,577.00	133,577.00	134,511.00	133,716.00		(139)		(139)		133,577.00				3,887	07/01/2036
314100-QW-4	FN 894269		12/01/2010	MBS PAYMENT		395,865.00	395,865.00	394,380.00	395,483.00		382		382		395,865.00				10,311	10/01/2036
314105-YK-7	FN 896314		12/01/2010	MBS PAYMENT		139,076.00	139,076.00	136,577.00	138,873.00		203		203		139,076.00				4,104	07/01/2035
31410T-L7-8	FN 896850		12/01/2010	MBS PAYMENT		79,383.00	79,383.00	79,861.00	79,380.00		3		3		79,383.00				2,618	08/01/2021
31411D-SB-6	FN 905114		12/01/2010	MBS PAYMENT		186,865.00	186,865.00	187,843.00	186,917.00		(52)		(52)		186,865.00				6,159	06/01/2036
31411J-TX-4	FN 909666		12/01/2010	MBS PAYMENT		166,374.00	166,374.00	166,541.00	166,153.00		220		220		166,374.00				5,842	09/01/2036
31411L-YN-5	FN 911617		12/01/2010	MBS PAYMENT		108,703.00	108,703.00	109,026.00	108,721.00		(17)		(17)		108,703.00				3,246	11/01/2036
31413F-GL-0	FN 944003		12/01/2010	MBS PAYMENT		182,729.00	182,729.00	181,530.00	182,592.00		137		137		182,729.00				5,653	02/01/2037
438701-NR-1	HONOLULU HAWAII CITY & CNTY		06/17/2010	CITIGROUP GLOBAL MARKETS		1,111,120.00	1,000,000.00	1,104,720.00	1,102,373.00		(4,316)		(4,316)		1,098,057.00		13,063.00	13,063.00	36,527.00	07/01/2020
454898-HT-7	INDIANA MUN PWR AGY PWR SUPPLY		06/17/2010	EMO CAPITAL MARKETS - US		513,580.00	500,000.00	524,103.00	524,103.00		(11,416)		(11,416)		512,686.00		894.00	894.00	29,250.00	01/01/2011
455167-T6-3	INDIANA UNIV REVS		06/17/2010	CABRERA CAPITAL MARKETS		1,117,920.00	1,000,000.00	1,102,070.00	1,100,181.00		(4,885)		(4,885)		1,095,295.00		22,625.00	22,625.00	27,917.00	06/01/2020
45528S-3W-4	INDIANAPOLIS IND LOC PUB IMPT		06/17/2010	COMPANY		555,275.00	500,000.00	552,510.00	550,940.00		(2,272)		(2,272)		548,668.00		6,607.00	6,607.00	20,139.00	02/01/2020
48944E-CG-0	KEWNER LA SALES TAX REV		06/01/2010	MATURITY		1,000,000.00	1,000,000.00	1,007,880.00	1,001,572.00		(1,572)		(1,572)		1,000,000.00				15,000.00	06/01/2010
650028-NZ-2	NEW YORK ST TWY AUTH ST PERS		06/21/2010	STONE & YOUNGBERG		1,136,350.00	1,000,000.00	1,095,050.00	1,083,904.00		(4,233)		(4,233)		1,079,671.00		56,679.00	56,679.00	38,750.00	03/15/2018
663507-AW-1	NORTHAMPTON CNTY PA GEN PURP		06/22/2010	COMPANY		1,112,910.00	1,000,000.00	1,220,870.00	1,072,047.00		(12,244)		(12,244)		1,059,804.00		53,106.00	53,106.00	42,167.00	10/01/2012
708792-S2-3	PENNSYLVANIA HSG FIN AGY		10/01/2010	MATURITY		1,000,000.00	1,000,000.00	1,004,000.00	1,000,413.00		(413)		(413)		1,000,000.00				45,500.00	10/01/2010
708792-S4-9	PENNSYLVANIA HSG FIN AGY		02/08/2010	100 000		1,000,000.00	1,000,000.00	1,003,940.00	1,000,864.00		(864)		(864)		1,000,000.00				16,404.00	10/01/2011
709223-PV-1	PENNSYLVANIA ST TPK COMMN TPK		12/01/2010	MATURITY		2,015,000.00	2,015,000.00	2,265,261.00	2,054,213.00		(39,213)		(39,213)		2,015,000.00				110,825.00	12/01/2010
956704-VC-1	WEST VIRGINIA UNIV REVS		06/21/2010	MORGAN STANLEY		1,052,420.00	1,000,000.00	1,051,600.00	1,050,770.00		(4,704)		(4,704)		1,046,065.00		6,355.00	6,355.00	36,528.00	10/01/2023
3199999	Bonds - U.S. Special Revenue and Special Assessment and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions					16,225,754.00	15,481,039.00	16,503,137.00	15,967,065.00		(91,745)		(91,745)		16,002,088.00		223,666.00	223,666.00	571,674.00	XXX
Bonds - Industrial and Miscellaneous (Unaffiliated)																				
02580H-AC-0	AMERICAN EXPRESS BK FSB		06/18/2010	MORGAN STANLEY		1,035,633.00	1,000,000.00	1,041,950.00	1,038,619.00		(9,438)		(9,438)		1,029,181.00		6,452.00	6,452.00	16,975.00	12/09/2011
17313V-AC-5	CITIGROUP FUNDING INC		06/18/2010	BARCLAYS AMERICAN		2,015,320.00	2,000,000.00	1,996,560.00	1,997,542.00		821		821		1,998,362.00		16,958.00	16,958.00	13,889.00	06/03/2011
24424D-AA-7	JOHN DEERE CAPITAL CORP		06/21/2010	MORGAN STANLEY		1,038,983.00	1,000,000.00	1,033,750.00	1,030,027.00		(5,756)		(5,756)		1,024,272.00		14,711.00	14,711.00	14,774.00	06/19/2012
291011-AR-5	EMERSON ELECTRIC CO		06/18/2010	BANK AMERICA		536,580.00	500,000.00	539,465.00	537,847.00		(6,347)		(6,347)		531,500.00		5,080.00	5,080.00	15,931.00	10/15/2012
36158V-CK-3	CEMCO 2001-2 A4		12/01/2010	MBS PAYMENT		8,313.00	8,313.00	8,460.00	8,325.00		(12)		(12)		8,313.00				376	07/01/2011
36967H-AD-9	GENERAL ELEC CAP CORP		06/18/2010	MORGAN STANLEY		1,033,486.00	1,000,000.00	1,036,978.00	1,031,899.00		(7,785)		(7,785)		1,024,115.00		9,371.00	9,371.00	16,167.00	12/09/2011
406216-AR-2	HALLIBURTON COMPANY		10/15/2010	MATURITY		1,000,000.00	1,000,000.00	1,029,510.00	1,010,396.00		(10,396)		(10,396)		1,000,000.00				55,000.00	10/15/2010
481247-AA-2	JPMORGAN CHASE & CO		06/23/2010	MORGAN STANLEY		1,034,842.00	1,000,000.00	1,004,970.00	1,003,237.00		(813)		(813)		1,002,424.00		32,418.00	32,418.00	17,969.00	12/01/2011
481247-AE-4	JPMORGAN CHASE & CO		06/21/2010	MORGAN STANLEY		1,024,352.00	1,000,000.00	1,012,073.00	1,010,911.00		(2,083)		(2,083)		1,008,828.00		15,524.00	15,524.00	10,743.00	06/22/2012
61757U-AH-3	MORGAN STANLEY		06/21/2010	MORGAN STANLEY		1,020,842.00	1,000,000.00	1,011,920.00	1,011,141.00		(2,136)		(2,136)		1,009,005.00		11,837.00	11,837.00	9,967.00	06/20/2012
69351C-AC-7	PNC FUNDING CORP		06/21/2010	MORGAN STANLEY		1,027,804.00	1,000,000.00	1,018,096.00	1,016,110.00		(3,077)		(3,077)		1,013,033.00		14,771.00	14,771.00	11,	



**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE D - PART 5**

Showing all Long-Term Bonds and Stocks **ACQUIRED** During Year and Fully **DISPOSED OF** During Current Year

1 CUSIP Identification	2 Description	3 Foreign Date Acquired	4 Name of Vendor	5 Disposal Date	6 Name of Purchaser	7 Par Value (Bonds) or Number of Shares (Stocks)	8 Actual Cost	9 Consideration	10 Book/ Adjusted Carrying Value at Disposal	11 Change in Book/Adjusted Carrying Value					17 Foreign Exchange Gain (Loss) on Disposal	18 Realized Gain (Loss) on Disposal	19 Total Gain (Loss) on Disposal	20 Interest and Dividends Received During Year	21 Paid for Accrued Interest and Dividends																		
										12 Unrealized Valuation Increase/ (Decrease)	13 Current Year's (Amortization)/ Accretion	14 Current Year's Other Than Temporary Impairment Recognized	15 Total Change In B./A. C.V. (12 + 13 - 14)	16 Total Foreign Exchange Change in B./A. C.V.																							
Bonds - U.S. Governments																																					
Bonds - All Other Governments																																					
Bonds - U.S. States, Territories and Possessions (Direct and Guaranteed)																																					
Bonds - U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)																																					
447819-BR-3	HURST EULESS BEDFORD TEX INDPT	01/15/2010	MORGAN KEEGAN & CO INC	06/17/2010	CABRERA CAPITAL MARKETS	500,000	556,485	556,025	555,037		(1,448)		(1,448)		988	988	10,903	2,639																			
2499999	Bonds - U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed)					500,000	556,485	556,025	555,037		(1,448)		(1,448)		988	988	10,903	2,639																			
Bonds - U.S. Special Revenue and Special Assessment and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions																																					
161036-GZ-5	CHARLOTTE N C ARPT REV	01/13/2010	MERRILL LYNCH	06/17/2010	BMO CAPITAL MARKETS - US	750,000	743,535	767,115	743,655		120		120		23,460	23,460	13,750																				
546589-QQ-8	LOUISVILLE & JEFFERSON CNTY KY	01/26/2010	MERRILL LYNCH	06/17/2010	STONE & YOUNGBERG	500,000	553,270	562,345	551,362		(1,908)		(1,908)		10,983	10,983	15,069	5,139																			
594700-BG-0	MICHIGAN ST TRUNK LINE FD	01/20/2010	CO	06/18/2010	CABRERA CAPITAL MARKETS	500,000	568,585	573,280	566,204		(2,381)		(2,381)		7,076	7,076	17,722	6,417																			
646080-KT-7	NEW JERSEY ST HIGHER ED ASSIST	01/14/2010	MERRILL LYNCH	06/18/2010	UBS SECURITIES	500,000	529,125	538,000	528,123		(1,002)		(1,002)		9,877	9,877	10,719																				
64971M-ZT-2	NEW YORK N Y CITY TRANSITIONAL	01/15/2010	J.P. MORGAN	06/21/2010	PIPER JAFFREY & CO	500,000	555,965	558,485	554,071		(1,894)		(1,894)		4,414	4,414	10,278																				
67766W-GW-6	OHIO ST WTR DEV AUTH WTR	05/11/2010	COMPANY	06/21/2010	GOLDMAN SACHS	500,000	594,585	590,805	593,747		(838)		(838)		(2,942)	(2,942)	14,802	11,885																			
796253-U8-3	SAN ANTONIO TEX ELEC & GAS	01/20/2010	JEFFERIES & CO	05/28/2010	EXCHANGE	1,000,000	1,116,760	1,112,962	1,112,962		(3,798)		(3,798)				41,389	24,306																			
796253-X9-8	SAN ANTONIO TEX ELEC & GAS	05/28/2010	EXCHANGE	06/21/2010	VARIOUS	180,000	200,333	203,497	200,279		(54)		(54)		3,219	3,219	3,250	2,925																			
796253-Y2-2	SAN ANTONIO TEX ELEC & GAS	05/28/2010	EXCHANGE	06/21/2010	RAMIREZ & CO	910,000	1,012,795	1,014,468	1,012,245		(550)		(550)		2,223	2,223	18,074	14,788																			
3199999	Bonds - U.S. Special Revenue and Special Assessment and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions					5,340,000	5,874,953	5,920,957	5,862,647		(12,306)		(12,306)		58,310	58,310	145,053	65,459																			
Bonds - Industrial and Miscellaneous (Unaffiliated)																																					
06050B-AG-6	BANK OF AMERICA CORP	01/20/2010	MORGAN STANLEY	06/18/2010	MORGAN STANLEY	1,000,000	1,018,495	1,022,916	1,015,107		(3,388)		(3,388)		7,809	7,809	13,592	4,725																			
17314J-AT-0	CITIBANK NA	01/20/2010	BANK AMERICA	06/21/2010	MORGAN STANLEY	2,000,000	2,002,018	2,029,796	2,001,776		(242)		(242)		28,020	28,020	23,042	8,167																			
209111-ET-6	CONS EDISON CO OF NY	05/12/2010	JEFFERIES & CO	06/18/2010	KEYBANC CAPITAL MARKETS	500,000	560,980	564,045	560,323		(657)		(657)		3,722	3,722	6,663	3,738																			
36967H-AH-0	GENERAL ELEC CAP CORP	01/20/2010	MORGAN STANLEY	06/18/2010	MORGAN STANLEY	2,000,000	2,041,466	2,050,178	2,034,214		(7,252)		(7,252)		15,964	15,964	23,833	5,256																			
373334-JQ-5	GEORGIA POWER COMPANY	03/09/2010	BARCLAYS AMERICAN	06/18/2010	JEFFERIES & CO	250,000	250,000	249,855	250,000						(145)	(145)		412																			
89233P-4B-9	TOYOTA MOTOR CREDIT CORP	06/14/2010	BANK AMERICA	06/18/2010	BNY MELLON CAPITAL MARKETS	350,000	349,566	353,315	349,567		1		1		3,747	3,747		187																			
3899999	Bonds - Industrial and Miscellaneous (Unaffiliated)					6,100,000	6,222,525	6,270,105	6,210,987		(11,539)		(11,539)		59,118	59,118	67,728	21,885																			
Bonds - Credit Tenant Loans																																					
Bonds - Hybrid Securities																																					
Bonds - Parent, Subsidiaries, and Affiliates																																					
8399998	Subtotals - Bonds					11,940,000	12,653,963	12,747,087	12,628,671		(25,292)		(25,292)		118,416	118,416	223,684	89,983																			
Preferred Stocks - Industrial and Miscellaneous (Unaffiliated)																																					
Preferred Stocks - Parent, Subsidiaries, and Affiliates (Unaffiliated)																																					
Common Stocks - Industrial and Miscellaneous (Unaffiliated)																																					
Common Stocks - Parent, Subsidiaries, and Affiliates																																					
Common Stocks - Mutual Funds																																					
Common Stocks - Money Market Mutual Funds																																					
9999999	Totals						12,653,963	12,747,087	12,628,671		(25,292)		(25,292)		118,416	118,416	223,684	89,983																			

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**SCHEDULE D - PART 6 - SECTION 1**

Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

1 CUSIP Identification	2 Description Name of Subsidiary, Controlled or Affiliated Company	3 Foreign	4 NAIC Company Code or Alien Insurer Identification Number	5 NAIC Valuation Method (See SVO Purposes and Procedures Manual)	6 Do Insurer's Assets Include Intangible Assets Connected with Holding of Such Company's Stock?	7 Total Amount of Such Intangible Assets	8 Book / Adjusted Carrying Value	Stock of Such Company Owned by Insurer on Statement Date	
								9 Number of Shares	10 % of Outstanding
NONE									
1999999 Totals								XXX	XXX

1. Amount of insurer's capital and surplus from the prior period's statutory statement reduced by any admitted EDP, goodwill and net deferred tax assets included therein: \$ .....
2. Total amount of intangible assets nonadmitted: \$ .....

**SCHEDULE D - PART 6 - SECTION 2**

1 CUSIP Identification	2 Name of Lower-Tier Company	3 Name of Company Listed in Section 1 Which Controls Lower-Tier Company	4 Total Amount of Intangible Assets Included in Amount Shown in Column 7, Section 1	Stock in Lower-Tier Company Owned Indirectly by Insurer on Statement Date	
				5 Number of Shares	6 % of Outstanding
NONE					
0399999 Total				XXX	XXX

**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE DA - PART 1**

Showing all **SHORT-TERM INVESTMENTS** Owned December 31 of Current Year

1	2	Codes		5	6	7	8	Change In Book/Adjusted Carrying Value				13	14	Interest					21	
		3	4					9	10	11	12			15	16	17	18	19		20
CUSIP Identification	Description	Code	Foreign Date Acquired	Name of Vendor	Maturity Date	Book/Adjusted Carrying Value	Unrealized Valuation Increase/(Decrease)	Current Year's (Amortization) / Accretion	Current Year's Other Than Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Par Value	Actual Cost	Amount Due And Accrued Dec. 31 of Current Year On Bond Not In Default	Non-Admitted Due and Accrued	Rate of	Effective Rate of	When Paid	Amount Received During Year	Paid for Accrued Interest	
Bonds: U.S. Governments Issuer Obligations																				
Bonds: U.S. Governments Single Class Mortgage-Backed/Asset-Backed Securities																				
Bonds: All Other Governments - Issuer Obligations																				
Bonds: All Other Governments - Single Class Mortgage-Backed/Asset-Backed Securities																				
Bonds: All Other Governments - Defined Multi-Class Residential Mortgage-Backed Securities																				
Bonds: All Other Governments - Other Multi-Class Residential Mortgage-Backed Securities																				
Bonds: All Other Governments - Defined Multi-Class Commercial Mortgage-Backed Securities																				
Bonds: All Other Governments - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities																				
Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Issuer Obligations																				
Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Single Class Mortgage-Backed/Asset-Backed Securities																				
Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Residential Mortgage-Backed Securities																				
Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Residential Mortgage-Backed Securities																				
Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Commercial Mortgage-Backed Securities																				
Bonds: U.S. States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities																				
Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Issuer Obligations																				
Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Single Class Mortgage-Backed/Asset-Backed Securities																				
Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Residential Mortgage-Backed Securities																				
Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Residential Mortgage-Backed Securities																				
Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Commercial Mortgage-Backed Securities																				
Bonds: U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities																				
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Issuer Obligations																				
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Single Class Mortgage-Backed/Asset-Backed Securities																				
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Defined Multi-Class Residential Mortgage-Backed Securities																				
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Other Multi-Class Residential Mortgage-Backed Securities																				
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Defined Multi-Class Commercial Mortgage-Backed Securities																				
Bonds: U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities																				
Bonds: Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations																				
Bonds: Industrial and Miscellaneous (Unaffiliated) - Single Class Mortgage-Backed/Asset-Backed Securities																				
Bonds: Industrial and Miscellaneous (Unaffiliated) - Defined Multi-Class Residential Mortgage-Backed Securities																				
Bonds: Industrial and Miscellaneous (Unaffiliated) - Other Multi-Class Residential Mortgage-Backed Securities																				
Bonds: Industrial and Miscellaneous (Unaffiliated) - Defined Multi-Class Commercial Mortgage-Backed Securities																				
Bonds: Industrial and Miscellaneous (Unaffiliated) - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities																				
Bonds: Credit Tenant Loans - Issuer Obligations																				
Bonds: Credit Tenant Loans - Single Class Mortgage-Backed Securities																				
Bonds: Hybrid Securities - Issuer Obligations																				
Bonds: Hybrid Securities - Single Class Mortgage-Backed/Asset-Backed Securities																				
Bonds: Hybrid Securities - Defined Multi-Class Residential Mortgage-Backed Securities																				
Bonds: Hybrid Securities - Other Multi-Class Residential Mortgage-Backed Securities																				
Bonds: Hybrid Securities - Defined Multi-Class Commercial Mortgage-Backed Securities																				
Bonds: Hybrid Securities - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities																				
Bonds: Parent, Subsidiaries and Affiliates Bonds - Issuer Obligations																				
Bonds: Parent, Subsidiaries and Affiliates Bonds - Single Class Mortgage-Backed/Asset-Backed Securities																				
Bonds: Parent, Subsidiaries and Affiliates Bonds - Defined Multi-Class Residential Mortgage-Backed Securities																				
Bonds: Parent, Subsidiaries and Affiliates Bonds - Other Multi-Class Residential Mortgage-Backed Securities																				
Bonds: Parent, Subsidiaries and Affiliates Bonds - Defined Multi-Class Commercial Mortgage-Backed Securities																				
Bonds: Parent, Subsidiaries and Affiliates Bonds - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities																				
Parent, Subsidiaries and Affiliates - Mortgage Loans																				
Parent, Subsidiaries and Affiliates - Other Short-Term Invested Assets																				
Mortgage Loans																				
Exempt Money Market Mutual Funds																				
Class One Money Market Mutual Funds																				
524706-30-4	WESTERN AST INS CSH RES-INS		12/30/2010	DIRECT		35,120,360						35,120,360	9,207		0.230	0.230	MAT			
	8999999 - Class One Money Market Mutual Funds					35,120,360					xxx	35,120,360	9,207		xxx	xxx	xxx			
Other Short-Term Invested Assets																				
<b>9199999 TOTALS</b>						<b>35,120,360</b>					<b>xxx</b>	<b>35,120,360</b>	<b>9,207</b>		<b>xxx</b>	<b>xxx</b>	<b>xxx</b>			

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Schedule DB - Part A - Section 1

**NONE**

Schedule DB - Part A - Section 2

**NONE**

Schedule DB - Part B - Section 1

**NONE**

Schedule DB - Part B - Section 2

**NONE**

Schedule DB - Part D

**NONE**

Schedule DL - Part 1

**NONE**

Schedule DL - Part 2

**NONE**



ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.

**SCHEDULE E - PART 2 - CASH EQUIVALENTS**

Show Investments Owned December 31 of Current Year

1 Description	2 Code	3 Date Acquired	4 Rate of Interest	5 Maturity Date	6 Book/Adjusted Carrying Value	7 Amount of Interest Due & Accrued	8 Amount Received During Year
U.S. Governments Issuer Obligations							
U.S. Governments Single Class Mortgage-Backed/Asset-Backed Securities							
All Other Governments - Issuer Obligations							
All Other Governments - Single Class Mortgage-Backed/Asset-Backed Securities							
All Other Governments - Defined Multi-Class Residential Mortgage-Backed Securities							
All Other Governments - Other Multi-Class Residential Mortgage-Backed Securities							
All Other Governments - Defined Multi-Class Commercial Mortgage-Backed Securities							
All Other Governments - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities							
U.S. States, Territories and Possessions (Direct and Guaranteed) - Issuer Obligations							
U.S. States, Territories and Possessions (Direct and Guaranteed) - Single Class Mortgage-Backed/Asset-Backed Securities							
U.S. States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Residential Mortgage-Backed Securities							
U.S. States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Residential Mortgage-Backed Securities							
U.S. States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Commercial Mortgage-Backed Securities							
U.S. States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities							
U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Issuer Obligations							
U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Single Class Mortgage-Backed/Asset-Backed Securities							
U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Residential Mortgage-Backed/Asset-Backed Securities							
U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Residential Mortgage-Backed Securities							
U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Defined Multi-Class Commercial Mortgage-Backed Securities							
U.S. Political Subdivisions of States, Territories and Possessions (Direct and Guaranteed) - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities							
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Issuer Obligations							
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Single Class Mortgage-Backed/Asset-Backed Securities							
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Defined Multi-Class Residential Mortgage-Backed Securities							
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Other Multi-Class Residential Mortgage-Backed Securities							
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Defined Multi-Class Commercial Mortgage-Backed Securities							
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities							
Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations							
WELLS FARGO ADV HER MMKT-SER.....		12/30/2010.....	0.010.....	02/15/2011.....	76,224.....		2
CITI DCCC U 92 MONEY MARKET.....		12/30/2010.....	0.052.....	01/15/2011.....	7,943,105.....	376.....	
3299999 - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations					8,019,328.....	376.....	2
Industrial and Miscellaneous (Unaffiliated) - Single Class Mortgage-Backed/Asset-Backed Securities							
Industrial and Miscellaneous (Unaffiliated) - Defined Multi-Class Residential Mortgage-Backed Securities							
Industrial and Miscellaneous (Unaffiliated) - Other Multi-Class Residential Mortgage-Backed Securities							
Industrial and Miscellaneous (Unaffiliated) - Defined Multi-Class Commercial Mortgage-Backed Securities							
Industrial and Miscellaneous (Unaffiliated) - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities							
3899999 - Subtotals - Industrial and Miscellaneous (Unaffiliated)					8,019,328.....	376.....	2
Credit Tenant Loans - Issuer Obligations							
Credit Tenant Loans Single Class Mortgage-Backed Securities							
Hybrid Securities - Issuer Obligations							
Hybrid Securities - Single Class Mortgage-Backed/Asset-Backed Securities							
Hybrid Securities - Defined Multi-Class Residential Mortgage-Backed Securities							
Hybrid Securities - Other Multi-Class Residential Mortgage-Backed Securities							
Hybrid Securities - Defined Multi-Class Commercial Mortgage-Backed Securities							
Hybrid Securities - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities							
Parent, Subsidiaries and Affiliates Bonds - Issuer Obligations							
Parent, Subsidiaries and Affiliates Bonds - Single Class Mortgage-Backed/Asset-Backed Securities							
Parent, Subsidiaries and Affiliates Bonds - Defined Multi-Class Residential Mortgage-Backed Securities							
Parent, Subsidiaries and Affiliates Bonds - Other Multi-Class Residential Mortgage-Backed Securities							
Parent, Subsidiaries and Affiliates Bonds - Defined Multi-Class Commercial Mortgage-Backed Securities							
Parent, Subsidiaries and Affiliates Bonds - Other Multi-Class Commercial Mortgage-Backed/Asset-Backed Securities							
7799999 - Subtotals - Issuer Obligations					8,019,328.....	376.....	2
8399999 - Subtotals - Bonds					8,019,328.....	376.....	2
Sweep Accounts							
Other Cash Equivalents							
8699999 Total Cash Equivalents					8,019,328.....	376.....	2

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**ANNUAL STATEMENT FOR THE YEAR 2010 OF THE HealthAmerica Pennsylvania, Inc.**

**SCHEDULE E PART 3 - SPECIAL DEPOSITS**

States, etc.	1 Type of Deposits	2 Purpose of Deposits	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
			3 Book/Adjusted Carrying Value	4 Fair Value	5 Book/Adjusted Carrying Value	6 Fair Value
1. Alabama	AL					
2. Alaska	AK					
3. Arizona	AZ					
4. Arkansas	AR					
5. California	CA					
6. Colorado	CO					
7. Connecticut	CT					
8. Delaware	DE					
9. District of Columbia	DC					
10. Florida	FL					
11. Georgia	GA					
12. Hawaii	HI					
13. Idaho	ID					
14. Illinois	IL					
15. Indiana	IN					
16. Iowa	IA					
17. Kansas	KS					
18. Kentucky	KY					
19. Louisiana	LA					
20. Maine	ME					
21. Maryland	MD					
22. Massachusetts	MA					
23. Michigan	MI					
24. Minnesota	MN					
25. Mississippi	MS					
26. Missouri	MO					
27. Montana	MT					
28. Nebraska	NE					
29. Nevada	NV					
30. New Hampshire	NH					
31. New Jersey	NJ					
32. New Mexico	NM					
33. New York	NY					
34. North Carolina	NC					
35. North Dakota	ND					
36. Ohio	OH	B	HMO Statutory Deposit		400,208	401,844
37. Oklahoma	OK					
38. Oregon	OR					
39. Pennsylvania	PA	B	HMO Statutory Deposit		102,121	102,514
40. Rhode Island	RI					
41. South Carolina	SC					
42. South Dakota	SD					
43. Tennessee	TN					
44. Texas	TX					
45. Utah	UT					
46. Vermont	VT					
47. Virginia	VA					
48. Washington	WA					
49. West Virginia	WV					
50. Wisconsin	WI					
51. Wyoming	WY					
52. American Samoa	AS					
53. Guam	GU					
54. Puerto Rico	PR					
55. US Virgin Islands	VI					
56. Northern Mariana Islands	MP					
57. Canada	CN					
58. Aggregate Other Alien	OT	XXX	XXX			
59. Total	XXX	XXX			502,328	504,358
<b>DETAILS OF WRITE-INS</b>						
5801.						
5802.						
5803.						
5898. Sum of remaining write-ins for Line 58 from overflow page	XXX	XXX				
5899. Totals (Lines 5801 - 5803 + 5898) (Line 58 above)	XXX	XXX				

**INTENTIONALLY LEFT BLANK**

# COVENTRY HEALTH CARE INC (CVH)

## 10-Q

Quarterly report pursuant to sections 13 or 15(d)

Filed on 11/04/2011

Filed Period 09/30/2011

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UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
Washington, D. C. 20549  
FORM 10-Q

QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d)  
OF THE SECURITIES EXCHANGE ACT OF 1934  
For the quarterly period September 30, 2011

OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d)  
OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from \_\_\_\_\_ to \_\_\_\_\_

COMMISSION FILE NUMBER 1-16477



**COVENTRY HEALTH CARE, INC.**  
(Exact name of registrant as specified in its charter)

**Delaware**  
(State or other jurisdiction of incorporation or organization)

**52-2073000**  
(I.R.S. Employer Identification Number)

**6705 Rockledge Drive, Suite 900, Bethesda, Maryland 20817**  
(Address of principal executive offices) (Zip Code)

Registrant's telephone number, including area code: **(301) 581-0600**

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes  No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes  No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer," and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer  Accelerated filer   
Non-accelerated filer  (Do not check if a smaller reporting company) Smaller reporting company

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes  No

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date.

<u>Class</u>	<u>Outstanding at October 31, 2011</u>
Common Stock \$.01 Par Value	144,277,685

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COVENTRY HEALTH CARE, INC.  
FORM 10-Q  
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**PART I. FINANCIAL INFORMATION**

ITEM 1: Financial Statements

<a href="#">Consolidated Balance Sheets at September 30, 2011 and December 31, 2010</a>	3
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**PART I. FINANCIAL INFORMATION****ITEM 1: Financial Statements****COVENTRY HEALTH CARE, INC. AND SUBSIDIARIES  
CONSOLIDATED BALANCE SHEETS  
(in thousands)**

	<b>September 30, 2011</b>	<b>December 31, 2010</b>
	(unaudited)	
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents	\$ 1,986,323	\$ 1,853,988
Short-term investments	222,631	16,849
Accounts receivable, net	257,720	276,694
Other receivables, net	496,631	515,882
Other current assets	262,903	371,528
Total current assets	<u>3,226,208</u>	<u>3,034,941</u>
Long-term investments	2,553,792	2,184,606
Property and equipment, net	262,432	262,282
Goodwill	2,559,605	2,550,570
Other intangible assets, net	383,582	431,886
Other long-term assets	38,277	31,300
Total assets	<u>\$ 9,023,896</u>	<u>\$ 8,495,585</u>
<b>LIABILITIES AND STOCKHOLDERS' EQUITY</b>		
Current liabilities:		
Medical liabilities	\$ 1,224,216	\$ 1,237,690
Accounts payable and other accrued liabilities	637,245	942,226
Deferred revenue	398,756	103,082
Current portion of long-term debt	233,903	-
Total current liabilities	<u>2,494,120</u>	<u>2,282,998</u>
Long-term debt	1,584,578	1,599,396
Other long-term liabilities	432,603	414,025
Total liabilities	<u>4,511,301</u>	<u>4,296,419</u>
Stockholders' equity:		
Common stock, \$.01 par value; 570,000 authorized 193,332 issued and 144,290 outstanding in 2011 191,512 issued and 149,427 outstanding in 2010	1,933	1,915
Treasury stock, at cost; 49,042 in 2011; 42,085 in 2010	(1,482,034)	(1,268,456)
Additional paid-in capital	1,840,845	1,784,826
Accumulated other comprehensive income, net	54,641	41,081
Retained earnings	4,097,210	3,639,800
Total stockholders' equity	<u>4,512,595</u>	<u>4,199,166</u>
Total liabilities and stockholders' equity	<u>\$ 9,023,896</u>	<u>\$ 8,495,585</u>

See accompanying notes to the condensed consolidated financial statements.

**COVENTRY HEALTH CARE, INC. AND SUBSIDIARIES**  
**CONSOLIDATED STATEMENTS OF OPERATIONS**  
(in thousands, except per share data)  
(unaudited)

	<b>Quarters Ended September 30,</b>		<b>Nine Months Ended September 30,</b>	
	<b>2011</b>	<b>2010</b>	<b>2011</b>	<b>2010</b>
<b>Operating revenues:</b>				
Managed care premiums	\$ 2,680,044	\$ 2,543,180	\$ 8,172,974	\$ 7,684,263
Management services	295,499	292,601	884,553	878,637
<b>Total operating revenues</b>	<b>2,975,543</b>	<b>2,835,781</b>	<b>9,057,527</b>	<b>8,562,900</b>
<b>Operating expenses:</b>				
Medical costs	2,185,568	1,963,016	6,709,521	6,109,914
Cost of sales	71,511	64,638	209,603	187,900
Selling, general and administrative	492,855	481,345	1,476,325	1,430,505
Provider class action	-	-	(159,300)	278,000
Depreciation and amortization	32,996	34,839	102,191	104,342
<b>Total operating expenses</b>	<b>2,782,930</b>	<b>2,543,838</b>	<b>8,338,340</b>	<b>8,110,661</b>
<b>Operating earnings</b>	<b>192,613</b>	<b>291,943</b>	<b>719,187</b>	<b>452,239</b>
Interest expense	28,227	20,388	70,844	60,713
Other income, net	22,913	20,667	66,201	59,162
<b>Earnings before income taxes</b>	<b>187,299</b>	<b>292,222</b>	<b>714,544</b>	<b>450,688</b>
Provision for income taxes	64,618	102,277	257,135	162,398
<b>Net earnings</b>	<b>\$ 122,681</b>	<b>\$ 189,945</b>	<b>\$ 457,409</b>	<b>\$ 288,290</b>
<b>Net earnings per share:</b>				
Basic earnings per share	\$ 0.85	\$ 1.30	\$ 3.13	\$ 1.98
Diluted earnings per share	\$ 0.84	\$ 1.29	\$ 3.09	\$ 1.96
<b>Weighted average common shares outstanding:</b>				
Basic	144,415	146,167	145,982	145,965
Effect of dilutive options and restricted stock	1,871	1,127	2,066	1,328
Diluted	146,286	147,294	148,048	147,293

**See accompanying notes to the condensed consolidated financial statements.**

**COVENTRY HEALTH CARE, INC. AND SUBSIDIARIES**  
**CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS**  
(in thousands)  
(unaudited)

	<b><u>Nine Months Ended September 30,</u></b>	
	<b><u>2011</u></b>	<b><u>2010</u></b>
Cash flows from operating activities:		
Net earnings	\$ 457,409	\$ 288,290
Adjustments to earnings:		
Depreciation and amortization	102,191	104,342
Amortization of stock compensation	29,964	31,145
Provider class action – (release) / charge	(159,300)	278,000
Provider class action – deferred tax adjustment	58,145	(103,385)
Changes in assets and liabilities:		
Provider class action – settlement	(150,500)	-
Accounts receivable, net	19,830	(12,641)
Other receivables	20,301	78,649
Medical liabilities	(16,019)	(402,903)
Accounts payable and other accrued liabilities	5,187	(59,634)
Deferred revenue	295,756	6,452
Other operating activities	7,776	12,930
Net cash from operating activities	<u>670,740</u>	<u>221,245</u>
Cash flows from investing activities:		
Capital expenditures, net	(53,895)	(41,380)
Proceeds from sales of investments	1,224,255	481,013
Proceeds from maturities of investments	196,554	515,838
Purchases of investments	(1,951,376)	(735,815)
Payments for acquisitions, net of cash acquired	(4,116)	(70,797)
Net cash from investing activities	<u>(588,578)</u>	<u>148,859</u>
Cash flows from financing activities:		
Proceeds from issuance of stock	42,091	1,432
Payments for repurchase of stock	(209,605)	(4,495)
Proceeds from issuance of debt, net	589,867	-
Repayment of debt	(380,029)	-
Excess tax benefit from stock compensation	7,849	992
Net cash from financing activities	<u>50,173</u>	<u>(2,071)</u>
Net change in cash and cash equivalents	132,335	368,033
Cash and cash equivalents at beginning of period	<u>1,853,988</u>	<u>1,418,554</u>
Cash and cash equivalents at end of period	<u>\$ 1,986,323</u>	<u>\$ 1,786,587</u>

See accompanying notes to the condensed consolidated financial statements.

**COVENTRY HEALTH CARE, INC. AND SUBSIDIARIES**  
**NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS**  
**(unaudited)**

**A. BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES**

**Basis of Presentation**

The condensed consolidated financial statements of Coventry Health Care, Inc. and its subsidiaries (“Coventry” or the “Company”) contained in this report are unaudited but reflect all normal recurring adjustments which, in the opinion of management, are necessary for the fair presentation of the results of the interim periods reflected. Certain information and footnote disclosures normally included in the consolidated financial statements prepared in accordance with accounting principles generally accepted in the United States of America (“GAAP”) have been omitted pursuant to applicable rules and regulations of the Securities and Exchange Commission (“SEC”). Therefore, it is suggested that these condensed consolidated financial statements be read in conjunction with the consolidated financial statements and notes thereto included in the Company’s Annual Report on Form 10-K for the year ended December 31, 2010. The results of operations for the interim periods reported herein are not necessarily indicative of results to be expected for the full year. The year-end balance sheet data included in this report was derived from audited financial statements.

**Significant Accounting Policies**

Beginning January 1, 2011, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, “PPACA”), mandates minimum medical loss ratios for health plans such that the percentage of health coverage premium revenue spent on health care medical costs and other allowable administrative expenses, including quality improvement and taxes, as defined by PPACA, equals or exceeds such minimum medical loss ratios with rebates to policyholders if the actual loss ratios fall below these minimums.

The Company has a detailed projection process to estimate full year medical loss ratio results. Based on these current full year estimates, the Company has accrued a liability for a proportional amount of the projected annual estimate in the current quarter. These projections will be updated every quarter with resulting changes in accrued liabilities recorded on a pro rata year-to-date basis. The potential rebate liabilities are recorded in the “accounts payable and other accrued liabilities” line in the accompanying balance sheets and as contra-revenue in “managed care premiums” in the accompanying statements of operations.

**B. NEW ACCOUNTING STANDARDS**

In January 2010, the Financial Accounting Standards Board (“FASB”) issued Accounting Standards Update (“ASU”) 2010-06, “Improving Disclosures about Fair Value Measurements.” ASU 2010-06 requires, among other things, the separate presentation (gross basis) of information about purchases, sales, issuances, and settlements of financial instruments in the roll forward of activity in fair value measurements using significant unobservable inputs (Level 3). The Company adopted this provision on January 1, 2011, as required. The adoption of ASU 2010-06 did not materially affect the Company’s financial position or results of operations.

In May 2011, the FASB issued ASU 2011-04, “Fair Value Measurement (Topic 820): Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and International Financial Reporting Standards.” ASU 2011-04 requires additional fair value measurement disclosures, including: (a) quantitative information about the significant unobservable inputs used for Level 3 fair value measurements, a qualitative discussion about the sensitivity of the measurements to changes in the unobservable inputs, and a description of a company’s valuation process, (b) any transfers between Level 1 and 2, (c) information about when the current use of a non-financial asset measured at fair value differs from its highest and best use, and (d) the hierarchy classification for items whose fair value is not recorded on the balance sheet but is disclosed in the notes. ASU 2011-04 is effective for fiscal periods beginning after December 15, 2011. The Company will adopt the disclosure requirements beginning in fiscal year 2012. The adoption of ASU 2011-04 is not expected to materially affect the Company’s financial position or results of operations.

In June 2011, the FASB issued ASU 2011-05, “Comprehensive Income (Topic 220): Presentation of Comprehensive Income.” ASU 2011-05 allows an entity the option to present the total of comprehensive income, the components of net income, and the components of other comprehensive income either in one continuous statement of comprehensive income or in two separate but consecutive statements. ASU 2011-05 eliminates the option to present the components of other comprehensive income as part of the statement of changes in stockholders’ equity. Also, reclassification adjustments between comprehensive income and net income must be presented on the face of the financial statements. ASU 2011-05 is effective for fiscal years and interim periods beginning after December 15, 2011, with early adoption permitted. The Company will adopt the disclosure requirements beginning in fiscal year 2012. The adoption of ASU 2011-05 is not expected to affect the Company’s financial position or results of operations.

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In July 2011, the FASB issued ASU 2011-06, "Other Expenses (Topic 720): Fees Paid to the Federal Government by Health Insurers." ASU 2011-06 addresses the timing, recognition and classification of the annual health insurance industry assessment fee imposed on health insurers by the PPACA. The mandatory annual fee of health insurers will be imposed for each calendar year beginning on or after January 1, 2014. This update requires that the liability for the fee be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. Although the federally mandated annual fee may be material, the adoption of ASU 2011-06 is not expected to materially affect the Company's financial position or results of operations.

In September 2011, the FASB issued ASU 2011-08, "Intangibles-Goodwill and Other (Topic 350): Testing Goodwill for Impairment." ASU 2011-08 permits an entity to first assess qualitative factors to determine whether it is "more likely than not" that the fair value of a reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment test described in Topic 350, Intangibles-Goodwill and Other. ASU 2011-08 is effective for annual and interim goodwill impairment tests performed for fiscal years beginning after December 15, 2011, with early adoption permitted. The Company will adopt ASU 2011-08 beginning in fiscal year 2012. The adoption of ASU 2011-08 is not expected to materially affect the Company's financial position or results of operations.

**C. SEGMENT INFORMATION**

The Company has the following three reportable segments: Health Plan and Medical Services, Specialized Managed Care and Workers' Compensation. Each of these reportable segments, which the Company also refers to as "Divisions," is separately managed and provides separate operating results that are evaluated by the Company's chief operating decision maker.

The Health Plan and Medical Services Division is primarily comprised of the Company's traditional health plan Commercial Risk, Medicare Advantage and Medicaid businesses and products. Additionally, through this Division the Company contracts with various federal employee organizations to provide health insurance benefits under the Federal Employees Health Benefits Program ("FEHBP") and offers managed care and administrative products to businesses that self-insure the health care benefits of their employees. This Division also contains the dental services business.

The Specialized Managed Care Division includes the Company's Medicare Part D, network rental and behavioral health benefits businesses.

The Workers' Compensation Division is comprised of fee-based, managed care services such as provider network access, bill review, care management services and pharmacy benefit management to underwriters and administrators of workers' compensation insurance.

The tables below summarize the operating results of the Company's reportable segments through the gross margin level, as that is the measure of profitability used by the chief operating decision maker to assess segment performance and make decisions regarding the allocation of resources. A reconciliation of gross margin to operating earnings at a consolidated level is also provided. Total assets by reportable segment are not disclosed as these assets are not reviewed separately by the Company's chief operating decision maker. The dollar amounts in the segment tables are presented in thousands.

	<b>Quarter Ended September 30, 2011</b>				
	<b>Health Plan and Medical Services</b>	<b>Specialized Managed Care</b>	<b>Workers' Comp.</b>	<b>Elim.</b>	<b>Total</b>
Operating revenues					
Managed care premiums	\$ 2,404,439	\$ 298,288	\$ -	\$(22,683)	\$2,680,044
Management services	79,615	22,195	196,198	(2,509)	295,499
Total operating revenues	2,484,054	320,483	196,198	(25,192)	2,975,543
Medical costs	1,985,572	222,679	-	(22,683)	2,185,568
Cost of sales	-	-	71,511	-	71,511
<b>Gross margin</b>	<b>\$ 498,482</b>	<b>\$ 97,804</b>	<b>\$ 124,687</b>	<b>\$ (2,509)</b>	<b>\$ 718,464</b>
Selling, general and administrative					492,855
Provider class action					-
Depreciation and amortization					32,996
<b>Operating earnings</b>					<b>\$ 192,613</b>

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**Quarter Ended September 30, 2010**

	<b>Health Plan and Medical Services</b>	<b>Specialized Managed Care</b>	<b>Workers' Comp.</b>	<b>Elim.</b>	<b>Total</b>
Operating revenues					
Managed care premiums	\$ 2,188,983	\$ 373,838	\$ -	\$(19,641)	\$2,543,180
Management services	79,869	25,700	189,485	(2,453)	292,601
<b>Total operating revenues</b>	<b>2,268,852</b>	<b>399,538</b>	<b>189,485</b>	<b>(22,094)</b>	<b>2,835,781</b>
Medical costs	1,691,936	290,721	-	(19,641)	1,963,016
Cost of sales	-	-	64,638	-	64,638
<b>Gross margin</b>	<b>\$ 576,916</b>	<b>\$ 108,817</b>	<b>\$ 124,847</b>	<b>\$ (2,453)</b>	<b>\$ 808,127</b>
Selling, general and administrative					481,345
Provider class action					-
Depreciation and amortization					34,839
<b>Operating earnings</b>					<b>\$ 291,943</b>

**Nine Months Ended September 30, 2011**

	<b>Health Plan and Medical Services</b>	<b>Specialized Managed Care</b>	<b>Workers' Comp.</b>	<b>Elim.</b>	<b>Total</b>
Operating revenues					
Managed care premiums	\$ 7,215,724	\$ 1,026,053	\$ -	\$(68,803)	\$8,172,974
Management services	231,473	72,606	587,821	(7,347)	884,553
<b>Total operating revenues</b>	<b>7,447,197</b>	<b>1,098,659</b>	<b>587,821</b>	<b>(76,150)</b>	<b>9,057,527</b>
Medical costs	5,899,190	879,134	-	(68,803)	6,709,521
Cost of sales	-	-	209,603	-	209,603
<b>Gross margin</b>	<b>\$ 1,548,007</b>	<b>\$ 219,525</b>	<b>\$ 378,218</b>	<b>\$ (7,347)</b>	<b>\$2,138,403</b>
Selling, general and administrative					1,476,325
Provider class action					(159,300)
Depreciation and Amortization					102,191
<b>Operating earnings</b>					<b>\$ 719,187</b>

**Nine Months Ended September 30, 2010**

	<b>Health Plan and Medical Services</b>	<b>Specialized Managed Care</b>	<b>Workers' Comp.</b>	<b>Elim.</b>	<b>Total</b>
Operating revenues					
Managed care premiums	\$ 6,420,567	\$ 1,321,617	\$ -	\$(57,921)	\$7,684,263
Management services	245,222	75,158	565,635	(7,378)	878,637
<b>Total operating revenues</b>	<b>6,665,789</b>	<b>1,396,775</b>	<b>565,635</b>	<b>(65,299)</b>	<b>8,562,900</b>
Medical costs	5,006,934	1,160,901	-	(57,921)	6,109,914
Cost of sales	-	-	187,900	-	187,900
<b>Gross margin</b>	<b>\$ 1,658,855</b>	<b>\$ 235,874</b>	<b>\$ 377,735</b>	<b>\$ (7,378)</b>	<b>\$2,265,086</b>
Selling, general and administrative					1,430,505
Provider class action					278,000
Depreciation and Amortization					104,342
<b>Operating earnings</b>					<b>\$ 452,239</b>

**D. DEBT**

The Company's outstanding debt consisted of the following (in thousands):

	<u>September 30, 2011</u>	<u>December 31, 2010</u>
5.875% Senior notes due 1/15/12 <sup>(1)</sup>	\$ 233,903	\$ 233,903
6.300% Senior notes due 8/15/14, net of unamortized discount of \$663 at September 30, 2011 <sup>(1)</sup>	374,434	374,264
6.125% Senior notes due 1/15/15 <sup>(1)</sup>	228,845	228,845
5.950% Senior notes due 3/15/17, net of unamortized discount of \$774 at September 30, 2011 <sup>(1)</sup>	382,461	382,355
5.450% Senior notes due 6/7/21, net of unamortized discount of \$1,162 at September 30, 2011	598,838	-
Revolving Credit Facility, originally due 7/11/12	-	380,029
<b>Total debt, including current portion</b>	<b><u>1,818,481</u></b>	<b><u>1,599,396</u></b>
Less current portion of total debt	233,903	-
<b>Total long-term debt</b>	<b><u>\$ 1,584,578</u></b>	<b><u>\$ 1,599,396</u></b>

<sup>(1)</sup> The carrying value is net of repurchases.

On June 7, 2011, the Company completed the sale of \$600.0 million aggregate principal amount of its 5.450% Senior Notes due 2021 (the "2021 Notes") at the issue price of 99.800% per note. The 2021 Notes are senior unsecured obligations of Coventry and rank equally with all of its other senior unsecured indebtedness.

During the quarter ended June 30, 2011, the Company repaid in full the \$380.0 million outstanding balance of the revolving credit facility due July 11, 2012 and the associated credit agreement was terminated on June 22, 2011.

On June 22, 2011, the Company entered into a new Credit Agreement (the "Credit Facility"). The Credit Facility provides for a five-year revolving credit facility in the principal amount of \$750.0 million, with the Company having the ability to request an increase in the facility amount up to an aggregate principal amount not to exceed \$1.0 billion. The Company pays commitment fees on the Credit Facility ranging from 0.200% to 0.400% per annum. The obligations under the Credit Facility are general unsecured obligations of the Company. As of September 30, 2011, there were no amounts outstanding under the Credit Facility.

The Company's senior notes and Credit Facility contain certain covenants and restrictions regarding, among other things, liens, asset dispositions and consolidations or mergers. Additionally, the Company's Credit Facility requires compliance with a leverage ratio of 3 to 1 and limits subsidiary debt. As of September 30, 2011, the Company was in compliance with the applicable covenants and restrictions under its senior notes and Credit Facility.

**E. CONTINGENCIES****Legal Proceedings**

As described in the Company's Annual Report on Form 10-K for the year ended December 31, 2010, the Company received a subpoena from the U.S. Attorney for the District of Maryland, Northern Division, requesting information regarding the operational process for confirming Medicare eligibility for its Workers' Compensation set-aside product. The Company is fully cooperating and is providing the requested information. The Company cannot predict what, if any, actions may be taken by the U.S. Attorney. However, based on the information known to date, the Company does not believe that the outcome of this investigation will have a material adverse effect on its financial position or results of operations.

First Health Group Corporation ("FHGC"), a subsidiary of the Company, was a party to various lawsuits filed in the state and federal courts of Louisiana involving disputes between providers and workers' compensation payors who access FHGC's contracts with these providers to reimburse them for services rendered to injured workers. FHGC has written contracts with providers in Louisiana which expressly state that the provider agrees to accept a specified discount off their billed charges for services rendered to injured workers. The discounted rate set forth in the FHGC provider contract is less than the reimbursement amount set forth in the Louisiana Workers' Compensation Fee Schedule. For this reason, workers' compensation insurers and third-party administrators ("TPAs") for employers who self insure workers' compensation benefits contract with FHGC to access the FHGC provider contracts. Thus, when a FHGC contracted provider renders services to an injured worker, the workers' compensation insurer or the TPA reimburses the provider for those services in accordance with the discounted rate in the provider's contract with FHGC. These workers' compensation insurers and TPAs are referred to as "payors" in the FHGC provider contract and the contract expressly states that the discounted rate will apply to those payors who access the FHGC contract. Thus, the providers enter into these contracts with FHGC knowing that they will be paid the discounted rate by every payor who chooses to access the FHGC contract.

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Four providers who have contracts with FHGC filed a state court class action lawsuit against FHGC and certain payors alleging that FHGC violated Louisiana's Any Willing Provider Act (the "Act"), which requires a payor accessing a preferred provider network contract to give a one time notice 30 days before that payor uses the discounted rate in the preferred provider network contract to pay the provider for services rendered to a member insured under that payor's health benefit plan. These provider plaintiffs alleged that the Act applies to medical bills for treatment rendered to injured workers and that the Act requires point of service written notice in the form of a benefit identification card. If a payor is found to have violated the Act's notice provision, the court may assess up to \$2,000 in damages for each instance when the provider was not given proper notice that a discounted rate would be used to pay for the services rendered. The provider plaintiffs filed a motion for partial summary judgment against FHGC seeking damages of \$2,000 for each provider visit where the provider was not given a benefit identification card at the time the service was performed. The state court granted the plaintiffs' motion for partial summary judgment in the amount of \$262 million. FHGC appealed both the partial summary judgment order and the court's prior order denying the motion by FHGC to decertify the class to the state's intermediate appellate court. Both appeals were denied by the intermediate appellate court.

As a result of the Louisiana appellate court's decision on July 1, 2010 to affirm the state trial court's summary judgment order, the Company recorded a \$278 million pre-tax charge to earnings and a corresponding accrued liability during the quarter ended June 30, 2010. This amount represented the \$262 million judgment amount plus post judgment interest and is included in "accounts payable and other accrued liabilities" in the accompanying balance sheet at December 31, 2010. The Company accrued for legal fees expected to be incurred related to this case as well as post judgment interest subsequent to the second quarter charge, which were included in "accounts payable and other accrued liabilities" in the accompanying balance sheet at December 31, 2010.

On February 2, 2011, FHGC, counsel for the class representatives and the class representatives executed a definitive settlement agreement which was acceptable to FHGC. FHGC would pay \$150.5 million to satisfy in full the amount of the partial summary judgment and to resolve and settle all claims of the class, including claims for pre- and post- judgment interest, attorneys fees and costs. In addition, Coventry would assign to the class certain rights it has to the proceeds of FHGC's insurance policies relating to the claims asserted by the class. In exchange for the settlement payment by FHGC, class members would release FHGC and all of its affiliates and clients for any claims relating in any way to re-pricing, payment for, or reimbursement of a workers' compensation bill, including but not limited to claims under the Act. Plaintiffs also agreed to a notice procedure that FHGC may follow in the future to comply with the Act. Accordingly, the Company made a \$150.5 million cash payment into escrow. On May 27, 2011, the court entered an order of final approval of the settlement and thus all contingencies in the definitive settlement agreement were satisfied. As a result of the resolution of the settlement agreement contingencies, including final court approval, the Company recorded a non-recurring pre-tax adjustment to earnings of \$159.3 million, or \$0.68 per diluted share after tax, in the second quarter of 2011. The \$150.5 million recorded as restricted cash in the balance sheet at June 30, 2011 was released to the Settlement Administrator for the class action plaintiffs on the settlement effective date of August 9, 2011 and, accordingly, is no longer included in the accompanying balance sheet at September 30, 2011.

On September 3, 2009, a shareholder filed a putative securities class action against the Company and three of its current and former officers in the federal district court of Maryland. Subsequent to the filing of the complaint, three other shareholders and/or investor groups filed motions with the court for appointment as lead plaintiff and approval of selection of lead and liaison counsel. By agreement, the four shareholders submitted a stipulation to the court regarding appointment of lead plaintiff and approval of selection of lead and liaison counsel. In December 2009, the court approved the stipulation and ordered the lead plaintiff to file a consolidated and amended complaint. The purported class period is February 9, 2007 to October 22, 2008. The consolidated and amended complaint alleges that the Company's public statements contained false, misleading and incomplete information regarding the Company's profitability, particularly the profit margins for its Medicare Private-Fee-For-Service ("Medicare PFFS") products. The Company filed a motion to dismiss the complaint. By Order, dated March 31, 2011, the court granted in part, and denied in part, the Company's motion to dismiss the complaint. The Company has filed a motion for reconsideration with respect to that part of the court's March 31, 2011 Order which denied the Company's motion to dismiss the complaint. The motion for reconsideration was denied but the court did rule that the class period was further restricted to April 25, 2008 to June 18, 2008. The Company will vigorously defend against the allegations in the lawsuit. Although it cannot predict the outcome, the Company believes this lawsuit will not have a material adverse effect on its financial position or results of operations.

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On October 13, 2009, two former employees and participants in the Coventry Health Care Retirement Savings Plan filed a putative ERISA class action lawsuit against the Company and several of its current and former officers, directors and employees in the U.S. District Court for the District of Maryland. Plaintiffs allege that defendants breached their fiduciary duties under ERISA by offering and maintaining Company stock in the Plan after it allegedly became imprudent to do so and by allegedly failing to provide complete and accurate information about the Company's financial condition to plan participants in SEC filings and public statements. Three similar actions by different plaintiffs were later filed in the same court and were consolidated on December 9, 2009. An amended consolidated complaint has been filed. The Company filed a motion to dismiss the complaint. By Order, dated March 31, 2011, the court denied the Company's motion to dismiss the amended complaint. The Company has filed a motion for reconsideration of the court's March 31, 2011 Order and has filed an Alternative Motion to Certify the Court's March 31, 2011 Order For Interlocutory Appeal to the Fourth Circuit Court of Appeals. Both of those motions are still pending. The Company will vigorously defend against the allegations in the consolidated lawsuit. Although it cannot predict the outcome, the Company believes this lawsuit will not have a material adverse effect on its financial position or results of operations.

### Guaranty Fund Assessments

The Company operates in a regulatory environment that may require the Company to participate in assessments under state insurance guaranty association laws. The Company's exposure to guaranty fund assessments is based on its share of business it writes in the relevant jurisdictions for certain obligations of insolvent insurance companies to policyholders and claimants.

The Pennsylvania Insurance Commissioner has placed Penn Treaty Network America Insurance Company and its subsidiary (collectively, "Penn Treaty"), neither of which is affiliated with the Company, in rehabilitation (an intermediate action before insolvency) and has petitioned a Pennsylvania state court for liquidation. If Penn Treaty is liquidated, the Company's health plans and other insurers may be required to pay a portion of Penn Treaty's policyholder claims through guaranty association assessments in future periods from various states in which Penn Treaty policyholders reside and in which the Company's health plans and insurance subsidiaries write premiums.

The Company is unable to estimate losses or ranges of losses because the Company cannot predict when the Pennsylvania state court will render a decision, the amount of the insolvency, if any, the amount and timing of any associated guaranty fund assessments or the availability and amount of any potential offsets, such as an offset of any premium taxes otherwise payable by the Company. Based on information known to date, the Company cannot predict the outcome of this matter. However, an assessment could have a material adverse effect on the Company's financial position and results of operations.

### F. COMPREHENSIVE INCOME

Comprehensive income was as follows (in thousands):

	Quarters Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
Net earnings	\$ 122,681	\$ 189,945	\$ 457,409	\$ 288,290
Other comprehensive income:				
Unrealized holding gains	18,293	25,459	34,153	52,765
Reclassification adjustments, net	(6,198)	(2,457)	(11,923)	(8,196)
Other comprehensive income, before income taxes	12,095	23,002	22,230	44,569
Income tax provision	(4,717)	(8,971)	(8,670)	(17,381)
Other comprehensive income, net of income taxes	7,378	14,031	13,560	27,188
Comprehensive income	\$ 130,059	\$ 203,976	\$ 470,969	\$ 315,478

### G. INVESTMENTS

The Company considers all of its investments as available-for-sale securities. For debt securities, if the Company either intends to sell or determines that it will more-likely-than-not be required to sell a debt security before recovery of the entire amortized cost basis or maturity of the debt security, the Company recognizes the impairment in earnings. If the Company does not intend to sell the debt security and the Company determines that it will not more-likely-than-not be required to sell the debt security but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other cases, which are recognized in other comprehensive income. Realized gains and losses on the sale of investments are determined on a specific identification basis.

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The amortized cost, gross unrealized gain or loss and estimated fair value of short-term and long-term investments by security type were as follows as of September 30, 2011 and December 31, 2010 (in thousands):

	Amortized Cost	Unrealized Gain	Unrealized Loss	Fair Value
<b>As of September 30, 2011</b>				
State and municipal bonds	\$ 784,098	\$ 48,525	\$ (66)	\$ 832,557
U.S. Treasury securities	93,130	3,267	(1)	96,396
Government-sponsored enterprise securities (1)	330,126	6,489	(22)	336,593
Residential mortgage-backed securities (2)	342,102	14,442	(35)	356,509
Commercial mortgage-backed securities	14,249	847	-	15,096
Asset-backed securities (3)	14,548	806	-	15,354
Corporate debt and other securities	1,085,396	23,513	(8,189)	1,100,720
	<u>\$ 2,663,649</u>	<u>\$ 97,889</u>	<u>\$ (8,313)</u>	<u>\$ 2,753,225</u>
Equity method investments (4)				23,198
				<u>\$ 2,776,423</u>
<b>As of December 31, 2010</b>				
State and municipal bonds	\$ 856,838	\$ 29,886	\$ (3,068)	\$ 883,656
U.S. Treasury securities	84,739	3,667	(7)	88,399
Government-sponsored enterprise securities (1)	332,421	7,477	(318)	339,580
Residential mortgage-backed securities (2)	308,250	10,421	(1,270)	317,401
Commercial mortgage-backed securities	22,025	952	-	22,977
Asset-backed securities (3)	29,143	1,192	-	30,335
Corporate debt and other securities	473,982	17,123	(588)	490,517
	<u>\$ 2,107,398</u>	<u>\$ 70,718</u>	<u>\$ (5,251)</u>	<u>\$ 2,172,865</u>
Equity method investments (4)				28,590
				<u>\$ 2,201,455</u>

(1) Includes FDIC-insured Temporary Liquidity Guarantee Program securities.

(2) Agency pass-through, with the timely payment of principal and interest guaranteed.

(3) Includes auto loans, credit card debt, and rate reduction bonds.

(4) Includes investments in entities accounted for under the equity method of accounting and therefore are presented at their carrying value.

The amortized cost and estimated fair value of available-for-sale debt securities by contractual maturity were as follows as of September 30, 2011 and December 31, 2010 (in thousands):

	As of September 30, 2011		As of December 31, 2010	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Maturities:				
Within 1 year	\$ 440,168	\$ 441,999	\$ 174,639	\$ 176,400
1 to 5 years	1,194,840	1,222,750	889,990	922,696
5 to 10 years	437,077	469,319	499,632	519,296
Over 10 years	591,564	619,157	543,137	554,473
Total	<u>\$ 2,663,649</u>	<u>\$ 2,753,225</u>	<u>\$ 2,107,398</u>	<u>\$ 2,172,865</u>

Investments with long-term option adjusted maturities, such as residential and commercial mortgage-backed securities, are included in the "Over 10 years" category. Actual maturities may differ due to call or prepayment rights.

Gross investment gains of \$6.5 million and gross investment losses of \$0.3 million were realized on sales of investments for the quarter ended September 30, 2011. This compares to gross investment gains of \$2.5 million and no gross investment losses realized on sales of investments for the quarter ended September 30, 2010. Gross investment gains of \$12.3 million and gross investment losses of \$0.4 million were realized on sales of investments for the nine months ended September 30, 2011. This compares to gross investment gains of \$14.2 million and gross investment losses of \$4.3 million realized on sales of investments for the nine months ended September 30, 2010. All realized gains and losses are recorded in other income, net in the Company's consolidated statements of operations.

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The following table shows the Company's investments' gross unrealized losses and fair value at September 30, 2011 and December 31, 2010, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position (in thousands):

<b>At September 30, 2011</b>	<b>Less than 12 months</b>		<b>12 months or more</b>		<b>Total</b>	
	<b>Fair Value</b>	<b>Unrealized Losses</b>	<b>Fair Value</b>	<b>Unrealized Losses</b>	<b>Fair Value</b>	<b>Unrealized Losses</b>
State and municipal bonds	\$ 16,021	\$ (57)	\$ 1,102	\$ (9)	\$ 17,123	\$ (66)
U.S. Treasury securities	422	(1)	-	-	422	(1)
Government sponsored enterprises	40,170	(22)	-	-	40,170	(22)
Residential mortgage-backed securities	10,523	(34)	51	(1)	10,574	(35)
Commercial mortgage-backed securities	-	-	-	-	-	-
Asset-backed securities	-	-	-	-	-	-
Corporate debt and other securities	309,491	(8,189)	-	-	309,491	(8,189)
<b>Total</b>	<b>\$ 376,627</b>	<b>\$ (8,303)</b>	<b>\$ 1,153</b>	<b>\$ (10)</b>	<b>\$ 377,780</b>	<b>\$ (8,313)</b>

<b>At December 31, 2010</b>	<b>Less than 12 months</b>		<b>12 months or more</b>		<b>Total</b>	
	<b>Fair Value</b>	<b>Unrealized Losses</b>	<b>Fair Value</b>	<b>Unrealized Losses</b>	<b>Fair Value</b>	<b>Unrealized Losses</b>
State and municipal bonds	\$ 156,894	\$ (3,068)	\$ -	\$ -	\$ 156,894	\$ (3,068)
U.S. Treasury securities	5,890	(7)	-	-	5,890	(7)
Government sponsored enterprises	19,551	(318)	-	-	19,551	(318)
Residential mortgage-backed securities	59,738	(1,269)	17	(1)	59,755	(1,270)
Commercial mortgage-backed securities	-	-	-	-	-	-
Asset-backed securities	-	-	-	-	-	-
Corporate debt and other securities	34,405	(588)	-	-	34,405	(588)
<b>Total</b>	<b>\$ 276,478</b>	<b>\$ (5,250)</b>	<b>\$ 17</b>	<b>\$ (1)</b>	<b>\$ 276,495</b>	<b>\$ (5,251)</b>

The unrealized losses presented in this table do not meet the criteria for treatment as an other-than-temporary impairment. The unrealized losses are the result of interest rate movements. The Company has not decided to sell, and it is not more-likely-than-not that the Company will be required to sell before a recovery of the amortized cost basis of these securities.

The Company continues to review its investment portfolios under its impairment review policy. Given the current market conditions and the significant judgments involved, there is a continuing risk that declines in fair value may occur and that other-than-temporary impairments may be recorded in future periods.

## H. FAIR VALUE MEASUREMENTS

### Financial Assets

Accounting Standards Codification ("ASC") Topic 820, "Fair Value Measurements and Disclosures," defines fair value and requires a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value based on the quality and reliability of the inputs or assumptions used in fair value measurements.

The Company's Level 1 securities primarily consist of U.S. Treasury securities and cash. The Company determines the estimated fair value for its Level 1 securities using quoted (unadjusted) prices for identical assets or liabilities in active markets.

The Company's Level 2 securities primarily consist of government-sponsored enterprise securities, state and municipal bonds, mortgage-backed securities, asset-backed securities, corporate debt and money market funds. The Company determines the estimated fair value for its Level 2 securities using the following methods: quoted prices for similar assets/liabilities in active markets, quoted prices for identical or similar assets in non-active markets (few transactions, limited information, non-current prices and high variability over time), inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves volatilities and default rates, among others), and inputs that are derived principally from or corroborated by other observable market data.

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For the Company's Level 2 assets, the following inputs and valuation techniques were utilized in determining the fair value of its financial instruments:

**Cash Equivalents:** Level 2 cash equivalents are valued using inputs that are principally from, or corroborated by, observable market data, primarily quoted prices for like or similar assets.

**Government-Sponsored Enterprises:** These securities primarily consist of bonds issued by government-sponsored enterprises, such as the Federal Home Loan Bank, the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation. The fair value of government-sponsored enterprises is based upon observable market inputs such as quoted prices for like or similar assets, benchmark yields, reported trades and credit spreads.

**State and Municipal Bonds, Corporate Debt and Other Securities:** The fair value of the Company's debt securities is determined by observable market inputs which include quoted prices for identical or similar assets that are traded in an active market, benchmark yields, new issuances, issuer ratings, reported trades of comparable securities and credit spreads.

**Residential and Commercial Mortgage-Backed Securities and Asset-Backed Securities:** The fair value of these securities is determined by a cash flow model which utilizes the following inputs: quoted prices for identical or similar assets, benchmark yields, prepayment speeds, collateral performance, credit spreads and default rates that are observable at commonly quoted intervals.

The Company's Level 3 securities primarily consisted of corporate financial holdings and mortgage-backed and asset-backed securities that were thinly traded due to market volatility and lack of liquidity. The Company determined the estimated fair value for its Level 3 securities using unobservable inputs that cannot be corroborated by observable market data including, but not limited to, broker quotes, default rates, benchmark yields, credit spreads and prepayment speeds.

The Company obtains one price for each security from an independent third-party valuation service provider, which uses quoted or other observable inputs for the determination of fair value as noted above. As the Company is responsible for the determination of fair value, the Company performs quarterly analyses on the prices received from the third-party provider to determine whether the prices are reasonable estimates of fair value.

The following table presents the fair value hierarchy for the Company's financial assets measured at fair value on a recurring basis at September 30, 2011 and December 31, 2010 (in thousands):

At September 30, 2011	Total	Quoted Prices in Active Markets for Identical Assets		Significant Other Observable Inputs		Significant Unobservable Inputs	
		Level 1	Level 2	Level 2	Level 3		
Cash and cash equivalents	\$1,986,323	\$	1,534,349	\$	451,974	\$	-
State and municipal bonds	832,557		-		832,557		-
U.S. Treasury securities	96,396		96,396		-		-
Government-sponsored enterprise securities	336,593		-		336,593		-
Residential mortgage-backed securities	356,509		-		356,509		-
Commercial mortgage-backed securities	15,096		-		15,096		-
Asset-backed securities	15,354		-		15,354		-
Corporate debt and other securities	1,100,720		1,902		1,098,818		-
<b>Total</b>	<b>\$4,739,548</b>	<b>\$</b>	<b>1,632,647</b>	<b>\$</b>	<b>3,106,901</b>	<b>\$</b>	<b>-</b>

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At December 31, 2010	Total	Quoted Prices in Active Markets for Identical Assets	Significant Other Observable Inputs	Significant Unobservable Inputs
		Level 1	Level 2	Level 3
Cash and cash equivalents	\$1,853,988	\$ 326,258	\$ 1,527,730	\$ -
State and municipal bonds	883,656	-	883,656	-
U.S. Treasury securities	88,399	88,399	-	-
Government-sponsored enterprise securities	339,580	-	339,580	-
Residential mortgage-backed securities	317,401	-	317,181	220
Commercial mortgage-backed securities	22,977	-	22,977	-
Asset-backed securities	30,335	-	30,208	127
Corporate debt and other securities	490,517	-	489,787	730
<b>Total</b>	<b>\$4,026,853</b>	<b>\$ 414,657</b>	<b>\$ 3,611,119</b>	<b>\$ 1,077</b>

Transfers between levels, if any, are recorded as of the end of the reporting period. During the quarter and nine months ended September 30, 2011, there were no transfers between Level 1 and Level 2. During the quarter ended September 30, 2011 there were no transfers to (from) Level 3 and, accordingly, a table summarizing changes in fair value of the Company's financial assets for the quarter ended September 30, 2011 is not presented. The following tables provide a summary of changes in the fair value of the Company's Level 3 financial assets for the quarter ended September 30, 2010 and nine months ended September 30, 2011 and 2010 (in thousands):

**Quarter Ended September 30, 2010**

	Total Level 3	Mortgage-backed securities	Asset-backed securities	Corporate and other
Beginning Balance, July 1, 2010	\$ 9,519	\$ 2,068	\$ 160	\$ 7,291
Transfers to (from) Level 3	(522)	-	-	(522)
Total gains or losses (realized / unrealized)				
Included in earnings	2,085	88	33	1,964
Included in other comprehensive income	(1,898)	(29)	(21)	(1,848)
Purchases, issuances, sales and settlements				
Purchases	-	-	-	-
Issuances	-	-	-	-
Sales	(5,640)	(151)	(33)	(5,456)
Settlements	-	-	-	-
Ending Balance, September 30, 2010	<u>\$ 3,544</u>	<u>\$ 1,976</u>	<u>\$ 139</u>	<u>\$ 1,429</u>

**Nine Months Ended September 30, 2011**

	<b>Total Level 3</b>	<b>Mortgage-backed securities</b>	<b>Asset-backed securities</b>	<b>Corporate and other</b>
Beginning Balance, January 1, 2011	\$ 1,077	\$ 220	\$ 127	\$ 730
Transfers to (from) Level 3 <sup>(1)</sup>	(856)	(258)	(119)	(479)
Total gains or losses (realized / unrealized)				
Included in earnings	107	16	7	84
Included in other comprehensive income	(55)	38	(8)	(85)
Purchases, issuances, sales and settlements				
Purchases	-	-	-	-
Issuances	-	-	-	-
Sales	(273)	(16)	(7)	(250)
Settlements	-	-	-	-
Ending Balance, September 30, 2011	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>

(1) The Company no longer relies upon broker quotes or other models involving unobservable inputs to value these securities, as there are sufficient observable inputs (e.g., trading activity) to validate the reported fair value. As a result, the Company transferred all securities from Level 3 to Level 2 during the quarter ended March 31, 2011.

**Nine Months Ended September 30, 2010**

	<b>Total Level 3</b>	<b>Mortgage-backed securities</b>	<b>Asset-backed securities</b>	<b>Corporate and other</b>
Beginning Balance, January 1, 2010	\$ 16,164	\$ 3,100	\$ 4,438	\$ 8,626
Transfers to (from) Level 3	(522)	(470)	470	(522)
Total gains or losses (realized / unrealized)				
Included in earnings	7,225	288	3,142	3,795
Included in other comprehensive income	(6,759)	(482)	(2,931)	(3,346)
Purchases, issuances, sales and settlements				
Purchases	1,950	1,745	-	205
Issuances	-	-	-	-
Sales	(14,514)	(2,205)	(4,980)	(7,329)
Settlements	-	-	-	-
Ending Balance, September 30, 2010	<u>\$ 3,544</u>	<u>\$ 1,976</u>	<u>\$ 139</u>	<u>\$ 1,429</u>

**Financial Liabilities**

The Company's fair value of publicly-traded debt (senior notes) is based on quoted market prices for the identical or similar liability when traded as an asset in an active market. The carrying value of the senior notes (including the long-term and current portions) was \$1.82 billion at September 30, 2011 and \$1.22 billion at December 31, 2010. The estimated fair value of the Company's senior notes (including the long-term and current portions) was \$1.98 billion at September 30, 2011 and \$1.27 billion at December 31, 2010.

The carrying value of the revolving credit facility approximated the fair value due to the short maturity dates of the draws. The Company had no outstanding borrowings under its current credit facility at September 30, 2011.

**I. STOCK-BASED COMPENSATION**

**Stock Options**

The Company recorded compensation expense related to stock options of \$4.3 million and \$4.8 million for the quarters ended September 30, 2011 and 2010, respectively, and \$11.7 million and \$16.3 million for the nine months ended September 30, 2011 and 2010, respectively. The total intrinsic value of options exercised was \$1.3 million and \$0.1 million for the quarters ended September 30, 2011 and 2010, respectively, and \$19.2 million and \$0.5 million for the nine months ended September 30, 2011 and 2010, respectively. As of September 30, 2011, there was \$24.7 million of total unrecognized compensation cost (net of expected forfeitures) related to non-vested stock option grants, which is expected to be recognized over a weighted average period of 2.1 years.

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The following table summarizes stock option activity for the nine months ended September 30, 2011:

	Shares (in thousands)	Weighted- Average Exercise Price	Aggregate Intrinsic Value (in thousands)	Weighted-Average Remaining Contractual Life
Outstanding at January 1, 2011	12,260	\$ 34.88		
Granted	1,528	\$ 35.13		
Exercised	(1,820)	\$ 23.12		
Cancelled and expired	(972)	\$ 45.66		
Outstanding at September 30, 2011	<u>10,996</u>	\$ 35.91	\$ 34,171	5.63
Exercisable at September 30, 2011	7,531	\$ 39.40	\$ 17,662	4.19

The Company continues to use the Black-Scholes-Merton option pricing model and amortizes compensation expense over the requisite service period of the grant. The methodology used in 2011 to derive the assumptions used in the valuation model is consistent with that used in 2010. The following average values and weighted-average assumptions for the quarters and nine months ended September 30, 2011 and 2010 were used for option grants.

	Quarters Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
Black-Scholes-Merton Value	\$ 10.84	\$ 6.94	\$ 11.08	\$ 7.42
Dividend yield	0.0%	0.0%	0.0%	0.0%
Risk-free interest rate	0.4%	0.9%	0.9%	1.4%
Expected volatility	48.0%	43.8%	41.9%	47.6%
Expected life (in years)	3.4	3.4	3.5	3.5

**Restricted Stock Awards**

The value of restricted shares is amortized over various vesting periods through 2015. The Company recorded compensation expense related to restricted stock grants, including restricted stock granted in prior periods, of \$7.1 million and \$5.1 million for the quarters ended September 30, 2011 and 2010, respectively, and \$18.3 million and \$14.8 million for the nine months ended September 30, 2011 and 2010, respectively. The total fair value of shares vested during the nine months ended September 30, 2011 and 2010 was \$23.4 million and \$13.0 million, respectively. The total unrecognized compensation cost (net of expected forfeitures) related to the restricted stock was \$39.6 million at September 30, 2011, and is expected to be recognized over a weighted-average period of 1.9 years.

The following table summarizes restricted stock award activity for the nine months ended September 30, 2011:

	Shares (in thousands)	Weighted-Average Grant-Date Fair Value Per Share
Nonvested, January 1, 2011	2,173	\$ 22.01
Awarded	787	\$ 34.71
Vested	(701)	\$ 25.87
Forfeited	(61)	\$ 24.56
Nonvested, September 30, 2011	<u>2,198</u>	\$ 26.86

**Performance Share Units**

Performance share units ("PSUs") represent hypothetical shares of the Company's common stock and vest based upon the achievement of certain performance goals and other criteria as of December 31, 2011. The Company recorded compensation expense related to the PSUs of \$0.5 million and \$6.1 million for the quarters ended September 30, 2011 and 2010, respectively, and \$15.4 million and \$10.5 million for the nine months ended September 30, 2011 and 2010, respectively. The related liability on the Company's balance sheets at September 30, 2011 and December 31, 2010 was \$20.3 million and \$23.1 million, respectively. During the nine months ended September 30, 2011, the Company paid \$18.2 million with respect to PSUs that vested December 31, 2010.

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The following table summarizes PSU activity for the nine months ended September 30, 2011:

	<b>Units (in thousands)</b>
Nonvested, January 1, 2011	585
Granted	393
Vested	-
Forfeited	(70)
Nonvested, September 30, 2011	<u>908</u>

**J. SHARE REPURCHASE PROGRAM**

The Company's Board of Directors has approved a program to repurchase its outstanding common shares. Share repurchases may be made from time to time at prevailing prices on the open market or in private transactions. In March 2011, the Company's Board of Directors approved an increase to the share repurchase program in an amount equal to 5% of the Company's then outstanding common stock, thus increasing the Company's repurchase authorization by 7.5 million shares. Under the share repurchase program, the Company purchased 4.3 million shares and 7.4 million shares of its common stock during the quarter and nine months ended September 30, 2011, respectively, at an aggregate cost of \$127.5 million and \$227.7 million, respectively. As of September 30, 2011, \$101.6 million of repurchased shares were settled and paid for by the Company. The remaining shares costing \$25.9 million were settled and paid by October 5, 2011. As of September 30, 2011, the total remaining number of common shares the Company is authorized to repurchase under this program is 5.3 million.

**K. OTHER DISCLOSURES**

**Earnings Per Share**

Basic earnings per share is calculated using the weighted-average number of common shares outstanding during the period. Diluted earnings per share assumes the exercise of all options and the vesting of all restricted stock using the treasury stock method. Potential common stock equivalents to purchase 5.8 million and 11.4 million shares for the quarters ended September 30, 2011 and 2010, respectively, and 6.2 million and 10.4 million shares for the nine months ended September 30, 2011 and 2010, respectively, were excluded from the computation of diluted earnings per share because the potential common stock equivalents were anti-dilutive.

**Other Income, net**

Other income, net includes interest income of \$16.4 million and \$18.1 million for the quarters ended September 30, 2011 and 2010, respectively, and \$52.4 million and \$53.5 million for the nine months ended September 30, 2011 and 2010, respectively.

**Concentration of Credit Risk**

The Company is a provider of health insurance coverage to State of Illinois employees and their dependents. In August 2009, the State of Illinois notified the Company of the State's significant budget deficit. The State of Illinois subsequently limited payments to the Company based on its available cash.

As of September 30, 2011, the Company has an outstanding premium receivable balance from the State of Illinois of approximately \$56.8 million, which represents six months of health insurance premiums. As the receivable is from a governmental entity which has been making payments, the Company believes that the full receivable balance will ultimately be realized and therefore has not reserved against the outstanding balance. The Company's regulated subsidiaries are required to submit statutory-basis financial statements to state regulatory agencies. For those financial statements, in accordance with state regulations, this receivable is being treated as an admitted asset in its entirety.

The Company believes its allowance for doubtful accounts adequately provides for estimated losses as of September 30, 2011. The Company has a risk of incurring losses if such allowances are not adequate.

The Company contracts with a pharmacy benefit management ("PBM") vendor to manage pharmacy benefits for its members and to provide rebate administration services on behalf of the Company. The Company had pharmacy rebate receivables of \$290.3 million and \$310.7 million as of September 30, 2011 and December 31, 2010, respectively, due from the PBM vendor resulting from the normal cycle of rebate processing, data submission and collection of rebates. The Company has credit risk due to the concentration of receivables with this single vendor although the Company does not consider the associated credit risk to be significant. The Company only records the pharmacy rebate receivables to the extent that the amounts are deemed probable of collection.

**L. SUBSEQUENT EVENTS**

On October 26, 2011, the Company announced that it signed a definitive agreement to acquire the business of Children's Mercy's Family Health Partners, a Medicaid health plan that is affiliated with Children's Mercy Hospital in Kansas City. This transaction, which is subject to regulatory approvals and other closing conditions customary for a transaction of this type, is expected to close in the first quarter of 2012. Children's Mercy's Family Health Partners has approximately 210,000 Medicaid members, with approximately 155,000 members in the State of Kansas and 55,000 members in the State of Missouri. This acquisition is not material to the Company's condensed consolidated financial statements.

**ITEM 2: Management's Discussion and Analysis of Financial Condition and Results of Operations****General Information**

This Form 10-Q contains forward-looking statements which are subject to risks and uncertainties in accordance with the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. Forward-looking statements typically include assumptions, estimates or descriptions of our future plans, strategies and expectations, and are generally identifiable by the use of the words "anticipate," "will," "believe," "estimate," "expect," "intend," "seek," or other similar expressions. Examples of these include discussions regarding our operating and growth strategy, projections of revenue, income or loss and future operations. Unless this Form 10-Q indicates otherwise or the context otherwise requires, the terms "we," "our," "our Company," "the Company" or "us" as used in this Form 10-Q refer to Coventry Health Care, Inc. and its subsidiaries.

These forward-looking statements may be affected by a number of factors, including, but not limited to, the "Risk Factors" contained in Part I, Item 1A, "Risk Factors," of our Annual Report on Form 10-K for the year ended December 31, 2010 and contained in Part II, Item 1A, "Risk Factors," of our quarterly report on Form 10-Q for the quarter ended March 31, 2011, and as may be further updated from time to time in our subsequent quarterly reports on Form 10-Q. Actual operations and results may differ materially from those forward-looking statements expressed in this Form 10-Q.

The following discussion and analysis relates to our financial condition and results of operations for the quarters and nine months ended September 30, 2011 and 2010. This discussion should be read in conjunction with our condensed consolidated financial statements and other information presented herein as well as "Management's Discussion and Analysis of Financial Condition and Results of Operations" contained in our Annual Report on Form 10-K for the year ended December 31, 2010, including the critical accounting policies discussed therein.

**Summary of Third Quarter 2011 Performance**

- Operating revenues of \$3.0 billion, up 4.9% from the prior year quarter.
- Diluted earnings per share of \$0.84 compared to \$1.29 for the prior year quarter.
- Commercial risk membership of 1,636,000, an increase of 103,000 members from the prior year quarter.
- Cash flows from operations of \$484.2 million, which includes the early receipt of the October 2011 Medicare premium payment from the Centers for Medicare and Medicaid Services ("CMS").
- Repurchased 4.3 million shares for \$127.5 million during the quarter. Total year-to-date share repurchase of 7.4 million shares for \$227.7 million.

**New Accounting Standards**

See Note B, New Accounting Standards, to the condensed consolidated financial statements for information and disclosures related to the new accounting standards, which is incorporated herein by reference.

**Membership**

The following table presents our membership (in thousands):

<b>Membership by Product</b>	<b>As of September 30,</b>		<b>Increase</b>
	<b>2011</b>	<b>2010</b>	<b>(Decrease)</b>
Health Plan Commercial Risk	1,636	1,533	103
Health Plan Commercial ASO	710	636	74
Medicare Advantage CCP	220	193	27
Medicaid Risk	467	462	5
<b>Health Plan Total</b>	<b>3,033</b>	<b>2,824</b>	<b>209</b>
Other National ASO	376	462	(86)
<b>Total Medical Membership</b>	<b>3,409</b>	<b>3,286</b>	<b>123</b>
Medicare Part D	1,148	1,618	(470)
<b>Total Membership</b>	<b>4,557</b>	<b>4,904</b>	<b>(347)</b>

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Total Health Plan membership increased 209,000 from the prior year quarter, primarily as a result of an increase from our acquisition of MHP, Inc. (“MHP”) in the fourth quarter of 2010. Other National ASO membership decreased 86,000 primarily due to a decline of our Federal Employees Health Benefit Program (“FEHBP”) membership and the attrition of membership associated with the runout of our National Accounts business. The decrease in Medicare Part D membership of 470,000 was a result of the loss of auto assign regions as well as a reduction in product offerings from five in 2010 to two in 2011.

### Results of Operations

The following table is provided to facilitate a discussion regarding the comparison of our consolidated results of continuing operations for the quarters and nine months ended September 30, 2011 and 2010 (dollars in thousands, except diluted earnings per share amounts):

	Quarters Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
Total operating revenues	\$ 2,975,543	\$ 2,835,781	\$ 9,057,527	\$ 8,562,900
Provider class action (release)/charge	\$ -	\$ -	\$ (159,300)	\$ 278,000
Operating earnings	\$ 192,613	\$ 291,943	\$ 719,187	\$ 452,239
Operating earnings as a percentage of revenues	6.5%	10.3%	7.9%	5.3%
Net Earnings	\$ 122,681	\$ 189,945	\$ 457,409	\$ 288,290
Diluted earnings per share	\$ 0.84	\$ 1.29	\$ 3.09	\$ 1.96
Selling, general and administrative as a percentage of revenue	16.6%	17.0%	16.3%	16.7%

### Comparison of Quarters Ended September 30, 2011 and 2010

#### Managed Care Premiums

Managed care premium revenue increased primarily as a result of the acquisition of MHP in 2010, as well as organic membership growth and an increase in the average realized premium per member per month. This was partially offset by a decrease in Medicare Part D revenue as a result of the loss of membership resulting from the aforementioned loss of auto assign regions and reduction in product offerings.

The increases mentioned above were also partially offset by an accrual for the minimum medical loss ratio rebate for our Commercial business required by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, “PPACA”). As a result of the PPACA minimum medical loss ratio mandates, rebates are required to be issued to policyholders if the actual loss ratios fall below these minimums. Accordingly, in the current quarter and year, we have recorded a rebate estimate based on a proportional amount of the projected annual estimate in the “accounts payable and other accrued liabilities” line in the accompanying balance sheet, at September 30, 2011, and as contra-revenue in “managed care premiums” in the accompanying statements of operations for the periods ended September 30, 2011.

#### Medical Costs and Cost of Sales

Medical costs increased primarily as a result of the acquisition of MHP as well as organic membership growth and medical trend. This was partially offset by the decrease in Medicare Part D membership, as noted above. Total medical costs as a percentage of premium revenue (“medical loss ratio” or “MLR”) increased 4.3% over the prior year quarter to 81.5% from 77.2% primarily as a result of the minimum MLR mandates previously mentioned as well as the MLR increases during the current year quarter for the Medicare Advantage products, as described in the segment results of operations discussion that follows.

Cost of sales increased due to continued growth of our pharmacy benefit management program in the Workers’ Compensation division.

#### Selling, General and Administrative

Selling, general and administrative expense increased primarily due to normal operating costs associated with MHP including, but not limited to, salaries and benefits, professional fees and premium taxes. The increase is also attributable to additional salaries and benefits associated with an increase in the number of full-time employees as we prepare for the expansion of our Medicaid products into the Commonwealth of Kentucky and anticipated growth of the Medicare Part D products. The increases were partially offset by lower stock-based compensation expense primarily as a result of changes in our stock price. For more information on our stock-based compensation, refer to Note I, Stock-Based Compensation, to the condensed consolidated financial statements, which is incorporated herein by reference.

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*Depreciation and Amortization*

Depreciation and amortization expense was lower during the current year quarter primarily due to certain assets becoming fully depreciated.

*Interest Expense and Other Income, Net*

Interest expense increased due to the issuance of \$600.0 million aggregate principal amount of our 5.450% Senior Notes due 2021 (the “2021 Notes”) in the second quarter of 2011.

Other income, net increased as income in the current quarter included larger realized gains on the sales of investments.

*Income Taxes*

The provision for income taxes decreased from the prior year quarter due to a decrease in earnings. The effective tax rate on operations decreased to 34.5% as compared to 35.0% for the prior year quarter, primarily due to the proportion of earnings in states with lower tax rates.

**Comparison of Nine Months Ended September 30, 2011 and 2010**

*Managed Care Premiums*

Managed care premium revenue increased from the prior year nine-month period primarily as a result of the acquisition of MHP in 2010, as well as an increase in Medicaid Risk revenue due to new markets entered during 2010 in the State of Nebraska and the Commonwealth of Pennsylvania. Revenue also increased as a result of organic membership growth and an increase in the average realized premium per member per month. This was partially offset by a decrease in Medicare Part D revenue as a result of the loss of membership resulting from the aforementioned loss of auto assign regions and reduction in product offerings.

The increases mentioned above were partially offset by an accrual for the minimum MLR rebate for our Commercial business, as discussed above.

*Medical Costs and Cost of Sales*

Medical costs increased from the prior year nine-month period primarily as a result of the acquisition of MHP, new Medicaid Risk markets entered during 2010 in the State of Nebraska and the Commonwealth of Pennsylvania, and as a result of organic membership growth and medical trend. This was partially offset by the decrease in Medicare Part D membership, as noted above. The overall MLR increased 2.6% over the prior year nine-month period to 82.1% from 79.5% primarily as a result of the minimum MLR mandates previously mentioned as well as the MLR increases during the current year quarter for the Medicare Advantage products, as described in the segment results of operations discussion that follows.

Cost of sales increased due to continued growth of our pharmacy benefit management program in the Workers’ Compensation division.

*Selling, General and Administrative and Provider Class Action*

Selling, general and administrative expense increased primarily due to normal operating costs associated with MHP including, but not limited to, salaries and benefits, professional fees and premium taxes. The increase is partially offset by lower legal fees in the current year nine-month period as the prior year nine-month period included incremental legal fees related to the provider class action in Louisiana that were not incurred in 2011.

During the second quarter of 2010, a \$278.0 million charge for a provider class action was recorded resulting from the Court of Appeal, Third Circuit for the State of Louisiana decision to affirm the trial court’s decision to grant summary judgment against a wholly-owned subsidiary of Coventry in provider class action litigation in Louisiana state court. On May 27, 2011, the court entered an order of final approval of a settlement and, accordingly, we recorded a non-recurring pre-tax adjustment to earnings of \$159.3 million in the second quarter of 2011. For additional information regarding the provider class action, refer to Note E, Contingencies, to the condensed consolidated financial statements, which is incorporated herein by reference.

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*Depreciation and Amortization*

Depreciation and amortization expense was lower during the current year nine-month period primarily due to certain assets becoming fully depreciated.

*Interest Expense and Other Income, Net*

Interest expense increased due to the issuance of our 2021 Notes in the second quarter of 2011, as discussed above. This increase was partially offset by reduced interest expense on our revolving credit facility due to the repayment of the outstanding balance in the second quarter of 2011.

Other income, net increased as income in the current nine-month period included larger realized gains on the sales of investments.

*Income Taxes*

The provision for income taxes increased from the prior year due to an increase in earnings. The effective tax rate on operations remained the same at 36.0% for both periods.

**Segment Results**

	Quarters Ended September 30,		Increase	Nine Months Ended September 30,		Increase
	2011	2010	(Decrease)	2011	2010	(Decrease)
<b>Operating Revenues (in thousands)</b>						
Commercial risk	\$ 1,497,133	\$ 1,380,019	\$ 117,114	\$ 4,499,081	\$ 4,064,696	\$ 434,385
Commercial Management Services	79,615	79,869	(254)	231,473	245,222	(13,749)
Medicare Advantage	591,051	522,202	68,849	1,783,534	1,534,877	248,657
Medicaid Risk	316,255	286,762	29,493	933,109	820,994	112,115
<b>Health Plan and Medical Services</b>	<b>2,484,054</b>	<b>2,268,852</b>	<b>215,202</b>	<b>7,447,197</b>	<b>6,665,789</b>	<b>781,408</b>
Medicare Part D	271,947	348,784	(76,837)	946,588	1,246,257	(299,669)
Other Premiums	26,341	25,054	1,287	79,465	75,360	4,105
Other Management Services	22,195	25,700	(3,505)	72,606	75,158	(2,552)
<b>Specialized Managed Care</b>	<b>320,483</b>	<b>399,538</b>	<b>(79,055)</b>	<b>1,098,659</b>	<b>1,396,775</b>	<b>(298,116)</b>
<b>Workers' Compensation</b>	<b>196,198</b>	<b>189,485</b>	<b>6,713</b>	<b>587,821</b>	<b>565,635</b>	<b>22,186</b>
Other/Eliminations	(25,192)	(22,094)	(3,098)	(76,150)	(65,299)	(10,851)
<b>Total Operating Revenues</b>	<b>\$ 2,975,543</b>	<b>\$ 2,835,781</b>	<b>\$ 139,762</b>	<b>\$ 9,057,527</b>	<b>\$ 8,562,900</b>	<b>\$ 494,627</b>

**Gross Margin (in thousands)**

Health Plan and Medical Services	\$ 498,482	\$ 576,916	\$ (78,434)	\$ 1,548,007	\$ 1,658,855	\$ (110,848)
Specialized Managed Care	97,804	108,817	(11,013)	219,525	235,874	(16,349)
Workers' Compensation	124,687	124,847	(160)	378,218	377,735	483
Other/Eliminations	(2,509)	(2,453)	(56)	(7,347)	(7,378)	31
<b>Total Gross Margin</b>	<b>\$ 718,464</b>	<b>\$ 808,127</b>	<b>\$ (89,663)</b>	<b>\$ 2,138,403</b>	<b>\$ 2,265,086</b>	<b>\$ (126,683)</b>

**Revenue and Medical Cost Statistics**

**Managed Care Premium Yields (per member per month):**

Health plan commercial group risk	\$321.43	\$315.82	1.8%	\$321.74	\$313.95	2.5%
Medicare Advantage risk (1)	\$893.22	\$899.89	(0.7%)	\$895.13	\$884.22	1.2%
Medicare Part D (2)	\$ 94.10	\$ 87.56	7.5%	\$ 92.89	\$ 88.70	4.7%
Medicaid risk	\$226.39	\$215.51	5.0%	\$221.94	\$217.29	2.1%

**Medical Loss Ratios:**

Health plan commercial group risk	82.5%	76.8%	5.7%	81.3%	78.4%	2.9%
Medicare Advantage risk (1)	82.0%	77.0%	5.0%	83.0%	81.3%	1.7%
Medicare Part D	76.8%	79.0%	(2.2%)	88.0%	89.2%	(1.2%)
Medicaid risk	88.1%	89.0%	(0.9%)	87.0%	85.8%	1.2%
<b>Total MLR</b>	<b>81.5%</b>	<b>77.2%</b>	<b>4.3%</b>	<b>82.1%</b>	<b>79.5%</b>	<b>2.6%</b>

(1) Beginning Q1 2010 excludes the Medicare PFFS product, which was not renewed effective January 1, 2010.

(2) Revenue per member per month Medicare excludes the effect of the CMS risk-share premium adjustments and revenue ceded to external parties.

**Health Plan and Medical Services Division**

*Quarters and Nine Months Ended September 30, 2011 and 2010*

Health Plan and Medical Services division revenue increased for the quarter and nine months ended September 30, 2011 as compared to the quarters and nine months ended September 30, 2010, primarily due to the acquisition of MHP in 2010 as well as entry into two new Medicaid markets during 2010 in the State of Nebraska and the Commonwealth of Pennsylvania. Partially offsetting this increase in revenue was a decrease in Commercial Management Services revenue due to a decline of our FEHBP membership. The increase in Commercial Risk revenue was primarily due to the acquisition of MHP, as well as organic membership growth, and was partially offset by the accruals for the minimum MLR rebates, discussed above. There was an increase in the average realized premium per member per month for the Commercial Risk business due to renewal rate increases. Medicare Advantage revenues increased primarily due to the acquisition of MHP, as well as a general increase in premiums per member per month. The increase in Medicaid Risk revenue is due primarily to the two new markets entered during 2010, as discussed above. The Medicaid Risk premiums per member per month increased as a result of a rate increase effective July 1, 2011, in Missouri, our largest Medicaid market as well as a change in member mix in our new State of Nebraska market.

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The gross margin for this Division decreased for the quarter and nine months ended September 30, 2011 as compared to the quarter and nine months ended September 30, 2010, primarily due to the accrual for the minimum MLR rebate for our Commercial business, discussed above, and a decrease in the Medicare Private Fee-for-Service ("Medicare PFFS") gross margin. The Medicare PFFS product was not renewed effective January 1, 2010. The Medicare PFFS gross margin decrease was a result of lower favorable incurred but not reported reserve development for the Medicare PFFS product experienced in the current year nine-month period, compared to the prior year nine-month period. These decreases were offset by the acquisition of MHP, as well as organic growth in existing markets. The Commercial Group Risk MLR increased for the quarter and nine months ended September 30, 2011 as compared to the quarter and nine months ended September 30, 2010, primarily due to the accruals for the minimum MLR rebates, discussed above, as well as utilization beginning to return to normal levels. The Medicare Advantage MLR and Medicaid MLR have increased for the quarter and nine months ended September 30, 2011 as compared to the quarter and nine months ended September 30, 2010, primarily due to utilization beginning to return to normal levels. The Medicare Advantage MLR for the nine months ended September 30, 2011 is largely consistent with our 2011 Medicare bid estimates.

### **Specialized Managed Care Division**

#### *Quarters and Nine Months Ended September 30, 2011 and 2010*

Specialized Managed Care division revenue decreased from the quarter and nine months ended September 30, 2011 as compared to the quarter and nine months ended September 30, 2010, primarily due to lower Medicare Part D membership as a result of the loss of auto assign regions as well as a reduction in product offerings from five in 2010 to two in 2011. Including the effect of the CMS risk sharing premium adjustments as well as ceded revenue, the premium per member per month was \$91.15 in 2011 compared to \$86.09 in 2010. Excluding the effect of CMS risk sharing premium adjustments and revenue ceded to external parties, Medicare Part D premium per member per month for 2011 increased to \$92.89 compared to \$88.70 in 2010, primarily due to pharmacy cost trends and the loss of the lower priced premium products.

When reviewing the premium yield for the Medicare Part D business, we believe that adjusting for the ceded revenue is useful for comparisons to competitors that may not have similar ceding arrangements. When reviewing the Medicare Part D business, adjusting for the risk sharing amounts is useful to understand the results of the Part D business because of our expectation that the risk sharing revenue will eventually be insignificant on a full year basis.

The decrease in gross margin was driven primarily by the Medicare Part D membership losses. This is partially offset by improved MLR on the Medicare Part D product and improved performance in our Mental Health products. The Medicare Part D MLR was lower than the prior year period as a result of improved performance in our basic benefit product in 2011.

### **Workers' Compensation Division**

#### *Quarters and Nine Months Ended September 30, 2011 and 2010*

Workers' Compensation division revenue increased for the quarter and nine months ended September 30, 2011 as compared to the quarter and nine months ended September 30, 2010 primarily due to the growth of our pharmacy benefit management program, which was partially offset by a decline in volume and rates in our network products.

Workers' Compensation gross margin decreased slightly for the quarter ended September 30, 2011 as compared to the quarter ended September 30, 2010 primarily due to decline in volume and rates in our network products offset by increased volume in our pharmacy benefit management program. Gross margin increased slightly for the nine months ended September 30, 2011 as compared to the nine months ended September 30, 2010 due to the growth of our pharmacy benefit management program. The increase was partially offset by a decline in volume and rates in our network products.

## **Liquidity and Capital Resources**

### **Liquidity**

Our investment guidelines require our fixed income securities to be investment grade in order to provide liquidity to meet future payment obligations and minimize the risk to principal. The fixed income portfolio includes government and corporate securities with an average quality rating of "AA" and an effective duration of 2.85 years as of September 30, 2011. Typically, the amount and duration of our short-term assets are more than sufficient to pay for our short-term liabilities, and we do not anticipate that sales of our long-term investment portfolio will be necessary to fund our claims liabilities.

Our cash and investments, consisting of cash and cash equivalents and short-term and long-term investments, but excluding deposits of \$73.4 million at September 30, 2011 and \$79.9 million at December 31, 2010 that are restricted under state regulations, increased by \$713.8 million, to \$4.7 billion at September 30, 2011 from \$4.0 billion at December 31, 2010.

We have classified all of our investments as available-for-sale securities. Contractual maturities of the securities are disclosed in Note G, Investments, to the condensed consolidated financial statements, which is incorporated herein by reference.

The demand for our products and services is subject to many economic fluctuations, risks, and uncertainties that could materially affect the way we do business. Management believes that the combination of our ability to generate cash flows from operations, our cash and investments on hand, and the excess funds held in certain of our regulated subsidiaries will be sufficient to fund continuing operations, capital expenditures, debt interest costs, debt principal repayments, and any other reasonably likely future cash requirements. In addition, our long-term investment portfolio is available for further liquidity needs, including satisfaction of policy holder benefits. Please refer to Part II, Item 1A, "Risk Factors," of this Form 10-Q, as well as Part II, Item 1A, "Risk Factors," of our Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, and Part I, Item 1A, "Risk Factors," of our Annual Report on Form 10-K for the year ended December 31, 2010, for more information about how risks and uncertainties could materially affect our business.

### **Cash Flows**

Net cash from operating activities for the nine months ended September 30, 2011 was an inflow as a result of net earnings, net of adjustments, and an increase in deferred revenue related to the early receipt of the October 2011 Medicare premium payment from CMS. Offsetting these inflows was \$150.5 million paid to settle the provider class action litigation in Louisiana. For additional information regarding this matter, refer to Note E, Contingencies, to the condensed consolidated financial statements, which is incorporated herein by reference.

Our net cash from operating activities for the nine months ended September 30, 2011 increased by \$449.5 million from the corresponding 2010 period. The increase was a result of the unusually low cash flows in the prior year due to payments of medical claims liabilities associated with the non-renewal of the Medicare PFFS product, effective January 1, 2010. The nature of our business is such that premium revenues are generally received in advance of the expected cash payment for the related medical costs. This results in strong cash inflows upon the implementation of a benefit program and cash outflows upon the termination. Also contributing to the increase in net cash from operating activities was the early receipt of the October 2011 Medicare premium payment from CMS and a decrease in other accrued liabilities outflows as a result of lower tax payments during the current nine-month period compared to the prior year. The lower tax payments in 2011 were a result of recognizing the deduction in 2011 for the settlement paid related to the provider class action in Louisiana.

Net cash from investing activities was an outflow for the nine months ended September 30, 2011, primarily due to investment purchases during the period. This outflow was partially offset by the proceeds received from the sales and maturities of investments.

Projected capital expenditures for fiscal year 2011 are estimated at \$70 to \$80 million and consist primarily of computer hardware, software and other equipment.

Net cash from financing activities was an inflow, primarily due to the proceeds from the issuance of the 2021 Notes, net of discount and issuance costs, partially offset by the repayment of the \$380.0 million outstanding balance on the previous revolving credit facility and share repurchases during the nine months ended September 30, 2011.

On June 22, 2011, we entered into a five-year revolving credit facility agreement in the principal amount of \$750.0 million. As of September 30, 2011, there were no amounts outstanding under this credit facility. For more information, refer to Note D, Debt, to the condensed consolidated financial statements, which is incorporated herein by reference.

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Under the share repurchase program, we purchased 4.3 million shares and 7.4 million shares of our common stock during the quarter and nine months ended September 30, 2011 at an aggregate cost of \$127.5 million and \$227.7 million, respectively. As of September 30, 2011, \$101.6 million of the repurchased shares were settled and paid for by the Company. The remaining shares costing \$25.9 million were settled and paid by October 5, 2011. As of September 30, 2011, the total remaining number of common shares we are authorized to repurchase under this program is 5.3 million.

### **Health Plans**

Our regulated Health Maintenance Organization (“HMO”) and insurance company subsidiaries are required by state regulatory agencies to maintain minimum surplus balances, thereby limiting the dividends our parent company may receive from our regulated subsidiaries. During the nine-months ended September 30, 2011, we received \$489.4 million in dividends from our regulated subsidiaries and made \$1.0 million in capital contributions to them. We had approximately \$1.7 billion of regulated capital and surplus at September 30, 2011.

We believe that all of our subsidiaries that incur medical claims maintain more than adequate liquidity and capital resources to meet these short-term obligations as a matter of both our policy and state insurance regulations.

Excluding funds held by entities subject to regulation and excluding our equity method investments, we had cash and investments of approximately \$1.6 billion and \$1.1 billion at September 30, 2011 and December 31, 2010, respectively. The increase primarily resulted from the issuance of the 2021 Notes discussed previously, dividends received from our regulated subsidiaries, and earnings generated from our non-regulated entities partially offset by repayment of debt, share repurchases and a cash payment into escrow related to the provider class action litigation in Louisiana.

### **Outlook**

*Health Plan and Medical Services Division* – We expect our Commercial Risk membership will be flat to slightly down for 2011 as compared to the 2010 ending membership of approximately 1.6 million. The forecasted Commercial group MLR is expected to be in the range of 80.5% to 81.5%, an increase from the 2010 MLR of 79.2%, largely driven by compliance with new healthcare reform regulations. The forecasted Commercial Individual MLR is expected to be in the range of 75.0% to 77.0%, an increase from the 2010 MLR of 66.1%, largely driven by compliance with new healthcare reform regulations.

For our Health Plan based Medicare Advantage product, we are forecasting membership to be slightly down for 2011 as compared to 2010. We expect the 2011 Medicare Advantage MLR to be in the lower end of the mid 80%’s, as compared to the 2010 MLR of 82.0%.

For our Health Plan based Medicaid business, we are forecasting a 2011 MLR in the high 80%’s.

*Specialized Managed Care Division* – We anticipate year-end membership in our Medicare Part D product to be down by approximately 500,000 members at December 31, 2011 from approximately 1.6 million at December 31, 2010. This decrease reflects the loss of auto assign regions as well as membership losses driven by a reduction in product offerings from five in 2010 to two in 2011. Our Medicare Part D MLR for 2011 is expected to be approximately consistent with the 2010 MLR.

*Workers’ Compensation Division* – We believe our Workers’ Compensation Division will grow slightly compared to 2010 with continued focus on streamlining the supporting administrative cost structure.

Regarding our balance sheet and liquidity, we ended the third quarter with approximately \$1.15 billion in free cash at the parent level which includes a provision for the cash required to fund the Children’s Mercy’s Family Health Partners acquisition. See Note L, Subsequent Events, to the condensed consolidated financial statements for additional information, which is incorporated herein by reference. After supporting the regulatory capital needs of our subsidiaries and maintaining overall liquidity, our first priority for deployment of our free cash is acquisitions.

We expect our effective tax rate will range from 35.5% to 36.5% for the full year of 2011.

### **Legal Proceedings**

See Note E, Contingencies, to the condensed consolidated financial statements for information and disclosures related to contingencies, which is incorporated herein by reference.

**ITEM 3: Quantitative and Qualitative Disclosures About Market Risk**

These disclosures should be read in conjunction with the condensed consolidated financial statements, Management’s Discussion and Analysis of Financial Condition and Results of Operations, and other information presented herein as well as in the Quantitative and Qualitative Disclosures About Market Risk section contained in our Annual Report on Form 10–K for the year ended December 31, 2010.

No material changes have occurred in our exposure to market risk since the date of our Annual Report on Form 10–K for the year ended December 31, 2010.

**ITEM 4: Controls and Procedures**

We have performed an evaluation as of the end of the period covered by this report of the effectiveness of our “disclosure controls and procedures” (as defined in Rule 13a-15(e) promulgated under the Securities Exchange Act of 1934), under the supervision and with the participation of our Chief Executive Officer and our Chief Financial Officer. Based upon our evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective.

There have been no significant changes in our internal control over financial reporting (as defined in Rule 13a–15(f) promulgated under the Securities and Exchange Act of 1934) during the quarter ended September 30, 2011 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

**PART II. OTHER INFORMATION**

**ITEM 1: Legal Proceedings**

See Note E, Contingencies, to the condensed consolidated financial statements for information and disclosures related to contingencies which is incorporated herein by reference.

**ITEM 1A: Risk Factors**

There have been no material changes with respect to the risk factors disclosed in our Annual Report on Form 10-K for the year ended December 31, 2010, as updated in our quarterly report on Form 10-Q for the quarter ended March 31, 2011.

**ITEM 2: Unregistered Sales of Equity Securities and Use of Proceeds**

The following table presents information about our purchases of our common shares during the quarter ended September 30, 2011 (in thousands, except average price paid per share information):

	<b>Total Number of Shares Purchased (1)</b>	<b>Average Price Paid per Share</b>	<b>Total Number of Shares Purchased as Part of Publicly Announced Plans</b>	<b>Maximum Number of Shares That May Yet Be Purchased Under The Plan or Program (2)</b>
July 1-31, 2011	-	\$ -	-	9,586
August 1-31, 2011	3,388	\$ 29.61	3,377	6,209
September 1-30, 2011	981	\$ 28.93	951	5,258
Totals	<u>4,369</u>	<u>\$ 29.46</u>	<u>4,328</u>	

- (1) Includes shares purchased in connection with the vesting of restricted stock awards to satisfy employees’ minimum statutory tax withholding obligations.
- (2) These shares are under a stock repurchase program previously announced on December 20, 1999, as amended. In March 2011, our Board of Directors approved an increase to the share repurchase program in an amount equal to 5% of our then outstanding common stock, thus increasing our repurchase authorization by 7.5 million shares.

**ITEM 3: Defaults Upon Senior Securities**

Not Applicable.

**ITEM 4: (Removed and Reserved)**

[Table of Contents](#)

**ITEM 5: Other Information**

Not Applicable.

**ITEM 6: Exhibits**

<b>Exhibit No.</b>	<b>Description of Exhibit</b>
31.1	Certification pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 made by Allen F. Wise, Chief Executive Officer and Chairman.
31.2	Certification pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 made by Randy P. Giles, Executive Vice President, Chief Financial Officer and Treasurer.
32	Certification pursuant to 18 U.S.C. Section 1350 as adopted pursuant to section 906 of the Sarbanes-Oxley Act of 2002 made by Allen F. Wise, Chief Executive Officer and Chairman and Randy P. Giles, Executive Vice President, Chief Financial Officer and Treasurer.
101	The following financial statements from Coventry Health Care, Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2011, formatted in eXtensible Business Reporting Language (XBRL): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Condensed Consolidated Statements of Cash Flows, and (iv) Notes to Condensed Consolidated Financial Statements.

**SIGNATURES**

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

**COVENTRY HEALTH CARE, INC.**

(Registrant)

Date: November 4, 2011

By: /s/ Allen F. Wise

Allen F. Wise

Chief Executive Officer and Chairman

Date: November 4, 2011

By: /s/ Randy P. Giles

Randy P. Giles

Executive Vice President, Chief Financial Officer and Treasurer

Date: November 4, 2011

By: /s/ John J. Ruhlmann

John J. Ruhlmann

Senior Vice President and Corporate Controller

INDEX TO EXHIBITS

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**CERTIFICATION PURSUANT TO  
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Allen F. Wise, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Coventry Health Care, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - a. designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - b. designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - c. evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - d. disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent functions):
  - a. all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - b. any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

By: /s/ Allen F. Wise  
Allen F. Wise  
Chief Executive Officer and Chairman  
Date: November 4, 2011

---

**CERTIFICATION PURSUANT TO  
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Randy P. Giles, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Coventry Health Care, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - a. designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - b. designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - c. evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - d. disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent functions):
  - a. all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - b. any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

By: /s/ Randy P. Giles  
Randy P. Giles  
Executive Vice President, Chief Financial  
Officer and Treasurer  
Date: November 4, 2011

---

**CERTIFICATION PURSUANT TO  
18 U.S.C. SECTION 1350  
AS ADOPTED PURSUANT TO  
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Quarterly Report of Coventry Health Care, Inc. (the "Company") on Form 10-Q for the period ending September 30, 2011, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned hereby certifies, pursuant to 18 U.S.C. ss. 1350, as adopted pursuant to ss. 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: November 4, 2011

By: /s/ Allen F. Wise  
Allen F. Wise  
Chief Executive Officer and Chairman

By: /s/ Randy P. Giles  
Randy P. Giles  
Executive Vice President, Chief Financial Officer and  
Treasurer

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Commonwealth of Pennsylvania



Department of Health  
and  
Insurance Department  
**CERTIFICATE OF AUTHORITY**  
TO OPERATE A HEALTH MAINTENANCE ORGANIZATION

This is to Certify that

HealthAmerica Pennsylvania, Inc.

Is Hereby Granted This Approval Under The Laws Of The Commonwealth Relating To Health Maintenance Organizations  
To Operate And Maintain A Health Maintenance Organization To Be Known As

HealthAmerica Pennsylvania, HealthAmerica of Pittsburgh, HealthAmerica of Central Pennsylvania

IN WITNESS WHEREOF, I have  
hereunto set my hand, and  
affixed the official seal of  
the Department of Health  
at the City of Harrisburg  
this 24th day of January 19 87

*Ch. Frank Richards, Jr.*  
Secretary of Health

IN WITNESS WHEREOF, I have  
hereunto set my hand, and  
affixed the official seal of  
the Insurance Department  
at the City of Harrisburg  
this 31st day of January 19 89

*Constance B. Fox*  
Insurance Commissioner

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# Commonwealth of Pennsylvania



DEPARTMENT OF HEALTH  
P. O. BOX 90  
HARRISBURG 17108-0090

DEPUTY SECRETARY FOR  
QUALITY ASSURANCE

January 13, 2010

(717) 783-1078

N. Timothy Guarneschelli  
Vice President and General Counsel  
HealthAmerica/HealthAssurance  
P.O. Box 67103  
3721 TecPort Drive  
Harrisburg, Pennsylvania 17106-7103

Re: HealthChoices – Southeast Pennsylvania

Dear Mr. Guarneschelli:

HealthAmerica has requested approval to operate in the five southeast Pennsylvania counties for HealthChoices business starting April 1, 2010. The Department of Health has reviewed the standard provider contracts, the network information and other materials that HealthAmerica has submitted in support of this expansion request. In addition, HealthAmerica commits to providing members with out-of-network coverage for any covered service in the event that no in-network provider is available or a reasonable appointment time cannot be obtained. Therefore, based upon this review, the Department of Health is approving HealthAmerica for HealthChoices business in Southeast Pennsylvania.

Sincerely,

A handwritten signature in cursive script that reads "Stacy Mitchell".

Stacy Mitchell

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**APPENDIX L**  
**DOMESTIC WORKFORCE UTILIZATION CERTIFICATION (07/24/09)**

To the extent permitted by the laws and treaties of the United States, each proposal will be scored for its commitment to use the domestic workforce in the fulfillment of the contract. Maximum consideration will be given to those offerors who will perform the contracted direct labor exclusively within the geographical boundaries of the United States or within the geographical boundaries of a country that is a party to the World Trade Organization Government Procurement Agreement. Those who propose to perform a portion of the direct labor outside of the United States and not within the geographical boundaries of a party to the World Trade Organization Government Procurement Agreement will receive a correspondingly smaller score for this criterion. In order to be eligible for any consideration for this criterion, offerors must complete and sign the following certification. This certification will be included as a contractual obligation when the contract is executed. Failure to complete and sign this certification will result in no consideration being given to the offeror for this criterion.

I, Chief Executive Officer [title] of HealthAmerica Pennsylvania, Inc. [name of Contractor] a Pennsylvania [place of incorporation] corporation or other legal entity, ("Contractor") located at 3721 TecPort Drive, Harrisburg, PA 17111 [address], having a Social Security or Federal Identification Number of 25-1264318, do hereby certify and represent to the Commonwealth of Pennsylvania ("Commonwealth") (Check one of the boxes below):

All of the direct labor performed within the scope of services under the contract will be performed exclusively within the geographical boundaries of the United States or one of the following countries that is a party to the World Trade Organization Government Procurement Agreement: Aruba, Austria, Belgium, Bulgaria, Canada, Chinese Taipei, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hong Kong, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Liechtenstein, Lithuania, Luxemburg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Singapore, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom

OR

\_\_\_\_\_ percent (\_\_\_\_ %) [Contractor must specify the percentage] of the direct labor performed within the scope of services under the contract will be performed within the geographical boundaries of the United States or within the geographical boundaries of one of the countries listed above that is a party to the World Trade Organization Government Procurement Agreement. Please identify the direct labor performed under the contract that will be performed outside the United States and not within the geographical boundaries of a party to the World Trade Organization Government Procurement Agreement and identify the country where the direct labor will be performed: \_\_\_\_\_

[Use additional sheets if necessary]

The Department of General Services [or other purchasing agency] shall treat any misstatement as fraudulent concealment of the true facts punishable under Section 4904 of the *Pennsylvania Crimes Code*, Title 18, of Pa. Consolidated Statutes.

Attest or Witness:

Jane Criniti  
Signature/Date

Jane Criniti, Administrative Assistant  
Printed Name/Title

HealthAmerica Pennsylvania, Inc.

Corporate or Legal Entity's Name

David W Fields  
Signature/Date

David W. Fields, CEO  
Printed Name/Title

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# **Business Continuity and Disaster Recovery For Coventry Health Care, Inc.**

Last Update: Nov. 22, 2011

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All rights reserved. This document was developed specifically for Coventry Health Care, Inc. The concepts and methodologies contained herein are proprietary and confidential to Coventry Health Care. Duplication, reproduction or disclosure of information in this document without the express written consent of Coventry Health Care Information Security Management is prohibited.

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## **Purpose**

This document provides general information relating to the Coventry Health Care, Inc. Business Continuity and Disaster Recovery Programs. Coventry actively engages in comprehensive business continuity and disaster recovery planning. Our plans are designed to include all levels within the organization.

## **Business Continuity and Disaster Recovery Organizations**

Coventry uses team approaches for the creation, testing, and implementation of business continuity and disaster recovery plans. Each team consists of a team leader, an alternate team leader, and team members. Teams are organized for response, recovery, and resumption actions following an incident.

Business continuity is organized and facilitated through our Business Continuity Office. The BC Office provides direction and control for ongoing business continuity planning for the business processes within Coventry.

Disaster recovery (IT based) at Coventry is organized and facilitated through our Disaster Recovery Office. The Disaster Recovery Office provides direction and control for ongoing disaster recovery planning efforts.

## **Business Continuity Office**

The Business Continuity Office was created to facilitate the business continuity and resumption processes within Coventry. The Business Continuity Office has the authority to:

- Create and maintain the business resumption process
- Facilitate plan development and testing
- Provide tools and resources to resumption teams
- Communicate the progress of business continuity efforts to management
- Provide direction and control with business resumption efforts at time of an interruption
- Communicate business continuity efforts to the Disaster Recovery Office

## **Business Continuity Plans (BCP)**

Objectives of business continuity plans at Coventry are to:

- Create an organized and effective approach for business resumption after an event occurs interrupting the normal business processes
- Minimize the impact of a business interruption
- Recover critical processes and activities within pre-determined timelines

- Resume business processes and activities back to normal as quickly as possible following an interruption

### **Disaster Recovery Office**

The Disaster Recovery Office was created to facilitate the disaster recovery process within Coventry Health Care. The Disaster Recovery Office has the authority to:

- Create and maintain the disaster recovery process
- Facilitate plan development and testing
- Provide tools and resources to IT planning teams
- Communicate the progress of disaster recovery efforts to management
- Provide direction and control with disaster recovery efforts
- Communicate disaster recovery efforts to the Business Continuity Office

### **Disaster Recovery Plans (DR)**

Objectives of disaster recovery plans at Coventry are to:

- Create an organized and effective approach for response to information technology interruptions
- Minimize the effects of an interruption
- Recover critical applications and technology infrastructures within pre-determined timelines
- Restore technology activities back to normal as quickly as possible following an interruption

### ***Testing***

Coventry recognizes that the testing of business continuity and disaster recovery plans is important; therefore, testing of these plans is a requirement. The plans are tested annually or as the business changes. Coventry's business resumption methodology outlines details associated with the comprehensive recovery testing of critical applications and systems.

### **Planning Resources**

Coventry uses standard planning resources for business continuity and disaster recovery in all areas of the organization. These resources were created or acquired to assist in planning, testing and maintenance. Resources include: Business

Continuity Office, Disaster Recovery Office, software, methodology, plan templates, alternate recovery sites (hot sites), and off-site storage vaults.

## **Software**

Coventry has acquired a third-party software tool for the purpose of creating, testing, and implementing business continuity and disaster recovery plans. This software tool has been customized to follow the standard planning approach used by Coventry. The software is hosted by the third-party and copies of the plans are maintained in a Coventry shared directory.

## **Methodology**

This is a step-by-step approach to the creation and testing of business continuity and disaster recovery plans. The process creates a standard approach to developing all types of BCP and DR plans. Included in this process are the testing and maintenance phases that help keep plans current once they are developed.

## **Plan Templates**

Plan templates were developed and integrated into the software tool. These templates help the planning process by providing standard formats for each plan.

## **Risk Avoidance Measures**

### ***Facility Physical Security***

- Continuous physical onsite security
- Card access required to enter any building from the exterior
- Manned security check points at building entrances and exits
- Building surveillance cameras inside and outside (including roof) with continuous video recording
- Physical tours within the facility by security personnel at frequent intervals
- Continuous security access logging

### ***Environmental Monitoring***

- Active facility monitoring system, which activate alarms locally as well as remotely via an escalating auto paging system

### ***Facility monitoring of data center and supporting areas***

- Ceiling mounted smoke detectors
- Smoke detectors mounted within raised floor areas
- Temperature monitors
- Humidity monitors
- Water entry and leak monitors
- Computerized Maintenance Management System (CMMS) ensures all maintenance protocols are performed correctly and on time

### ***Emergency Electrical Power***

- Dedicated electrical feed for the data center
- Separate electrical feed for all supporting areas
- Electrical power monitoring and emergency failover
- Emergency power generator
- Weekly backup generator testing
- Generator capacity: .75 megawatt
- UPS Battery (parallel redundant system)
- Onsite 3 day fuel supply of the generator
- Priority fuel delivery contracts to ensure fuel during extended emergencies

### ***Fire Suppression Measures***

- Fire suppression monitoring in place
- Gaseous fire suppression (Inergen) to protect below and above the data center raised floor
- Backup double interlocked sprinkler system

### ***Facility Environmental Control – HVAC***

- All data center cooling equipment is redundant
- Full monitoring of the cooling system

### ***Additional System Redundancy Measures***

- Telecommunication Controls including the ability to reroute calls
- Multiple telecommunication feeds originating from separate Central Teleco offices
- Fault tolerant disk subsystems utilizing RAID 5 technology

## **Incident Declaration**

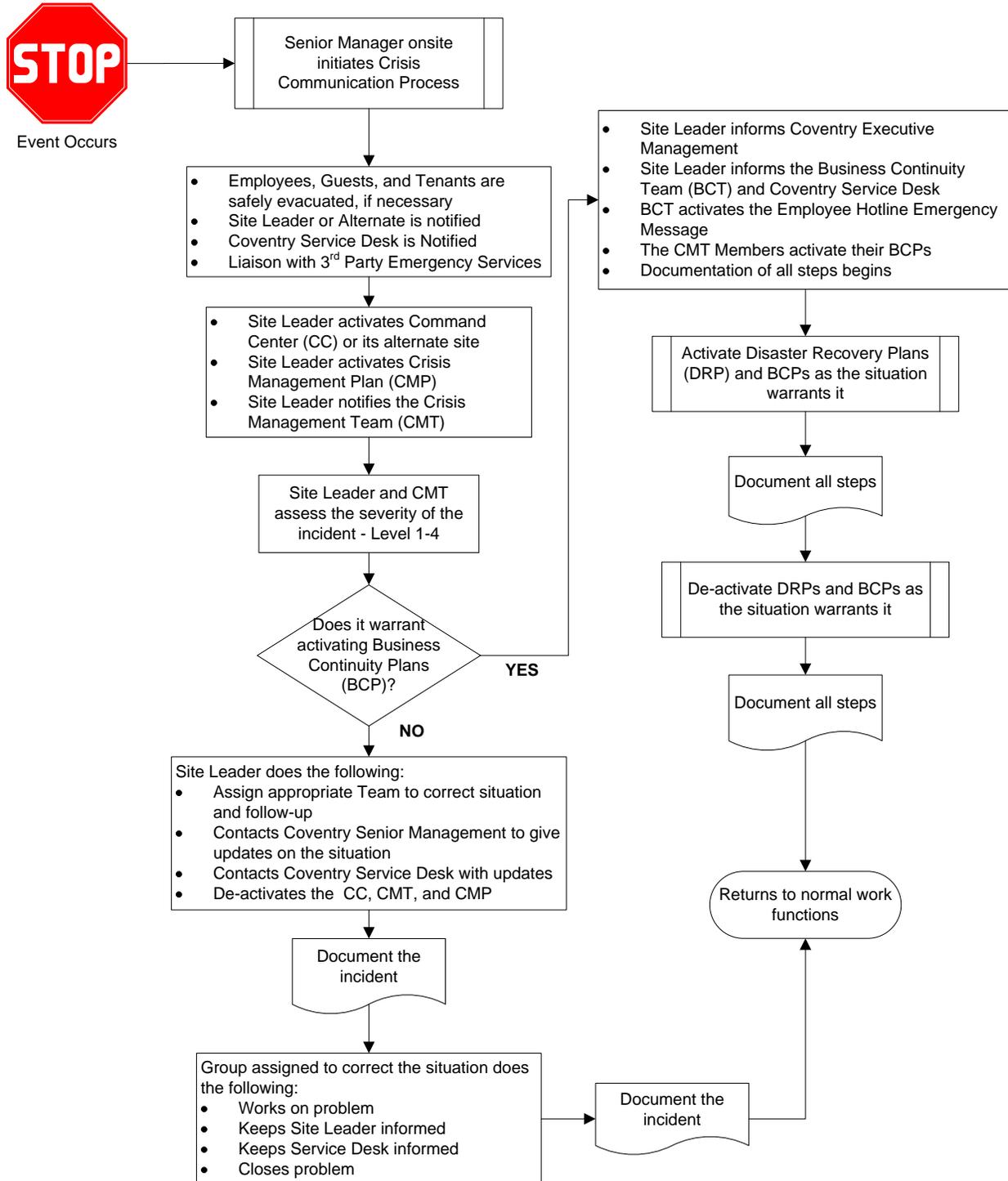
### Coventry IT Disaster Declaration Team

The Disaster Declaration Authorization team (DDAT) is authorized to declare a disaster. The IT disaster recovery hotsite and backup data offsite providers interface with members of the DDAT during an activation. The use of authentication ensures the validity of a declaration. At the time of the declaration, members of DDAT notify the Executive Crisis Management Team of the decision to activate. A disaster is based on extent and duration of the event. The Executive Crisis Management Team is kept informed regarding any extended service outage that may affect our members and providers. Additional client notification is coordinated by Account Management.

## **Worker's Compensation BCP Procedures**

Worker's Compensation billing process is performed in two Coventry locations, Tampa, Florida and Tucson, Arizona. Testing the failover from Tampa to Tucson is performed and documented annually to ensure that appropriate processes are kept current.

### Crisis Communication Flowchart



## **Incident Declaration at Other Coventry Facilities**

Each Coventry location has its own autonomous Crisis Management (CMP) and Business Continuity (BCP) plans. The Crisis Management Team (CMT) is comprised of the senior leader and all managers at that location. Each BCP contains the internal management escalation and notification procedures. Plans are maintained and updated by each site's business continuity team.

## **Recovery Strategy**

Coventry has an agreement with a third party vendor (IBM) for the purpose of providing alternate recovery facilities (hotsite). A hotsite is the main facility where recovered hardware and network infrastructure would reside. This 'hotsite' and the various local access suites provide facilities and hardware resources, which enable expedient recovery of critical systems and business functions. Recovery facilities are conveniently located remotely from the production Data Centers.

## **Backup and Offsite Storage Overview**

Daily backup of critical data

Data is backed up nightly and stored in an offsite vault

### **Iron Mountain Offsite Storage Facility**

- The offsite vaulting service ensures our backup data is always protected and retrievable wherever and whenever we need it
- The data resides in a safe physical environment to ensure its protection from corruption, contamination, or exposure
- Inside and outside perimeter security cameras are positioned throughout the offsite vault facility
- Security badge and identification is required throughout the vault facility
- Identification badge scanning is included throughout the vault facility
- Limitation of physical access to the vault area by authorized personnel only
- Continuous inspection and audit of the vault facility
- Backup tape retrieval, authorized only by specific Coventry staff members, is password protected
- Coventry employees may enter the vault only when escorted by vault personnel
- Coventry vaulted media may only be accessed by Coventry personnel

## **Recovery Exercises**

Coventry's objective is to test the disaster recovery process for critical applications twice annually.

The Disaster Recovery Exercise was conducted May 13-15, 2011 at the IBM recovery center in Sterling Forest, NY.

## **Next Disaster Recovery Exercise**

The Disaster Recovery coordinators work with the recovery team members and IBM to schedule the exercise, define objectives, and perform the next recovery exercise. The next Disaster Recovery exercise is scheduled for December 7-9, 2011 (60 hours).

## **Customer Service Operations (CSO) Backup/Contingency Capabilities**

In the event of an uneven distribution of call volume coming into the Customer Service Call Centers, calls can be readily re-allocated to other call centers. Coventry has 9 major CSO's located in dispersed areas of the country. The CSO's are capable of supporting one another's customer calls in the event of a failure. Telephone traffic can be rerouted to any of these facilities in order to provide service while repairs are underway. This type of back-up service ensures customer access to Coventry at all times.

Coventry's state-of-the-art Call Centers assures that members always have access to a Customer Service Representative (CSR) even in the event of a disaster at one site. Should any one of our Call Centers experience an emergency situation (natural catastrophe, physical/building problems, etc.), Coventry routes inbound calls to an alternative site. The routing of calls to an alternative site is one part of Coventry's formal business continuity plan. This plan is summarized:

- A systematic routing of inbound phone calls to alternate CSO sites
- Formal management communication among site Vice Presidents to ensure appropriate staffing and site management
- Daily debriefing sessions to ensure all operational areas are kept current on status

## **Epidemic and/or Pandemic Preparedness**

Coventry monitors the World Health Organization's (WHO) Epidemic and Pandemic Alert and Response operations, the Centers for Disease Control (CDC), Federal Emergency Management Agency (FEMA) and other sources as appropriate to ensure that up-to-the-minute communications regarding the worldwide status of spreading diseases are available. Coventry's corporate crisis management team is tasked with

overall event coordination as identified during the crisis management triage process. Primary command-and-control operations are coordinated through Coventry's corporate headquarters located in Bethesda, Maryland.

The following key points are outlined in the preparedness plan:

- Business Continuity planning for Coventry's operations
  - Call Center/Customer Service
  - Corporate Facilities
  - Corporate Data Center(s)
  - Member Communications
  - Optional Coventry's Emergency Responses
- Personal hygiene recommendations, enhanced workplace cleanliness, development of policies on social distancing (e.g., minimizing face-to-face meetings)
- Expansion of "work at home" capabilities

## **Examples of Recent / Relevant Disruptive events and actions taken by Coventry Health Care, Inc.**

### ***Incident Response (2011) – Virginia Earthquake***

On August 23, 2011 at 1:51 PM EDT a magnitude 5.9 earthquake occurred with the epicenter near Mineral, VA. The quake was felt from Georgia to Canada and as far west as Illinois, triggering evacuations in multiple Coventry sites on the East coast. Phones for the Newark, DE Customer Service Organization (CSO) were re-routed to the Houston, TX site temporarily during the disruption until staff could safely re-enter the building.

A staff member who lives in VA notified the Business Continuity Team (BCT) as she was experiencing the earthquake. The BCT initiated an open communication conference line on behalf of business leaders during the event ensuring continuity of operations for the large CSO in the Newark office and gathering critical information on the status of the 19 sites impacted by the quake. All but one site allowed re-entry of staff within <30 minutes and experienced little to no business impact. A small office in West Virginia closed for the day due to local authorities mandating no re-entry to the building for the day.

### ***Incident Response (2011) – Winter Storms***



The Winter of 2011 produced a higher than normal number of severe storms, blanketing not just the Northeast and Eastern seaboard but the Midwest, Southeast and deep South with various types of hazardous participation - snow, ice, and freezing rain.

Coventry experienced delayed site openings, early office closures, and some site outages or closures at ~30% of their sites located in the impacted areas during 1Q2011 with no impact to our members and providers. Coventry is a geographically dispersed organization with the established failover capabilities. A strategy is in place and was implemented to ensure capacity requirements for an increase of telecommuting and remote services.

### ***Incident Response (2009) - G20 Summit***

The city of Pittsburgh, Pennsylvania was declared the host city for the September 2009 G20 Summit. Coventry has an office located in the downtown area as represented by the blue box towards the lower left side of the picture. The convention center is the large building towards the upper right side of the picture.



As information was disseminated to the local business leaders, Coventry made the decision to close the office on Stanwix for three days, September 23 – 25, 2009. Arrangements were made to relocate employees to other offices in Pennsylvania or to work from home. With the ability to pre-plan this closure, Coventry did not experience any interruptions of service and customers were not impacted.

### ***Incident Response (2008) - Hurricane Ike***

During hurricane season, Coventry's Business Continuity Team (BCT) monitors NOAA's National Hurricane Center. As Hurricane Ike was forming in the Atlantic, the BCT watched the situation very closely. When it became apparent that Ike's trajectory was close to Houston, Texas, the Crisis Management Team (CMT) began meetings to discuss the BCP. The decision was made to close the office in Houston at 11:15 PM, Thursday, September 11, 2008. Calls were re-routed to other call centers and our

systems were shut down calmly. Many of Coventry's Houston employees were in mandatory evacuation areas and had to move inland. Daily status conference calls were made as Ike hit Galveston, Texas. Houston suffered area-wide power outages and Coventry's CSO was affected. Our backup CSO's continued to provide service until power to the facility was restored on Thursday, September 18, 2008. The office was re-opened on Friday, September 19, 2008.

## **Summary**

Through the Business Continuity and Disaster Recovery Offices, Coventry employs leading-edge planning solutions to help meet clients' expectations and deliver world-class products and services. Coventry recognizes that business continuity and disaster recovery are ongoing activities and that they are subject to change without notice.