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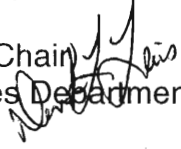
FINANCE AND ADMINISTRATIVE SERVICES DEPARTMENT

115 S. Andrews Avenue, Room 513 • Fort Lauderdale, Florida 33301
954-357-7130 • FAX 954-357-7134 • Email: finance@broward.org

MEMORANDUM

DATE: August 19, 2010

TO: Insurance Selection Committee
Phil Allen, Director, Port Everglades
Kent George, Director, Aviation Department
Kayla Olsen, Director, Office of Management and Budget
Chris Walton, Director, Transportation Department

FROM: Dinah L. Lewis, CFO/Director (SC Chair) 
Finance and Administrative Services Department

RE: Insurance Selection Committee Meeting
Combination Short listing/Presentation and Ranking Meeting
Health Insurance Program – Plan Year 2011

The meeting of the above referenced Selection Committee is scheduled for August 26, 2010 at 9:30 - 1:30pm, in Room 430 of the Broward County Governmental Center, 115 South Andrews, Ft. Lauderdale, Florida.

Attached please find an Agenda, Minutes and accompanying Executive Summary from EDIFY, our benefits consultant.

Cc: Kevin Kelleher, Interim Director, Human Resources
Danielle French, Interim Director, Risk Management
Evan Lukic, County Auditor
Adam Katzman, Assistant County Attorney
Mary O'Donnell, Interim Director, Accounting Division
Karen Walbridge, Purchasing Division
Mitch Cohen, Purchasing Division
Norman Taylor, Director Economic Development
Karen Ruh, Employee Benefit Services Manager
Howard Gruverman, EDIFY

AGENDA
for
SELECTION COMMITTEE
HEALTH INSURANCE RLI
RLI # R0843005R1

August 26, 2010, 9:30 am - 1:30 p.m.
Broward County Governmental Center – Room #430

Combination Shortlisting/Presentation and Ranking Meeting

1. CALL TO ORDER
 - a. Day, date, time and place of meeting
 - b. State the purpose of meeting
 - c. Quorum of voting members is present
 - d. Circulation of Sign-In sheet
 - e. Cone of Silence
2. APPROVE MINUTES – JUNE 24, 2010
3. ESTIMATED TIME PERIOD TO CONCLUDE AGREEMENT NEGOTIATIONS
4. CONSULTANT/STAFF PRESENTATION – REVIEW OF SUBMITTALS
5. DETERMINATION TO DEVELOP A SHORTLIST AND RANKING FOR EACH OF THE FUNDING OPTIONS: FULLY- INSURED AND SELF-INSURED.
6. DETERMINATION OF RESPONDENTS RESPONSIVENESS
7. DETERMINATION OF RESPONDENTS RESPONSIBILITY
8. DETERMINATION OF FIRMS TO BE SHORT LISTED
9. VOTING – TALLY BALLOTS
10. APPROVE NAMES OF SHORTLISTED FIRMS
11. VENDOR PRESENTATIONS
12. COMMITTEE INSTRUCTIONS AND DISCUSSION ON SELECTED VENDOR'S PLAN DESIGNS
13. DISCUSSION AND VOTE TO RANK FIRMS AND TALLY BALLOTS
14. *OTHER BUSINESS*
15. ADJOURN MEETING

BROWARD COUNTY HEALTH INSURANCE SELECTION COMMITTEE
115 S Andrews Ave - Room 430, Fort Lauderdale, FL 33301

MINUTES OF JUNE 24, 2010 MEETING, 9:00 A.M.

MEMBERS PRESENT:

Vice Mayor Sue Gunzburger
Commissioner Albert Jones
Commissioner Ilene Lieberman
Commissioner Lois Wexler
Dinah L. Lewis, CFO/Director, Finance and Administrative Services Department
Phil Allen, Director, Port Everglades Department
Kayla Olsen, Director, Office of Management and Budget

MEMBERS ABSENT: Mayor Ken Keechl
Commissioner Rodstrom

OTHERS PRESENT:

Torey Alston, Chief of Staff, County Commission Office
Kevin Kelleher, Interim Director, Human Resources
Evan Lukic and Mike Keeler, County Auditor's Office
Justin Shepherd, Office of Budget and Management
Adam Katzman, County Attorney's Office
Howard Gruverman, Amy Tree and Julie Biles, EDIFY
Peter Joseph, Regional Vice President, John Cantillo, Cathy Aguirre, Dally Perez,
Coventry Health Care
Al Zingales, Regional Manager, AFLAC
R. Parker-Pickett, Workforce One
Karen Walbridge and Mitch Cohen, Purchasing Division
Leah Brasso, Assistant to Department Director, Finance and Administrative Services
Department
Will Vargas, FOPE
Mary Ann Smith and Rick Cutshaw, GSAF
Karen Ruh, Lisa Morrison, Tammy Futrell, and Paulette Jules, Human Resources
Division

A meeting of the Insurance Selection Committee was held on Thursday, June 24, 2010, in Room 430 of the Governmental Center, 115 S. Andrews Avenue, Fort Lauderdale.

The Chair called the meeting to order at 9:05a.m. Members of the Committee present were: Dinah Lewis, CFO/Director, Finance and Administrative Services Department, and Chair of the Committee, Vice Mayor Sue Gunzburger, Commissioners Albert Jones, Ilene Lieberman, Lois Wexler, and Phil Allen, Director Port Everglades Department, Kayla Olsen, Director, Office of Management and Budget, plus staff from EDIFY, the County's Benefit Consultant and staff from the County Attorney's Office, the County Auditor's Office, Human Resources and Purchasing.

The first item on the agenda was the approval of the minutes. Vice Mayor Gunzburger made a motion and it was seconded by Commissioner Jones, the motion carried unanimously.

The Chair stated that the purpose of the meeting was for EDIFY to give a presentation including information about Broward County's Health Insurance contract history to date and present options going forward.

Prior to EDIFY's presentation, Mr. Kelleher provided the additional information requested at the May 25, 2010 meeting specifically whether AFLAC provided a group rate. He advised that AFLAC does provide a discount to the County's current plan as opposed to a direct pay basis. Mr. Kelleher also advised there were no renewals remaining and the options were to release an RLI or not offer these plans. He advised that staff had met with the Union Advisory Committee previously and they indicated they would like to see the existing plan continue. Mr. Kelleher asked Purchasing if there was a way of extending the current contract. Ms. Walbridge responded that it cannot be extended. Mr. Allen asked if the Board has the ability to waive the procurement code to which Vice Mayor Gunzburger asked the County Attorney for an opinion. Commissioner Jones asked if waiving would present any other problems. Mr. Katzman responded that the better option would be to release an RLI or the Board can waive the procurement code.

Commissioner Lieberman asked what would happen to people who wanted to continue in the existing plan, if a new vendor or group plan was chosen. Ms. Ruh responded that they would be guaranteed the same premium as they are currently paying and would be direct billed on a monthly basis.

Commissioner Lieberman expressed her concerns regarding the group rate being significantly lower than an individual policy direct bill rate. She also asked if the 300 people currently in the plan were to switch to a new vendor would that vendor also maintain the group rate on a direct bill method of payment. Ms. Ruh responded that this would be included as part of the contract.

Commissioner Lieberman requested that staff look at the current contract because the direct pay is substantially higher; Vice Mayor Gunzburger answered in the affirmative. Commissioner Lieberman further stated that with furlough days and other plan changes the possible increase to employees caused her concern.

Mr. Allen stated that he thought that the contract was still in place and the Board would have the ability to amend it by adding another year. Mr. Kelleher confirmed that the contract does not expire until December 31, 2010.

Mr. Allen then clarified that between now and December 31, 2010, the Board would have the ability to add another year and that as major changes are likely to the overall benefit programs another year could be added. The Chair confirmed with Ms. Walbridge that it is still a live contract and that the option of extending the contract for another year was possible.

Ms. Walbridge responded that a contract that is not expired can be amended. The Chair requested an opinion from Mr. Katzman and he responded that the Board can waive the procurement code as long as the contract is not expired.

Commissioner Lieberman recommended that the response should be to amend the existing contract to provide one year additional extension to the contract.

Mr. Allen suggested that a friendly amendment be made and Commissioner Lieberman advised that it should be at the same rates or less and this was seconded by Vice Mayor Gunzburger and Mr. Allen. Then Commissioner Wexler suggested an additional friendly amendment that it be imbedded that this is the last year. Commissioner Lieberman indicated her agreement.

Mr. Lukic stated that in his opinion regardless of the action or proposal from the Committee today, it seems important to pursue the issue of whether or not benefits are going to continue beyond the expiration of this contract. He further suggested that the Committee direct the County Attorney's office to follow up relative to continuation of these benefits at the group cost when and if this contract ends. Mr. Lukic suggested that the vote be tabled until the information is obtained.

The Chair then asked Commissioner Lieberman to clarify her motion. Commissioner Lieberman responded that the original motion was to move on with the agenda and lay this on the table to give the County Attorney a chance to look at the contract.

Commissioner Jones stated that we need to know about the grandfathering status.

Commissioner Lieberman advised that this was also a major concern for her because of the difference from direct pay is from \$3.00 - \$7.00 per week and with all the other changes this year, this is not a year to force those additional costs.

The Chair then advised if there was no objection, this item would be laid on the table and brought up at the end of the meeting.

The Chair advised that the next item was a presentation on the health insurance renewal negotiation.

Mr. Kelleher provided a brief summary of the current situation and stated that at the May 18, 2010 meeting, the Insurance Committee voted to defer the decision to conduct an RLI for the 2011 health benefits and instructed EDIFY and staff to negotiate with Coventry and return with a final cost of the current plan design, a zero plan option and any other recommended options in between. EDIFY and staff negotiated with Coventry on multiple occasions and is prepared to present their results from those negotiations. These options were also shared with the County's Union Advisory Group which indicated its concern over the cost of the existing plan and the proposed radical changes in the new plan design. Furthermore due to the possibility of a premium increase for the new plan design, the union groups indicated their preference is to stay with the plan closer to the current plan design less the gym membership even if it resulted in a premium increase. He further advised the options to be considered today

were to accept Coventry's renewal proposal of any one of the plan designs or reject Coventry's renewal proposal and issue the RLI that was approved by the Board on June 15, 2010 and with any other plan options. He further stated this meeting has been sunshined as a negotiation meeting so if Coventry wanted to update any renewal rates they are free to do so.

Commissioner Wexler advised that she saw two choices either keeping the plan the way it is and direct staff to ask the Board for additional monies from the reserves or release the RLI.

Commissioner Lieberman advised that she didn't think there was any other options other than to put out an RLI and the Committee just needed to talk about plan designs.

Commissioner Jones advised that going out with an RLI would provide an opportunity to see what is in the marketplace.

Commissioner Lieberman made a motion to release the RLI and was seconded by Commissioner Jones and Vice Mayor Gunzburger the motion passed unanimously.

The Chair advised the Committee that the RLI had been approved by the Board, but has not been released by Purchasing staff.

Mr. Gruverman advised that some work still has to be done on the RLI and will be completed by the following Monday or Tuesday. He also stated that he thought it was imperative that the Committee come up with some direction so the RLI can be more specific.

Vice Mayor Gunzburger stated the gym membership should be taken out next year and Commissioner Jones agreed.

Ms. Olsen suggested that three plan designs be prepared one being the current design as a baseline, the second being the two million dollar increase on the Coventry proposal and something in between that.

Commissioner Wexler stated that she was interested in releasing a plan design which the Committee can embrace and although the peach plan (which is a hybrid that includes co-pays for primary care physicians, specialists, emergency room and allergy co-pays) addressed the money aspect, it is significantly more costly to the employee, so there is no way she could consider this plan. She then requested that Mr. Gruverman use his expertise to craft a creative plan that would save money.

Mr. Gruverman advised that there were a couple of comments he thought were pertinent to consider as we're going to be here next year and we're going to have a similar discussion about health care because health care costs are increasing and in designing plans for his clients across the Country it's the same conversation: that they have to give the people the tools to be accountable for their actions, they have to give them choices that will incentivize the right behavior just as we've talked about a core and a buy-up strategy.

Commissioner Wexler advised that this was the School Board's model which is not as rich as Broward County.

Mr. Gruverman further stated that there are three parts to the plan. The employee is impacted by their contribution, the benefits they pay when they receive services from a physician or an ancillary provider and their HRA account. He further stated that the HRA account is real dollars and becomes their money unless they leave or retire. The second thing is providing incentives for people to be healthy. He further stated that people do things for fear or greed and we have to give people the right reasons to go and get a physical; go to an urgent care center, primary physician or the emergency room. He further stated that in 2009, the County had 21,546 primary care physician visits, and 58,061 specialist's visits; in addition, 1,973 emergency room visits and 974 people in the hospital overnight. He stated that we have to look at these kinds of things and give people the proper incentives to do the right things.

Mr. Gruverman then addressed the core buy-up strategy and advised that this is a well thought out and well developed process that is being used across the County and further stated it is going to meet the qualifications of the Government with the new Health Care Reform Act and is something that is going to be stable and predictable over time. He stated the question was how we can mitigate increasing costs by giving people tools and educating people to change their behaviors.

Vice Mayor Gunzburger advised that she had one question to be included in the RLI which was how much they match the current providers, so we know how much disruption if their doctor is not on the new plan.

Commissioner Lieberman noted that there is a small number of people that have very high catastrophic claims and asked the question is there any ability to deal with that on a separate level. Mr. Gruverman responded that the County has stop-loss on a fully insured basis. Commissioner Lieberman responded that the problem with the current stop-loss policy is that it raises the premium and the 43% of the group rate we spent \$500.00 or less for medical insurance. Commissioner Lieberman further asked if there was a way to move into a re-insurance or some other mechanism with catastrophic coverage for claims above a certain amount.

Commissioner Lieberman commented that there are people who have good health behaviors who do wellness without us incentivizing them and they are 43% of our group claim and there are people who don't have good behavior, for some people it's outside their control, but there are some people who continue to adopt non-wellness.

Commissioner Lieberman also stated that she needed a better understanding of HSA's versus HRA's. She also stated that the issue of opt-out's needs to be addressed.

Commissioner Lieberman suggested that the Committee decide how much money they have to spend and request the insurance companies provide their best plan for the money available and further stated that she was not interested in seeing plans that exceed the budgeted amount.

Mr. Gruverman responded that there are two types of large claims: there are chronic patients and acute patients and we don't know who they are, but you're going to have these kinds of patients every year. He further stated that re-insurance is absolutely critical and that you pay a premium to mitigate the highs and lows so this needs to be part of the plan design. He further advised that today, there is an eight million dollar difference so the employees have to pay that through contributions or the County has to absorb it. Even through a competitive bid, if there is a two or three million dollar difference, that has to be shared. So the only way to change it without changing the benefits is to give people the incentive to make different choices that are less expensive. He further stated that RX is 20% and this was another creative solution that the Committee would have to come up with and give people the reason to do the things the Committee mentioned.

Commissioner Lieberman then asked about HSA versus HRA.

Mr. Gruverman responded that the way the current HRA is set up, it is similar to an HSA, the only difference is that the current plan is set up for first dollar coverage whereas with HSA's there is no first dollar coverage.

Mr. Allen asked if the plan design is a self-insured or a fully-insured plan.

Mr. Gruverman responded that was part of the RLI and in 2009 the County would have been responsible for two million dollars more if the County were self-insured and not fully-insured.

Commissioner Wexler then addressed the issue of the opt-out and stated that at some point it needs to be discussed about it being reduced to zero and further asked for clarification regarding the HRA if the \$600.00 HRA contribution was just for the employee or each dependent.

Mr. Gruverman confirmed that \$600.00 is for the employee only and spouse gets \$600.00 and family coverage is more.

Commissioner Wexler continued that the Committee had to look at the totality of the contributions of the employee and the County and try to find that balance and encourage people to be well and not to take advantage. Perhaps offering programs where children could be insured and it's not just putting an RLI on the street and receiving bids but understanding the total cost to County Government for a program. She further stated it's trying to find that balance of what we put in the plan design and encourage wellness and not make it punitive. She further stated that she was starting from the premise that looking at no raises this year and five furlough days that the health insurance should not become more punitive for employees.

Mr. Gruverman then commented on self-insurance. He stated that self-insurance is something continually being evaluated. It is not something we're going to say didn't work last year so we're never going to evaluate it again.

Commissioner Lieberman advised that the problem was the risk of the 587 employees whose claims are \$10,000.00 or more and eight or ten claims which are close to one million dollars.

The Chair suggested that the Committee should ask for various plan designs in the RLI and that the issues of funding and cost sharing would be addressed at that time.

Mr. Kelleher stated the funding of the insurance program, which is separate from the plan design discussion, and is presented to the entire Board in late August or September.

Commissioner Lieberman then addressed the issue of self-insurance and stated that 7% of the work force has claims of \$10,000.00 or more and until we get a handle on what's causing the catastrophic claims and how to reduce them, we cannot be self-insured.

Ms. Olsen then responded regarding concerns about the opt-out amount, HRA amounts, premium distribution among tiers, pharmacy rate and health premiums. She advised the first thing the Committee needs is to have something manageable that they can work with and then bring the other things together as a full package so the Committee can see the entire picture. She further stated that the Committee really can't do anything with any of these situations until we have a series of health premiums that we can work with and based on this go out for a few different plan design scenarios that will coincide with the budget.

Commissioner Wexler stated that she recognized that this meeting was regarding plan design to issue the RLI but sooner or later the Committee needed to have the conversation regarding the funding because that's the net dollar amount that costs the County. The Chair indicated her agreement with Commissioner Wexler's submission.

Vice Mayor Gunzburger asked the question how much the opt-out costs the County. Mr. Gruverman responded about three million dollars and it was confirmed by Ms. Olsen. Ms. Olsen went on to advise that opt-out employees are the least expensive employees on the plan.

Vice Mayor Gunzburger asked the question if it would pay for the County to go down to zero. Ms. Olsen responded it would be more costly. Chair stated assuming that all of the people that opted-out would opt-in. This was confirmed by Ms. Olsen. Mr. Kelleher stated that it is a balancing act and that there was probably still room for reduction and further reduction is being reviewed. Mr. Gruverman stated the average cost was \$9,300.00 per employee enrolled per year versus \$3,100.00 and successfully during the last two years it has been reduced down slowly to a manageable point.

Vice Mayor Gunzburger noted that not all of them are healthy and may have a better plan with a spouse. Mr. Gruverman verified that information.

Vice Mayor Gunzburger further noted that some employees opt-out because they don't need our plan, but we don't know how many are taking another plan through a spouse or partner and how many are taking it because they feel they are young and healthy.

Mr. Allen noted that they still have to prove they have insurance in order to receive the opt-out. Mr. Kelleher advised that currently this is not the case. Mr. Gruverman stated that this is an issue that needs to be reviewed. The Chair advised that staff will obtain the data and the demographic of ages.

Chair indicated that we are now at a point where the Committee needs to make a decision about the plan and what plan designs to include in the RLI and asked what else was to be included.

The Committee members then discussed their individual ideas concerning the direction of the health insurance plan.

Mr. Allen indicated that he had a question for Purchasing and the County Attorney, question being can the Committee appropriately delegate the authority to the consultant and staff to come up with a plan design or does the Committee have to endorse a specific plan design before the release of the RLI?

Ms. Walbridge responded that the approval of the RLI documents is at the purview of the Purchasing Director and the Committee does not need to approve it.

Committee Members discussed the issues associated with the re-insurance aspect of the plan. The Chair summarized the discussion by stating that the Committee wants a disclosure on the re-insurance in the RLI response.

Mr. Gruverman clarified that this should specify who the re-insurer was and who has the ultimate risk.

The Chair then directed staff to include this in the RLI, for the current plan under fully- and self-insured.

Ms. Ruh asked Mr. Gruverman if he has statistics on the financial aspect from moving from the HMO to the CDH plans. Mr. Gruverman advised that the HMO is more costly.

The Chair asked for a show of hands of those members of the Committee who would like to include in the RLI the current plan and then those members who would like to see in the RLI the light blue CDH plan (100% coinsurance model). The Chair then asked who could support the peach model (hybrid model with copays and coinsurance).

The Chair confirmed that the Committee was going to ask for those three alternatives and open it up for any other alternatives that the responder would like to include. The Chair asked if that was acceptable to the Committee as a recommendation.

Commissioners Jones, Lieberman and Wexler indicated their assent.

The Chair indicated the next item to be discussed was the pharmacy and the negotiated rate from Walgreens pharmacy renewal.

Mr. Gruverman advised that the County contract with Walgreens does not expire for another year after this year but in the middle of the contract contractual changes were negotiated which lowered the cost by about \$715,000.00.

Commissioner Lieberman asked if there was any negative to accepting the changes.

Mr. Gruverman responded no.

Commissioner Lieberman then made a motion to accept the negotiated changes and was seconded by Vice Mayor Gunzburger.

A discussion amongst the Committee members ensued regarding issues concerning prescribing generic as opposed to brand name medicines and concerns regarding education about the formulary for employees.

The Chair asked if there was an update from the County Attorney's office regarding the AFLAC contract.

Mr. Katzman stated he reviewed the contract and the contract does not explicitly guarantee a rate for an employee, if the coverage expires.

The Chair clarified that the contract had not expired.

Mr. Katzman stated this was correct however there could be an option to clarify with AFLAC if they would do that and then process an amendment to the contract or there is still the alternative of the RLI.

Commissioner Lieberman indicated that she would like to continue the program at this time.

The Chair clarified that Commissioner Lieberman's motion was to extend the contract for one year.

Commissioner Lieberman stated just one year.

Mr. Lukic asked if it was the practice with AFLAC to continue coverage at the current rate.

Mr. Kelleher responded that Al Zingales the Regional Business Representative indicated that current individuals would pay the same amount even after the year, but on a direct pay basis.

The Chair asked Commissioner Lieberman if her motion should include that clarification in the contract extension.

Commissioner Lieberman advised that in her opinion Mr. Zingales would have to come forward and tell the Committee that he was authorized to bind his company, and say that if an RLI was issued this year, and he is not chosen, then his company would offer the current rates and issue direct bill otherwise you would have to deal with issues in an extension.

Chair clarified that the motion was to extend the contract with conditions.

Commissioner Lieberman clarified that tail coverage should be requested in the extension.

Chair asked if there was a second to the motion, which produced multiple seconds.

Commissioner Wexler asked the Chair if the motion was to extend and continue payroll deductions for this year. Commissioner Lieberman responded yes.

Chair asked for a vote, unanimously passed.

The Chair asked for any further business, and hearing none the meeting was adjourned.



FINANCE AND ADMINISTRATIVE SERVICES DEPARTMENT
PURCHASING DIVISION

115 S. Andrews Avenue, Room 212 • Fort Lauderdale, Florida 33301 • 954-357-6065 • FAX 954-357-8535

DATE: August 12, 2010

TO: Selection Committee Members

THRU: Brenda J. Billingsley, Director *BAB*
Purchasing Division

FROM: Mitch Cohen, Purchasing Negotiator *MC*

SUBJECT: Responsiveness and Responsibility Determination
RLI No: R0843005R1 Health Insurance Services

REFERENCE: (a) Procurement Code Subsection 21.83 e
(b) Procurement Code Subsection 21.30.f.5
(c) Summary Report provided by the Project Manager

In accordance with reference (a), the Purchasing Director reviews all submittals for responsiveness, and recommends to the Selection Committee her findings, which the Selection Committee may accept or arrive at a different conclusion.

Three (3) submittals were received by the Purchasing Division. No Certified Business Enterprise (CBE) participation goal requirements were assigned to this RLI and therefore the Office of Economic and Small Business Development Division has made no determination of responsiveness. At the request of the Director of Purchasing, the Office of Economic and Small Business Development Division reviewed the submittals to identify any programs that would indicate a respondent's intention of having certified CBE firm(s) participation, since the Office of Economic and Small Business Development Division encouraged, rather than required, CBE participation for this project. None of the respondents defined any CBE participation in their proposals.

In accordance with reference (b), the Selection Committee determines whether or not the firms submitting proposals are responsible. Pursuant to Procurement Code Subsection 21.8.b.65, a responsible firm is one that has the capability in all respects to perform fully the contract requirements, and the integrity and reliability which will assure good faith performance. To assist the Selection Committee in this determination, the disclosure of financial information and litigation history is provided.

A draft of the Purchasing Director's Recommendation Memorandum and the three (3) supporting memoranda from the Office of Economic and Small Business Development, the Accounting Division, and the County Attorney's Office were e-mailed to proposers with a request that, if the proposers desired to explain any deficiencies noted in their RLI response submittals, they should do so in writing. All written explanations were subsequently reviewed by the Accounting Division, and the County Attorney's Office. Information in the Office of Economic and Small Business Development supporting memorandum serves as the basis for the Purchasing Director's recommendation of responsiveness or non-responsiveness as to the CBE requirements. The information in the supporting memoranda from the Accounting Division and the County Attorney's Office is provided for use by each Selection Committee member in his or her individual evaluation of the firms for short listing.

RLI No: R0843005R1
Health Insurance
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A. RESPONSIVENESS RECOMMENDATION

Recommendations regarding the responsiveness of proposers to the County Business Enterprise Program requirements are based on the following criteria from the RLI:

Office of Economic and Small Business Development Division Program

The Broward County Business Opportunity Act of 2004 and the County Business Enterprise (CBE) Act of 2009 establish the County's policies for participation by small business enterprises, county business enterprises, and federal disadvantaged business enterprises in all County contracts and in other selected activities.

There were no goals assigned to this RLI.

After careful review of the information provided in reference (b) against the requirements of the RLI as detailed above, the following recommendations are provided for consideration and final determination by the Selection Committee:

| <u>Name of Firm</u> | <u>Findings of Responsiveness</u> | <u>Remarks</u> |
|----------------------|-----------------------------------|----------------|
| Aetna | Not Applicable | CBE |
| Coventry Health Care | Not Applicable | CBE |
| United Healthcare | Not Applicable | CBE |

Although the Office of Economic and Small Business Development assigned no specific CBE project goals to the RLI for Health Insurance Services, the Office of Economic and Small Business Development has encouraged health insurance vendors to utilize the services of CBE-certified firms whenever possible.

In their July 30, 2010 Memo, the Office of Economic and Small Business Development reported on their office's review of the three vendor submittals to determine if any defined subcontractors in the submittals were CBE-certified. None of the three proposing firms listed CBE-certified firms in their list of subcontractors.

Since the Office of Economic and Small Business Development established no CBE goal requirements, but rather encouraged proposing firms to utilize CBE-certified firms, this is not a matter of responsiveness and is only provided for the information of the Selection Committee.

1. DISCLOSURE OF FINANCIAL INFORMATION

The information provided below is intended to inform the Selection Committee regarding each proposer's disclosure or failure to disclose financial information. The information provided is based on a review by the Accounting Division.

The disclosure of financial information by proposers is a matter of responsibility. Each Selection Committee member should consider and reflect his or her individual assessment of each proposer's responsibility regarding the requested disclosure of litigation history in his or her overall evaluation, short list determination, and/or ranking.

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Health Insurance
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Additional details from the Finance Division concerning each proposer's disclosure or failure to disclose the required financial information are provided in the following summary:

ACCOUNTING DIVISION:

Two (2) of the three (3) firms submitted financial information in accordance with the RLI requirements and were determined to have met the financial responsibility requirements. Aetna was the only firm to not provide the financial information with their submittal.

Aetna – Aetna did not submit two (2) years of financial information in accordance with the RLI requirements. However, as Aetna is a publicly held corporation, traded on the NYSE, the Accounting Division Director was able to obtain the companies financials via the internet.

A draft of the Purchasing Director's Memorandum was forwarded to Aetna with a request for further information. Aetna did not respond or provide further information.

Therefore, each member of the Selection Committee should consider this information and give it whatever weight he or she deems appropriate in evaluating all the firm's compliance with the financial information disclosure requirement of the RLI.

Coventry Health Care – Coventry Health Care did supply a copy of their summary of financial statements as reported in their annual earnings report to shareholders. A draft of the Purchasing Director's Memorandum was forwarded to Coventry Health Care with a request for further information. Coventry Health Care did not respond or provide further information.

Therefore, each member of the Selection Committee should consider this information and give it whatever weight he or she deems appropriate in evaluating the firm's compliance with the financial information disclosure requirement of the RLI.

United Healthcare – United Healthcare did supply a copy of their summary of financial statements as reported in their annual earnings report to shareholders. A draft of the Purchasing Director's Memorandum was forwarded to United Healthcare with a request for further information. United Healthcare did not respond or provide further information.

Therefore, each member of the Selection Committee should consider this information and give it whatever weight he or she deems appropriate in evaluating the firm's compliance with the financial information disclosure requirement of the RLI.

2. DISCLOSURE OF LITIGATION HISTORY

The information provided below is intended to inform the Selection Committee regarding each proposer's disclosure or failure to disclose its litigation history. The information provided is based on review by the County Attorney's Office:

The disclosure of litigation information by proposers is a matter of responsibility. Each Selection Committee member should consider and reflect his or her individual assessment of each proposer's responsibility regarding the requested disclosure of litigation history in his or her overall evaluation, short list determination, and/or ranking.

RLI No: R0843005R1
Health Insurance
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Additional details from the County Attorney's Office concerning each proposer's disclosure or failure to disclose its required litigation history are provided in the following summaries:

COUNTY ATTORNEY'S OFFICE:

Aetna – Aetna disclosed no (0) cases and complaints in its RLI submittal. The County Attorney's Office found thirty-nine (39) cases in the past three years which were not disclosed by the company. The firm did state in its submittal, "There is no litigation that would materially affect Aetna's ability to provide the services proposed under this RFP....All material litigation is reported in Aetna's public filings on www.aetna.com." A draft of the Purchasing Director's Memorandum was forwarded to the firm for further information about the undisclosed cases. Aetna did not respond or provide further information.

Therefore, each member of the Selection Committee should consider this information and give it whatever weight he or she deems appropriate in evaluating the firm's compliance with the litigation history information disclosure requirement of the RLI.

Coventry Health Care – Coventry Health Care disclosed no (0) cases and complaints in its RLI submittal. The County Attorney's Office found thirty-five (35) cases in the past three years which were not disclosed by the company. The firm did state "...there will be no material adverse effect on the plan's financial position or results of operations resulting from the litigation."

A draft of the Purchasing Director's Memorandum was forwarded to the firm for further information about the undisclosed cases. Coventry Health Care did respond with a statement that "...Coventry is willing to disclose litigation specifics as requested on a case by case basis." They also provided an updated litigation history.

Therefore, each member of the Selection Committee should consider this information and give it whatever weight he or she deems appropriate in evaluating the firm's compliance with the litigation history information disclosure requirement of the RLI.

United Healthcare – United Healthcare disclosed no (0) cases and complaints in its RLI submittal. The County Attorney's Office found sixty-three (63) cases in the past three years which were not disclosed by the company. The firm stated "...The majority of suits brought against our company are brought by those seeking to challenge benefit decisions or allege liability for malfeasance of some nature...." A draft of the Purchasing Director's Memorandum was forwarded to the firm for further information about the undisclosed case. United Healthcare did not respond or provide further information.

Therefore, each member of the Selection Committee should consider this information and give it whatever weight he or she deems appropriate in evaluating the firm's compliance with the litigation history information disclosure requirement of the RLI.

Copy to: Kevin Kelleher, Interim Director, Human Resources Division
Karen Ruh, Employee Benefits Manager, Human Resources Division
Adam Katzman, Assistant County Attorney
Glenn Miller, Assistant County Attorney
Karen Walbridge, Purchasing Manager, Purchasing Division

BJB:mc

RLI No: R0843005R1
Health Insurance
Page 5 of 5

Jeffrey J. Newton
County Attorney



OFFICE OF THE COUNTY ATTORNEY
115 S. Andrews Avenue, Suite 423
Fort Lauderdale, Florida 33301


954-357-7600 · FAX 954-357-7641

July 30, 2010

HUMAN RES. AUG 2 '10 04:11:12

MEMORANDUM

TO: Kevin Kelleher,
Director of Human Resources, Broward County

From:  Adam Katzman
Assistant County Attorney

Re: **Litigation Report for Health Insurance RLI R0843005R1**

Per your request, we have prepared a litigation report for Health Insurance RLI R00843005R1, based upon a review of the following: the vendor's responses to the questionnaire regarding litigation; the results of a search of the Broward County, Palm Beach County, and Miami-Dade County Clerks of Courts' websites regarding vendor litigation filed in, or concerning, any entity or agency in those three counties; and the results of a search of the Federal Courts' website for Florida cases. Below is a compilation, by company, of the litigation history within the last three (3) years.

1. Aetna, Inc.

- a. Vendor's Response: "There is no litigation that would materially affect Aetna's ability to provide the services proposed under this RFP. Aetna and its affiliates are routinely involved in non-material litigation regarding the administration of health, life, disability, and dental plans. Most of this litigation involves a single claim for benefits or payment for provider services. All material litigation is reported in Aetna's public filings and on www.aetna.com."
- b. Broward County Clerk:
 - *North Broward Hospital District v. Aetna Health Ins. Co.*, 10-016654, Circuit Court, Contract and Indebtedness, pending.
 - *North Broward Hospital District v. Aetna Health, Inc.*, 10-002845, County Court, \$5,000-\$10,000, pending.
 - *Broward Hospital District v. Aetna Health, Inc.*, 09-016347, County Court, \$5,000-\$10,000, pending.

- *Brendon Teeter v. Aetna Health, Inc.*, 08-009649, Circuit Court, Contract and Indebtedness, pending.
- *Amisub (North Ridge) v. Aetna Health, Inc.*, 08-08390, County Court, \$5,000-\$10,000, closed.
- *Nidal Masri MD PA v. Aetna Health Ins. Co.*, 08-009224 – County Court, closed.
- *Nidal Masri MD PA v. Aetna Health Ins. Co.*, 08-009228 – County Court, closed.
- *Nidal Masri MD PA v. Aetna Health Ins. Co.*, 08-009450 – County Court, closed.
- *Nidal Masri MD PA v. Aetna Health Ins. Co.*, 08-009453 – County Court, closed.
- *Nidal Masri MD PA v. Aetna Health Ins. Co.*, 08-009230 – County Court, closed.
- *North Broward Hospital District v. Aetna Health Ins. Co.*, 09-002255, Circuit Court, Contract and Indebtedness, closed.
- *Tenet v. Aetna Health Inc.*, 09-063111, Circuit Court, Contract and Indebtedness, closed.
- *Eye Surgeons and Consultants v. Aetna Health, Inc.*, 09-056329, Circuit Court, Contract and Indebtedness, closed.
- *Aetna Health Inc., v. Dynamic Health Care Providers*, 09-004612, County Court, \$5,000-\$10,000, closed.

c. Palm Beach County Clerk:

- *Peter Peck v. Aetna*, 502010CA00457, Circuit Court, Other Negligence, pending.

d. Miami-Dade County Clerk:

- *Gabriel Salloum, MD (PA) v. Aetna Health Care*, 2010-7219-SP-23, County Court, Contract and Indebtedness, pending.
- *Gabriel Salloum, MD (PA) v. Aetna Health Care*, 2010-14709-SP-23, County Court, Contract and Indebtedness, pending.
- *Gabriel Salloum, MD (PA) v. Aetna Health Care*, 2010-14715-SP-23, County Court, Contract and Indebtedness, pending.
- *M Felix Freshwater, MD (PA) v. Aetna Health Insurance Co.*, 2010-12730-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Nidal Masri Md PA v. Aetna Health Ins. Co.*, 08-22466-CC-23 County Court, pending.
- *Mark Broudo MD PA v. Aetna Health Ins. Co.*, 08-22463-CC-23 County Court, pending.
- *Mark Broudo MD PA v. Aetna Health Ins. Co.*, 08-22465-CC-23 County Court, pending.

- *Mark Broudo MD PA v. Aetna Health Ins. Co.*, 08-22462-SP-23, County Court, pending.
- *Aetna Health Inc. v. Allied Cash Holdings*, 2008-1950-CA-01, Circuit Court, pending.
- *Baptist Hospital of Miami, Inc. v. Aetna Health Inc.*, 07-43759-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Lifemark Hospitals of Fla., Inc., v. Aetna Health Inc.*, 2009-11392-CC-23, County Court, Contract and Indebtedness, closed.
- *McCallen Medical Center v. Aetna Health Inc.*, 2009-74270-CA-01, Circuit Court, closed.
- *LifeMark Hospitals of Fla., Inc., v. Aetna Health Inc.*, 2008-63886-CA-01, Circuit Court, Contract and Indebtedness, closed.
- *Nidal Masri Md PA v. Aetna Health Ins. Co.*, 08-22467-CC-23 County Court, closed.
- *Tenet Hialeah Healthsystems Inc., v. Aetna Health Inc.*, 2008-10496-CA-01, Circuit Court, Contract and Indebtedness, closed.
- *Tenet Hialeah Healthsystems Inc. v. Aetna Health Inc.*, 08-49195-CA-01, Circuit Court, Contract and Indebtedness, closed.
- *United Surgical Ass'ts, Inc. v. Aetna Health Inc.*, 08-56180-CA-01, Circuit Court, Contract and Indebtedness, closed.
- *Tenet Hialeah Healthsystem Inc. v. Aetna Health Inc.*, 08-62353-CA-01, Circuit Court, Contract and Indebtedness, closed.

e. Florida Federal Cases:

- *Antell v. Aetna, Inc., et al.*, 10-cv-22403, Southern District of Florida, Statutory Action, pending.
- *Blaikie v. Rsight, Inc., et al.*, 09-cv-01770, Middle District of Florida, pending.
- *Frost v. Aetna Health, Inc.*, 10-cv-00071, Middle District of Florida, ERISA, closed.
- *Szambelak v. Aetna Health Ins. Co.*, 09-cv-00230, Middle District of Florida, ERISA, closed.
- *C.N. Guerriere v. Aetna Health, Inc.*, 08-cv-01139, Middle District of Florida, ERISA, closed.
- *McKinney v. Aetna Ins. Co.*, 08-cv-61164, Insurance, closed.

2. Coventry

- a. Vendor's Response: "In the normal court of business operations, we are involved in routine litigation with members, beneficiaries, and others, and a number of such

lawsuits are pending at any given time. In the opinion of the plan's leadership team, there will be no material adverse effect on the plan's financial position or results of operations resulting from the litigation. The plan is willing to disclose litigation specifics as requested on a case by case basis."

b. Broward County Clerk's Office:

- *Clayton M. Berger v. Vista Healthplan of South Fla. Inc.*, 10-10649, County Court, \$5,000-\$15,000, pending.
- *Elizabeth Perez v. Coventry Healthcare Corp. et al.*, 09-67570, Circuit Court, Negligence, pending.
- *Vista Healthplan Inc. v. Boca Raton Community Hospital*, 09-23764, Circuit Court, Contract and Indebtedness, pending.
- *Florida, Pediatric Critical Care v. Vista Healthplan of South Fla. Inc.*, 09-26623, Circuit Court, Temporary/Permanent Injunction, pending.
- *North Broward Hospital District v. Vista Healthplan, Inc.*, 08-30012, County Court, \$5,000-\$10,000, pending.
- *Ulises Quintero v. Coventry Health Care, Inc.*, 09-001363, Circuit Court, Contract and Indebtedness, closed.
- *Amaya Marshall v. Vista Healthplan, Inc., et al.*, 08-51012, other civil action, closed.
- *Rajkumar Nebhrajani v. Vista Healthplan, Inc.*, 10-00737, County Court, \$2,500-\$5,000, closed.
- *Rajkumar Nebhrajani v. Vista Healthplan, Inc.*, 10-00738, County Court, \$2,500-\$5,000, closed.
- *Rajkumar Nebhrajani v. Vista Healthplan, Inc.*, 10-00739, County Court, \$2,500-\$5,000, closed.
- *Norman Kurszewski v. Vista Healthplan, Inc.*, 08-13054, Circuit Court, Contract and Indebtedness, closed.
- *Oncology & Radiation Assoc. v. Vista Healthplan, Inc.*, 08-22997, Circuit Court, Contract and Indebtedness, closed.
- *Melissa Falkowski v. Vista Healthplan, Inc.*, 08-16221, County Court, \$5,000-\$10,000, closed.
- *Leison Maldonado v. Vista Healthplan, Inc.*, 08-53852, Circuit Court, Contract and Indebtedness, closed.
- *North Broward Hospital District v. Vista Healthplan, Inc.*, 08-30014, County Court, \$5,000-\$10,000, closed.
- *South Broward Hospital District v. Vista Healthplan, Inc.*, 09-16205, County Court, \$5,000-\$10,000, closed.
- *North Broward Hospital District v. Vista Healthplan of South Fla. Inc.*, 09-061431, Circuit Court, Contract and Indebtedness, closed.
- *North Broward Hospital District v. Vista Healthplan of South Fla. Inc.*, 09-061916, Circuit Court, Contract and Indebtedness, closed.
- *Clayton M Berger, MD (PA) v. Vista Healthplan of South Fla. Inc.*, 10-03235, County Court, \$500-\$2,500, closed.

c. Palm Beach County Clerk's Office: Website displayed 0 cases within the last 3 years.

d. Miami-Dade Clerk's Office:

- *Pathology Consultants of South Etc v. Coventry Health Care of Fla. Inc.*, 2010-16066-CA-01, Circuit Court, pending.
- *Amaya Marshall v. Coventry Health Plan of Fla. Inc.*, 2010-29311-CA-01, Circuit Court, pending.
- *Palmetto Pathology Services v. Coventry Health Care of Fla. Inc.*, 2010-35036-CA-01, Circuit Court, pending.
- *Gabriel Salloum (MD), PA v. Vista Health Care*, 2010-3752-SP-23, County Court, pending.
- *Gabriel Salloum (MD), PA v. Vista Health Care*, 2010-7220-SP-23, County Court, pending.
- *Gabriel Salloum (MD), PA v. Vista Health Care*, 2010-14713-SP-23, County Court, pending.
- *Vista Healthplan Inc. v. Vincent Chen*, 2008-15698-CA-01, Circuit Court, pending.
- *Gervasio Llorente v. Vista Healthplan Inc.*, 2008-40639-CA-01, Circuit Court, pending.
- *Palmetto Pathology Services v. Vista Healthplan of South Fla. Inc.*, 2007-21497-CA-01, Circuit Court, closed.
- *Coral Reef Radiology Association v. Vista Healthplan Inc.*, 2008-65344-CA-01, Circuit Court, closed.
- *Public Health Trust of Miami v. Vista Healthplan Inc.*, 2009-17856-CA-01, Circuit Court, closed.
- *Aida Martinez v. Vista Healthplan, Inc.*, 2009-2437-CC-24, County Court, closed.

e. Florida Federal Cases:

- *Mercy Hospital v. Autonation, Inc. et al.*, 10-cv-20066, Southern District of Florida, ERISA, pending.
- *Peter F. Merkle, MD (PA) v. Vista Healthplan, Inc.*, 10-cv-80347, Southern District of Florida, ERISA, pending.
- *Perez v. Coventry Healthcare Corp.*, 09-cv-61972, Southern District of Florida, FLSA, closed.
- *Dudley v. Vista Healthplan, Inc.*, 08-cv-60650, Southern District of Florida, ERISA, closed.

3. United Healthcare

a. Vendor's Response: "For confidentiality reasons, our company does not disclose detailed information about its litigation history. However, we are willing to share

some general comments. We have been involved in litigation incidental to providing management of health care services and administrative services. The majority of suits brought against our company are brought by those seeking to challenge benefit decisions or allege liability for malfeasance of some nature. All suits filed against our company are referred to the law department for handling. The law department does an initial assessment of the merits and recommends whether the matter should be resolved or referred to local counsel for defense. Many of the suits against the company are resolved by dispositive motion or by settlement, and none has had a known, material impact on our businesses or practices."

b. Broward County Clerk's Office:

- *North Broward Hospital District v. Maltide Elma, et al.*, 10-018470, Circuit Court, Contract and Indebtedness, pending.
- *FPC v. United Healthcare Ins. Co.*, 09-021121, Circuit Court, Other Civil Action, pending.
- *United Healthcare Ins. Co. v. General Crane Inc.*, 09-038433, Circuit Court, Contract and Indebtedness, pending.
- *Annmarie Taylor v. Edward D. Hirsch, MD (PA), et al.*, 09-0505825, Circuit Court, Negligence, pending.
- *North Broward Hospital District v. Jennifer Allen, et al.*, 08-030013, County Court, \$5,000-\$10,000, pending.
- *Anesco North Broward v. United Health Care of Fla. Inc.*, 09-006505, Circuit Court, Contract and Indebtedness, pending.
- *MBA v. Medical Diagnostic Corp., et al.*, 09-014690, Circuit Court, Contract and Indebtedness, pending.
- *North Broward Hospital District v. United Healthcare, Inc.*, 09-051819, Circuit Court, Contract and Indebtedness, closed.
- *North Broward Hospital District v. United Healthcare, Inc.*, 09-19312, Circuit Court, Contract and Indebtedness, closed.
- *United Healthcare of Fla. Inc. v. Van Dee Services, Inc.*, 08-040321, Circuit Court, Contract and Indebtedness, closed.

c. Palm Beach County Clerk's Office: Website displayed 0 cases within the last 3 years.

d. Miami-Dade County Clerk's Office:

- *Delgado v. United Healthcare of Fla. Inc.*, 2010-30182-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *AM Rywlin & Associates v. United Healthcare of Fla.*, 2010-31400-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Salloum v. United Healthcare*, 2010-14711-SP-23, County Court, Contract and Indebtedness, pending.
- *Salloum v. United Healthcare*, 2010-14712-SP-23, County Court, Contract and Indebtedness, pending.

- *Diaz v. United Healthcare of Fla. Inc.*, 2010-36041-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Collier Pathology Services v. United Healthcare of Fla. Inc.*, 2010-39222-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Salloum v. United Healthcare*, 2010-3751-SP-23, County Court, Contract and Indebtedness, pending.
- *Public Health Trust of Miami Dade v. Jesus Bodes, et al.*, 2010-12939-CA-01, Circuit Court, Other Civil Complaint, pending.
- *Salloum v. Unitedhealthcare*, 2010-7218-SP-23, County Court, Contract and Indebtedness, pending.
- *United Healthcare Ins. Co. v. T&R Rehab & Diagnostic Center Inc.*, 2010-5050-CC-05, County Court, PIP, pending.
- *De La Pedraja v. United Healthcare of Fla. Inc.*, 2010-24107-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Pathology Assoc. of South Miami v. United Healthcare of Fla. Inc.*, 2009-46303-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Pathology Consultants of South Broward v. United Healthcare of Fla. Inc.*, 2009-46309-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Comprehensive Pathology Associates v. United Healthcare of Fla. Inc.*, 2009-46299-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Hialeah Pathology Associates v. United Healthcare of Fla. Inc.*, 2009-46295-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *East Coast Pathology v. United Healthcare of Fla. Inc.*, 2009-46290-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Miami Children's Hospital Pathologists v. United Healthcare of Fla. Inc.*, 2009-46288-CA-01, Contract and Indebtedness, pending.
- *St. Vincent's Pathology Associates v. United Healthcare of Fla. Inc.*, 2009-46308-CA-01, Contract and Indebtedness, pending.
- *Gonzalez v. United Healthcare of Fla. Inc.*, 2009-48293-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Cuevas v. United Healthcare of Fla. Inc.*, 2009-63215-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *A&L Medical Center Inc. v. United Healthcare Ins. Co.*, 2009-14048-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Schurr v. United Healthcare of Fla. Inc.*, 2009-1421-CC-26, County Court, Contract and Indebtedness, pending.
- *United Healthcare Ins. Co. v. Permasteelisa*, 2008-18785-CA-01, Circuit Court, Contract and Indebtedness, pending.
- *Voglino v. United Healthcare of Fla. Inc.*, 2008-6005-CA-01, Circuit Court, Contract and Indebtedness, closed.
- *Correa v. United Healthcare Ins. Co.*, 2008-816-CC-26, County Court, Contract and Indebtedness, closed.
- *Gables INS Recovery v. United Healthcare Ins. Co.*, 2008-1908-SP-21, County Court, PIP, closed.

- *Lazega v. United Healthcare Ins. Co.*, 2008-17087-SP-23, County Court, Contract and Indebtedness, closed.
- *United Surgical Asst. Inc. v. United Healthcare Ins. Co.*, 2008-31342-CA-01, Circuit Court, Contract and Indebtedness, closed.
- *Biscayne Medical Center, Inc. v. United Healthcare Ins. Co.*, 2008-42227-CA-01, Circuit Court, Contract and Indebtedness, closed.
- *Fairlawn Medical Center v. United Healthcare Ins. Co.*, 2008-16835-SP-25, County Court, PIP, closed.
- *Fairlawn Medical Center v. United Healthcare Ins. Co.*, 2008-17383-SP-25, County Court, Contract and Indebtedness, closed.
- *Fairlawn Medical Center v. United Healthcare Ins. Co.*, 2008-17488-SP-25, County Court, Contract and Indebtedness, closed.
- *Public Health Trust of Miami Dade v. United Healthcare Ins. Co.*, 2009-2008-CC-26, County Court, Contract and Indebtedness, closed.
- *Goldman v. United Healthcare Ins. Co.*, 2009-4446-CC-05, County Court, Contract and Indebtedness, closed.
- *Garri v. United Healthcare*, 2009-5003-SP-25, County Court, Other Civil Action, closed.
- *Blair v. United Healthcare Ins. Co.*, 2009-16662-CC-23, County Court, Contract and Indebtedness, closed.
- *Alcalde v. United Healthcare*, 2009-10114-SP-25, County Court, Contract and Indebtedness, closed.
- *Surgery Center of Coral Gables v. United Healthcare of Fla. Inc.*, 2010-6629-SP-05, County Court, Contract and Indebtedness, closed.

e. Florida Federal Cases:

- *De La Pedraja v. United Healthcare of Fla. Inc.*, 10-cv-21677, Southern District of Florida, pending.
- *Lieberman v. United Healthcare Ins. Co.*, 09-cv-81050, Southern District of Florida, closed.
- *Feldman v. United Healthcare Ins. Co.*, 08-cv-00033, Northern District of Florida, closed.
- *Lee v. United Healthcare Ins. Co.*, 10-cv-00036, Middle District of Florida, closed.
- *Knight v. United Healthcare Ins. Co.*, 08-cv-00097, Middle District of Florida, closed.
- *Gadoury v. United Healthcare Ins. Co.*, 09-cv-00227, Middle District of Florida, closed.
- *Layne v. United Healthcare Ins. Co.*, 09-cv-00227, Middle District of Florida, closed.
- *Cassanese v. United Healthcare Ins. Co.*, 08-cv-00373, Middle District of Florida, closed.
- *Haley v. United Healthcare Ins. Co.*, 08-cv-00801, Middle District of Florida, closed.

- *Laboratory Physicians v. United Healthcare of Fla. Inc.*, 08-cv-01685, Middle District of Florida, closed.
- *Blackwell v. United Healthcare Ins. Co.*, 09-cv-21364, Southern District of Florida, closed.
- *Midgley v. United Healthcare of Fla. Inc.*, 08-cv-80072, Southern District of Florida, closed.
- *United Surgical Assistants, Inc. v. United Healthcare Ins. Co.*, Southern District of Florida, closed.
- *Hill Dermaceuticals, Inc. v. Rx Solutions, et al.*, 08-cv-00330, Middle District of Florida, closed.
- *Sheridan Healthcorp, Inc. v. United Healthcare of Fla. Inc.*, 09-cv-60298, Southern District of Florida, closed.

Cc: Karen Ruh, Human Resources
Mitchell Cohen, Purchasing Division



**Finance and Administrative Services
Accounting Division**

115 S. Andrews Avenue, Room 220 • Fort Lauderdale, Florida 33301 • 954-357-7141 • FAX 954-357-7693

MEMORANDUM

To: Karen Ruh, Project Manager
Human Resources

From: Mary O'Donnell, Interim Director
Accounting Division

A handwritten signature in cursive script, appearing to read "M. O'Donnell".

Cc: Mitchell Cohen, Purchasing Agent III - Negotiator
Purchasing Division

Date: July 27, 2010

Re: RLI R0843005R1 –Health Insurance

I reviewed the financial information provided by the respondents to the above referenced RLI, which seeks to select and negotiate an agreement with a firm to provide health insurance to Broward County employees.

My comments below will describe the financial information submitted by the respondents and indicate whether or not I believe there is any reason to question the financial capabilities of the firms.

AETNA is a publicly held corporation headquartered in Hartford Connecticut. The company is traded on the NYSE under the symbol AET and its audited financial statements are readily available. Aetna employs approximately 36,000 people and had 2009 revenues of \$34.8B, net income of \$1.3BM, assets of \$39B and shareholder's equity of \$9.5B. **I believe the company has met its responsibility requirements.**

UnitedHealthcare Group is a publicly held corporation headquartered in Minnetonka, MN. The Company is traded on the NYSE under the symbol UNH and its audited financial statements are readily available. UnitedHealthcare employs approximately 80,000 people and had 2009 revenue of \$87.1B, net income of \$6.4B, assets of \$59B and shareholder equity of \$23.6B. **I believe the company has met its responsibility requirements.**

Coventry Health Care of Florida Inc./Coventry Health and Life Insurance Company is headquartered in Sunrise. Coventry Health Care is headquartered in Bethesda, MD, is traded on the NYSE under the symbol CVH and its audited financial statements are readily available. Coventry Health Care employs approximately 14,400 people and had 2009 revenue of \$13,9B, net income of \$242.3M, assets of \$8.2B and shareholder equity of \$3.7B. **I believe the company has met its responsibility requirements.**


Please let me know if you have any questions relative to the above.



OFFICE OF ECONOMIC AND SMALL BUSINESS DEVELOPMENT

Governmental Center Annex
115 S. Andrews Avenue, Room A680 • Fort Lauderdale, Florida 33301
954-357-6400 • FAX 954-357-5674 • TTY 954-357-5664

MEMORANDUM

DATE: July 30, 2010
TO: Karen Ruh, Employee Benefits Manager
Human Resources Division
FROM: Freddy Justino Castillo, Manager 
Office of Economic and Small Business Development
SUBJECT: RLI No. R0843005R1, Health Insurance

The Office of Economic and Small Business Development did not establish County Business Enterprise (CBE) goals for this project. Consistent with the County Business Enterprise Act of 2009, Broward County encourages vendors to give full consideration to the use of CBE firms in the contract. Responding vendors are encouraged to note in their responses any intended participation by certified CBE firms.

Based on the responses received, the following is a report on the efforts made by the three respondents to RLI No. R0843005R1, Health Insurance:

Aetna

Aetna submitted a list of subcontractors none of which are CBE-certified.

Coventry Health Care of Florida

Coventry submitted a list of subcontractors none of which are CBE-certified. In addition, Coventry offered a summary of their efforts concerning community outreach.

United Health Group

An explanation of subcontracting scopes of work was submitted by United Health Group, including subcontractors for some of the scopes. None of the subcontractors are CBE-certified.

Compliance Comments

The Office of Economic and Small Business Development reviewed the efforts made by the respondents and found no CBE participation in the proposals.

cc: Norman E. Taylor, Director, Office of Economic & Small Business Development
Shelia Pitts-Howard, Assistant to the Director, OESBD
Christopher L. Atkinson, Small Business Development Manager, OESBD
Marcia Young, Small Business Development Manager, OESBD
Ricardo Martinez, Small Business Development Specialist, OESBD

Health RLI R0843005R1 Contract Deviations

The following are contract deviations submitted by prospective companies:

1. Aetna, Inc.

Article 7 - Penalties

- 7.1 – Aetna does not allow self billing for fully insured arrangements.
- 7.2 – Aetna's "Performance Guarantee" outlines how penalties are paid.
- 7.3 – Disputed penalties must be agreed to by both Aetna and Broward County prior to any payments being made.

Comments: The guarantee and penalty process is essentially handled by Aetna. Aetna does not appear to delineate a process if there is a dispute between the parties.

Article 8 - Termination

- 8.3 – If County's delay or nonperformance continues for a beyond the premium due date, Aetna may immediately terminate this contract upon transmission of written notice to County. The County has the right to terminate at any time during a period for which premium has been paid. For self funded products with respect to obligations to make payments under this contract, if County's delay or nonperformance continues for a period of at least five business days, Aetna may immediately terminate this Services agreement upon transmission of written notice to the County.
- 8.5 – Aetna is unable to agree to withholding payments until requested documents are received.

Comments: Florida law provides when an insurer can terminate.

Article 10 - Ownership of Documents

- Aetna requires an administrative services agreement (which they did not provide) that includes wording holding Aetna harmless for releasing any individually identifiable information, or a separate confidentiality agreement that must be signed before releasing certain data. All documents, records, reports and data, including data reported in Aetna's processing system relating to claims is property of Aetna and is preserved in accordance with applicable laws and regulations.

Comments: The County's agreement specifically references that the vendor will not be required to release PHI or other records without the appropriate release of the individual.

Article 11 – Audit Right and Retention of Records

- Aetna welcomes independent audits of relevant records and documentation provided that the audit does not interfere with business operations or the confidential interests of the company.

Comments: Aetna does not provide any deviations from this article in the proposed contract.

Article 18 – Indemnification

- Aetna will not indemnify the County for 100% of a loss if Aetna is only partially at fault. Aetna would only be liable for conduct deemed to be negligent in each instance. Aetna proposes to have the right to control the defense of any such action. Party seeking indemnification will provide notice of any actual or threatened action. The indemnification does not apply to acts or omissions of health care providers.

Comments: The County's indemnification provision applies if there is an intentional or negligent act or omission by Aetna.

Article 19 – Insurance

- Aetna made minor changes to this provision.

Comments: Risk management reviewed the changes and concurs with the changes.

Article 32 – HIPAA Compliance

- A business associate agreement is not required for insured products.

Comments: This is correct; a business associate agreement is not required.

Article 33 – Incorporation by Reference

- Aetna proposed an order of preference to which document would prevail: Aetna's Filed Group Policy, the Agreement between the County and Aetna, Aetna's response to the RLI, any changes made by the County to the RLI, the initially submitted RLI.

Comments: The filed group policy should not be inconsistent with the Agreement between the County and Aetna.

2. Coventry Health Care, Inc.

Article 4 – Termination (misabeled by Coventry, should be Article 8)

- Coventry provides when it may non-renew or terminate the Agreement in accordance with applicable Florida law.

Comments: Florida law provides when an insurer can terminate. Coventry's proposal is consistent with Florida law.

Article 19 – Insurance

- Coventry made minor changes to this provision.

Comments: Risk management has concurred with the changes.

Article 22 – Conflict of Interest

- Coventry proposes that their employees will not violate these provisions within the scope of their employment with Coventry.

Comments: The County's agreement appears to already provide the necessary protection that Coventry is seeking.

Article 32 – HIPAA Compliance

- Coventry deleted the provision to execute a business associate agreement if requested. Coventry also proposes for the County to execute a "Plan Sponsor Privacy Certification."

Comments: There is no requirement for a business associate agreement.

3. United Healthcare, Inc.

Article 10 – Ownership of Documents

- United proposes that all documents created exclusively for the County and not applicable to United's general book of business will be considered property of the County.

Article 11 – Audit Right and Retention of Records

- United proposes that an audit is limited to once per calendar year, the type, time, place, duration, and frequency is reasonable agreed to by the parties and that payment for the audit will be required when the audit extends passed the time thresholds agreed to by the parties.

Comments: The proposed language provided by United seeks to limit the County's authority to audit.

Article 13 – Assignment and Performance

- United proposes to add language that permits it to assign certain rights and obligations to their affiliates. United seeks to limit County's written consent where United uses subcontractors to perform "core" services under the Agreement.

Comments: United's proposed changes to this article would not require that the County provide written consent before the assignment or transfer of any right or interest in the Agreement. United proposes to provide the County notice if it does assign the rights or interest.

Article 32 – HIPAA Compliance

- United proposes to utilize its own business associate agreement in order to provide more consistency.

Comments: A business associate agreement is not required.

Attachment #A-11

Attachment #A-11

| RFP Language | Aetna's Clarification/Deviation |
|-----------------------|--|
| Copyrighted Materials | <p>Certain Aetna information regarding its network, contracts with hospitals and healthcare providers, related cost information, claims data, and information regarding the processes and cost involved in resolving claims, constitute confidential trade secrets within the definition of section 812.081, Florida Statutes, and documents containing such information are exempt from disclosure under the public records law pursuant to sections 815.04(3) and 815.045, Florida Statutes and <i>SePRO Corp. v. Dep't. of Envir. Prot.</i>, 839 So.2d 781 (Fla. 1st DCA 2003). “</p> <p>Aetna will conspicuously mark all such documents as “Confidential Trade Secret” and requests that it be provided sufficient notice and an opportunity to protect such records from disclosure in a court of competent jurisdiction before any documents marked accordingly are released pursuant to a public records request.</p> <p>To the extent permitted by applicable law, we would like to receive prompt notice whenever a party requests information from our Proposal so that we may promptly seek an appropriate court order to protect our information.</p> |

Attachment #A-11

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| <p>List all business related claims, arbitrations, administrative hearings, and lawsuits that are pending or were filed in any state or federal court in the State of Florida during the last three (3) years brought by or against the firm, its predecessor organization(s), or any wholly-owned subsidiary including but not limited to those claims, arbitrations, administrative hearings and lawsuits that allege negligence, error, or omission, or default, termination, suspension, failure to perform, or improper performance of an obligation of a contract or a legal duty related to a contract. The list should include all case names; case, arbitration, or hearing identification numbers; identification of the project involved in the dispute; a description of the subject matter of the dispute; and the final outcome or current status if the matter has not become final.</p> | <p>There is no litigation that would materially affect Aetna's ability to provide the services proposed under this RFP. Aetna and its affiliates are routinely involved in non-material litigation regarding the administration of health, life, disability and dental plans. Most of this litigation involves a single claim for benefits or payment for provider services. All material litigation is reported in Aetna's public filings and on www.aetna.com.</p> |
| <p>ARTICLE 7 Payment of Penalties 7.1 PENALTY INVOICES: If COUNTY, through its Contract Administrator, finds PLAN has incurred penalties pursuant to the terms of this Agreement, COUNTY will submit a written invoice to PLAN detailing the dates, Members' names and identification numbers, if applicable, and alleged performance failures.</p> | <p>We are unable to allow self billing for fully insured arrangements.</p> |

Attachment #A-11

7.2 AGREED PENALTIES: Any time penalties are incurred by PLAN pursuant to the terms of this Agreement, COUNTY will submit an invoice to PLAN for payment of these penalties no later than the end of the month following the period for which penalties were assessed. Unless PLAN files a dispute pursuant to Section 7.3 herein, PLAN must pay these penalties within twenty (20) days from the date of invoice. If a penalty is not paid by PLAN pursuant to the terms of this Agreement, COUNTY may automatically deduct the penalty amounts from COUNTY's monthly premium payment.

We have included Performance Guarantees which outline how penalties are paid.

Attachment #A-11

7.3 DISPUTED PENALTIES: Any time penalties are assessed by the Contract Administrator against PLAN pursuant to the terms of this Agreement, PLAN may appeal the assessment of such penalties to the Director of Purchasing within ten (10) days after notice of the assessment pursuant to Article 9 of this Agreement. The appeal shall be in writing and PLAN shall state the reasons why the penalties should be reduced or not assessed. If the appeal is not resolved by mutual agreement, the Director of Purchasing shall promptly issue a decision in writing, after consulting with the County Attorney's Office. The decision shall state the reasons for the action taken, and inform PLAN of its right to administrative review. If PLAN disagrees with the decision of the Director of Purchasing, it may seek administrative review by filing notice with the Director of Purchasing not later than ten (10) days after the decision of the Director of Purchasing. COUNTY and PLAN agree that the hearing procedures shall be in accordance with the provisions of Section 21.120 of the Broward County Procurement Code, as may be amended from time to time.

Disputed penalties must be agreed to by both Aetna and BCG prior to any payments being made.

Attachment #A-11

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| <p>8.3 Termination of Agreement by Plan</p> | <p>For insured products we can generally agree with this provision, however with respect to obligations to make premium payments under this contract, if the County's delay or nonperformance continues for a beyond the premium due date, Aetna may immediately terminate this contract upon transmission of written notice to the County. The County has the right to terminate at any time by giving written notice to Aetna provided the termination date will not be effective during a period for which premium has been paid.</p> <p>For self funded products with respect to obligations to make payments under this contract, if County's delay or nonperformance continues for a period of at least five (5) business days, Aetna may immediately terminate this Services Agreement upon transmission of written notice to the County</p> |
| <p>8.5 In the event this Agreement is terminated for any reason, any amounts due PLAN shall be withheld by COUNTY until all documents are provided to COUNTY pursuant to Article 10 of this Agreement.</p> | <p>We are unable to agree to withholding payments until requested documents are received.</p> |

Attachment #A-11

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| <p>Article 10, Ownership of Documents</p> | <p>For self funded products, we agree that all documents, records, reports and data initially supplied by the customer, is the property of the customer. Data recorded in our data processing systems, related to the receipt, processing and payment of claims, and manipulated in any way by Aetna, and any information deidentified as to the identity of the customer or member in a manner consistent with HIPAA -- will be the property of Aetna, to be used and maintained in a manner consistent with HIPAA. The administrative services agreement must be signed which includes wording holding Aetna harmless for releasing any individually identifiable information, or a separate confidentiality agreement must be signed before we can release this data.</p> <p>Under a fully insured arrangement, all documents, records, reports and data, including data recorded in our processing systems, related to the receipt, processing and payment of claims, including all claim histories, shall be the property of Aetna to be preserved in accordance with all applicable laws and regulations.</p> <p>Also, Aetna can agree if the Goods or Services are Customized, which means based on the County's written specifications, (ii) paid for separately by the Customer to Aetna, and (iii) pursuant to a written statement of work signed by both parties.</p> |
| <p>Article 11, Audit Right and Retention of Records</p> | <p>In addition we welcome independent audits of relevant records and documentation by our customers or their representatives, provided no audit interferes with our business operations or the confidential interests of our company or another party. We have assumed for the purpose of this contract that an "audit" is defined as performing a review of claim transactions for the purpose of assessing the accuracy of benefit determinations and shall be subject to mutual agreement as to nature, scope, format, structure and cost. We work from established audit guidelines that are accepted in this industry and we are confident we can meet your needs in this important area as well.</p> |

Attachment #A-11

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| Article 18, Indemnification | <p>Your Indemnification language is generally acceptable. However, we wish to clarify the following:</p> <ol style="list-style-type: none">(1) Aetna can agree to indemnify the County on a comparative negligence theory, but we are not prepared to indemnify the County for 100% of a loss if Aetna is only partially at fault. As such, the words "that portion of" should be inserted before "any and all causes..." in the first line.(2) Consistent with the last comment, a standard of care should be introduced so that Aetna would only be liable for conduct deemed to be negligent in each instance. We are prepared to discuss other formulations of the standard of care.(3) In the final language, we will be adding a sentence clarifying that Aetna will have the right to control the defense of any such action.(4) In the final language, we will also be adding a sentence requiring the party seeking indemnification to provide the indemnifying party reasonable notice of any actual or threatened action.5) Neither the County nor Aetna is responsible for the health care delivered by health care providers, whether network or non-network. The indemnification obligation set forth above would not apply to any portion of any claim, demand or legal action caused by the acts or omissions of health care providers with respect to Members. |
| Article 32, HIPAA Compliance | Please note that for the insured products a BAA is not required. |

Attachment #A-11

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| <p>Article 33, Incorporation by Reference</p> | <p>For FI business: We are willing to make the agreed upon provisions part of a Side Letter whose order of precedence will be dictated as follows, but we cannot override the provisions of the filed Group Policy as they are state filed which must govern for regulatory reasons.</p> <p>For Fully Insured, the following order is Acceptable:</p> <ol style="list-style-type: none">1. Aetna's filed Group Policy.2. A Side Agreement (acceptable provisions from the customer's proposed agreement would be the origin of this).3. Aetna's response to the RFP.4. Any change the customer makes to the RFP.5. Initially submitted RFP. <p>For SI business: We can agree as long as the Administrative Services Contract between the parties is at the highest level of priority and governs in the event of any conflict between these documents. Further, any of Aetna's responses to the listed documents take precedence over the initially submitted copies of these documents. The order of precedence would be as follows:</p> <ol style="list-style-type: none">1. ASO Agreement2. Aetna's response to the RFP, Notice of Intent to Contract, etc..3. Any change the customer makes to the RFP.4. Initially submitted RFP. |
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Attachment #A-11

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| Article 19 Insurance | <p>19.1 Insurance Coverage. In order to insure the indemnification obligation contained above, PLAN shall, at a minimum, provide, pay for, and maintain in force at all times during the term of this Agreement (unless otherwise provided), the insurance coverages set forth in Subsections 19.1, through 19.7, in accordance with the terms and conditions required by this Article. Each insurance policy shall clearly identify the foregoing indemnification as insured.</p> <p>19.2 Such policy or policies shall be without any deductible amount unless otherwise noted in this Agreement and shall be issued by approved companies authorized to do business in the State of Florida, and having agents upon whom service of process may be made in Broward County, Florida. PLAN shall pay all deductible amounts, if any. PLAN shall specifically protect COUNTY and the Broward County Board of County Commissioners by naming COUNTY and the Broward County Board of County Commissioners as additional insureds under the Commercial General Liability Policy. The official title of the certificate holder is Broward County Board of County Commissioners. This official title shall be used in all insurance documentation.</p> <p>19.3 Commercial General Liability Insurance. A Commercial General Liability Insurance Policy shall be provided evidenced, which shall contain minimum limits of One Million Dollars (\$1,000,000) per occurrence, and shall contain minimum limits of Two Million Dollars (\$2,000,000) per aggregate. Coverage must be afforded on a form no more restrictive than the latest edition of the Commercial General Liability Policy, without restrictive endorsements, as filed by the Insurance Service Office ("ISO") and must include: Premises and/or operations. Independent contractors. Products and /or Completed Operations for contracts. Broad Form Contractual Liability Coverage applicable to this specific Agreement, including any hold harmless and/or indemnification Agreement. Personal Injury Coverage with Employee and Contractual Exclusions removed, with minimum limits of coverage equal to those required for Bodily Injury Liability and Property Damage Liability.</p> |
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Attachment #A-11

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| | <p>19.4 Business Automobile Liability. A Business Automobile Liability Policy shall be provided evidenced, which shall contain minimum limits of One Million Dollars (\$1,000,000) per occurrence, combined single limit for Bodily Injury Liability and Property Damage Liability. Coverage must be afforded on a form no more restrictive than the latest edition of the Business Automobile Liability Policy, without restrictive endorsements, as filed by the ISO, and must include: Owned Vehicles, if applicable. Hired and Non-Owned Vehicles, if applicable. Employers' Non-Ownership, if applicable.</p> <p>19.5 Umbrella or Excess Liability. PLAN may satisfy the liability limits required above for Commercial General Liability or Business Auto Liability under an Umbrella or Excess Liability policy. There is no minimum Per Occurrence limit of liability under the Umbrella or Excess Liability; however, the Annual Aggregate limit shall not be less than the highest "Each Occurrence" limit for either Commercial General Liability or Business Auto Liability.</p> <p>19.6 Workers' Compensation Insurance. Workers' Compensation insurance is to apply for all employees in compliance with Chapter 440, Florida Statutes, as may be amended from time to time, the "Workers' Compensation Law" of the State of Florida and all applicable federal laws. In addition, the policy(ies) must include: Employer's Liability with a minimum limit of One Hundred Thousand Dollars (\$100,000) each accident.</p> <p>19.7 Professional Liability Insurance: PLAN shall maintain, for the term of this Agreement, Professional Liability Insurance, including coverage for errors and omissions, in the minimum amount of Five Million Dollars (\$5,000,000) per claim. If written with a deductible, PLAN shall be solely responsible for payment of that deductible. PLAN shall notify COUNTY in writing within thirty (30) calendar days of any claims filed or made against the Professional Liability Insurance Policy.</p> |
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Section A – General Questions & Information

**Broward County
RLI: R0843005R1**

Attachment #A-11

| | |
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| | <p>19.8 PLAN shall furnish to the COUNTY's Contract Administrator Certificate of Insurance at the time of award of this Agreement and attached hereto as Exhibit "D." The required days after notification of award of this Agreement and attached hereto as Exhibit "D." The required Certificates of Insurance shall name the types of policies provided, refer specifically to this Agreement, and state that such insurance is as required by this Agreement. The Certificate of Insurance shall be in form similar to and contain the information set forth in Form 00708, to be provided by the COUNTY's Risk Management Division. PLAN's failure to provide to COUNTY the Certificates of Insurance at the time of award of this Agreement and attached hereto as Exhibit "D." evidencing the insurance coverage within fifteen (15) calendar days shall provide the basis for the termination of the Agreement.</p> <p>19.9 Coverage is not to cease and is to remain in force (subject to cancellation notice) until all performance required of PLAN is completed. All policies must be provided and will endeavor to provide COUNTY with at least thirty (30) days' notice of expiration or, cancellation and of renewal of the insurance coverages will expire prior to the completion of the work , copies of renewal Certificate of Insurance shall be furnished at least thirty (30) days prior to the date of their expiration.</p> <p>19.10 COUNTY reserves the right to review and reasonably revise any insurance requirements at the time of renewal or amendment of this Agreement, including, but not limited to, deductibles, limits, coverage, and endorsements based on insurance market conditions affecting the availability or affordability of coverage, or changes in the scope of work or specifications that affect the applicability of coverage. If PLAN is authorized to use a subcontractor, PLAN shall ensure that subcontractor names COUNTY as an additional insured.</p> |
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| <p>RFP Language</p> <p>General Terms and Conditions</p> <p>12. Replacement</p> | <p>Aetna's Clarification/Deviation</p> <p>Aetna can not be responsible for replacement costs as such costs are beyond the control of Aetna. In addition, Aetna will discharge its obligations under the Services Agreement with that level of reasonable care which a similarly situated administrator of claims would exercise under similar circumstances. In connection with its fiduciary powers and duties hereunder, Aetna shall observe the standard of care and diligence required of a fiduciary under ERISA Section 404 (A) (1) (B).</p> |
|--|--|

Service Agreement Deviations

The plan recommends the following Service Agreement revisions to ensure the plan's compliance with Florida law, HIPAA and contractual obligations; however, the plan is willing to discuss the proposed changes in an effort to provide contractual language that is agreeable to the County.

- 3.1 PLAN shall provide group health insurance benefits to COUNTY employees under the Consumer Driven Health (CDH) Group Policy and the Certificate of Coverage and Certificate of Insurance in Exhibit "A," attached hereto and incorporated herein, entitled "Certificate".
- 4.3 TERMINATION OF THIS AGREEMENT BY PLAN: In accordance with applicable Florida law, PLAN may non-renew or terminate this Agreement only for one or more of the following reasons:
- 4.3.1 COUNTY failed to pay premiums or contributions in accordance with the terms of this Agreement or PLAN has not received timely premium payments;
 - 4.3.2 COUNTY performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Agreement;
 - 4.3.3 COUNTY failed to comply with a material provision of the Agreement which relates to rules for employer contributions or group participation;
 - 4.3.4 PLAN ceases offering this specific plan coverage or large group coverage;
 - 4.3.5 There is no longer any enrollee who lives or works in the PLAN service area.
- 19.1 Insurance Coverage. In order to insure the indemnification obligation contained above, PLAN shall, at a minimum, provide, pay for, and maintain in force at all times during the term of this Agreement (unless otherwise provided), the insurance coverages set forth in Subsections 19.1, through 19.7, in accordance with the terms and conditions required by this Article. ~~Each insurance policy shall clearly identify the foregoing indemnification as insured.~~
- 19.2 Such policy or policies shall be ~~without any deductible amount unless otherwise noted in this Agreement and shall be issued by approved companies authorized to do business in the State of Florida, and having agents upon whom service of process may be made in Broward County, Florida.~~ PLAN shall pay all deductible amounts, if any. PLAN shall specifically protect COUNTY and the Broward County Board of County Commissioners by naming COUNTY and the Broward County Board of County Commissioners as additional insureds under the Commercial General Liability Policy ~~as well as on any Excess Liability Policy coverage.~~ The official title of the certificate holder is Broward County Board of County Commissioners. This official title shall be used in all insurance documentation.
- 19.3 Commercial General Liability Insurance. Unless the provisions of Subsection 19.10.1 apply, a Commercial General Liability Insurance Policy shall be provided, which shall contain minimum



limits of One Million Dollars (\$1,000,000) per occurrence, and shall contain minimum limits of Two Million Dollars (\$2,000,000) per aggregate. Coverage must be afforded on a form no more restrictive than the latest edition of the Commercial General Liability Policy, without restrictive endorsements, as filed by the Insurance Service Office ("ISO") and must include:

Premises and/or operations.

Independent contractors.

Products and /or Completed Operations for contracts.

Broad Form Contractual Liability Coverage applicable to this specific Agreement, ~~including any hold harmless and/or indemnification Agreement.~~

Personal Injury Coverage with ~~Employee and Contractual Exclusions removed~~, with minimum limits of coverage equal to those required for Bodily Injury Liability and Property Damage Liability.

- 19.7 Professional Liability Insurance: Unless the provisions of Subsection 19.10.01 apply, PLAN shall maintain, for the term of this Agreement, Professional Liability Insurance, including coverage for errors and omissions, in the minimum amount of Five Million Dollars (\$5,000,000) per claim. If written with a deductible, PLAN shall be solely responsible for payment of that deductible. PLAN shall notify COUNTY in writing within thirty (30) calendar days of any claims filed or made against the Professional Liability Insurance Policy related to COUNTY.
- 19.8 PLAN shall furnish to the COUNTY's Contract Administrator Certificate of Insurance ~~or endorsements~~ evidencing the insurance coverage specified by this Article within fifteen (15) calendar days after notification of award of this Agreement and attached hereto as Exhibit "D." The required Certificates of Insurance shall name the types of policies provided, and refer specifically to this Agreement, ~~and state that such insurance is as required by this Agreement. The Certificate of Insurance shall be in form similar to and contain the information set forth in Form 00708, to be provided by the COUNTY's Risk Management Division.~~ PLAN's failure to provide to COUNTY the Certificates of Insurance ~~or endorsements~~ evidencing the insurance coverage within fifteen (15) calendar days shall provide the basis for the termination of the Agreement.
- 19.9 Coverage is not to cease and is to remain in force (subject to cancellation notice) until all performance required of PLAN is completed. All policies must ~~be endorsed to provide~~ COUNTY with at least thirty (30) days' notice of expiration, and/or cancellation ~~and/or restriction~~. If any of the insurance coverages will expire prior to the completion of the work, copies of renewal Certificates of Insurance ~~policies~~ shall be furnished ~~at least thirty (30) days~~ prior to the date of their expiration, or as soon as practicable.

ARTICLE 22

CONFLICT OF INTEREST

22.1 PLAN agrees that no employee or principal shall within their scope of employment, during the term of this Agreement, serve as an expert witness, or an adverse or hostile witness, against COUNTY in any legal or administrative proceeding, unless a party to such action is compelled to give testimony by court process. Further, PLAN agrees that neither PLAN, any principal, employee, nor agent within their scope of employment shall give sworn testimony or issue a report or writing as an expression of his or her opinion which is adverse or prejudicial to the interests of COUNTY in connection with any such pending or threatened legal or administrative proceeding. The limitations of this section shall not preclude PLAN or any other persons from representing themselves in any action or in any administrative or legal proceeding.

ARTICLE 32

HIPAA COMPLIANCE

PLAN shall fully protect individually identifiable health information as required by HIPAA and, ~~if requested by COUNTY, shall execute a Business Associate Agreement in the form attached hereto as Exhibit "E" for the purpose of complying with HIPAA.~~ PLAN shall handle and secure such PHI in compliance with HIPAA and its related regulations, as may be amended from time to time and, if required by HIPAA or other laws, include in its "Notice of Privacy Practices" notice of PLAN's and COUNTY's uses of client's PHI. The requirement to comply with this provision and HIPAA shall survive the expiration or earlier termination of this Agreement. COUNTY hereby authorizes the County Administrator to sign Business Associate Agreements on its behalf. In order to ensure HIPAA compliance, the plan requires the County to execute the Plan Sponsor Privacy Certification.

The Plan Sponsor Privacy Certification document is included in the Plan Sponsor Privacy Certification tab of the RLI.

LEGAL CLARIFICATIONS

SAMPLE AGREEMENT:

SELF-FUNDED/ASO - The terms and conditions of the attached Sample Agreement are not applicable to an arrangement in which UnitedHealthcare is providing claims administration services to Broward County's self-funded benefit plan. We encourage the Broward County to supplement a contract with relevant terms and conditions from our standard Administrative Services Agreement that were presented during the proposal process and are pertinent to our selection by you. See copy in Section 5 of this proposal binder. That Agreement contains terms and conditions that relate to products and services we generally provide to our self-funded customers and is designed to clearly, accurately and mutually define the roles of the parties to the Agreement.

- **Article 10, Ownership of Documents:**

UnitedHealthcare would prefer to include clarifying language that all documents, records, reports and data created exclusively for the County under this Agreement, and not applicable to UnitedHealthcare's general book of business, shall be considered the property of the County.

- **Article 11, Audit Right and Retention of Records:**

- UnitedHealthcare would prefer to include clarifying provisions which afford the County or a mutually agreeable entity to audit us once per calendar year to determine whether we are fulfilling our performance obligations under the contract. We permit annual claims processing audits which are consistent with generally acceptable governmental auditing standards, such as a statistically valid, random sample audit. The type, time, place, duration and frequency of the audits should be reasonable and agreed to by the parties. The information reviewed shall relate to that calendar year or the previous calendar year. Payment for our audit report services will be required where the audit extends beyond the time thresholds previously agreed to by the parties. We will be given a reasonable opportunity to review and comment on any audit conclusions. **Article 13, Assignment and Performance:**

UnitedHealthcare would prefer the ability to add clarifying language that we may assign certain rights and obligations under such an Agreement to our affiliates. We also request clarification that we shall only be obligated to obtain the County's prior written consent should we use subcontractors to perform "core" services under the Agreement. We propose that the following clarification be added to this provision: *"Notwithstanding, UnitedHealthcare may assign this Agreement, including all of its rights and obligations, to its affiliates, to an entity controlling, controlled by, or under common control with UnitedHealthcare, or a purchaser of all or substantially all of its assets, subject to notice to the County. And, UnitedHealthcare shall only be obligated to obtain the County's prior written consent should we use subcontractors to perform "core" services under the Agreement.*

- **Article 32, HIPAA Compliance:**

- In order to assure compliance with the HIPAA Privacy and Security Rules, UnitedHealthcare needs to maintain some level of consistency with respect to the Business Associate Agreements that we enter into with our self-funded customers. Our standard Business Associate language more accurately describes UnitedHealthcare's internal administrative processes concerning use of PHI in our possession. Consistency means fewer errors, which will certainly protect the County and the County's members' interests. A copy of our Business Associate Addendum is attached to our sample Administrative Services Agreement which can be found at Section 5.



**Insurance Selection Committee Meeting
2011 Health Insurance RLI
Short-listing and Presentations**

August 26, 2010

Room 430 9:30am – 1:30pm

CLARIFY. SIMPLIFY.  EDIFY.



**Insurance Selection Committee Meeting
2011 Health Insurance RLI
Initial Analysis**

August 26, 2010

Table of Contents

- I. Executive Summary
- II. Financials
 - a. Fully Insured
 - b. Self Insured
 - c. Performance Guarantees
- III. Provider Disruption
- IV. Geographic Accessibility
- V. Plan Designs
- VI. Plan Deviations
- VII. References



Broward County Government 2011 Health Insurance RLI Analysis

**Executive Summary
August 26, 2010**

Background

Broward County Government (BCG) offers Health Insurance Benefits to its employees and their eligible dependents via a fully-insured plan through Coventry Health Plan. BCG posted a Request for Letter of Interest in July 2010, and responses were received from the following vendors:

- Coventry (incumbent)
- Aetna
- United HealthCare (UHC)

Purpose of August 26th Insurance Selection Committee Meeting

Determine short list of vendors who will be considered as finalists and invited those vendors to make finalist presentations.

Initial Analysis

This report represents EDIFY USA, LLC (Consultant) and County Staff's initial analysis of the vendor submissions, focusing on the following Key Elements:

- Pricing
 - Fully Insured Quotes
 - Self-Insured
 - Performance Guarantees
- Network Comparison
- Geographic Accessibility
- Disease Management & Wellness
- Plan Design

No specific weighting or point factors have been given to any elements; however, within each section those vendors who have presented more favorable offerings have been identified based on quantitative data from their submissions.

Pricing –

The County is currently in a fully-insured funding arrangement. This arrangement ensures the most conservative offering from a total risk perspective, but may not offer the maximum cost savings opportunity to the County.

Therefore, vendors were asked to provide both Fully-Insured and Self-Insured Quotes based on the current plan design, as well as several alternative plan designs.

| | Coventry | Aetna | UHC |
|---------------------|----------|-------|------|
| Fully-Insured Quote | Yes | Yes | No |
| Self-Insured Quote | Yes | Yes | Yes* |

*Note: UHC only provided a self-insured quote. Their quote was based on the current plan designs with the addition of Out-of-Network services for the CDH Low and CDH High plans. Plan designs have been provided in Tab V.

Initial Pricing –

Figures below are based on current plan designs for both Fully-Insured and Self-Insured.

| | Coventry | | Aetna | | UHC |
|--------------------------------------|-----------------------------------|------------------|----------------------------------|------------------|-----------------|
| <i>Current Fully-Insured</i> | \$35.7 M | | | | |
| <i>Fully-Insured Proposal</i> | \$43.6 M +21.9 % | | \$43.2 M +20.8% | | n/a |
| <i>Self-Insured Proposal</i> | Mature | Immature | Mature | Immature | Mature |
| <u>Expected Cost</u> | \$44.9 M | \$ 33.2 M | \$42.5 M | \$ 40.8 M | \$47.0 M |
| <u>Maximum Cost</u> | \$54.7 M | \$ 40.0 M | \$51.4 M | \$ 49.6 M | \$57.3 M |

NOTE: Self-Insured quotes are based on Individual Stop Loss Deductible of \$200,000 and include all proposed fixed Administrative Fees. Mature costs are based on 15 months of claims expense (as requested in the RLI) and immature are based on only 12 months of claims expense.

Self-Insured Considerations

- County's population size is considered statistically valid and large enough
 - Minimum group size for predictable benefits begins at approximately 500 employees
- Risk versus potential savings
 - County risk limited by Stop Loss Insurance
 - Individual/Specific
 - Aggregate
- Current plan designs and offerings, initial quotes Self-Insured could result in:
 - a. a possible first year savings of as much as \$1 million based on expected costs; or
 - b. a potential increase in cost of as much as \$8 million based on maximum exposure

Performance Guarantees –

Each vendor was asked to provide fees at risk based on various Performance Guarantees. The primary categories of performance included:

- Implementation
- Claims Processing
- Member Services
- Account Management
- Disease Management ROI

Some could not meet the standards that were suggested for all of the categories, but most submitted reasonable standards as part of their initial response. Submissions are summarized on the following page and a detailed report can be found behind Tab II.

Performance Guarantees –

Annual Maximum Performance Guarantee Summary

| | Coventry | Aetna | UHC Self-Insured Only |
|-------------------------------|------------------|-------------------|--------------------------|
| Implementation | \$15,000 | \$63,168 | \$68,000 |
| Claims Processing | \$40,000 | \$63,168 | \$102,000 |
| Member Services | \$20,000 | \$42,112 | \$68,000 |
| Account Management | \$15,000 | \$126,336 | \$62,000 |
| Disease Management ROI | \$10,000 | \$559,897* | TBD* |
| Total Fees at Risk | \$100,000 | \$294,784 | \$300,000 |

*Aetna DM dollars represent anticipated savings and are not actual dollars at risk; therefore these dollars have not been included in the Total Fees at Risk. UHC proposal did not indicate an amount at risk, nor did they quantify anticipated savings.

Full chart with measurement standards and fees is located behind Tab II.

Plan Design and Deviations -

Vendors were asked to provide pricing based on the current plan design, as well as several alternative plan designs. They were also given the opportunity to propose a plan design of their own choosing for the County to consider.

We would recommend that any plan design alternatives be explored further during presentations and selection as any prospective vendor should be able to accommodate plan changes.

Each carrier was also asked to identify any plan deviations from the current plans that they would not be able to accommodate. Two vendors identified some plan deviations which should be discussed further during final vendor presentations. Further detail of actual deviations has been provided behind Tab VI.

| | Coventry | Aetna | UHC |
|-----------------|----------|-------|-----|
| Plan Deviations | No | Yes | Yes |

Vendor Proposed Plan Designs

Each vendor was given the opportunity to suggest a plan design option for the County in addition to the provided plan designs.

Aetna –

Aetna provided the current plan designs (Reference RX-9) with the addition of providing for the administration of the County's Health Reimbursement Accounts. Currently the County's Health Reimbursement Accounts are administered by FBMC. We were unable to determine any pricing associated with the inclusion of these services.

Coventry –

Coventry has quoted a variety of plan designs that are variations of the current plan designs. They have also provided a "build your own plan" model, which includes various decrements that can be used to model other scenarios. Coventry has also quoted a "Kids Plan" alternative which could be offered along with the other plans.

UHC –

UHC has quoted the current plan designs (Reference RX-9) with the addition of "Out-of-Network" services for each of the plans. They are unable to quote matching plans with In-Network only services.

Network Comparison -

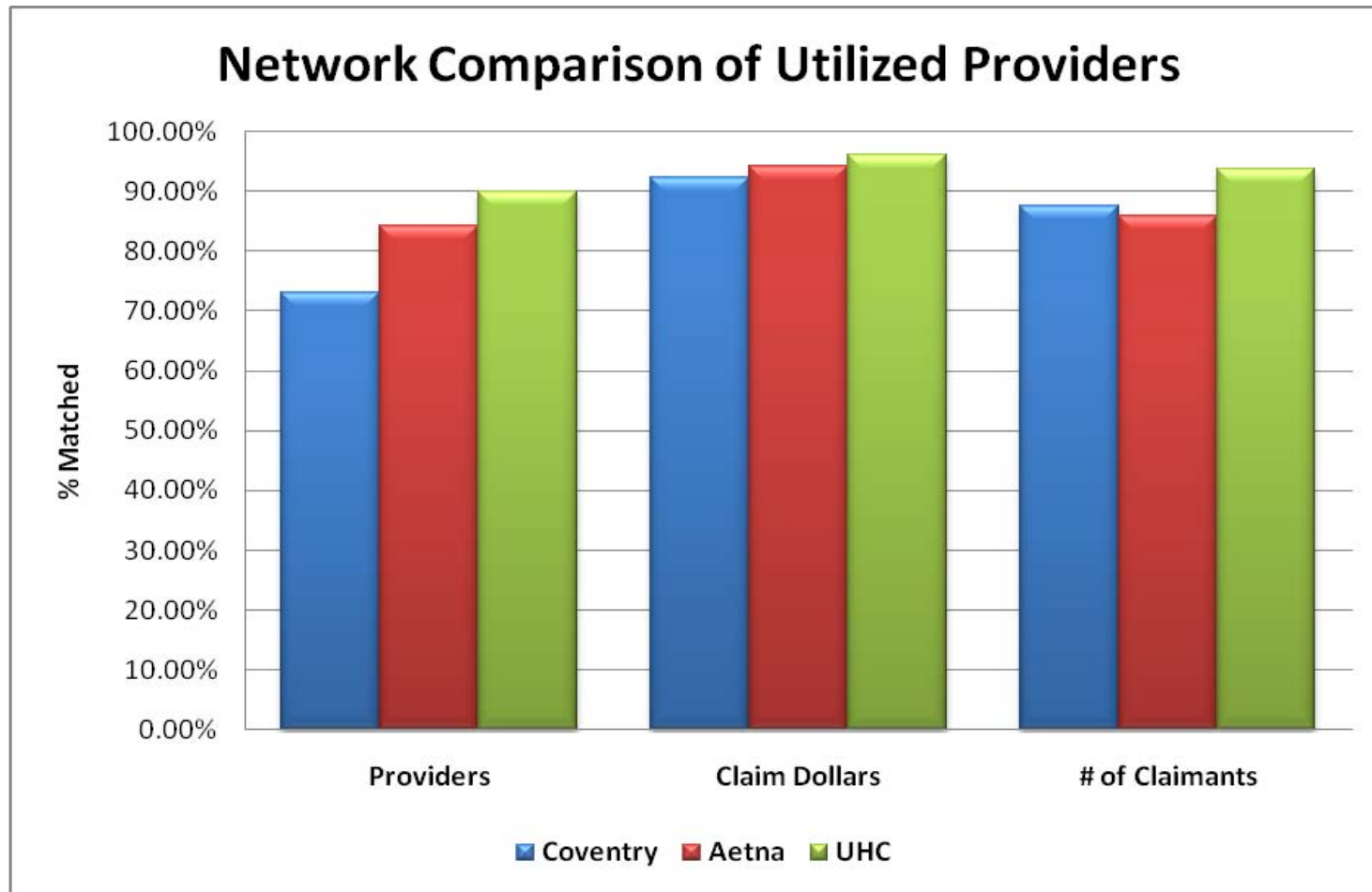
Consultant compared the vendor's network of providers on a "claim to claim" basis using the actual 2,679 providers utilized by BCG members in 2009, which were paid \$32,499,526 for BCG member claims in 2009 and on a "provider to provider" basis. These providers and claims are illustrated in the following graphs on the next pages:

- **Providers:** Of the 2,679 providers, what percent are in each vendor's network
- **Claim Dollars:** Of the \$32.5 million in '09 claims, what percent of those dollars matched would be spent in each vendor's network
- **# of Claimants:** The 2,679 providers utilized in 2009 represents 40,950 visits by BCG members, and of these visits, what percent are in each vendor's network

This analysis helps identify the potential for:

- Loss of "network" providers
 - Which means greater disruption and possibly dissatisfaction for participants who may need to find replacement physician to take advantage of in-network savings
 - Plus potentially a higher occurrence of claims paid at the out-of-network level, thus greater expense to plan and participants
- Gain of "network" providers
 - Which would mean less disruption and a larger network of providers for participants to access and fewer would need to find a replacement physician
 - Plus potentially a higher occurrence of claims paid at in-network level, thus greater savings to plan and participants

There appears to be no significant negative disruption for any of the vendors. There does appear to be opportunity for increased network coverage from vendors as highlighted in the chart below.



Full detail has been provided in the report behind Tab III.

Geographic Access –

Geographic Accessibility was compared to ensure that BCG members have adequate access to network physicians and facilities in the following categories:

- Primary Care Physicians – 2 within 10 miles
- Pediatricians – 2 within 10 miles
- OB/GYNs – 2 within 10 miles
- Specialists – 2 within 10 miles
- Hospitals – 1 within 15 miles

Summary –

No significant difference in accessibility was identified; all vendors indicated **98.6%** coverage or better

Further detail is provided in the report behind Tab IV.

Pharmacy Integration

- All vendors can accept a data feed from the Pharmacy Benefit Manager
 - Coventry does not charge a fee for this service
 - Aetna did not complete this section of the RLI with their submission
 - UHC fees are built into their Predictive Modeling Fees
- All vendors are willing to use the data feed from the Pharmacy Benefit Manager to track and monitor Utilization
- All vendors with also use this data to assist in Wellness Initiatives and Disease Management
- Aetna will include Pharmacy data in their Standard reporting package. All other vendors don't report on this data if they are not the Pharmacy Benefit Manager.

Reporting Capabilities

- All vendors have online reporting tools and can deliver a standard reporting package.
- The vendors can provide Custom Reporting as follows:
 - Coventry - no pricing was provided regarding Custom Reporting. Coventry deferred to the EDIFY Data Warehouse for BCG custom reporting needs, however agreement should be reached regarding data elements or circumstances where the Data Warehouse may not be able to provide specific reporting.
 - Aetna – provides 25 prepaid hours – each additional hour is \$200
 - UHC – cost based on an Ad Hoc Basis

Disease Management (DM) and Wellness Summary -

All vendors offer a Disease Management Program as part of their medical plan offering. Some common Disease Management Conditions that are covered by the vendors are; Asthma, Diabetes and Heart Failure. The following illustrates how many Disease Management Conditions the vendors will manage and the anticipated Return on Investment (ROI):

| | Coventry | Aetna | UHC |
|--------------------------------|--------------|------------|------------|
| # of Conditions managed | 5 | 35 | 5 |
| ROI | 2.5:1 | 2:1 | 2:1 |

- All vendors have agreed to pay the \$10 PEPY Wellness fee and will provide an on-line Health Risk Assessment at no cost
- UHC has provided pricing for Biometric Screenings at \$28.00 per participant; we were unable to locate specific Biometric Pricing for Coventry and Aetna
- All vendors indicated that they have in-house DM Programs
- All vendors automatically enroll participants but offer an “Opt Out” enrollment model with the exception of Coventry which offers both an Opt Out and Opt in model
- All vendors have the ability to administer some form of incentives for their Wellness Programs and can provide the necessary reporting for processing those incentives
- All vendors have online tools for members to access information regarding their condition

Other Items of Consideration

Identified below are some important items that either one or more vendor were not able to accommodate. These items are important and should be considered during Short Listing and Negotiations.

- Minimum Participation Requirements for premiums quoted to be applicable
 - All vendors included language regarding the right to modify their pricing based on changes in participation, contribution strategy or other data used in pricing assumptions
- Dedicated Service Unit for County employees – Coventry is the only vendor that will provide a Dedicated Service Unit
- UHC did not include costs for printing and mailing Welcome Packets and Summary Plan Descriptions in their standard costs
- All vendors have offered CEO or President as a resource to discuss partnering opportunities and resolve issues to the Benefits Staff with the exception of Aetna. Aetna's Account Management Team is located in Tampa, FL.
- Contingency Fees – Aetna indicates that they will be paying \$2 PEPM to the Florida Association of Counties and that this has not been incorporated into fees; further clarification required
- Explanation of Benefits (EOBs) – Aetna and UHC do not print and mail EOBs to members if there is \$0 member cost or of only a co-pay is incurred; all vendors have on-line tools available to provide members claims data
- Discount Dental and Vision – Aetna and UHC have not included discount dental or vision benefits in their pricing

Broward County Government

Proposed Fully Insured Medical Benefit Comparison

Plan Year 1/1/2011 thru 12/31/2011

| | Coventry | | | Aetna | | | UHC | | |
|---|----------------|--------------------------------|----------------------------|----------------|--------------------------------|----------------------------|------------------------------------|--------------------------------|----------------------------|
| | Annual Premium | \$ Variance From Current | % Variance From Current | Annual Premium | \$ Variance From Current | % Variance From Current | Annual Premium | \$ Variance From Current | % Variance From Current |
| Current - 2010 Plan Designs/Rates | \$35,740,484 | - | - | | | | | | |
| <u>Proposed</u> | | | | | | | | | |
| Plan A - <u>Current Design w/mandates</u> | \$43,561,517 | \$7,821,033 | 21.88% | \$43,166,574 | \$7,426,090 | 20.78% | Did not quote Fully Insured | | |
| Plan B | \$37,734,738 | \$1,994,254 | 5.58% | \$42,909,856 | \$7,169,372 | 20.06% | | | |
| Plan C | \$37,152,159 | \$1,411,675 | 3.95% | \$42,851,150 | \$7,110,666 | 19.90% | | | |
| Plan D | \$35,868,802 | \$128,317 | 0.36% | \$42,653,030 | \$6,912,546 | 19.34% | | | |
| Plan E | \$35,434,619 | (\$305,866) | -0.86% | \$43,166,574 | \$7,426,090 | 20.78% | | | |
| Plan F | \$36,486,790 | \$746,305 | 2.09% | \$730 | \$0 | 0.00% | | | |
| Plan G | \$36,024,304 | \$283,819 | 0.79% | \$0 | \$0 | 0.00% | | | |
| Plan H | \$36,715,485 | \$975,001 | 2.73% | \$7,426,090 | \$0 | 0.00% | | | |
| Plan I | \$35,044,149 | (\$696,335) | -1.95% | \$0 | \$0 | 0.00% | | | |

Broward County Government

Proposed Fully Insured Medical Benefit Comparison

Plan Year 1/1/2011 thru 12/31/2011

Coventry

| | Current Plan Designs 2010 Rates | | | Current Plan Designs - 2011 (with Mandates) - Plan A | | | Proposed Exhibit RX 10 - Plan B | | | Proposed Exhibit RX 11 - Plan C | | | Proposed Exhibit RX 12 (CoIns) - Plan D | | | Proposed Exhibit RX 13 - Plan E Vendor Recommended | | |
|---------------------------------|------------------------------------|--------------------|--------------------|---|--------------------|--------------------|---------------------------------|--------------------|--------------------|---------------------------------|--------------------|--------------------|---|--------------------|--------------------|---|--------------------|--------------------|
| | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON |
| Enrollment | | | | | | | | | | | | | | | | | | |
| Employee Only | 1,703 | 593 | 128 | 1,703 | 593 | 128 | 1,703 | 593 | 128 | 1,703 | 593 | 128 | 1,703 | 593 | 128 | 1,703 | 593 | 128 |
| Employee + Spouse | 838 | 177 | 39 | 838 | 177 | 39 | 838 | 177 | 39 | 838 | 177 | 39 | 838 | 177 | 39 | 838 | 177 | 39 |
| Employee + Child | 520 | 178 | 7 | 520 | 178 | 7 | 520 | 178 | 7 | 520 | 178 | 7 | 520 | 178 | 7 | 520 | 178 | 7 |
| Employee + Family | 524 | 215 | 9 | 524 | 215 | 9 | 524 | 215 | 9 | 524 | 215 | 9 | 524 | 215 | 9 | 524 | 215 | 9 |
| | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 |
| Fully Insured Rates | | | | | | | | | | | | | | | | | | |
| Employee Only | \$359.10 | \$339.42 | \$448.92 | \$437.68 | \$413.70 | \$547.16 | \$393.00 | \$313.50 | \$489.84 | \$389.28 | \$300.95 | \$485.76 | \$368.67 | \$313.50 | \$462.74 | \$364.99 | \$307.97 | \$451.70 |
| Employee + Spouse | \$772.31 | \$730.00 | \$965.49 | \$941.31 | \$889.75 | \$1,176.77 | \$845.21 | \$674.25 | \$1,053.49 | \$837.22 | \$647.25 | \$1,044.72 | \$792.88 | \$674.25 | \$995.21 | \$784.98 | \$662.35 | \$971.46 |
| Employee + Child | \$660.43 | \$624.24 | \$825.60 | \$804.95 | \$760.84 | \$1,006.27 | \$722.77 | \$576.56 | \$900.85 | \$715.94 | \$553.48 | \$893.35 | \$678.02 | \$576.56 | \$851.01 | \$671.27 | \$566.38 | \$830.71 |
| Employee + Family | \$1,128.97 | \$1,067.11 | \$1,411.36 | \$1,376.02 | \$1,300.63 | \$1,720.21 | \$1,235.54 | \$985.61 | \$1,540.00 | \$1,223.86 | \$946.15 | \$1,527.17 | \$1,159.05 | \$985.61 | \$1,454.80 | \$1,147.50 | \$968.21 | \$1,420.09 |
| Monthly Premium by Plan | \$2,193,747 | \$671,029 | \$113,597 | \$2,673,795 | \$817,875 | \$138,456 | \$2,400,828 | \$619,782 | \$123,952 | \$2,378,126 | \$594,968 | \$122,919 | \$2,252,191 | \$619,782 | \$117,094 | \$2,229,742 | \$608,843 | \$114,300 |
| Premium PEPM by Plan | \$611.92 | \$576.98 | \$620.75 | \$745.83 | \$703.25 | \$756.59 | \$669.69 | \$532.92 | \$677.33 | \$663.35 | \$511.58 | \$671.69 | \$628.23 | \$532.92 | \$639.86 | \$621.96 | \$523.51 | \$624.59 |
| Annual Premium | \$26,324,964 | \$8,052,353 | \$1,363,168 | \$32,085,544 | \$9,814,498 | \$1,661,475 | \$28,809,940 | \$7,437,379 | \$1,487,419 | \$28,537,508 | \$7,139,619 | \$1,475,032 | \$27,026,293 | \$7,437,379 | \$1,405,130 | \$26,756,899 | \$7,306,115 | \$1,371,604 |
| Annual PEPM | \$611.92 | \$576.98 | \$620.75 | \$745.83 | \$703.25 | \$756.59 | \$669.69 | \$532.92 | \$677.33 | \$663.35 | \$511.58 | \$671.69 | \$628.23 | \$532.92 | \$639.86 | \$621.96 | \$523.51 | \$624.59 |
| Annual Premium All Plans | \$35,740,484 | | | \$43,561,517 | | | \$37,734,738 | | | \$37,152,159 | | | \$35,868,802 | | | \$35,434,619 | | |
| Premium PEPM All Plans | \$604.01 | | | \$736.18 | | | \$637.71 | | | \$627.87 | | | \$606.18 | | | \$598.84 | | |
| \$ Variance | | | | \$7,821,033 | | | \$1,994,254 | | | \$1,411,675 | | | \$128,317 | | | (\$305,866) | | |
| % Variance | | | | 21.88% | | | 5.58% | | | 3.95% | | | 0.36% | | | -0.86% | | |

Broward County Government

Proposed Fully Insured Medical Benefit Comparison

Plan Year 1/1/2011 thru 12/31/2011

Coventry

| Current Plan Designs 2010 Rates | | | Proposed Exhibit RX 13 - Plan F Vendor Recommended | | | Proposed Exhibit RX 13 - Plan G Vendor Recommended | | | Proposed Exhibit RX 13 - Plan H Vendor Recommended | | | Proposed Exhibit RX 13 - Plan I Vendor Recommended | | | |
|------------------------------------|--------------|--------------|---|--------------|--------------|---|--------------|--------------|---|--------------|--------------|---|--------------|--------------|-------------|
| CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | |
| Enrollment | | | | | | | | | | | | | | | |
| Employee Only | 1,703 | 593 | 128 | 1,703 | 593 | 128 | 1,703 | 593 | 128 | 1,703 | 593 | 128 | 1,703 | 593 | 128 |
| Employee + Spouse | 838 | 177 | 39 | 838 | 177 | 39 | 838 | 177 | 39 | 838 | 177 | 39 | 838 | 177 | 39 |
| Employee + Child | 520 | 178 | 7 | 520 | 178 | 7 | 520 | 178 | 7 | 520 | 178 | 7 | 520 | 178 | 7 |
| Employee + Family | 524 | 215 | 2 | 524 | 215 | 2 | 524 | 215 | 2 | 524 | 215 | 2 | 524 | 215 | 2 |
| | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 |
| Fully Insured Rates | | | | | | | | | | | | | | | |
| Employee Only | \$359.10 | \$339.42 | \$448.92 | \$377.23 | \$312.10 | \$470.48 | \$370.92 | \$312.10 | \$470.48 | \$380.00 | \$312.10 | \$480.24 | \$358.09 | \$312.10 | \$457.42 |
| Employee + Spouse | \$772.31 | \$730.00 | \$965.49 | \$811.30 | \$671.24 | \$1,011.86 | \$797.73 | \$671.24 | \$1,011.86 | \$817.26 | \$671.24 | \$1,032.85 | \$770.14 | \$671.24 | \$983.77 |
| Employee + Child | \$660.43 | \$624.24 | \$825.60 | \$693.77 | \$573.99 | \$865.25 | \$682.17 | \$573.99 | \$865.25 | \$698.87 | \$573.99 | \$833.20 | \$658.57 | \$573.99 | \$841.24 |
| Employee + Family | \$1,128.97 | \$1,067.11 | \$1,411.36 | \$1,185.96 | \$981.22 | \$1,479.14 | \$1,166.13 | \$981.22 | \$1,479.14 | \$1,194.69 | \$981.22 | \$1,509.82 | \$1,125.80 | \$981.22 | \$1,438.09 |
| Monthly Premium by Plan | | | | | | | | | | | | | | | |
| Premium PEPM by Plan | \$2,193,747 | \$671,029 | \$113,597 | \$2,304,496 | \$617,017 | \$119,053 | \$2,265,955 | \$617,017 | \$119,053 | \$2,321,434 | \$617,017 | \$121,173 | \$2,187,580 | \$617,017 | \$115,748 |
| | \$611.92 | \$576.98 | \$620.75 | \$642.82 | \$530.54 | \$650.56 | \$632.07 | \$530.54 | \$650.56 | \$647.54 | \$530.54 | \$662.15 | \$610.20 | \$530.54 | \$632.50 |
| Annual Premium | | | | | | | | | | | | | | | |
| Annual PEPM | \$26,324,964 | \$8,052,353 | \$1,363,168 | \$27,653,946 | \$7,404,208 | \$1,428,636 | \$27,191,460 | \$7,404,208 | \$1,428,636 | \$27,857,206 | \$7,404,208 | \$1,454,072 | \$26,250,962 | \$7,404,208 | \$1,388,979 |
| | \$611.92 | \$576.98 | \$620.75 | \$642.82 | \$530.54 | \$650.56 | \$632.07 | \$530.54 | \$650.56 | \$647.54 | \$530.54 | \$662.15 | \$610.20 | \$530.54 | \$632.50 |
| Annual Premium All Plans | | | | | | | | | | | | | | | |
| Premium PEPM All Plans | \$35,740,484 | | | \$36,486,790 | | | \$36,024,304 | | | \$36,715,485 | | | \$35,044,149 | | |
| | \$604.01 | | | \$616.62 | | | \$608.81 | | | \$620.49 | | | \$592.24 | | |
| \$ Variance | | | | | | | | | | | | | | | |
| % Variance | | | | \$746,305 | | | \$283,819 | | | \$975,001 | | | (\$696,335) | | |
| | | | | 2.09% | | | 0.79% | | | 2.73% | | | -1.95% | | |

Broward County Government

Proposed Fully Insured Medical Benefit Comparison

Plan Year 1/1/2011 thru 12/31/2011

Aetna

| | Current Plan Designs 2010 Rates | | | Current Plan Designs - Plan A (with Mandates) | | | Proposed Exhibit RX 10 - Plan B | | | Proposed Exhibit RX 11 - Plan C | | | Proposed Exhibit RX 12 (CoIns) - Plan D | | | Proposed Exhibit RX 13 - Plan E Vendor Recommended | | |
|---------------------------------|------------------------------------|--------------------|--------------------|--|--------------------|--------------------|---------------------------------|--------------------|--------------------|---------------------------------|--------------------|--------------------|---|--------------------|--------------------|---|--------------------|--------------------|
| | Aetna | | | Aetna | | | Aetna | | | Aetna | | | Aetna | | | | | |
| | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON | CDH High | CDH Low | CDH OON |
| Enrollment | | | | | | | | | | | | | | | | | | |
| Employee Only | 1,703 | 593 | 128 | 1,703 | 593 | 128 | 1,703 | 593 | 128 | 1,703 | 593 | 128 | 1,703 | 593 | 128 | 1,703 | 593 | 128 |
| Employee + Spouse | 838 | 177 | 39 | 838 | 177 | 39 | 838 | 177 | 39 | 838 | 177 | 39 | 838 | 177 | 39 | 838 | 177 | 39 |
| Employee + Child | 520 | 178 | 7 | 520 | 178 | 7 | 520 | 178 | 7 | 520 | 178 | 7 | 520 | 178 | 7 | 520 | 178 | 7 |
| Employee + Family | 524 | 215 | 9 | 524 | 215 | 9 | 524 | 215 | 9 | 524 | 215 | 9 | 524 | 215 | 9 | 524 | 215 | 9 |
| | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 | 3,585 | 1,163 | 183 |
| Fully Insured Rates | | | | | | | | | | | | | | | | | | |
| Employee Only | \$359.10 | \$339.42 | \$448.92 | \$451.06 | \$432.23 | \$655.02 | \$448.39 | \$429.68 | \$651.13 | \$447.06 | \$428.40 | \$649.18 | \$445.72 | \$427.12 | \$647.24 | \$451.06 | \$432.23 | \$655.02 |
| Employee + Spouse | \$772.31 | \$730.00 | \$965.49 | \$911.43 | \$873.01 | \$1,327.51 | \$906.00 | \$867.81 | \$1,319.58 | \$903.28 | \$865.21 | \$1,315.62 | \$900.57 | \$862.61 | \$1,311.66 | \$911.43 | \$873.01 | \$1,327.51 |
| Employee + Child | \$660.43 | \$624.24 | \$825.60 | \$778.63 | \$745.86 | \$1,133.52 | \$774.00 | \$741.42 | \$1,126.76 | \$771.68 | \$739.20 | \$1,123.38 | \$769.36 | \$736.99 | \$1,119.99 | \$778.63 | \$745.86 | \$1,133.52 |
| Employee + Family | \$1,128.97 | \$1,067.11 | \$1,411.36 | \$1,309.83 | \$1,254.46 | \$1,909.47 | \$1,302.01 | \$1,246.97 | \$1,898.05 | \$1,298.10 | \$1,270.23 | \$1,892.34 | \$1,294.19 | \$1,239.48 | \$1,886.63 | \$1,309.83 | \$1,254.46 | \$1,909.47 |
| Monthly Premium by Plan | \$2,193,747 | \$671,029 | \$113,597 | \$2,623,172 | \$813,307 | \$160,735 | \$2,607,569 | \$808,474 | \$159,778 | \$2,599,770 | \$811,860 | \$159,299 | \$2,591,962 | \$803,637 | \$158,821 | \$2,623,172 | \$813,307 | \$160,735 |
| Premium PEPM by Plan | \$611.92 | \$576.98 | \$620.75 | \$731.71 | \$699.32 | \$878.34 | \$727.36 | \$695.16 | \$873.10 | \$725.18 | \$698.07 | \$870.49 | \$723.00 | \$691.00 | \$867.87 | \$731.71 | \$699.32 | \$878.34 |
| Annual Premium | \$26,324,964 | \$8,052,353 | \$1,363,168 | \$31,478,064 | \$9,759,686 | \$1,928,824 | \$31,290,833 | \$9,701,687 | \$1,917,336 | \$31,197,238 | \$9,742,325 | \$1,911,587 | \$31,103,539 | \$9,643,639 | \$1,905,853 | \$31,478,064 | \$9,759,686 | \$1,928,824 |
| Annual PEPM | \$611.92 | \$576.98 | \$620.75 | \$731.71 | \$699.32 | \$878.34 | \$727.36 | \$695.16 | \$873.10 | \$725.18 | \$698.07 | \$870.49 | \$723.00 | \$691.00 | \$867.87 | \$731.71 | \$699.32 | \$878.34 |
| Annual Premium All Plans | \$35,740,484 | | | \$43,166,574 | | | \$42,909,856 | | | \$42,851,150 | | | \$42,653,030 | | | \$43,166,574 | | |
| Premium PEPM All Plans | \$604.01 | | | \$729.51 | | | \$725.17 | | | \$724.18 | | | \$720.83 | | | \$729.51 | | |
| \$ Variance | | | | \$7,426,090 | | | \$7,169,372 | | | \$7,110,666 | | | \$6,912,546 | | | \$7,426,090 | | |
| % Variance | | | | 20.78% | | | 20.06% | | | 19.90% | | | 19.34% | | | 20.78% | | |

Broward County Government

Proposed Administrative Cost Summary

Plan Year 1/1/2011 thru 12/31/2011

| Vendor | COVENTRY | Aetna | UHC |
|--|--------------------|--------------------|--------------------|
| Plan | 2A - 2E | 2A - 2E | Current |
| Policy Period Duration (Months) | 12 | 12 | 12 |
| Current Enrollment | 4,931 | 4,931 | 4,931 |
| Administrative Services/Fees | | | |
| Administration | \$39.94 | \$32.30 | \$37.21 |
| HIPAA | Included | \$0.00 | Included |
| 24 Hour/7 days a week Nurseline | Included | Included | \$1.00 |
| Claims Administration | Included | Included | Included |
| Customer Service | Included | Included | Included |
| Disease Management | Included | \$0.00 | \$1.94 |
| Wellness | Included | Included | \$1.55 |
| Predictive Modeling | Included | \$0.10 | \$0.36 |
| Survivor Benefit | Included | Included | Not Included |
| Transplant (Outsourced Y/N) | Included | Not Included | Included |
| Corporate Allocation | Included | Included | Included |
| ID Cards | Included | Included | Included |
| Risk Margin | Included | Included | Included |
| Profit | Included | Included | Included |
| Provider Network Access | Included | \$4.50 | Included |
| Reporting | Included | Included | Included |
| e-Commerce | Included | Included | Included |
| Total Administrative Costs PEPM | \$39.94 | \$36.90 | \$42.06 |
| Annual Administrative Costs | \$2,363,330 | \$2,183,447 | \$2,488,774 |
| Year 2 ASO Fee PEPM | \$39.94 | \$38.19 | \$0.00 |
| Year 3 ASO Fee PEPM | \$39.94 | \$39.53 | \$0.00 |
| Year 4 ASO Fee PEPM | \$0.00 | \$41.10 | \$0.00 |
| Year 5 ASO Fee PEPM | \$0.00 | \$42.75 | \$0.00 |

Broward County Government
Proposed Self Insured Medical Benefit Comparison (Rx not included)
Plan Year 1/1/2011 thru 12/31/2011

| Vendor | COVENTRY | Aetna | Aetna | UHC | UHC |
|------------------------------------|-------------------------|-------------------------|-------------------------|---------------------|---------------------|
| Plan | Exhibits 2A - 2E | Exhibits 2A - 2E | Exhibits 2A - 2E | Exhibit 2E | Exhibit 2E |
| Policy Period Duration (Months) | 12 | 12 | 12 | 12 | 12 |
| Current Months Enrollment | 4,931 | 4,931 | 4,931 | 4,931 | 4,931 |
| Administrative Costs | | | | | |
| Administrative Costs PEPM | \$39.94 | \$36.90 | \$36.90 | \$42.06 | \$42.06 |
| Annual Administrative Costs | \$2,363,330 | \$2,183,447 | \$2,183,447 | \$2,488,774 | \$2,488,774 |
| Stop Loss (ISL and ASL) | | | | | |
| ISL Contract Basis | 12/15 | 12/12 w/TLO | 12/15 | 12/12 w/TLO | 12/12 w/TLO |
| ISL Deductible | \$200,000 | \$200,000 | \$200,000 | \$200,000 | \$200,000 |
| ISL Lifetime Maximum | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| ASL Corridor | 125% | 125% | 125% | 125% | 125% |
| ASL Annual Maximum | \$1,000,000 | \$1,000,000 | \$1,000,000 | Unlimited | Unlimited |
| ISL PEPM | \$52.29 | \$61.63 | \$73.80 | \$51.10 | \$51.10 |
| ASL PEPM | \$1.46 | \$0.56 | \$0.71 | \$1.61 | \$1.61 |
| Stop Loss PEPM | \$53.75 | \$62.19 | \$74.51 | \$52.71 | \$52.71 |
| Annual Stop Loss Costs | \$3,180,495 | \$3,679,907 | \$4,408,906 | \$3,118,956 | \$3,118,956 |
| Grand Total Fixed Costs | \$5,543,825 | \$5,863,353 | \$6,592,353 | \$5,607,730 | \$5,607,730 |
| Claims | | | | | |
| | <i>Mature</i> | <i>Immature</i> | <i>Mature</i> | <i>Immature</i> | <i>Mature***</i> |
| Expected Claims PEPM | \$664.62 | \$461.74 | \$606.06 | \$594.53 | \$699.17 |
| Annual Expected Claims | \$39,327,131 | \$27,321,998 | \$35,861,743 | \$35,179,529 | \$41,371,126 |
| Attachment Point PEPM | \$830.78 | \$577.17 | \$757.57 | \$743.16 | \$873.96 |
| Annual Claims Maximum | \$49,158,914 | \$34,152,497 | \$44,827,178 | \$43,974,411 | \$51,713,908 |
| Grand Total Expected Costs | \$44,870,956 | \$33,185,351 | \$42,454,095 | \$40,787,260 | \$46,978,857 |
| Grand Total Maximum Costs | \$54,702,739 | \$40,015,851 | \$51,419,531 | \$49,582,142 | \$57,321,638 |

*Note: All quotes exclude Rx claims from Stop Loss coverage.

** Aetna did not originally provide a mature 12/15 contract but later applied their maturation factor and that is what is illustrated as mature.

*** UHC did not provide a mature 12/15 contract so a maturation factor of 1.176 was used.

**Broward County Government
2010 Health Insurance RLI
Performance Guarantee Comparison**

| Item | Measurement Standard | Coventry | Aetna | UHC - Quoted Self Insured Only |
|---|---|---|---|---|
| All Performance Guarantees are for both Fully Insured and Self Insured unless noted otherwise | | | | |
| Implementation | | | | |
| ID Card Production - New Hires/Status Changes | 99% mailed within 10 business days after final member eligibility is received, system loaded and quality assurance check | Can Meet Measurement Standard | Can Meet Measurement Standard | Off Implementation ID Card Production is not tracked |
| ID Card Production - Open Enrollment | 99% mailed within 10 business days after final member eligibility is received, system loaded and quality assurance check - no later than 1/15/10 | Can Meet Measurement Standard | Can Meet Measurement Standard | Can Meet Measurement Standard |
| Medical Eligibility Tape Loading | Load all medical eligibility tapes to eligibility system within 3 business days of receipt | Can Meet Measurement Standard | Can Meet Measurement Standard | Can Meet Measurement Standard |
| Implementation TOTAL | | \$15,000 | \$63,168 | \$68,000 |
| Claims Processing | | | | |
| Claim Turnaround Time | 96% of clean claims processed within 10 business days, 99% of clean claims processed within 30 calendar days | 90% within 15 calendar days; 98% within 30 calendar days | Can Meet Measurement Standard | 94% within 10-15 days |
| Explanation of Benefits | EOB's will be generated for all plans within 30 calendar days | Can Meet Measurement Standard | Aetna is unable to measure at this time | Can Meet Measurement Standard |
| Financial Accuracy: Percentage of submitted charges processed correctly | 99% Gradients are: 98.99% - 98.76% 98.75% - 98.50% 98.49% - 98.25% 98.24% - 98.00% Below 98.00% | 98% Gradients are: 97.99% - 97.76% 97.75% - 97.50% 97.49% - 97.25% 97.24% - 97.00% Below 97.00% | Can Meet Measurement Standard for Self Insured Only - No Performance Guarantee for Fully Insured | Can Meet Measurement Standard |
| Procedural Accuracy: Percentage of claims processed without non-financial error | 99% Gradients are: 98.99% - 98.76% 98.75% - 98.50% 98.49% - 98.25% 98.24% - 98.00% Below 98.00% | 95% Gradients are: 94.99% - 94.50% 94.49% - 94.00% 93.99% - 93.50% 93.49% - 93.00% Below 93.00% | 97% for Self Insured Only - No Performance Guarantee for Fully Insured | 97% Gradients are: 96.99% - 96.50% 96.49% - 96.00% 95.99% - 95.00% Below 95.00% |
| Claims Processing TOTAL | | \$40,000 | \$63,168 | \$102,000 |
| Member Services | | | | |
| Average Speed to Answer | 15 seconds or less Gradients are: 17 seconds or less 19 seconds or less 21 seconds or less 23 seconds or less Greater than 23 seconds | 30 seconds or less Gradients are: 32 seconds or less 34 seconds or less 36 seconds or less 38 seconds or less Greater than 38 seconds | 25 Seconds | 30 seconds or less Gradients are: 32 seconds or less 34 seconds or less 36 seconds or less 38 seconds or less Greater than 38 seconds |
| Abandonment Rate | 2.5% Gradients are: 2.51% - 3.00% 3.01% - 3.50% 3.51% - 4.00% 4.01% - 4.50% Greater than 4.50% | 5.0% Gradients are: 5.01% - 5.50% 5.51% - 6.00% 6.01% - 6.50% 6.51% - 7.00% Greater than 7.00% | 2.50% | 2.0% Gradients are: 2.01% - 2.50% 2.51% - 3.00% 3.01% - 3.50% 3.51% - 4.00% Greater than 4.00% |
| Member Services TOTAL | | \$20,000 | \$42,112 | \$68,000 |
| Account Management | | | | |
| Communication: Account Manager responds to emails and phone calls | Within 24 Hours | Can Meet Measurement Standard | Can Meet Measurement Standard | Can Meet Measurement Standard |
| Issue resolution: Account Manager responds to issues in a timely manner. | Within 24 Hours | Can Meet Measurement Standard | Aetna has offered their First Call Resolution Guarantee of 90% for Self Insured Only - no Performance Guarantee for Fully Insured | Can Meet Measurement Standard |
| Reporting: Provide timely and accurate account specific reports | As requested | Will provide standard quarterly reporting - all Ad Hoc reporting must be done through Consultant | Can Meet Measurement Standard | Can Meet Measurement Standard |
| Member Satisfaction Survey - must be through a third party vendor and will include health, dental and vision* | Quarterly | Annually | Can Meet Measurement Standard | Annually for medical coverage only |
| Account Management TOTAL | | \$15,000 | \$126,336 | \$62,000 |
| Disease Management | | | | |
| Disease Management Engagement and ROI | Minimum ROI of 2.5:1 | Can Meet Measurement Standard | ROI of 2:1 | ROI of 2:1 |
| Disease Management TOTAL | | \$10,000 | \$559,897* | \$0 |
| Total Fees At Risk | | \$100,000 | \$294,784 | \$300,000 |

* Aetna DM dollars represent anticipated savings and are not actual dollars at risk, therefor these dollars have not been included in the Total Fees at Risk.

Broward County Government Medical Provider Disruption Comparison

Based on Claims Processed in 2009 from Incumbent Medical Carrier

| Provider Data | | | | | | |
|-------------------|---------------------------------------|------------------------------------|--------------------------|----------------|--|----------------|
| Vendor | Network | Number of Providers in Source Data | Provider Matches Network | | Provider Does Not Match Network - Disruption | |
| | | | # of Providers | % of Providers | # of Providers | % of Providers |
| Coventry | | 2,679 | 1,960 | 73.16% | 719 | 26.84% |
| Aetna | Self Insured Aetna Choice POS II | 2,679 | 2,252 | 84.06% | 427 | 15.94% |
| Aetna | Self Insured Open Access Aetna Select | 2,679 | 2,252 | 84.06% | 427 | 15.94% |
| Aetna | Fully Insured Open Choice PPO | 2,679 | 2,256 | 84.21% | 423 | 15.79% |
| Aetna | Fully Insured Health Network Only | 2,679 | 2,192 | 81.82% | 487 | 18.18% |
| United Healthcare | | 2,679 | 2,412 | 90.03% | 267 | 9.97% |

| Claim Dollars | | | | | | |
|-------------------|---------------------------------------|--------------------|-----------------------|----------------------------|---------------------------|--------------------------------|
| Vendor | Network | Claim Dollars Used | Claim Dollars Matched | % of Claim Dollars Matched | Claim Dollars Not Matched | % of Claim Dollars Not Matched |
| Coventry | | \$32,449,526 | \$29,956,281 | 92.32% | \$2,493,245 | 7.68% |
| Aetna | Self Insured Aetna Choice POS II | \$32,449,526 | \$30,557,025 | 94.17% | \$1,892,502 | 5.83% |
| Aetna | Self Insured Open Access Aetna Select | \$32,449,526 | \$30,555,689 | 94.16% | \$1,893,838 | 5.84% |
| Aetna | Fully Insured Open Choice PPO | \$32,449,526 | \$30,561,617 | 94.18% | \$1,887,910 | 5.82% |
| Aetna | Fully Insured Health Network Only | \$32,449,526 | \$30,499,192 | 93.99% | \$1,950,334 | 6.01% |
| United Healthcare | | \$32,449,526 | \$31,215,183 | 96.20% | \$1,234,343 | 3.80% |

| Claims | | | | | | |
|-------------------|---------------------------------------|----------------------------|---------------------|---------------------|-------------------------|-------------------------|
| Vendor | Network | # of Claims in Source Data | # of Claims Matched | % of Claims Matched | # of Claims Not Matched | % of Claims Not Matched |
| Coventry | | 88,933 | 80,949 | 91.02% | 7,984 | 8.98% |
| Aetna | Self Insured Aetna Choice POS II | 88,933 | 79,280 | 89.15% | 9,653 | 10.85% |
| Aetna | Self Insured Open Access Aetna Select | 88,933 | 79,275 | 89.14% | 9,658 | 10.86% |
| Aetna | Fully Insured Open Choice PPO | 88,933 | 79,324 | 89.20% | 9,609 | 10.80% |
| Aetna | Fully Insured Health Network Only | 88,933 | 78,487 | 88.25% | 10,446 | 11.75% |
| United Healthcare | | 88,933 | 83,632 | 94.04% | 5,301 | 5.96% |

| Claimants | | | | | | |
|-------------------|---------------------------------------|-------------------------------|------------------------|------------------------|----------------------------|----------------------------|
| Vendor | Network | # of Claimants in Source Data | # of Claimants Matched | % of Claimants Matched | # of Claimants Not Matched | % of Claimants Not Matched |
| Coventry | | 40,950 | 35,880 | 87.62% | 5,070 | 12.38% |
| Aetna | Self Insured Aetna Choice POS II | 40,950 | 35,122 | 85.77% | 5,828 | 14.23% |
| Aetna | Self Insured Open Access Aetna Select | 40,950 | 35,118 | 85.76% | 5,832 | 14.24% |
| Aetna | Fully Insured Open Choice PPO | 40,950 | 35,141 | 85.81% | 5,809 | 14.19% |
| Aetna | Fully Insured Health Network Only | 40,950 | 34,441 | 84.11% | 6,509 | 15.89% |
| United Healthcare | | 40,950 | 38,382 | 93.73% | 2,568 | 6.27% |

| Services | | | | | | |
|-------------------|---------------------------------------|------------------------------|-----------------------|-----------------------|---------------------------|---------------------------|
| Vendor | Network | # of Services in Source Data | # of Services Matched | % of Services Matched | # of Services Not Matched | % of Services Not Matched |
| Coventry | | 32,910 | 28,499 | 86.60% | 4,411 | 13.40% |
| Aetna | Self Insured Aetna Choice POS II | 32,910 | 30,308 | 92.09% | 2,602 | 7.91% |
| Aetna | Self Insured Open Access Aetna Select | 32,910 | 30,298 | 92.06% | 2,612 | 7.94% |
| Aetna | Fully Insured Open Choice PPO | 32,910 | 30,387 | 92.33% | 2,523 | 7.67% |
| Aetna | Fully Insured Health Network Only | 32,910 | 30,044 | 91.29% | 2,866 | 8.71% |
| United Healthcare | | 32,910 | 31,176 | 94.73% | 1,734 | 5.27% |

**Broward County Government
Medical Geographic Accessibility Summary
All Products**

Primary Care Physicians (PCPs) - 2 within 10 Miles

| States Included in Analysis | Vendor | Product | # of Employees | Total # PCPs Within Zip Code | Total # EEs Covered by PCPs Within Desired Access | % of EEs Covered by PCPs Within Desired Access |
|--|-------------------|---|----------------|------------------------------|---|--|
| Arkansas Florida Georgia Illinois Maryland Michigan North Carolina Ohio Pennsylvania Tennessee Texas Virginia | Aetna | Health Fund Choice POS II (SI) | 5,938 | 3,546 | 5,933 | 99.9% |
| | Aetna | Health Fund Open Access Aetna Select (SI) | 5,938 | 3,523 | 5,933 | 99.9% |
| | Aetna | Health Fund Open Choice PPO (FI) | 5,938 | 3,616 | 5,933 | 99.9% |
| | Aetna | Health Network Only (FI) | 5,921 | 3,131 | 5,918 | 99.9% |
| | Coventry | HMO | 5,916 | 2,067 | 5,890 | 99.6% |
| | Coventry | PPO | 5,916 | 5,973 | 5,910 | 99.9% |
| | United Healthcare | Choice Plus | 5,938 | 6,471 | 5,931 | 99.9% |

Pediatricians - 2 within 10 Miles

| States Included in Analysis | Vendor | Product | # of Employees | Total # Pediatricians Within Zip Code | Total # EEs Covered by Pediatricians Within Desired Access | % of EEs Covered by Pediatricians Within Desired Access |
|--|-------------------|---|----------------|---------------------------------------|--|---|
| Arkansas Florida Georgia Illinois Maryland Michigan North Carolina Ohio Pennsylvania Tennessee Texas Virginia | Aetna | Health Fund Choice POS II (SI) | 5,938 | 2,863 | 5,926 | 99.8% |
| | Aetna | Health Fund Open Access Aetna Select (SI) | 5,938 | 2,843 | 5,926 | 99.8% |
| | Aetna | Health Fund Open Choice PPO (FI) | 5,938 | 2,884 | 5,926 | 99.8% |
| | Aetna | Health Network Only (FI) | 5,921 | 2,550 | 5,913 | 99.9% |
| | Coventry | HMO | 5,916 | 884 | 5,835 | 98.6% |
| | Coventry | PPO | 5,916 | 1,551 | 5,906 | 99.8% |
| | United Healthcare | Choice Plus | 5,938 | 2,236 | 5,928 | 99.8% |

OB / GYNs - 2 within 10 miles

| States Included in Analysis | Vendor | Product | # of Employees | Total # OB / GYNs Within Zip Code | Total # EEs Covered by OB / GYNs Within Desired Access | % of EEs Covered by OB / GYNs Within Desired Access |
|--|-------------------|---|----------------|-----------------------------------|--|---|
| Arkansas Florida Georgia Illinois Maryland Michigan North Carolina Ohio Pennsylvania Tennessee Texas Virginia | Aetna | Health Fund Choice POS II (SI) | 5,938 | 1,234 | 5,921 | 99.7% |
| | Aetna | Health Fund Open Access Aetna Select (SI) | 5,938 | 1,231 | 5,921 | 99.7% |
| | Aetna | Health Fund Open Choice PPO (FI) | 5,938 | 1,233 | 5,921 | 99.7% |
| | Aetna | Health Network Only (FI) | 5,921 | 1,115 | 5,911 | 99.8% |
| | Coventry | HMO | 5,916 | 638 | 5,835 | 98.6% |
| | Coventry | PPO | 5,916 | 1,176 | 5,904 | 99.8% |
| | United Healthcare | Choice Plus | 5,938 | 1,281 | 5,925 | 99.8% |

Specialists - 2 within 10 Miles

| States Included in Analysis | Vendor | Product | # of Employees | Total # Specialists Within Zip Code | Total # EEs Covered by Specialists Within Desired Access | % of EEs Covered by Specialists Within Desired Access |
|--|-------------------|---|----------------|-------------------------------------|--|---|
| Arkansas Florida Georgia Illinois Maryland Michigan North Carolina Ohio Pennsylvania Tennessee Texas Virginia | Aetna | Health Fund Choice POS II (SI) | 5,938 | 30,134 | 5,932 | 99.9% |
| | Aetna | Health Fund Open Access Aetna Select (SI) | 5,938 | 29,976 | 5,932 | 99.9% |
| | Aetna | Health Fund Open Choice PPO (FI) | 5,938 | 30,112 | 5,932 | 99.9% |
| | Aetna | Health Network Only (FI) | 5,921 | 27,799 | 5,918 | 99.9% |
| | Coventry | HMO | 5,916 | 9,114 | 5,835 | 98.6% |
| | Coventry | PPO | 5,916 | 58,320 | 5,914 | 100.0% |
| | United Healthcare | Choice Plus | 5,938 | 16,496 | 5,931 | 99.9% |

Hospitals - 1 within 15 Miles

| States Included in Analysis | Vendor | Product | # of Employees | Total # Hospitals Within Zip Code | Total # of Employees Covered by Hospitals Within Desired Access | % of Employees Covered by Hospitals Within Desired Access |
|--|-------------------|---|----------------|-----------------------------------|---|---|
| Arkansas Florida Georgia Illinois Maryland Michigan North Carolina Ohio Pennsylvania Tennessee Texas Virginia | Aetna | Health Fund Choice POS II (SI) | 5,938 | 77 | 5,930 | 99.9% |
| | Aetna | Health Fund Open Access Aetna Select (SI) | 5,938 | 77 | 5,930 | 99.9% |
| | Aetna | Health Fund Open Choice PPO (FI) | 5,938 | 77 | 5,930 | 99.9% |
| | Aetna | Health Network Only (FI) | 5,921 | 71 | 5,917 | 99.9% |
| | Coventry | HMO | 5,916 | 55 | 5,835 | 98.6% |
| | Coventry | PPO | 5,916 | 152 | 5,909 | 99.9% |
| | United Healthcare | Choice Plus | 5,938 | 91 | 5,938 | 100.0% |

Notes:
Coventry only included Florida the Geo Access Reporting

Broward County Government - 2011 RLI Plan Design Options Detail

| Current 2010 Plan Design with Healthcare Reform Mandates - Reference RX-9 | | | | |
|--|-----------------------------------|------------------------------------|--|---|
| Plan Description | CDH Low Option Open Access | CDH High Option Open Access | CDH with Out-of-Network Open Access | |
| | In Network | In Network | In Network | Out-of-Network |
| Annual Deductible (Individual / Family) | \$2,100 / \$4,200 | \$1,100 / \$2,200 | \$1,100 / \$2,200 | \$1,500 / \$3,000 |
| Coinsurance Maximum (Individual / Family) | \$1,500 / \$3,000 | \$1,500 / \$3,000 | \$1,500 / \$3,000 | |
| Primary Care Physician (PCP) office visits | \$20 Copay | \$20 Copay | \$20 Copay | 30% after deductible |
| Specialist Office Visits and Consultations | \$35 Copay | \$35 Copay | \$35 Copay | 30% after deductible |
| Emergency Room (waived if admitted) | \$150 Copay | \$150 Copay | \$150 Copay | \$150 Copay |
| Allergy Injections | \$20 Copay | \$20 Copay | \$20 Copay | 30% after deductible |
| Mental Health, Alcohol & Substance Abuse | No Copay | No Copay | No Copay | 30% after deductible |
| Inpatient Hospital/Physician Services Coinsurance | 20% after deductible | 20% after deductible | 20% after deductible | 30% after deductible plus \$500 copay per admission |

| RLI Proposed Plan Design - Reference RX-10 | | | | |
|---|-----------------------------------|------------------------------------|--|---|
| Plan Description | CDH Low Option Open Access | CDH High Option Open Access | CDH with Out-of-Network Open Access | |
| | In Network | In Network | In Network | Out-of-Network |
| Annual Deductible (Individual / Family) | \$2,100 / \$4,200 | \$1,300 / \$2,600 | \$1,300 / \$2,600 | \$2,100 / \$4,200 |
| Coinsurance Maximum (Individual / Family) | \$1,500 / \$3,000 | \$1,500 / \$3,000 | \$1,500 / \$3,000 | |
| Primary Care Physician (PCP) office visits | 30% after deductible | \$30 Copay | \$30 Copay | 30% after deductible |
| Specialist Office Visits and Consultations | 30% after deductible | \$60 Copay | \$60 Copay | 30% after deductible |
| Emergency Room (waived if admitted) | 30% after deductible | \$250 Copay | \$250 Copay | \$250 Copay |
| Allergy Injections | 30% after deductible | \$25 Copay | \$25 Copay | 30% after deductible |
| Mental Health, Alcohol & Substance Abuse | 30% after deductible | 20% after deductible | 20% after deductible | 30% after deductible |
| Inpatient Hospital/Physician Services Coinsurance | 30% after deductible | 20% after deductible | 20% after deductible | 30% after deductible plus \$500 copay per admission |

Broward County Government - 2011 RLI Plan Design Options Detail

| RLI Proposed Plan Design - Reference RX-11 | | | | |
|---|-----------------------------------|------------------------------------|--|---|
| Plan Description | CDH Low Option Open Access | CDH High Option Open Access | CDH with Out-of-Network Open Access | |
| | In Network | In Network | In Network | Out-of-Network |
| Annual Deductible (Individual / Family) | \$2,100 / \$4,200 | \$1,300 / \$2,600 | \$1,300 / \$2,600 | \$2,100 / \$4,200 |
| Coinsurance Maximum (Individual / Family) | \$4,000 / \$8,000 | \$2,500 / \$5,000 | \$2,500 / \$5,000 | |
| Primary Care Physician (PCP) office visits | 30% after deductible | \$30 Copay | \$30 Copay | 30% after deductible |
| Specialist Office Visits and Consultations | 30% after deductible | \$60 Copay | \$60 Copay | 30% after deductible |
| Emergency Room (waived if admitted) | 30% after deductible | \$250 Copay | \$250 Copay | \$250 Copay |
| Allergy Injections | 30% after deductible | \$25 Copay | \$25 Copay | 30% after deductible |
| Mental Health, Alcohol & Substance Abuse | 30% after deductible | 20% after deductible | 20% after deductible | 30% after deductible |
| Inpatient Hospital/Physician Services Coinsurance | 30% after deductible | 20% after deductible | 20% after deductible | 30% after deductible plus \$500 copay per admission |

| RLI Proposed Plan Design - Reference RX-12 | | | | |
|---|-----------------------------------|------------------------------------|--|---|
| Plan Description | CDH Low Option Open Access | CDH High Option Open Access | CDH with Out-of-Network Open Access | |
| | In Network | In Network | In Network | Out-of-Network |
| Annual Deductible (Individual / Family) | \$2,100 / \$4,200 | \$1,300 / \$2,600 | \$1,300 / \$2,600 | \$2,100 / \$4,200 |
| Coinsurance Maximum (Individual / Family) | \$1,500 / \$3,000 | \$1,500 / \$3,000 | \$1,500 / \$3,000 | |
| Primary Care Physician (PCP) office visits | 30% after deductible | 20% after deductible | 20% after deductible | 30% after deductible |
| Specialist Office Visits and Consultations | 30% after deductible | 20% after deductible | 20% after deductible | 30% after deductible |
| Emergency Room (waived if admitted) | 30% after deductible | 20% after deductible | 20% after deductible | 20% after deductible |
| Allergy Injections | 30% after deductible | 20% after deductible | 20% after deductible | 30% after deductible |
| Mental Health, Alcohol & Substance Abuse | 30% after deductible | 20% after deductible | 20% after deductible | 30% after deductible |
| Inpatient Hospital/Physician Services Coinsurance | 30% after deductible | 20% after deductible | 20% after deductible | 30% after deductible plus \$500 copay per admission |

Benefit Review Document

We have reviewed Broward County's requested medical plan designs and matched them as closely as possible to Aetna's Open Choice PPO, Health Network Only with HealthFund, Open Access Aetna Select and Aetna Choice POS II with HealthFund, medical plan designs. In the attached we have listed those benefits we cannot administer exactly as requested.

Where benefits were not specified, we have assumed that Aetna's standard benefit provisions will apply. We have assumed that Aetna standard claim policies, schedule frequencies, definitions and exclusions will also apply unless noted otherwise.

All plans and benefits are subject to and governed by applicable contracts, policies and government regulations. The information herein is believed accurate as of the date of submission and is subject to change without notice. All benefits of the plan are subject to coordination of benefits and the terms (including exclusions) of the Contract.

Our plan reviews are based on both Self Insured and contract situs of Florida. Plan features and product availability are subject to extra-territorial mandates and federal requirements as applicable.

Benefit Review Document

| Plan Design | RFP/SPD Ref | Benefit Category | Requested Benefit | Comments |
|--|-------------------|---|--|---|
| All Aetna Health Fund® Plans - ASC and Fully Insured | CDH; High and Low | Ambulance – In Network | Emergency Only | Clarification: We do not exclude coverage for medically necessary but non-emergent ambulance services. For example, a member may require transportation from one facility to another, and although this is not an emergency it may be medically necessary for the member to be transported by ambulance. We can apply a \$150 copay per transport. |
| All Aetna Health Fund® Plans - ASC and Fully Insured | CDH; High and Low | Cardiac Rehabilitation – Outpatient – In Network | \$25 copay | Clarification: We cover Cardiac Rehab at the plan cost share for Specialists. \$35 copay would apply. |
| Aetna Health Fund® Choice POS II - HRA / ASC and PPO - HRA / Fully Insured | CDH | Chemotherapy / Radiation -In and Out Of Network | Hospital Coinsurance/OON-40%; Facility \$0 copay/OON-30% | Clarification: We are not able to pay differently based on place of service, hospital or facility. We would cover all out of network radiation/chemotherapy at the same overall out of network plan coinsurance-70%. |
| All Aetna Health Fund® Plans - ASC and Fully Insured | CDH; High and Low | Diabetes -In and Out Of Network | Diabetic Supplies including glucose monitor | Clarification: We assume we will not be covering this benefit since it falls under the current Pharmacy vendor. We would standardly cover diabetic supplies as part of our Pharmacy benefit and Pharmacy Management Blood Glucose Monitor Program. |
| Aetna Health Fund® Choice POS II - HRA / ASC and PPO - HRA / Fully Insured | CDH | Diagnostic Laboratory and X-ray – Outpatient – In Network | Hospital \$25 copay/OON-40%Freestanding Facility \$0 copay/OON 30% | Clarification: We are not able to pay differently based on place of service, hospital or facility. Alternatively, we can cover all outpatient Lab and X-ray at a \$25 copay in network and 70% out of network. |
| Aetna Health Fund® Choice POS II - HRA / ASC and PPO - HRA / Fully Insured | CDH | Diagnostic X-ray for Complex Imaging – Outpatient – In and Out of Network | Hospital Coinsurance/OON 40%Facility No Copay/OON 30% | Clarification: We are not able to pay differently based on place of service, hospital or facility. Alternatively, we would cover all outpatient Diagnostic, lab services at one benefit i.e., \$25 copay and 70% out of network. |
| Aetna Health Fund® HNO - HRA / Fully Insured; OA AS - HRA / ASC | CDH; High and Low | Diagnostic X-ray for Complex Imaging – Outpatient – In Network | Hospital CoinsuranceFacility No Copay | Clarification: We are not able to pay differently based on place of service, hospital or facility. Alternatively, we would cover all outpatient Diagnostic, lab services at one benefit i.e., \$25 copay. |
| Aetna Health Fund® Choice POS II - HRA / ASC and PPO - HRA / Fully Insured | CDH | Emergency Room – Out of Network | \$200 copay | Clarification: Emergency use of the Emergency room is covered at the same benefit level for in-network and out of network benefits. It is our interpretation that members should not be penalized for receiving out of network care for emergency situations. Alternatively, coverage of the in-network benefit level (\$150), will apply to both in-network and out of network emergency room care. |
| Aetna Health Fund® HNO - HRA / Fully Insured; OA AS - HRA / ASC | CDH Low | Family Planning – Basic Infertility/ Diagnosis and Treatment – In Network | Not Covered | Clarification: We do not exclude coverage for diagnosis & treatment for the underlying medical cause of infertility. We would cover at plan cost share. We can exclude coverage for Comprehensive and ART services. |
| Aetna Health Fund® Choice POS II - HRA / ASC and PPO - HRA / Fully Insured | CDH | Family Planning – Voluntary Sterilization -In and Out of Network | Facility \$35 copay/OON-30%; Hospital coinsurance/OON-40% | Clarification: We cover at plan cost share based on office versus hospital, and overall plan coinsurance for in and out of network services. All out of network would be at 30%, no 40% level. |
| Aetna Health Fund® Choice POS II - HRA / ASC and PPO - HRA / Fully Insured | CDH | Family Planning Abortion -In and Out Of Network | Medically necessaryFacility \$25 copay/OON-30%Hospital coinsurance/OON-40%Elective not covered | Clarification: We cover at plan cost share based on office versus hospital, and overall plan coinsurance for in and out of network services. All out of network would be at 30%, no 40% level. We can exclude elective abortions out of network. |

Benefit Review Document

| Plan Design | RFP/SPD Ref | Benefit Category | Requested Benefit | Comments |
|--|-------------------|--|--|---|
| Aetna Health Fund® HNO - HRA / Fully Insured; OA AS - HRA / ASC | CDH; High and Low | Family Planning Abortion -In Network | Facility \$25 copay;Hospital coinsurance | Clarification: We cover at plan cost share based on office (Specialist - \$35) versus hospital services at overall plan's member coinsurance of in (20%) and out of network (30%). |
| Aetna Health Fund® Choice POS II - HRA / ASC and PPO - HRA / Fully Insured | CDH | Maximum – Lifetime – In and Out of Network | In network-\$2,000,000; Out of network \$1,000,000 | Compliance Issue: Due to compliance concerns we are unable to support this maximum as requested. New Health Care Reform requirements prohibit applying plan lifetime maximums (effective six months after enactment). Thus to remain in compliance, we recommend having an "unlimited" lifetime maximum for both In-Network and Out-of-Network expenses. |
| Aetna Health Fund® HNO - HRA / Fully Insured; OA AS - HRA / ASC | CDH; High and Low | Maximum – Lifetime – In Network | \$2,000,000 | Compliance Issue: Due to compliance concerns we are unable to support this maximum as requested. New Health Care Reform requirements prohibit applying plan lifetime maximums (effective six months after enactment). Thus to remain in compliance, we recommend having an "unlimited" lifetime maximum for both In-Network and Out-of-Network expenses. |
| All Aetna Health Fund® Plans - ASC and Fully Insured | CDH; High and Low | Nutrition -In and Out of Network | Limited to \$2500 up to age 24 | Clarification: We do not place age limits on nutritional needs. Alternatively, we can agree to apply an annual maximum after plan cost share. |
| All Aetna Health Fund® Plans - ASC and Fully Insured | CDH; High and Low | Prosthetic Devices (Internal/External Combined) -In and Out Of Network | External Prosthetics and Orthotics \$2500 maximum | Clarification: We do not limit prosthetic devices as indicated. We cover orthotics and prosthetics at plan cost share in accordance to claim guidelines without limits. |
| All Aetna Health Fund® Plans - ASC and Fully Insured | CDH; High and Low | Pulmonary Rehabilitation – Outpatient – In Network | Respiratory Therapy \$25 copay | Clarification: We cover Respiratory Therapy at the plan cost share for Specialists. \$35 copay would apply. |
| All Aetna Health Fund® Plans - ASC and Fully Insured | CDH; High and Low | Second Surgical Opinion -In Network | \$25 copay; 40% of allowed amount | Clarification: There is no longer a separate CPT code for Second Surgical Opinion, thus no way to identify it differently than any other office visits. Therefore any second opinion visits will be covered the same as any other specialist visit (\$35). Out of network benefits under the CDH OON plan only would be at a 30% member coinsurance, no 40%. |
| All Aetna Health Fund® Plans - ASC and Fully Insured | CDH; High and Low | Spinal Manipulation Therapy – Outpatient – In Network | 1 visit and treatment per day. | Clarification: We do not limit benefits on a per day or per treatment basis. We can support a 24 visits per calendar year limit. |
| Aetna Health Fund® Choice POS II - HRA / ASC and PPO - HRA / Fully Insured | CDH | Surgery – Outpatient – In and Out of Network | Hospital Coinsurance/OON-40% Facility \$25 copay/OON-30% | Clarification: We are not able to pay differently based on place of service, hospital or facility. Alternatively, we can cover all outpatient surgery at a \$25 copay in network and 70% out of network. |
| All Aetna Health Fund® Plans - ASC and Fully Insured | CDH; High and Low | Transplant Services – In Network | \$5000 copay per inpatient stay No deductible | Clarification: We do not treat transplants differently than any other hospital confinements. Transplant services would be covered at the same overall hospital and office visit plan cost share. No separate \$5,000 copay would apply. |

Clarifications:

~This review may not reflect the impact of all of the newly passed health care reform legislation, nor the regulations that will be issued to clarify and implement the law. Certain provisions of the law and forthcoming regulations may have a material impact on this review.

~Federal Mental Health Parity provisions were effective 10/03/09, except for collective bargaining plans. Separate visit or day limits are no longer allowed for Mental Health & Substance Abuse benefits. Aetna will provide unlimited visit or days with no dollar per visit maximums, unless these are Bargained Plans. For Collective Bargaining plans: The law is effective on plan years beginning the later of Jan. 1, 2009 or the date on which the LAST collective bargaining agreement relating to the plan terminates. If this case meets this criteria, Aetna will consider administering limits.

~We assume Aetna standard exclusions and limitations apply to all benefits not mentioned.

~Pharmacy - We assume this will be covered under the current vendor.

~Preventive Dental Care - We assume this will be covered under the current vendor.

~Vision Eyewear / In Network - We assume this will be covered under the current vendor.

~Aetna standard Precertification guidelines apply.

~Infertility- Diagnosis and treatment for underlying cause is covered.

~Maternity copay applies to first visit that diagnosis is pregnancy.

~Second Surgical Opinion - Aetna considers the requirement of a second surgical opinion to not be a cost effective requirement. Therefore, any specialist seen will be covered same as any other.

~Organ Transplants care administered by the National Medical Excellence, Institutes of Excellence

~Organ Transplants Transportation \$10,000 maximum: The recommended standard benefit is Travel & Lodging \$10,000.00 per episode of care. The maximum reimbursement for lodging expenses is up to \$50.00 per person, per night, subject to the overall maximum listed above.

| Plan Design Issue | Deviation | Suggested Benefits |
|----------------------|--|--|
| Compatibility Review | | |
| Ambulance | <p>Customer Requests:</p> <ol style="list-style-type: none"> Ambulance: (Emergency Only) \$150 copay Ambulance: (Emergency Only) CDH High Option Plan - 80% after deductible <p>CDH Low Option Plan - 70% after deductible Open Access CDH Plan Network: 80% after deductible Non Network: \$150 copay</p> | <p>Suggested alternative is to allow ambulance services (Emergency & Non Emergency) to the nearest hospital in which services are available at the same benefit levels</p> |
| Dermatology | <p>Customer Requests:</p> <p>Dermatology: 5 visits per 12 months visits exceeding the 5 visits require an authorization</p> | <p>Suggested alternative is to allow a calendar year visit limit for Dermatology instead of one visit limit that requires authorization when the limit is exhausted.</p> |
| Maternity | <p>Customer Requests:</p> <p>Maternity: (Pre Natal & Post Natal Care) Physician's Office: one time \$25 copay Sub Specialty Office: \$25 copay</p> | <p>Suggested alternative is to apply copay to the initial office visit only, cover all other services for pre and post natal office visits in a Physician's Office and Sub Specialty Office under the global delivery fee.</p> |

| Plan Design Issue | Deviation | Suggested Benefits |
|-------------------|---|--|
| Abortion | <p>Customer Requests:</p> <p>1. Abortions: (Therapeutic) Office or Free Standing Facility: \$25 copay Outpatient Hospital: 80% after deductible</p> <p>Abortions: (Elective) Office or Free Standing Facility: \$35 copay Outpatient Hospital: 80% after deductible</p> <p>2. Abortions: (Therapeutic) Network: Office or Free Standing Facility: \$25 copay Outpatient Hospital: 80% after deductible Non Network: Office or Free Standing Facility: 70% after deductible Outpatient Hospital: 60% after deductible</p> <p>Abortions: (Elective) Network: Office or Free Standing Facility: \$35 copay Outpatient Hospital: 80% after deductible Non Network: Office or Free Standing Facility: Not Covered Outpatient Hospital: Not Covered</p> <p>3. Abortions: (Therapeutic) Network: Office or Free Standing Facility: \$25 copay Outpatient Hospital: 80% after deductible Non Network: Office or Free Standing Facility: 70% after deductible Outpatient Hospital: 60% after deductible</p> | <p>UNET can administer the same benefits for Therapeutic & Elective Abortions. Suggest administering the same benefits for Therapeutic & Elective Abortions.</p> |

| Plan Design Issue | Deviation | Suggested Benefits |
|------------------------------------|---|---|
| | <p>Abortions: (Elective) Network: Office or Free Standing Facility: \$25 copay Outpatient Hospital: 80% after deductible Non Network: Office or Free Standing Facility: Not Covered Outpatient Hospital: Not Covered</p> <p>4. Abortions: (Therapeutic) Network: Office or Free Standing Facility: 80% after deductible Outpatient Hospital: 80% after deductible Non Network: Office or Free Standing Facility: 70% after deductible Outpatient Hospital: 60% after deductible</p> <p>Abortions: (Elective) Network: Office or Free Standing Facility: 80% after deductible Outpatient Hospital: 80% after deductible Non Network: Office or Free Standing Facility: Not Covered Outpatient Hospital: Not Covered</p> | |
| Chiropractic / Spinal Manipulation | <p>Customer Requests: Chiropractic Care: 24 visits per calendar year 1 visit and treatment per day</p> | <p>UNET can administer a limit of 24 visits per calendar year for Chiropractic Care. Suggest administering a limit of 24 visits per calendar year for Chiropractic Care and remove the limit of 1 visit and treatment per day.</p> |

| Plan Design Issue | Deviation | Suggested Benefits |
|-----------------------|---|--|
| Diabetic Services | Customer Requests: Diabetic Supplies: \$50 copay per month | UNET can administer 100% coinsurance after deductible for Diabetic Supplies. Suggest administering 100% coinsurance after deductible for Diabetic Supplies. |
| Emergency Room | Customer Requests: 1. Emergency Room: Network: \$150 copay Non Network: \$200 copay 2. Emergency Room: Network: \$250 copay Non Network: \$200 copay 3. Emergency Room: Network: 80% after deductible Non Network: \$200 copay | UNET can administer Non Network Emergency Room at the Network benefit level the same as Network Emergency Room. Suggest administering Non Network Emergency Room at the Network benefit level the same as Network Emergency Room. |
| Infertility | Customer Requests: Infertility: (Artificial Insemination) 6 cycles per lifetime | Suggested alternative is to limit infertility services to a dollar maximum per lifetime. |
| Inpatient Facility | Customer Requests: Inpatient Hospital: Non Network: 70% after plan deductible and \$500 copay per admission | UNET can administer a Non Network Inpatient Hospital copay per admission when a Non Notification deductible penalty is not being administering a Non Network Inpatient Hospital copay per admission when a Non Notification deductible penalty is not being applied. |
| Wigs/Hair Prosthetics | Customer Requests: Wigs: \$250 maximum per calendar year covered when related to restoration after cancer or brain tumor treatment. | Suggested alternative is to cover Wigs as medically necessary. |

HMO Plan as HNO HRA

Section 1

Page 4

- Definition of dependents is more restrictive than Aetna's definition. Aetna does not require legal guardianship nor that stepchildren be claimed as exemptions. Any child that resides with you in a parent-child relationship and any stepchild is an eligible dependent. If our Florida state filing permits the requested definition and the plan sponsor assumes responsibility for verifying eligibility we can include this less liberal definition.
- New Health Care Reform requirements prohibit dependent coverage being limited to less than 26 years of age (effective six months after enactment. To remain in compliance, we recommend covering dependents to age 26 regardless of student status.

Page 6

- Coverage for military personnel will be administered in a manner that is consistent with Florida Statute 250.341 and federal USERRA legislation.

Page 7

- We cannot support legal separation as a qualifying event. A legally separated spouse is continued on the plan until the divorce is final.

Page 8

- We do not support pre-existing conditions limitation that postpones coverage for 18 months and applies only to late enrollees. Alternatively, we can administer a 12 month postponement for all enrollees or no pre-existing conditions limitations for all members.

Page 9

- Aetna standard business response for all plans liberalizes HIPAA's 63 day lapse period to allow for creditable coverage within 90 days of enrollment, and we apply a waiver of the plan's PEC rule when the rule is met. We do not apply a credit for only the amount of time the member was covered under the prior plan, so pre-ex is waived entirely if member had prior coverage within 90 days prior to enrollment date.

- Our standard will apply for this transferred business that pre-ex is waived for all members whose coverage is effective on date of transfer.

Section 3

Page 15

- We assume all references to VISTA will be replaced by Aetna.
- Aetna's HNO product allows for open access to all in-network providers. Members do not have to select a Primary Care Physician (PCP).
- We are not able to substitute the current carrier's transition of care policy for our own. Aetna Transition of Care policy determinations are made on a case by case basis for members in an active course of treatment and woman who are in the 27th week or later in their pregnancy. During the approved Transition of Care period, the enrollee receives out of network services at the in-network level. Patient Management would be able to determine if these members qualify and the length of time allowed at the in network level.
- Aetna's HNO product allows for open access to all in-network providers with no referral requirement. Members do not need referrals to specialists such as obstetricians or gynecologists.

Page 16

- Aetna's HNO product allows for open access to all in-network providers with no referral requirement. Members do not need to select a PCP nor do they need referrals to specialists.
- We assume that the copay maximum provision will not apply to this plan as Health Reimbursement Accounts do not include copays. An out-of-pocket maximum within the filed range allowed in Florida could be included.

Pages 17 - 18

- Due to system limitations and administrative concerns, Aetna is not able to duplicate another carrier's administrative precertification requirements. Therefore, Aetna's standard requirements, timing and application of penalties will apply to

the administration of Pre-certification under the plan. Aetna's plans include pre-certification for inpatient hospital, treatment facility, convalescent facility, home health care, hospice care and private duty nursing care. It is the responsibility of the contracted provider to precertify in-network stays.

- Aetna plans do not cover any service that is not medically necessary. However, we are not able to agree to penalize a member with no coverage for medically necessary services that were not precertified.

Page 19

- We are not able to apply the 80% of daily charges for regular hospital services at its lowest private room rate. Network hospitals that have only private rooms have negotiated rates with Aetna that will be applied.
- Aetna covers expenses for second opinions the same as any other medically necessary expense under the plan without office visit/consultation limits or requirements.

Page 20

- Charges for blood, blood plasma, blood derivatives or the cost of receiving services of professional blood donors are not covered. Administration, processing of blood, processing fees and fees related to autologous blood donations are covered.

Page 21

- Aetna adopts nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention. Additionally, we may adopt recommendations from other nationally recognized sources such as the National Cancer Institute and the American Cancer Society.
- Aetna does not require preauthorization of short term rehabilitation. Utilization review will be initiated after the 25 visit for chiropractic, speech, occupational and physical therapy.

Page 22

- Physical, speech and occupational therapy would be covered for loss or impairment due to other medical conditions, such as disease, as well as injury, stroke or surgery.

- Due to system limitations and as a matter of public policy, we do not restrict ambulance coverage to emergency only. Medically necessary, but non-emergent, ambulance expenses will be covered the same as any other expense under the plan. Elective air transport will require preauthorization.

Page 23

- Aetna covers experimental or investigational drugs if it is determined that the available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
- Due to system limitations we are not able to cover accidental dental injuries under the HNO plan.

Page 24

- Due to system limitations we are not able to limit dermatologic services to 5 visits every 12 months. Alternatively, we will cover these services the same as any other medically necessary expense under the plan.

Page 25

- We are not able to administer the family planning benefit as requested and cover only sperm count, endometrial biopsy, hysterosalpingography and diagnostic laparoscopy. We can administer the proposed plan to exclude Infertility Services such as Artificial Insemination and In Vitro Fertilization. However, our standard plans cannot exclude coverage for treatment of the underlying cause of infertility. Aetna will cover the diagnosis and treatment of the underlying cause of infertility the same as any other medical condition.
- Aetna covers the services of a podiatrist for treatment of a disease or injury, including but not limited to treatment of corns, calluses, keratoses, bunions, and ingrown nails. Aetna does not cover pedicure services, such as routine cutting of nails, in the absence of disease of nails.
- Aetna considers genetic testing medically necessary to establish a molecular diagnosis of an inheritable disease when certain criteria are met as outlined in Clinical Policy Bulletin #140 – Genetic Testing.
- Aetna considers genetic counseling in connection with pregnancy management under plans with benefits for family planning medically necessary for evaluation

certain conditions as outlined in Clinical Policy Bulletin #189 – Genetic Counseling. Additionally, Aetna considers molecular susceptibility testing for breast and/or ovarian cancer ("BRCA testing") medically necessary in certain categories of high-risk women, as recommended by the American College of Medical Genetics and outlined in Clinical Policy Bulletin #227 - BRCA Testing, Prophylactic Mastectomy, Tamoxifen, and Prophylactic Oophorectomy for Persons at Risk for Breast and Ovarian Cancer.

Pages 26 -27

- Aetna provides hospice care through its Compassionate Care Program. We are not able to include a requirement that bereavement counseling be provided within 3 months of the member's death. No specific requirements apply to bereavement counseling.

Page 28

- Aetna considers planned deliveries at home and associated services not medically appropriate. Home births are covered only when mandated by law.
- Due to system limitations we are not able to limit transportation costs of newborns to and from appropriate facilities to \$1,000 as requested. Alternatively, these services will be covered the same as any other medically necessary expense under the plan.
- Aetna plans do not require circumcision to be performed within the first month of life. Aetna's standard claim guidelines will apply.
- We are unable to exclude all TMJ expenses from coverage under the plan. Florida House Bill 109 requires coverage for medically necessary diagnostic or surgical procedures involving bones or joints of the jaw and face, when resulting from congenital or developmental deformity, disease or injury. The required coverage does not include inter-oral prosthetic devices, treatment of the teeth or gums, or surgical procedures for cosmetic purposes. We will administer the plan in compliance with this legislation.

Page 29

- Aetna considers bone mass measurement using the established techniques listed below medically necessary for members who meet the medical criteria outlined in Clinical Policy Bulletin # 134.

Page 31

- Aetna does not require that Skilled Nursing Care services be provided in lieu of hospitalization only.
- We are not sure that we understand the intent of the references to referral to a skilled nursing or assisted living facility associated with the member's continuing care or retirement community. Aetna's HNO is an open access product so no referral would be necessary. However, the facility would have to be contracted with Aetna for expenses to be covered under the plan.
- We are not sure we understand the reference to coverage for TMJ when it is specifically excluded on page 28. We will administer the plan in compliance with Florida House Bill 109.

Page 32

- Due to system limitations we are not able to support customer-specific transplant lists. We have contracts with Institutes of Excellence facilities for our list of transplants that includes heart, lung, heart/ lung, simultaneous pancreas kidney (SPK), pancreas, kidney, liver, intestine, bone marrow/stem cell transplant, multiple organs replaced during one transplant surgery, tandem transplants (Stem Cell), sequential transplants and re-transplant of same organ type within 180 days of the first transplant. Cornea transplants are not administered through the National Medical Excellence/Institutes of Excellence program. They are covered the same as any other medically necessary expense under the plan.
- We would not be able to support customer-specific claim guidelines for organ transplant services such as bone marrow. We do not include clinical guidelines in our documents, in part because claim guidelines are subject to change with new technologies and practices. We feel that our claim guidelines fit well with contemporary medical practice and we are not able to substitute another carrier's claim guidelines for our own.
- Aetna covers the charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

- We are not able to agree to include the \$75 per day maximum for lodging expenses. Reimbursement of expenses incurred by the patient and companion for hotel lodging away from home is reimbursed at a rate of \$50 per night per person (or \$100 per night total). This is in line with IRS guidelines.

Page 33

- Due to system limitations we are not able to cover travel expenses at plan coinsurance with a \$5,000 maximum per transplant. Travel & Lodging reimbursement for travel to an IOE facility will be limited to \$10,000 for any one transplant or procedure type, including tandem transplants.
 - We are not able to restrict coverage for wigs to restoration after cancer treatment or brain tumor treatment. Aetna covers a wig or hairpiece (synthetic, human hair or blends) prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of a disease, except for male pattern baldness.
 - We do not track and limit wig expenses to a \$250 limit per calendar year.
- Aetna's standard definition of emergency will apply. Aetna follows the "Prudent Layperson" emergency room policy set forth in the Balanced Budget Act of 1997. Aetna covers emergency room screening and stabilization for conditions that reasonably appear to constitute an emergency, based on the patient's presenting symptoms.
- Aetna's HNO product allows for open access to all in-network providers. Members do not have to coordinate follow up care through a Primary Care Physician (PCP), just received from an in-network provider.

Section 5

Page 34

- We do not exclude abdominoplasty and /panniculectomy as requested. Aetna considers panniculectomy medically necessary according to certain medical criteria as outlined in Clinical Policy Bulletin #211.
- Due to system limitations, we are not able to exclude acupuncture as requested. Aetna plans include coverage for acupuncture only when provided in lieu of anesthesia by a licensed physician.

- Due to system limitations and administrative concerns we are not able to exclude all alternative medicine as requested. (a) Hypnosis may be a covered behavioral health expense when rendered by a recognized provider when certain other criteria are met. (b) Massage therapy is covered as a modality of physical therapy. Massage therapy is not considered medically necessary for prolonged periods and is limited to the initial or acute phase of an injury or illness. (c) Aetna plans include coverage for acupuncture only when provided in lieu of anesthesia by a licensed physician.
- Due to system limitations and as a matter of public policy, we do not restrict ambulance coverage to emergency only. Medically necessary, but non-emergent, ambulance expenses will be covered the same as any other expense under the plan.
- We are not sure that we understand the reference to excluding support hose. Aetna covers compression garments for the legs subject to the claim guidelines outlined in Clinical Policy Bulletin #482.
- Due to a lack of system support, we cannot distinguish treatment needed for injuries resulting from an athletic event or training from any other expense. Therefore, these expenses will be covered subject to the appropriate level of coverage the same as any other expense under the plan.
- Due to system limitations, we are not able to administer to exclude biofeedback as requested. Aetna will administer coverage for biofeedback according to our claim guidelines outlined in Clinical Policy Bulletin #132, Biofeedback.
- Aetna considers breast reduction surgery cosmetic unless breast hypertrophy is causing significant pain, paresthesias, or ulceration subject to the medical criteria outlined in Clinical Policy Bulletin #17. Reduction mammoplasty for asymptomatic members is considered cosmetic.
- Due to system limitations and as a matter of public policy we do not exclude treatment of complications resulting from non-covered services or treatment. These expenses will be covered the same as any other medically necessary expense under the plan provided the service itself is a recognized expense under the plan.

Page 35

- We are not able to substitute the requested claim guidelines for reconstructive surgery for our own. Aetna covers cosmetic surgery as outlined in Claim Policy Bulletin #31 – Cosmetic Surgery. Our coverage would include cosmetic surgery that improves the functioning of a body part, even if it coincidentally also improves cosmesis. Medically necessary treatment of functional complications resulting from cosmetic surgery and prompt repair of complications of cosmetic surgery that don't cause functional impairment. Also, plans cover cosmetic surgery when it is performed in conjunction with a staged reconstructive surgical procedure to improve or restore bodily function. Surgery to correct severe congenital (existing at birth) anomalies is covered if it improves the function of a body part.
- Due to system limitations and as a matter of public policy we do not exclude treatment of complications resulting from non-covered services or treatment. These expenses will be covered the same as any other medically necessary expense under the plan provided the service itself is a recognized expense under the plan.
- We will coordinate coordination with benefits provided by no-fault automobile insurance coverage to avoid duplication of benefits. We can only apply coordination of benefits (COB) to no-fault automobile insurance coverage in the states that allow coordination.
- Therapy services that are primarily for marital problems are excluded under the plan. However, marriage counseling/marital therapy/couples counseling is a covered benefit when at least 1 party in the relationship has a diagnosed behavioral health disorder. If there is medical criteria and the services meet claim guidelines as well as criteria in the DSM-IV then coverage can be allowed the same as any other medical expense.
- Due to a lack of system support, we cannot distinguish treatment needed for injuries or illness resulting from an illegal act or while under the influence of substances from any other expense. Therefore, these expenses will be covered subject to the appropriate level of coverage the same as any other expense under the plan.

Page 36

- Dental care is excluded under the plan. Medical in nature oral surgery, as Aetna defines it, is covered under the plan.
- We are unable to exclude all TMJ expenses from coverage under the plan. Florida House Bill 109 requires coverage for medically necessary diagnostic or surgical procedures involving bones or joints of the jaw and face, when resulting from

congenital or developmental deformity, disease or injury. The required coverage does not include inter-oral prosthetic devices, treatment of the teeth or gums, or surgical procedures for cosmetic purposes. We will administer the plan in compliance with this legislation.

- Aetna's standard definition of Durable Medical equipment and replacement rules for DME will apply.
- We do not exclude all experimental and investigation treatments and procedures. Necessary treatment as determined by Aetna will be covered, including provisions for experimental or investigational services or drugs when specific criteria, as determined by Aetna, is met.

Page 37

- We are not sure what the reference to excluding gene therapy refers to.
- Aetna's standard claim guidelines for covering home oxygen equipment will apply.

Page 38

- Due to system limitations and administrative concerns we are not able to exclude hypnotism as requested. Hypnosis may be a covered behavioral health expense when rendered by a recognized provider when certain other criteria are met.
- Due to a lack of system support, we cannot distinguish treatment needed for injuries or illness resulting from illegal actions from any other expense. Therefore, these expenses will be covered subject to the appropriate level of coverage the same as any other expense under the plan.
- Due to a lack of system support, we cannot effectively distinguish expenses for treatment provided by a relative or member of the household from any other expense. Therefore, these services will be covered subject to the appropriate level of coverage under the plan.
- We can exclude prescription medication for the treatment of impotence. However, Aetna considers the diagnosis and treatment of erectile dysfunction (impotence) medically necessary according to the medical criteria outlined in Clinical Policy Bulletin #007.

- We can administer the proposed plan to exclude Infertility Services such as Artificial Insemination and In Vitro Fertilization in states that do not have mandates. However, our standard plans cannot exclude coverage for treatment of the underlying cause of infertility. Aetna will cover the diagnosis and treatment of the underlying cause of infertility the same as any other medical condition.
- We are not sure that we understand the references to excluding certain diagnosis for coverage under the plan. Aetna does not cover services which are educational in nature. However, if there is medical criteria and the services meet claim guidelines as well as criteria in the DSM-IV then coverage can be allowed the same as any other medical expense.
- We are not sure that we understand the reference to excluding Mental Health treatment when the plan designs included coverage.
- We are unable to exclude all TMJ expenses from coverage under the plan. Florida House Bill 109 requires coverage for medically necessary diagnostic or surgical procedures involving bones or joints of the jaw and face, when resulting from congenital or developmental deformity, disease or injury. The required coverage does not include inter-oral prosthetic devices, treatment of the teeth or gums, or surgical procedures for cosmetic purposes. We will administer the plan in compliance with this legislation.

Page 39

- Due to a lack of system support, we cannot distinguish treatment needed for injuries or illness resulting from a self-inflicted injury or suicide attempt from any other expense. Therefore, these expenses will be covered subject to the appropriate level of coverage the same as any other expense under the plan.

Page 40

- Aetna considers the diagnosis and treatment of obstructive sleep apnea (OSA) in adults age 18 and older medically necessary according to the medical criteria outlined in Clinical Policy Bulletin #004.

- Due to system limitations and administrative concerns, we cannot exclude hypnotherapy, biofeedback, acupuncture and sleep therapy services as requested. Hypnosis may be a covered behavioral health expense when rendered by a recognized provider when certain other criteria are met. Aetna considers biofeedback medically necessary for certain conditions as outlined in CPB #132. Acupuncture is covered in lieu of anesthesia only. Additionally, the diagnosis and treatment of obstructive sleep apnea (OSA) in adults age 18 and older medically necessary according to the medical criteria outlined in Clinical Policy Bulletin #004.

- We are unable to exclude all TMJ expenses from coverage under the plan. Florida House Bill 109 requires coverage for medically necessary diagnostic or surgical procedures involving bones or joints of the jaw and face, when resulting from congenital or developmental deformity, disease or injury. The required coverage does not include inter-oral prosthetic devices, treatment of the teeth or gums, or surgical procedures for cosmetic purposes. We will administer the plan in compliance with this legislation.

- Due to system limitations and as a matter of public policy we cannot exclude treatment of complications and required follow up care resulting from non-covered transplant services or treatment. These expenses will be covered the same as any other medically necessary expense under the plan provided the service itself is a recognized expense under the plan.

- Due to system limitations and as a matter of public policy we cannot exclude treatment of complications resulting from non-covered obesity services or treatment. These expenses will be covered the same as any other medically necessary expense under the plan provided the service itself is a recognized expense under the plan.

Page 41

- Due to a lack of system support, we cannot distinguish treatment needed for injuries or illness resulting from war or an act of war from any other expense. Therefore, these expenses will be covered subject to the appropriate level of coverage the same as any other expense under the plan.

- We are not able to restrict coverage for wigs to restoration after cancer treatment or brain tumor treatment. Aetna covers a wig or hairpiece (synthetic, human hair or blends) prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of a disease, except for male pattern baldness.

- We do not track and limit wig expenses to a \$250 limit per calendar year.

Out of Network Plan as PPO HRA

Section 1

Page 4

- Definition of dependents is more restrictive than Aetna's definition. Aetna does not require legal guardianship nor that stepchildren be claimed as exemptions. Any child that resides with you in a parent-child relationship and any stepchild is an eligible dependent. If our Florida state filing permits the requested definition and the plan sponsor assumes responsibility for verifying eligibility we can include this less liberal definition.
- New Health Care Reform requirements prohibit dependent coverage being limited to less than 26 years of age (effective six months after enactment. To remain in compliance, we recommend covering dependents to age 26 regardless of student status.

Page 6

- Coverage for military personnel will be administered in a manner that is consistent with Florida Statute 250.341 and federal USERRA legislation.

Page 7

- We do not support legal separation as a qualifying event. A legally separated spouse is continued on the plan until the divorce is final.

Pages 8 - 9

- We do not support pre-existing conditions limitation that postpones coverage for 18 months and applies only to late enrollees. Alternatively, we can administer a 12 month postponement for all enrollees or no pre-existing conditions limitations for all members.
- Aetna standard business response for all plans liberalizes HIPAA's 63 day lapse period to allow for creditable coverage within 90 days of enrollment, and we apply a waiver of the plan's PEC rule when the rule is met. We do not apply a credit for only the amount of time the member was covered under the prior plan, so pre-ex is waived entirely if member had prior coverage within 90 days prior to enrollment date.

- Our standard will apply for this transferred business that pre-ex is waived for all members whose coverage is effective on date of transfer.

Section 3

Page 15

- We assume all references to Coventry will be replaced by Aetna.
- Aetna is not able to base out-of-network rates on the lesser of billed charges or the Florida Medicare fee schedule. Alternatively, out-of-network expenses will be subject to the 80th percentile of Reasonable and Customary.
- We are not able to substitute the current carrier's transition of care policy for our own. Aetna Transition of Care policy determinations are made on a case by case basis for members in an active course of treatment and woman who are in the 27th week or later in their pregnancy. During the approved Transition of Care period, the enrollee receives out of network services at the in-network level. Patient Management would be able to determine if these members qualify and the length of time allowed at the in network level.

Page 16

- Aetna's standard policy for radiologists, anesthesiologists and pathologists (RAPs) will apply. All services rendered by a participating RAP are paid as preferred. Services rendered by a non-preferred RAP in a par facility are covered at the preferred level. All other non-par RAPS are paid at the non-preferred level unless prior authorization is given. All emergency room services will be covered at the in-network level of coverage.

Page 18

- We assume that copays will not apply to this plan as Health Reimbursement Accounts do not include copays.

Page 19

- Due to system limitations, we are unable to support 3 month deductible carryover as proposed. Alternatively, a new deductible will need to be satisfied each year.

Page 20

- Due to compliance concerns we are unable to support a lifetime plan maximum as requested. New Health Care Reform requirements prohibit applying Plan lifetime maximums (effective six months after enactment). To remain in compliance, we recommend having an "unlimited" lifetime maximum for both In-Network and Out-of-Network expenses.
- Due to system limitations and administrative concerns, Aetna is not able to duplicate another carrier's administrative precertification requirements. Therefore, Aetna's standard requirements, timing and application of penalties will apply to the administration of Pre-certification under the plan. Aetna's plans include pre-certification for inpatient hospital, treatment facility, convalescent facility, home health care, hospice care and private duty nursing care. It is the responsibility of the contracted provider to precertify in-network stays.

Page 21

- We are not able to apply the 80% of daily charges for regular hospital services at its lowest private room rate. Network hospitals that have only private rooms have negotiated rates with Aetna that will be applied.
- Aetna covers expenses for second opinions the same as any other medically necessary expense under the plan without office visit/consultation limits or requirements.

Page 23

- Aetna adopts nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention. Additionally, we may adopt recommendations from other nationally recognized sources such as the National Cancer Institute and the American Cancer Society.
- Aetna does not require preauthorization of short term rehabilitation. Utilization review will be initiated after the 25 visit for chiropractic, speech, occupational and physical therapy.

Page 24

- Physical, speech and occupational therapy would be covered for loss or impairment due to other medical conditions, such as disease, as well as injury, stroke or surgery.

- Due to system limitations and as a matter of public policy, we do not restrict ambulance coverage to emergency only. Medically necessary, but non-emergent, ambulance expenses will be covered the same as any other expense under the plan. Elective air transport will require preauthorization.

Page 25

- Aetna covers experimental or investigational drugs if it is determined that the available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
- Due to system limitations we are not able to administer the requested requirements for accidental dental injury. Aetna covers accidental injury to sound natural teeth in the year of and the year following the accident.

Page 26

- Aetna's standard definition and coverage for durable medical equipment will apply.
- We can cover all contraceptive services provided in a physician's office.
- Aetna covers the services of a podiatrist for treatment of a disease or injury, including but not limited to treatment of corns, calluses, keratoses, bunions, and ingrown nails. Aetna does not cover pedicure services, such as routine cutting of nails, in the absence of disease of nails.

Page 27

- Aetna considers genetic testing medically necessary to establish a molecular diagnosis of an inheritable disease when certain criteria are met as outlined in Clinical Policy Bulletin #140 – Genetic Testing.
- Aetna considers genetic counseling in connection with pregnancy management under plans with benefits for family planning medically necessary for evaluation certain conditions as outlined in Clinical Policy Bulletin #189 – Genetic Counseling. Additionally, Aetna considers molecular susceptibility testing for breast and/or ovarian cancer ("BRCA testing") medically necessary in certain categories of high-risk women, as recommended by the American College of

Medical Genetics and outlined in Clinical Policy Bulletin #227 - BRCA Testing, Prophylactic Mastectomy, Tamoxifen, and Prophylactic Oophorectomy for Persons at Risk for Breast and Ovarian Cancer.

Page 29

- Aetna considers planned deliveries at home and associated services not medically appropriate. Home births are covered only when mandated by law.

- Due to system limitations we are not able to limit transportation costs of newborns to and from appropriate facilities to \$1,000 as requested. Alternatively, these services will be covered the same as any other medically necessary expense under the plan.

- A separate plan deductible will apply to all newborn admissions, not just admission to the Neonatal Intensive Care Unit.

- Aetna plans do not require circumcision to be performed within the first month of life. Aetna's standard claim guidelines will apply.

- We are unable to exclude all TMJ expenses from coverage under the plan. Florida House Bill 109 requires coverage for medically necessary diagnostic or surgical procedures involving bones or joints of the jaw and face, when resulting from congenital or developmental deformity, disease or injury. The required coverage does not include inter-oral prosthetic devices, treatment of the teeth or gums, or surgical procedures for cosmetic purposes. We will administer the plan in compliance with this legislation.

Page 30

- Aetna considers bone mass measurement using the established techniques listed below medically necessary for members who meet the medical criteria outlined in Clinical Policy Bulletin # 134.

Page 31

- Aetna does not require that Skilled Nursing Care services be provided in lieu of hospitalization only.

Page 32

- Due to system limitations we are not able to support customer-specific transplant lists. We have contracts with Institutes of Excellence facilities for our list of transplants that includes heart, lung, heart/ lung, simultaneous pancreas kidney (SPK), pancreas, kidney, liver, intestine, bone marrow/stem cell transplant, multiple organs replaced during one transplant surgery, tandem transplants (Stem Cell), sequential transplants and re-transplant of same organ type within 180 days of the first transplant. Cornea transplants are not administered through the National Medical Excellence/Institutes of Excellence program. They are covered the same as any other medically necessary expense under the plan.
- We would not be able to support customer-specific claim guidelines for organ transplant services such as bone marrow. We do not include clinical guidelines in our documents, in part because claim guidelines are subject to change with new technologies and practices. We feel that our claim guidelines fit well with contemporary medical practice and we are not able to substitute another carrier's claim guidelines for our own.
- Aetna covers the charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- We are not able to agree to include the \$75 per day maximum for lodging expenses. Reimbursement of expenses incurred by the patient and companion for hotel lodging away from home is reimbursed at a rate of \$50 per night per person (or \$100 per night total). This is in line with IRS guidelines.
- Due to system limitations we are not able to cover travel expenses at plan coinsurance with a \$5,000 maximum per transplant. Travel & Lodging reimbursement for travel to an IOE facility will be limited to \$10,000 for any one transplant or procedure type, including tandem transplants.
- We are not able to restrict coverage for wigs to restoration after cancer treatment or brain tumor treatment. Aetna covers a wig or hairpiece (synthetic, human hair or blends) prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of a disease, except for male pattern baldness.

- We do not track and limit wig expenses to a \$250 limit per calendar year.

Page 33

- Aetna's standard definition of emergency will apply. Aetna follows the "Prudent Layperson" emergency room policy set forth in the Balanced Budget Act of 1997. Aetna covers emergency room screening and stabilization for conditions that reasonably appear to constitute an emergency, based on the patient's presenting symptoms.

Section 5

Page 34

- Due to system limitations, we are not able to exclude acupuncture as requested. Aetna plans include coverage for acupuncture only when provided in lieu of anesthesia by a licensed physician.
- We are not sure that we understand the reference to excluding treatment of alcoholism and drug abuse when the plan designs included coverage.
- Due to system limitations and administrative concerns we are not able to exclude all alternative medicine as requested. (a) Hypnosis may be a covered behavioral health expense when rendered by a recognized provider when certain other criteria are met. (b) Massage therapy is covered as a modality of physical therapy. Massage therapy is not considered medically necessary for prolonged periods and is limited to the initial or acute phase of an injury or illness. (c) Aetna plans include coverage for acupuncture only when provided in lieu of anesthesia by a licensed physician.
- Due to system limitations and as a matter of public policy, we do not restrict ambulance coverage to emergency only. Medically necessary, but non-emergent, ambulance expenses will be covered the same as any other expense under the plan.
- We are not sure that we understand the reference to excluding support hose. Aetna covers compression garments for the legs subject to the claim guidelines outlined in Clinical Policy Bulletin #482.
- Due to a lack of system support, we cannot distinguish treatment needed for injuries resulting from an athletic event or training from any other expense.

Therefore, these expenses will be covered subject to the appropriate level of coverage the same as any other expense under the plan.

- Due to system limitations, we are not able to administer to exclude biofeedback as requested. Aetna will administer coverage for biofeedback according to our claim guidelines outlined in Clinical Policy Bulletin #132, Biofeedback.
- We do not understand the reference to excluding blood and blood products when coverage was included on page 22.
- Due to system limitations and as a matter of public policy we do not exclude treatment of complications resulting from non-covered services or treatment. These expenses will be covered the same as any other medically necessary expense under the plan provided the service itself is a recognized expense under the plan.
- We are not able to substitute the requested claim guidelines for reconstructive surgery for our own. Aetna covers cosmetic surgery as outlined in Claim Policy Bulletin #31 – Cosmetic Surgery. Our coverage would include cosmetic surgery that improves the functioning of a body part, even if it coincidentally also improves cosmesis. Medically necessary treatment of functional complications resulting from cosmetic surgery and prompt repair of complications of cosmetic surgery that don't cause functional impairment. Also, plans cover cosmetic surgery when it is performed in conjunction with a staged reconstructive surgical procedure to improve or restore bodily function. Surgery to correct severe congenital (existing at birth) anomalies is covered if it improves the function of a body part.

Page 35

- We will coordinate coordination with benefits provided by no-fault automobile insurance coverage to avoid duplication of benefits. We can only apply coordination of benefits (COB) to no-fault automobile insurance coverage in the states that allow coordination.
- Therapy services that are primarily for marital problems are excluded under the plan. However, marriage counseling/marital therapy/couples counseling is a covered benefit when at least 1 party in the relationship has a diagnosed behavioral health disorder. If there is medical criteria and the services meet claim guidelines as well as criteria in the DSM-IV then coverage can be allowed the same as any other medical expense.
- Due to a lack of system support, we cannot distinguish treatment needed for injuries or illness resulting from an illegal act or while under the influence of substances from any other expense. Therefore, these expenses will be covered subject to the appropriate level of coverage the same as any other expense under the plan.

Page 36

- Dental care is excluded under the plan. Medical in nature oral surgery, as Aetna defines it, is covered under the plan.
- We are unable to exclude all TMJ expenses from coverage under the plan. Florida House Bill 109 requires coverage for medically necessary diagnostic or surgical procedures involving bones or joints of the jaw and face, when resulting from congenital or developmental deformity, disease or injury. The required coverage does not include inter-oral prosthetic devices, treatment of the teeth or gums, or surgical procedures for cosmetic purposes. We will administer the plan in compliance with this legislation.
- Aetna's standard definition of Durable Medical equipment and replacement rules for DME will apply.
- We cannot exclude all experimental and investigation treatments and procedures. Necessary treatment as determined by Aetna will be covered, including provisions for experimental or investigational services or drugs when specific criteria, as determined by Aetna, is met.

Page 37

- Aetna covers the services of a podiatrist for treatment of a disease or injury, including but not limited to treatment of corns, calluses, keratoses, bunions, and ingrown nails. Aetna does not cover pedicure services, such as routine cutting of nails, in the absence of disease of nails.
- Not sure what the reference to excluding gene therapy refers to.
- Aetna's standard claim guidelines for covering home oxygen equipment will apply.
- Due to system limitations and administrative concerns we are not able to exclude hypnotism as requested. Hypnosis may be a covered behavioral health expense when rendered by a recognized provider when certain other criteria are met.
- Due to a lack of system support, we cannot distinguish treatment needed for injuries or illness resulting from illegal actions from any other expense. Therefore, these expenses will be covered subject to the appropriate level of coverage the same as any other expense under the plan.

- Due to a lack of system support, we cannot effectively distinguish expenses for treatment provided by a relative or member of the household from any other expense. Therefore, these services will be covered subject to the appropriate level of coverage under the plan.

Page 38

- We can agree to exclude prescription medication for the treatment of impotence. However, Aetna considers the diagnosis and treatment of erectile dysfunction (impotence) medically necessary according to the medical criteria outlined in Clinical Policy Bulletin #007.
- We can administer the proposed plan to exclude Infertility Services such as Artificial Insemination and In Vitro Fertilization in states that do not have mandates. However, our standard plans cannot exclude coverage for treatment of the underlying cause of infertility. Aetna will cover the diagnosis and treatment of the underlying cause of infertility the same as any other medical condition.
- We are not sure that we understand the references to excluding certain diagnosis for coverage under the plan. Aetna does not cover services which are educational in nature. However, if there is medical criteria and the services meet claim guidelines as well as criteria in the DSM-IV then coverage can be allowed the same as any other medical expense.
- We are not sure that we understand the reference to excluding Mental Health treatment when the plan designs included coverage.
- We are unable to exclude all TMJ expenses from coverage under the plan. Florida House Bill 109 requires coverage for medically necessary diagnostic or surgical procedures involving bones or joints of the jaw and face, when resulting from congenital or developmental deformity, disease or injury. The required coverage does not include inter-oral prosthetic devices, treatment of the teeth or gums, or surgical procedures for cosmetic purposes. We will administer the plan in compliance with this legislation.

Page 39

- Due to a lack of system support, we cannot distinguish treatment needed for injuries or illness resulting from a self-inflicted injury or suicide attempt from any

- other expense. Therefore, these expenses will be covered subject to the appropriate level of coverage the same as any other expense under the plan.
- Aetna considers the diagnosis and treatment of obstructive sleep apnea (OSA) in adults age 18 and older medically necessary according to the medical criteria outlined in Clinical Policy Bulletin #004.

 - Due to system limitations and administrative concerns, we cannot exclude hypnotherapy, biofeedback, acupuncture and sleep therapy services as requested. Hypnosis may be a covered behavioral health expense when rendered by a recognized provider when certain other criteria are met. Aetna considers biofeedback medically necessary for certain conditions as outlined in CPB #132. Acupuncture is covered in lieu of anesthesia only. Additionally, the diagnosis and treatment of obstructive sleep apnea (OSA) in adults age 18 and older medically necessary according to the medical criteria outlined in Clinical Policy Bulletin #004.

 - Due to system limitations and as a matter of public policy we cannot exclude treatment of complications and required follow up care resulting from non-covered transplant services or treatment. These expenses will be covered the same as any other medically necessary expense under the plan provided the service itself is a recognized expense under the plan.

 - Due to system limitations and as a matter of public policy, we cannot restrict ambulance coverage to emergency only. Medically necessary, but non-emergent, ambulance expenses will be covered the same as any other expense under the plan. Elective air transport will require preauthorization.

 - Due to system limitations and as a matter of public policy we cannot exclude treatment of complications resulting from non-covered obesity services or treatment. These expenses will be covered the same as any other medically necessary expense under the plan provided the service itself is a recognized expense under the plan.

Page 40

- Due to a lack of system support, we cannot distinguish treatment needed for injuries or illness resulting from war or an act of war from any other expense.

Therefore, these expenses will be covered subject to the appropriate level of coverage the same as any other expense under the plan.

- We are not able to restrict coverage for wigs to restoration after cancer treatment or brain tumor treatment. Aetna covers a wig or hairpiece (synthetic, human hair or blends) prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of a disease, except for male pattern baldness.

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RLI R0843005R1**

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|---|---|--|--|---|--|---|--|---|--|
| | Contact | Mary Deparno 904-630-1212 X 6719 | Sheila Gann 904-529-4919 | Mike Kushner 863-534-5265 | Jennifer Laufenberg 239-533-2004 | Jennifer S. Cohen 305-586-4866 | Ted Pafundi 727-588-6282 | Jerry Visco 321-633-2103 | Sandra Kenefake 904-390-2811 |
| 1 | Please confirm the following information as regards the type of products offered by the vendor as well as participation volume. (When printing out I'd just cut and past the numbers and indicate yes or no; if no, repeat what the reference said... | HMO regular- 8,649 * HMO High deductible- 480 * POS- 830 * PPO – 7 retirees (no dependent data) *(Employees and retirees without dependent data) | 2 HMO's: Basic- 1,948 employees; Premium HMO- 1,015 employees High deductible HSA plan – 233 employees (no dependent data provided) | Self funded plan. Provides Stop Loss coverage and health plan Administrator. EPO (Aetna select plan) – 75% of active employees HRA-25% of active employee FSA- not many people took plan. Approx. have 3,600 subscribers (active employees) | Aetna handles 9 different entities HMO Select Plan –29,821 employees and POS plan- 1,328 employees (total participants as of 06/2010) Dental- 4,067 employees only (no dependents) | 2 HMO's: HMO 1- 4,253 members; HMO 2- 12,367 members; 1 PPO – 996 members; 1 HRA plan – 4,231 members (employees and dependents) | POS -400 employees CDH- 167 employees 2 HMO –11,500 employees (no dependent data provided) | Self insured. Provided Administrative services. Purchased physician and network and TPA services for their HMO and PPO plans. Had 2,000 employees and retirees (no dependents included with the number) | POS, Medicare advantage plans (No numbers provided) |
| 2 | What do you consider as this vendor's strength? | Willingness to help with anything. Go out of their way to resolve issues. Very helpful onsite representative | Market leader in technology. No one could compare to their DM program. New pharmacy program helps track people from overdosing. Great Adm. staff to work with. | Clinical capability. They have a care engine that integrates data from personal health assessments to claims. Flexible medical Mgt. program. Their Behavioral health is integrated with the medical plan. | Claim processing Very good network for employees and retirees. Liaison located in Tampa, helps members over the phone with issues not resolved through the regular customer service line. Weekly Electronic upload | Medical plan set up with complicated plan design (different levels of service within and outside of health system). Set up of plans, flexibility in programming, Role out and delivery of care Mgt (health coaching to DM). | Very strong network, DM and wellness programs | Large national network. Ability to negotiate with provider on a large scale | Very efficient, good network, responsive to their need, good service representative. |

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|----|--|----------------------------------|---|--|--|--|---|---|--|
| 3 | This vendor's weakness? | None | "Building" at the very beginning. The number of providers in 2003 were a few but no longer an issue nowadays since more providers were added to the network | Billing. Aetna charges for everything and likes to negotiate everything. | None at this moment | Network discount highly utilized (i.e. Baptist Health system/hospitals) | None | Sometimes where inflexible. Not able to customize some of the programs needed | Replaced due to price. Did RFP and Aetna did not come first. Does not recall, no major problems. |
| 4 | Have all your benefit/program issues been thoroughly resolved to your satisfaction in the past year? If not, please explain. | Yes | Yes | Yes. Aetna has been responsive to Polk County's request. (i.e. asked Aetna to be more proactive and hands on with members) | Yes | Yes. Every member in need of transitional care received the proper help | Selected different carrier for 2010 price driven Very prompt resolving issues in 2009 | All issues resolved. No overlapping issues | Yes |
| 5 | If you could suggest one improvement, what would it be? | None | Way to reconcile FSA account. Plan year begins on 10/1, not 1/1. | Better job with member outreach | No complaints | Trying to communicate with covered dependents. Overall, pleased with Aetna. | Very please with the service. Reporting at times confusing. For the most part were excellent | Greater flexibility with large national account | Their Medicare area could be more responsive to retirees. |
| 6 | How long have you had your assigned Account Manager? How would you describe the expertise of this person(s) assigned to your account? | Two years. Very knowledgeable | Since October 2003 Excellent. The Account Manager has a back up person if not available. | Since January 2008 Good | Since 01/2003 Extremely knowledgeable | Since 07/2008 "She is a gem", experienced, able to anticipate their need. | Excellent expertise. During 2001-2009 had several account managers and everyone was excellent | 5 years Very well equipped, highly skilled, very professional | 6 years. 8 out of 10 |
| 7 | | | | | | | | | |
| a. | Responsiveness to Benefits Staff | Very responsive | Normally within one hour response. | Excellent | Deal with liaison who is very helpful | Very responsive resolving issues | Excellent. Onsite representative and local account team | Very responsive | Very good. 7 or 8 out of 10 |

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|----|---|---|---|---|---|---|---|---|---|
| b. | Responsiveness to Members | Very responsive | Resolve most of the members' questions right away. | Excellent | Very helpful | Very responsive. Have designated service team. Able to monitor level of service provided by service team. | Excellent, prompt response to members | Average | Good. No complaints received |
| c. | DM - Creativity of Disease Management Program | Do everything they can to reach out to members. Not require to participate. Getting members engaged | Have 29 different programs. When claims come in, it triggers claim and someone from the team will reach out to enroll the member in the program and help them through different illnesses | Flexible and creative. Able to work with Aetna's clinic. Data sent to Aetna is integrated into their system for better results. Aetna makes calls to members | Can not say. Claim information triggers calls to employees for coordination of care | The member has one point of contact. The designated nurse helps members with the DM program, regardless what the member condition is. | Created special program for diabetes. Partner with Pinellas, very well received and creative. | Not very creative. Plain program. They discontinued Aetna in 2005 | Purchased standard plan. Very effective DM program. |
| d. | DM - # of member engagements in DM Program | Data not available | High amount. About 40 to 50% of people diagnosed end up enrolling in the program. Non-members will get reminders on DM programs. | Polk County has own DM program with over 1,000 members in Hypertension and Diabetes programs. Aetna handles other disease Mgt. programs and have between 1,500 to 2,000 members | Do not know | With Aetna since 1/1/09. 3,650 members in DM | Not sure but program worked very well. | No | Had different programs. Fully insured, do not have statistics due to HIPAA. |
| e. | DM – ROI of Program | Data not available | Do not know | 2.57 to 1 avoided hospitalization and Emergency Room visits (Does not include productivity) Hard dollars saving. | Do not know | Unable to determine yet. Not enough data. Maybe available in the next 6 months. | Very good | No | Fully insured |

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|----|--|---|--|--|---|--|--|---|---|
| f. | Wellness - Creativity of Wellness Programs | They provide monies toward their internal wellness program | Provide allowance to pay for health screening, flu shot, and educational material. Account Manager helps with “learn and lunches.” | No comment. Mainly focused on DM program. Aetna has capability for health coaching, web base fitness program, challenges, nutrition, simple steps to healthy life. | Had a wellness coordinator a year and a half ago. Position vacant. Program not utilized | Incorporated University own wellness program with Aetna’s to avoid duplication of programs. “Healthy Lifestyle coaching” is the most successful. | Have own wellness program. Aetna provided resource and funding, flu shots, wellness seminars, HRA and other wellness initiative. | Just getting started at the time, “plain basic stuff” | Supplemented wellness staff. Provided support and material to staff |
| g. | # of member engagements in Wellness Programs | Currently less than 100 members since program started on 7/1/2010 | Attendance and health fair: 75% of employees attend, 2500 to 4000 people showed up to health fair | No comment | Not available | 819 members. The Health Risk Assessment Program Launched recently 1/1/10-3/31/10 | Not sure | No | About 12,600 employees. Around 2000 retirees without including dependents |
| h. | Wellness – ROI of Programs | Program just started effective July 1, 2010 | Have monthly newsletter. Renewal 40 percentile. Aetna’s 4 years renewal came around 8 to 9%. Last year was higher, about 10% | No comment | Not available | Not available | Good | No | Fully insured |
| i. | Timely adjudication of claims? | Good. No problems | Auto adjudicated. Quick response within days from time they get claims | Excellent. Strong point on processing time. No complaints about claims. | Very timely | No issues with delaying claim processing. | Very a few claim issues | Very timely, no problems | Very timely |
| j. | Timely issuance of EOB’s? | Good | Within 10 to 14 days after claim paid, Maybe sooner | Timely. Option to receive via regular mail or electronically | Timely | No issues | Timely | No problems | Quick |
| k. | Depth and ease of understanding claims reporting | Good | Gets pertinent information. Out of pocket, deductible amount. A few | Very good reporting package. Clear ad easy to understand, easy to access. Good IT | Good reporting. Website base reports through secure website | No issues. Aetna was able to customized their claim reporting to fit the University | Statements sent to members were easy to understand. Some reports the company | No problems. Very simple program | Fairly clear |

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|----|---|--|--|---|--|--|-----------------------------------|---|-------------------------|
| | | | questions about EOB's received by employees | support | | of Miami request | received were a little confusing. | | |
| l. | Satisfaction of Customer Service | Great | 1 or 2 complaints per year. The reason is because the employee did not get the answer they wanted. Sometimes Customer Service gets confused with effective date 10/01 versus 01/01 | Excellent | Very happy | Very satisfied | Very good | Very satisfied | Excellent |
| m. | Satisfaction with onsite Staff (if applicable) | Great. One onsite staff full time, 5 days per week | Excellent | Excellent | Not applicable | Very satisfied | Excellent | Not applicable | Excellent |
| n. | Satisfaction with Network | Great network | Very good. Improved so much for the last 7 years. | Excellent. Nationwide network, very strong. | Very satisfied. Have nationwide network | Very satisfied. One of the most important factor looked at. Minimal disruption to employees. | Great | Not satisfied. Aetna's network was the primary reason they left the carrier. Locally, where a partial network. Brevard County has two major hospitals and Aetna's contracted services with only one hospital network. | Sufficient |
| o. | Satisfaction with Network specific to Mental Health and Substance Abuse | Good | Do not know. Not sure of the facilities around the area but Aetna provides the coverage. | Some shortfalls in the past. Aetna recently acquired Horizon Behavioral Health that would help with their | Smaller network. Not a great deal of providers in Lee County | Carved-out. University has own vendor. | Very good | Did not provide services | Satisfied |

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|----|--|--|---|--|---|--|--|---|--|
| | | | | network | | | | | |
| p. | Flexibility and adaptability to individual client/customer needs | Very satisfied | Work with clients to get service needed | Very flexible in terms of customer needs. | Very satisfied. (Self insured program) | Very satisfied | Very good. Very a few complaints from employees. Onsite Rep resolved issues timely | Marginal | Excellent, no complaints received |
| q. | Overall performance? | Very good | Great | Very good. Need to improve their outreach to members | Excellent. No complaints | Very satisfied | Very good | Very good | 9 out of 10 |
| 8 | Have you received any complaints about this vendor from employees? If yes, please provide a general overview of the typical issues raised. | No | About 2-3 years ago, employees were not satisfied when Aetna changed their pharmacy network from up North to a local pharmacy. | No major complaints | No more than a typical complaint. (i.e. doctors out of network, did not like member service answer) | Two instances with hospitalization regarding impatient diagnosis coding. Aetna spoke with hospital and worked with hospital to resubmit claims. Issues with the hospital not Aetna | Yes. Referral and claim issues caused by physician office and onsite rep always corrected and have it resolved | Yes, generally how bills where processed (i.e. if bills where from network providers, contract rates properly applied). | No complaints received. One year, they had a closed formulary that caused a lot of complaints. The year after, the formulary changed and the complaints stopped. |
| 9 | What is the #1 complaint members have? | Not applicable since no complaints received | None | No major complaints. Claim related complaints | No major complaints | Understanding of EOB by members | Pharmacy issues, tiers | Billing processing | Do not recall having any. |
| 10 | What are the strengths (if any) in this vendor's cost management and mitigation efforts for you? | Fully insured. Diligent watching the claims, saving monies with DM program by reaching out to members. | DM program saved money. Very good job making sure employee's dependents were actually their dependents. Yearly review on areas to worked on and | Below trend on claims. From 2008 to 2009 claims increased about 5% (below industry trend). Overall is very good cost containment | Do not know | In terms of Care Mgt, claim review process, subrogation | Very good job making sure procedures tests ordered were medically necessary | Hard to say | Aetna assisted with wellness, had DM program, cost containment program |

**Broward County Government
Health Plan References – Vendor Reference: Aetna
RLI R0843005R1**

| | References for AETNA | #1 Current City of Jacksonville | #2 Current Clay County Schools | #3 Current Polk County Government | #4 Current Lee County | #5 Current University of Miami | #1 Former Pinellas County Schools | #2 Former Brevard County | #3 Former Duval Schools |
|----|--|--|---|--|---|---|---|---------------------------------|---|
| | | | provided suggestions for improvement. The home delivery program saved money | | | | | | |
| 11 | Does this vendor also provide DM/Wellness or is that carved out or supplemented by another provider? | Provide DM program. City of Jacksonville have their own Wellness program | Included with the medical plan | Included with the medical plan | Included with medical plan. Wellness program not utilized at this time. | Included with medical plan | Included with the medical plan | Included with medical plan | Yes. Provided DM program. School Bd. had own wellness program. Aetna supplemented the program by providing speakers, materials, and prices. |
| 12 | Have you realized any quantifiable results from this vendor's disease management/wellness programs? | Unknown | Hospital stay decreased on several diseases. | Yes. No reports available at this time | No | Too early in the process to determine | Saw some incremental gain. Wellness and DM are long term programs | Not quantifiable | Hard to know since they changed carriers. |
| 13 | Have you realized a reduction in Pharmacy expenses from these programs? | Unknown | Population grows older. Not much turnover. Medium age is 45-46. Their obesity ratio on employees decreased. Geriatric program added to program. | No | Do not know | Too early in the process to determine. Started with Aetna on 1/1/09 | Saw reduction in pharmacy expense. The Generic utilization went up and cause decrease in cost | Pharmacy was carved out | Hard to say. Maybe controlling pharmacy in one part but trend of health going up on another part |
| 14 | What methods does this vendor use to ensure employee engagement in their DM programs? | Website, phone calls, letters | Website, direct contact, mail. | Phone calls, written communication, mail to home, follow up calls, use email | Phone calls and letters | Direct contact via phone and mailing | Phone calls, mail in | Phone contact and mailing | Letters, seminars on weekends on their own time. Fully insured, unions did not want employees' data therefore, unable to provide data. |

**Broward County Government
Health Plan References – Vendor Reference: Aetna
RLI R0843005R1**

| | References for AETNA | #1 Current City of Jacksonville | #2 Current Clay County Schools | #3 Current Polk County Government | #4 Current Lee County | #5 Current University of Miami | #1 Former Pinellas County Schools | #2 Former Brevard County | #3 Former Duval Schools |
|----|--|--|---|---|--------------------------------|---|--|---|---|
| 15 | Does your Vendor use the Opt-In or Opt-Out method of enrollment for the DM programs? | Opt-In | Opt-In | Opt-Out method | Do not know. | Opt-In | Opt-In | Opt-In | Opt-In |
| 16 | Do you think the DM program(s) have improved employee retention? | Not applicable | Do not know, not tracked | Can not correlate data | Do not know | No impact | Yes | No | Hard to quantify. People satisfied |
| 17 | What is one area of improvement you would like to see this vendor improve upon? | None | Way to reconcile FSA account. Plan year begins 10/01 | Member outreach | None at this time | Communicating with employee's dependents. | Not applicable. Not longer their vendor | Flexibility | Do not have Aetna anymore and not sure what Aetna currently provides. |
| 18 | What is one area in which this vendor excels above other vendors you have worked with? | Large Network of doctors, customer service, willingness to work with staff and employees | DM program, willing to work with client is a huge factor, accessible. | Clinical capability | Electronic reporting | The one point of contact service provided for their DM program. | Very responsive | No one specific area | Can not compare competitively |
| 19 | Does this vendor provide you EAP services as part of their Core Medical program? If so what services are included? | Yes. Have 10 free visits for employees and dependents, mandatory supervisory referral program, training to staff | No | Not part of the core medical program, have to pay extra but do have an EAP program. | No. Have a separate EAP vendor | No. University have own internal EAP program | No | No | No |
| 20 | Why did you discontinue services with this vendor? | | | | | | Cost | In 2005, network issue, looking for single carrier with all providers | Price |
| 21 | Would you contract to use this vendor's services again? | | | | | | Yes | Yes | yes |

**Broward County Government
Health Plan References – Vendor Reference: Aetna
RLI R0843005R1**

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|----|---|--|---|--|----------------------------------|---|--|-------------------------------------|------------------------------------|
| 22 | Would you still recommend this vendor to other companies? | | | | | | Yes | Yes | Yes, definitely. |

**Broward County Government
Health Plan References – Vendor Reference: Coventry Health Care of Florida
RLI R0843005R1**

| | References for Coventry Health Care of Florida | #1 Current School Board of Broward County | #2 Current State of Florida | #3 Current AutoNation | #4 Current Federal Employees Health Benefits Program | #5 Current Broward Sheriff's Office | #1 Former Walgreen's | #2 Former Gunther Motors | #3 Former Feick Security |
|---|---|--|--|--|--|--|--------------------------------------|--|--|
| | Contact | Glenn Parks 754-321-3103 | Michael Talbot 850-413-8993 | Mark Snow 954-769-3931 | Toisha Faraji 202-606-0737 | Laurel Owens 954-321-4433 | Kimberly Korley 800-825-5467 | Gwen Castro 954-797-1660 | Leticia Mendieta 305-259-3000 |
| 1 | Please confirm the following information as regards the type of products offered by the vendor as well as participation volume. (When printing out I'd just cut and past the numbers and indicate yes or no; if no, repeat what the reference said... | HMO high-23,870 employees HMO low- 2,282 employees CDH -791 employees PPO –115 employees (Just for active employees enrolled) 1,506 employees opt out | HMO and High deductible plans (data not available but 7,500 total members with Coventry) Have 178,000 total members | HMO with three options: 100% plan- 500 employees 90% plan-300 employees; 80% plan-300 employees (no dependent data provided) | HMO – 3,000 enrolled employees | 1 HMO open access, 1 HMO Gated, 1 POS and 1 PPO (No number or employees/members information provided) | HMO – 3690 employees (no dependents) | 2HMO's- 1 PPO- Under both plans, 200 total members. Unable to provide data for each plan. | HMO- 120 employees, PPO – 3 employees without dependents |
| 2 | What do you consider as this vendor's strength? | Prices | No referral, open access plan, preventive vision program, discount membership, online health portal E-Phit | Network of hospitals and doctors in South Florida area. | Excellent customer service Provides adequate benefits for employees | Very responsive | Willingness to work with company | Very good with employee issues | Resolved all issues |
| 3 | This vendor's weakness? | Specialist network, for certain specialties | None | Claim processing and administration. New system will help with this weakness | None | Network availability | None | Difficulty with claims been paid (company used two different systems- Vista was taken over by Coventry). | None |
| 4 | Have all your benefit/program issues been thoroughly resolved to your satisfaction in the past year? If not, please | Yes | Yes | Yes | Yes | Yes | Yes | Still having some outstanding bills | Yes |

**Broward County Government
Health Plan References – Vendor Reference: Coventry Health Care of Florida
RLI R0843005R1**

| | References for Coventry Health Care of Florida | #1 Current School Board of Broward County | #2 Current State of Florida | #3 Current AutoNation | #4 Current Federal Employees Health Benefits Program | #5 Current Broward Sheriff's Office | #1 Former Walgreen's | #2 Former Gunther Motors | #3 Former Feick Security |
|----|--|---|---|---|---|---|--|--|---|
| | explain. | | | | | | | | |
| 5 | If you could suggest one improvement, what would it be? | Auxiliary program need a follow up (i.e. over the counter, update E-Phit) | More account managers. Currently only with two Account Managers | Needed to upgrade claims paying system. New system that went into effect June 1 st will help improve the claim processing. | Expansion of their network | Network availability | No complaints. Person assigned knew account | Getting their system updated | Unknown at this moment |
| 6 | How long have you had your assigned Account Manager? How would you describe the expertise of this person(s) assigned to your account? | 5 years Very good | About 19 years Very knowledge and independent | 3 years. Very good, very knowledgeable. Quick response time | 8 years Very knowledgeable | 3-4 years Very knowledgeable | Had two Account Mgr's -9 years or longer. Billing and enrollment extremely knowledgeable with account | One year. Account Mgr still helping with outstanding claims. Great person to work with. | One year Did not deal with person directly. dealt with agent first |
| 7 | | | | | | | | | |
| a. | Responsiveness to Benefits Staff | Excellent | Very good. They go out of their way to help members | Quick response | Quick response within 24 hours | Onsite representative, very responsive | Quick response within one day. | Great customer service | Very quick response |
| b. | Responsiveness to Members | Excellent | Average | Not many complaints received. No issues | Do not know. No complaints received | Timely | No complaints | Good | No complaints received from any members |
| c. | DM - Creativity of Disease Management Program | Cannot respond. Not enough information | Coventry administers the state program. | Average. Good contact and follow through | Not enough information | Quick initiative. Based on what they have done, is very positive and well enhanced. | Not familiar with the program | Not included. Not applicable | Information not available |

**Broward County Government
Health Plan References – Vendor Reference: Coventry Health Care of Florida
RLI R0843005R1**

| | References for Coventry Health Care of Florida | #1 Current School Board of Broward County | #2 Current State of Florida | #3 Current AutoNation | #4 Current Federal Employees Health Benefits Program | #5 Current Broward Sheriff's Office | #1 Former Walgreen's | #2 Former Gunther Motors | #3 Former Feick Security |
|----|---|--|---|---|---|--|--|--|--|
| d. | DM - # of member engagements in DM Program | Cannot respond | Do not have data | None | Not enough information | None | Unknown | Not included. Not applicable | Information not available |
| e. | DM – ROI of Program | Cannot respond | Do not have data | Not tracked | Not enough information | None | Unknown | Not included. Not applicable | Information not available |
| f. | Wellness - Creativity of Wellness Programs | School Board have internal program and the program works great with Coventry. Creativity comes from employees' ideas, carrier funds the ideas. Very good providing raffle prizes, speakers, incentives, etc. | State provides their standards and Coventry administers the program. Do benefit fairs and open enrollment | Very standard, members can call and get fitness membership discounts. | With medical plan. Handles annual health fair. Have "Healthy Life Style" program, web-base information, newsletters sent twice per year, discounted fitness membership, weight watchers and Jenny Craig | Do not have a wellness program. Only annual health fair. Used to have monthly wellness seminars. Goals for next year will be to provide wellness program | Not sure if program offered with medical program | Had only one wellness fair. Very creative, managed to get flu shots, psychological issues with mental health, eating disorders, helpful providing information to members | Did not provide wellness program with medical plan |
| g. | # of member engagements in Wellness Programs | Have free fitness membership - 25% utilization. 45% to 50% member engagement | Do not have data | None | Unknown | None | Unknown | Information not available | Did not provide wellness program with medical plan |
| h. | Wellness – ROI of Programs | Not able to measure, hard to arrive to ROI. | Do not have data | Not tracked | Unknown | None | Unknown | Not available | Did not provide wellness program with medical plan |
| i. | Timely adjudication of claims? | No problem in years | Standard used 14 days for clean claims. 30 days for all claims. No problems so far. | Very good. Performance Standards met | Respond with reasonable amount of time | Very satisfied | No complaints received | Not timely. Still having some outstanding claims | Very quick |
| j. | Timely issuance of EOB's? | No problems | Very quick | Very good | Timely | No complaints, satisfied | Not complaints received | No complaints | Very good |

**Broward County Government
Health Plan References – Vendor Reference: Coventry Health Care of Florida
RLI R0843005R1**

| | References for Coventry Health Care of Florida | #1 Current School Board of Broward County | #2 Current State of Florida | #3 Current AutoNation | #4 Current Federal Employees Health Benefits Program | #5 Current Broward Sheriff's Office | #1 Former Walgreen's | #2 Former Gunther Motors | #3 Former Feick Security |
|----|---|---|---|--|---|---|---|--|--|
| k. | Depth and ease of understanding claims reporting | Fine | Good | Very good. Meet with them twice a year to go over anything outstanding | Good | Not much reporting from Coventry | No claim reporting received | No claim reporting received | Unable to answer the question. Reports provided to broker directly |
| l. | Satisfaction of Customer Service | Excellent | Heard some complaints from members regarding follow ups, not quick enough for their liking. | Very good. No issues, no complaints | Excellent | Satisfied | Not able to answer question since did not deal with customer service staff directly. No complaints from members | Very good | Very good |
| m. | Satisfaction with onsite Staff (if applicable) | Excellent. Have 6 onsite representatives | No onsite representative. Account Mgr available as needed. | No onsite representative. Not applicable | Not applicable | Very good | Had billing enrollment and Marketing representatives. Very satisfied | Not applicable | Not applicable |
| n. | Satisfaction with Network | Adequate. Their specialty network needs improvement | No complaints received | Very good. Do not have any complaints | Adequate | Could be better | No complaint | Very satisfied. One plus when Coventry took over, their network expanded | Good |
| o. | Satisfaction with Network specific to Mental Health and Substance Abuse | Adequate | No complaints received | Do not know | Increase through mental parity. Currently expanding | Have EAP Mgr and does follow up directly with Coventry. | Do not know | Hard to answer question. Not involved due to confidentiality | Not with medical plan. Only had basic plan |
| p. | Flexibility and adaptability to individual client/customer needs | Excellent | Very good | Very flexible. No problems with Coventry | Very good | Satisfied | Unknown | Can not answer. Did not request anything specific from provider | Good |

**Broward County Government
Health Plan References – Vendor Reference: Coventry Health Care of Florida
RLI R0843005R1**

| | References for Coventry Health Care of Florida | #1 Current School Board of Broward County | #2 Current State of Florida | #3 Current AutoNation | #4 Current Federal Employees Health Benefits Program | #5 Current Broward Sheriff's Office | #1 Former Walgreen's | #2 Former Gunther Motors | #3 Former Feick Security |
|----|--|--|--|--|---|--|--|--|--|
| q. | Overall performance? | Excellent | Good. Not at the bottom of plan list | 8 out of 10 | Good | Happy with Coventry | No complaints, 10 out of 10. Easy to work with | Only complaint was getting some claims paid | Good |
| 8 | Have you received any complaints about this vendor from employees? If yes, please provide a general overview of the typical issues raised. | Yes. Not enough specialists, some prescriptions not covered, some issues with procedure pre-authorization. | Yes. Slow services, members billed by providers. | No. Only questions regarding claims | No | Yes. Some employees concern with physicians network and availability. People concern with transition of care | No major complaints received from employees. If so, where just enrollment issues | Just on the claims been paid. Otherwise, carrier was very helpful with everything else. | No |
| 9 | What is the #1 complaint members have? | Premium and co-pays | Billing from the providers versus billing from Coventry. | Questions regarding claims | Not applicable | Network | None | Claims been paid timely | None |
| 10 | What are the strengths (if any) in this vendor's cost management and mitigation efforts for you? | Cost containment | Not much. Emphasis in quick service versus cost management. Co-pays increased this year. | Do not know. Are HMO's, fully insured, is their bottom line. If they are managing claims, they should be holding cost down and rates given should be reasonable. | Coventry went "green" this year to be able to save monies to the plan | Did not have opportunity to focus on that area. Not utilized. | Not able to answer question | Able to help minimize some cost factors. Before Coventry was their carrier, their premiums went up over 33% and plan changed with fewer benefits. When Coventry came on board provided, it affordable benefits needed. | Inexpensive plan. Had the plan only for one year |
| 11 | Does this vendor also provide DM/Wellness or is that carved out or | Included | Included | Included | Included | Yes, included | Did not know if it was part of the contract of not | Very good with the wellness program included with | Does not know details of the plan |

**Broward County Government
Health Plan References – Vendor Reference: Coventry Health Care of Florida
RLI R0843005R1**

| | References for Coventry Health Care of Florida | #1 Current School Board of Broward County | #2 Current State of Florida | #3 Current AutoNation | #4 Current Federal Employees Health Benefits Program | #5 Current Broward Sheriff's Office | #1 Former Walgreen's | #2 Former Gunther Motors | #3 Former Feick Security |
|----|---|---|--|--|---|---|--------------------------------|---|--|
| | supplemented by another provider? | | | | | | | medical plan. DM program not included with the plan | |
| 12 | Have you realized any quantifiable results from this vendor's disease management/wellness programs? | Not aware of any quantifiable measures | No | Not tracked. Viewed as their responsibility and shows up on their cost. Judge on what they charge for their services | Not tracked | No | No | Not tracked | Unknown |
| 13 | Have you realized a reduction in Pharmacy expenses from these programs? | No | No. Pharmacy is integrated | No | Enhanced pharmacy program for the smoking cessation | Have not done the breakdown so far on any benefits. Initiative for next year. | No | Not tracked | No |
| 14 | What methods does this vendor use to ensure employee engagement in their DM programs? | Not sure. Coventry have nursing program to help individuals navigate through the process. | Mail, phone calls, follow up calls. | Mail, phone calls | Not known | Mail, phone calls | No idea on their communication | DM program not included with medical plan | Only had plan for a year |
| 15 | Does your Vendor use the Opt-In or Opt-Out method of enrollment for the DM programs? | Opt-Out | Opt-In | Do not know | Do not know | Do not know. Not able to answer | No idea if program available | DM program not included with medical plan | Unknown |
| 16 | Do you think the DM program(s) have improved employee retention? | Not measured | Not sure | No effect on it. | Not measured | No turnover | Unknown | DM program not included with medical plan | Unknown |
| 17 | What is one area of improvement you would like to see this vendor | Response time on reports | Very responsive, so far no improvement needed. | Need to improve their administration and claim processing. | Not sure | Network | None | Paying the claims timely | Do not know. Did not have enough time to judge the |

**Broward County Government
Health Plan References – Vendor Reference: Coventry Health Care of Florida
RLI R0843005R1**

| | References for Coventry Health Care of Florida | #1 Current School Board of Broward County | #2 Current State of Florida | #3 Current AutoNation | #4 Current Federal Employees Health Benefits Program | #5 Current Broward Sheriff's Office | #1 Former Walgreen's | #2 Former Gunther Motors | #3 Former Feick Security |
|----|--|--|------------------------------------|--|---|--|---|--|--|
| | improve upon? | | | New system will help. | | | | | company's overall performance |
| 18 | What is one area in which this vendor excels above other vendors you have worked with? | Customer service is outstanding | Their Account Mgr works very well. | Providing good network for local South Florida area. Their success is their network. | Customer service | Responsiveness | Resolving administrative issues regarding eligibility and billing | Customer service | Not able to compare. New company just started with health plan for first year. |
| 19 | Does this vendor provide you EAP services as part of their Core Medical program? If so what services are included? | No. School Board has own EAP program | No. | No. Service offered outside of the contract but available through Coventry to members. | Not included with medical plan. EAP program provided by employer. | Yes | No | Yes. Also had a separate program. Employees had the option to utilize Coventry plan. | Unknown |
| 20 | Why did you discontinue services with this vendor? | | | | | | Walgreens discontinued all HMO's | Having claims been paid on time | Prices |
| 21 | Would you contract to use this vendor's services again? | | | | | | Yes, if corporate decides to open the HMO market | Yes, if the company's merger was finalized | Yes |
| 22 | Would you still recommend this vendor to other companies? | | | | | | Yes | Yes | Yes |

**Broward County Government
Health Plan References – Vendor Reference: UnitedHealthcare
RLI R0843005R1**

| | References for UnitedHealthCare | #1 Current The School District of Palm Beach County | #2 Current City of Orlando | #3 Current Orange County Government | #4 Current Pinellas County | #5 Current Pasco County Government | #1 Former Miami Dade Community College | #2 Former Miami Dade County Public Schools | #3 Former Not available |
|---|--|--|---|---|---|---|---|---|----------------------------|
| | Contact | Diane Howard 561-357-7518 | Cindy Merrithew 407-434-8414 | Jennifer Addleman 407-836-2951 | David Blasewitz 727-464-4570 | Jane Calano 727-847-8028 | Marta Arrieta 305-237-0363 | Joseph Flynn 305-995-7006 | Not available |
| 1 | Please confirm the following information as regards the type of products offered by the vendor as well as participation volume. (When printing out I'd just cut and past the numbers and indicate yes or no; if no, repeat what the reference said | 4 plans: PPO, POS, HMO, EPO HMO- approx 17,000 employees 1,200 in EPO, 420 in POS, 35 in PPO (no dependent data provided) | HMO and POS Total active and retirees is about 3,000 90 % under the HMO and 10% in the POS plan | HMO-7000 employees POS- 1000 employees (not including dependents) | POS -90% of participants 2,800 employees active side and 800 retirees (without dependents) HRA -115 employees FSA -100 employees | 2 HMO Open Access – 97% of employees 1 POS – 3% of employees in the plan | Contacted/no reply | Fully insured 4 HMO plans 42,000-43,000 insured employees | Not available |
| 2 | What do you consider as this vendor's strength? | Good account Manager and great network | Large network National reciprocity (able to access outside network in other states) Technology web base online access to view claims, benefits, ID cards. Online tools and accessibility to members | Network Open Access plan | Good discount due to self-funding. Broad network. Solid Customer service. Implemented strong DM program a year ago | Good wellness initiative | Contacted/no reply | Large network | Not available |
| 3 | This vendor's weakness? | UHC is an insurance company to make a profit | Occasionally some claims but handled by onsite Rep. Direct communication to members without notifying employer/administrator first. | Customization to fit their needs. | No significant weaknesses | Their pharmacy plan | Contacted/no reply | Slightly inflexible with requested changes. Changes based on technology needs or work environment | Not available |

**Broward County Government
Health Plan References – Vendor Reference: UnitedHealthcare
RLI R0843005R1**

| | References for UnitedHealthCare | #1 Current The School District of Palm Beach County | #2 Current City of Orlando | #3 Current Orange County Government | #4 Current Pinellas County | #5 Current Pasco County Government | #1 Former Miami Dade Community College | #2 Former Miami Dade County Public Schools | #3 Former Not available |
|---|--|--|---|--|--|---|---|---|------------------------------------|
| 4 | Have all your benefit/program issues been thoroughly resolved to your satisfaction in the past year? If not, please explain. | Yes | Yes | Reporting issue due to customization. For the most part, are able to work with issues | Very responsive with issues that arise. Account team very strong | Yes | Contacted/no reply | Still have pending issues since 12/09 | Not available |
| 5 | If you could suggest one improvement, what would it be? | Customized reports | Better communication with employer/administrator | More ownership of customer service. Would be nice for members to call one point of contact, like a Care Mgr. | Integration between Account Mgt team and Specialty Section. | More flexibility Their pharmacy program has supply limits restrictions | Contacted/no reply | Flexibility | Not available |
| 6 | How long have you had your assigned Account Manager? How would you describe the expertise of this person(s) assigned to your account? | 5 years Excellent | 10 years. Also have a Strategic Acct Mgr above the Acct Mgr. Twice a year carrier has a customer client meeting and provides update to employer on new things coming up, claims processing, and waiting times on some issues. Wonderful. If unable to answer questions, gets information and gets back to you. Knowledgeable. | Since 2002 Have assigned Acct Mgr and Strategic Mgr. Very good. Coordinate to get info needed. Always willing to research all requests. Currently rolling out consumer plan for next year. Acct Mgr. coordinated over 100 training sessions of the new plan throughout the County. | 8-9 years Very expert | Since 10/1/09 Very good, very knowledgeable | Contacted/no reply | Had two different Account Managers, but not sure for how long | Not available |
| 7 | | | | | | | | | |

**Broward County Government
Health Plan References – Vendor Reference: UnitedHealthcare
RLI R0843005R1**

| | References for UnitedHealthCare | #1 Current The School District of Palm Beach County | #2 Current City of Orlando | #3 Current Orange County Government | #4 Current Pinellas County | #5 Current Pasco County Government | #1 Former Miami Dade Community College | #2 Former Miami Dade County Public Schools | #3 Former Not available |
|----|---|---|--|---|---|---------------------------------------|---|---|----------------------------|
| a. | Responsiveness to Benefits Staff | Excellent | Very good. Have weekly call to Acct. Mgr for opportunity to open questions. Have access to Mgr via email | Improved over the years. Have a dedicated team | Very good. Have onsite representative | Very good | Contacted/no reply | Unable to answer | Not available |
| b. | Responsiveness to Members | Excellent | Very responsive. A few years ago, they changed their customer service to resolve concerns – “Customer help advocate” person able to do more (if claim denied, rep able to escalate to reprocess claim) | Responsive | Very good | Satisfied | Contacted/no reply | Unable to answer | Not available |
| c. | DM - Creativity of Disease Management Program | Struggle with every carrier in that area. Company have a new “Diabetes program” (co-pays will change) | Very creative. Sent out information, have nurses that call patient to follow up with their care, diabetic reading. | Hard to compare with others. Have comprehensive program with case Mgr that does outreach. Did pilot diabetes program and helped with reporting and to funnel claims and different co-pays for people in the program | Organization culture presentation prepared which was aligned with UHC staff for an aggressive wellness program. Dedicated team that understands their culture. Preparation, roll out on first year was very good. Received well by employees. | Fairly good | Contacted/no reply | Unable to answer | Not available |
| d. | DM - # of member engagements in DM Program | Difficult to measure | Information not available from carrier | Less than 100 people. Members have to be high risk and moderate risk to be in the program | 2010 is the first year performance – 581 enrolled participants and 344 actively engaged | Unknown | Contacted/no reply | Unable to answer | Not available |

**Broward County Government
Health Plan References – Vendor Reference: UnitedHealthcare
RLI R0843005R1**

| | References for UnitedHealthCare | #1 Current The School District of Palm Beach County | #2 Current City of Orlando | #3 Current Orange County Government | #4 Current Pinellas County | #5 Current Pasco County Government | #1 Former Miami Dade Community College | #2 Former Miami Dade County Public Schools | #3 Former Not available |
|----|--|---|---|--|---|--|---|---|------------------------------------|
| e. | DM – ROI of Program | Do not know | Information not available | Not measured. Need a period of time for successful data | Too early to measure. Negotiated at no cost, ROI is positive. | Unknown | Contacted/no reply | Unable to answer | Not available |
| f. | Wellness - Creativity of Wellness Programs | Have wellness coordinator. Carrier works with you. Have a new “personal health” program. Carrier will provide one free kiosk (\$8k-\$9k in value) and will be able to measure PMIs, and biometrics) | In the past two years received funding program. The city has a wellness program since 1984. Have a variety of wellness programs (i.e. physiologist, 8 community centers, 24 fitness facility at secure sites, mammograms, flu shots, health risk appraisals, biometrics, seminars, half day well women retreat) | Looking into option where can help with different programs like UHC online program where points given for different activities for measurement purposes. | Good resources. Have integral active program. Used for ideas, “Loose to Win Program” utilizes Train the Trainer strategy. Follow UHC guidelines for establishing wellness program. Solid resource for County. | Wellness program started June 2010. Creative, providing training and health fair | Contacted/no reply | Unable to answer | Not available |
| g. | # of member engagements in Wellness Programs | No. Difficult to Measure. It depends in the type of program (i.e. Diabetes versus Heart program) | Data captured per event. Unable to provide specific data. Limited resources available. | Due to financial incentive, 95% of the employees participate | Started to track # of participants. Have fitness center on main campus with 1,100 members. Regular fitness campus have 300 members | Too early to determine | Contacted/no reply | Unable to answer | Not available |
| h. | Wellness – ROI of Programs | No | Information not available. | Not measured. Need a period of time for successful data | Started to measure. | Too early to determine | Contacted/no reply | Unable to answer | Not available |
| i. | Timely adjudication of claims? | Very good | A few claims issues. Doing fine currently. Weekly conference call with Mgr helps with claims (15-20 claims open at the time) | Good | Good. Most of claims are adjudicated | Very good | Contacted/no reply | Unable to answer | Not available |

**Broward County Government
Health Plan References – Vendor Reference: UnitedHealthcare
RLI R0843005R1**

| | References for UnitedHealthCare | #1 Current The School District of Palm Beach County | #2 Current City of Orlando | #3 Current Orange County Government | #4 Current Pinellas County | #5 Current Pasco County Government | #1 Former Miami Dade Community College | #2 Former Miami Dade County Public Schools | #3 Former Not available |
|----|---|--|--|---|---|---|---|---|------------------------------------|
| j. | Timely issuance of EOB's? | No problems | HMO plans does not provide EOB's Online personalized website. POS only mails EOB's if claim is out of network. | Good. Also provided online | No complaints received | Very good Members receive email notifications to login to their account within a week of service to view their EOB | Contacted/no reply | Unable to answer | Not available |
| k. | Depth and ease of understanding claims reporting | Consultant summarizes the report | Online provides the basic. EOB's are typical. Summary done quarterly, depending on the members (pharmacy, medical) | Not able to answer. | Fine, have very comprehensive reporting package | Clear | Contacted/no reply | Unable to answer | Not available |
| l. | Satisfaction of Customer Service | Very good | Very good | Very good. At first, had issues due to self insured but not anymore | Good | Very good | Contacted/no reply | Unable to answer | Not available |
| m. | Satisfaction with onsite Staff (if applicable) | Very good | Not applicable | Not applicable | Very high | Not applicable | Contacted/no reply | Unable to answer | Not available |
| n. | Satisfaction with Network | Very good | Excellent. One of the most positive areas for members. | Very good. UHC negotiating with Florida Hospital for higher service fees. | Strong, have about 96.5% in network usage | Very good. Continue to recruit physicians | Contacted/no reply | Unable to answer | Not available |
| o. | Satisfaction with Network specific to Mental Health and Substance Abuse | No complaints received | Good. Members go through a separate customer service number to access the service | Good | Carved-out mental health. Not applicable | No complaints | Contacted/no reply | Unable to answer | Not available |

**Broward County Government
Health Plan References – Vendor Reference: UnitedHealthcare
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|----|--|--|---|--|---|---|---|---|------------------------------------|
| p. | Flexibility and adaptability to individual client/customer needs | They do a good job | Very good. Anything asked (fully insured plan) is given. Are very flexible with requests | Good. UHC is big, sometimes diabetes program paperwork done manually and have some errors with the manual process. | Very good. Very responsive | Have some pharmacy plan issues. Customer service answer according to the contract agreement | Contacted/no reply | Unable to answer | Not available |
| q. | Overall performance? | Very good | Very good | Good | Excellent | Good | Contacted/no reply | Unable to answer | Not available |
| 8 | Have you received any complaints about this vendor from employees? If yes, please provide a general overview of the typical issues raised. | Once in a while. Pre-approval on certain medications | Yes, sometimes. Claims not paid correctly, having trouble finding a doctor. For the most part employees are satisfied with the plan | Occasionally. Most of the time is resolved. Example will be claims not properly filed by the provider | Rarely. For example, contract negotiation with physicians; Center of Excellent geriatric program have strict guidelines. | Pharmacy supply limit restrictions | Contacted/no reply | Unable to answer | Not available |
| 9 | What is the #1 complaint members have? | Not many complaints received. Can't really say for certain | Occasionally a claim issue. Change of Lab services/facility, complaint from employees (i.e. wait a long period of time for appointment) | Problem resolution with customer service | No number one complaint | Pharmacy supply limit restrictions | Contacted/no reply | Unable to answer | Not available |
| 10 | What are the strengths (if any) in this vendor's cost management and mitigation efforts for you? | Not sure what they are doing in that area | Not involved | Provides reports and suggestions for improving in certain areas. Currently do not have the pharmacy plan with UHC but did before. Did manage pharmacy tier and did a good job. | Good. Had two claims audit and in both instances showed claims properly paid. UHC let County know what they are doing with the high claims. | Receives good reports from carrier | Contacted/no reply | Management had some concerns but unable to comment | Not available |

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Health Plan References – Vendor Reference: UnitedHealthcare
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|----|--|--|--|--|---|---|---|---|------------------------------------|
| 11 | Does this vendor also provide DM/Wellness or is that carved out or supplemented by another provider? | Carved out in 2009. Provided with medical coverage in 2010 | Provided with medical coverage | Provided with medical coverage | Provided DM but not the Wellness program. Pulled risk factor data from the County. Pharmacy data is given to UHC to qualify DM participants. Have online “healthy reward program” that tracks activity and assign credits for what members do to qualify them for incentives. | Yes, provided with medical coverage | Contacted/no reply | Unable to answer | Not available |
| 12 | Have you realized any quantifiable results from this vendor’s disease management/wellness programs? | No. It is something that you have to do yourself (sometimes reports can make the program look very good) | Yes. Carrier provides funding and let the city handle the “Biometric Screening and incentives” (900 employees participated in the program). Their “Weight program” have a high number of participating employees | No | Too early on the DM program just completed first year. | No | Contacted/no reply | Unable to answer | Not available |
| 13 | Have you realized a reduction in Pharmacy expenses from these programs? | Difficult to measure (i.e. having higher deductible this year, getting lower increases) | No able to track the information | No. Pharmacy is through a different provider. | Do not know yet. Expect better compliance and higher pharmacy expenses | No | Contacted/no reply | Unable to answer | Not available |
| 14 | What methods does this vendor use to ensure employee engagement in their DM programs? | Depending on severity of problem start with phone calls, newsletters, letters, and post cards. | Phone call, by mail, nurse line, internet personalized site, at wellness health fair provide hand outs. | Post cards, direct phone calls, reach directly to providers. | Direct phone calls, email notification, work with specific patient need and coordinate with pharmacy program. | Phone calls, letters, email, follow-ups | Contacted/no reply | Unable to answer | Not available |

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|----|--|--|---|--|--|--|---|---|------------------------------------|
| 15 | Does your Vendor use the Opt-In or Opt-Out method of enrollment for the DM programs? | Opt-In | Not known | Opt-out. If see at risk, they will go to the provider | Opt-In. Measure enrolled members, then the actively engaged members. | Opt-In | Contacted/no reply | Unable to answer | Not available |
| 16 | Do you think the DM program(s) have improved employee retention? | No | A lot of employees benefit from the program but not sure if helps with employee retention (The current HMO plan have \$15 co-pay, \$10/20/10 pharmacy co-pay, \$200 co-pay for inpatient care) Program no longer provided by UHC to other employers | Not able to answer | Not sure Average age of employees is 48 | Does not have an impact | Contacted/no reply | Unable to answer | Not available |
| 17 | What is one area of improvement you would like to see this vendor improve upon? | Not one specific area. Self funded program. Struggle to get trend numbers to use | Laboratory network could improve. | Help with claims and continuity to members with chronic condition. | Do not know. | Removal of the pharmacy supply limits. To provide what it was asked during negotiations. Carrier needs to be more flexible | Contacted/no reply | Unable to answer | Not available |
| 18 | What is one area in which this vendor excels above other vendors you have worked with? | Open access network | Large network and capability of having reciprocity (outside Florida network with the HMO plan) | Innovative with analysis and trend because they have a lot of data. Coming up with different programs. | Not a fair question. With UHC for 12 years. Unable to compare right now. | Carrier does not excel above other vendors. Currently doing a good job | Contacted/no reply | Unable to answer | Not available |
| 19 | Does this vendor provide you EAP services as part of their Core Medical | No. Have another vendor | Yes, "Care 24 program" provides counseling services, | Yes. Supervisory referrals, counseling, legal issues, discounts, | No. Carved-out with mental health. | No. County has stand-alone program | Contacted/no reply | Unable to answer | Not available |

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|----|---|--|--|--|---------------------------------------|---|---|--|------------------------------------|
| | program? If so what services are included? | | 24/7 service, have access to different services, legal/ financial/careers/ marriage counseling. Fully insured group, EAP is part of the whole package. | referral services finding a provider/day care provider. Also have separate EAP provider for non-members. Working on combining both into one. | | | | | |
| 20 | Why did you discontinue services with this vendor? | | | | | | Contacted/no reply | Bid for self and fully insured products. School Board decided in self insured and chose Cigna due to cost, other factors and bid response to self insured administration | Not available |
| 21 | Would you contract to use this vendor's services again? | | | | | | Contacted/no reply | Yes | Not available |
| 22 | Would you still recommend this vendor to other companies? | | | | | | Contacted/no reply | Unable to answer | Not available |



Our Best.
Nothing Less.

FINANCE AND ADMINISTRATIVE SERVICES DEPARTMENT

115 S. Andrews Avenue, Room 513 • Fort Lauderdale, Florida 33301
954-357-7130 • FAX 954-357-7134 • Email: finance@broward.org

MEMORANDUM

DATE: August 24, 2010

TO: Insurance Selection Committee
Phil Allen, Director, Port Everglades Department
Kent George, Director, Aviation Department
Kayla Olsen, Director, Office of Management and Budget
Chris Walton, Director, Transportation Department

FROM: Dinah L. Lewis, CFO/Director (SC Chair)
Finance and Administrative Services Department

RE: Health Insurance RLI#R0843005R1
Additional Vendor Q & A

Attached please find additional Q & A follow up from each of the three responding vendors regarding clarification of their pricing methodology. Our consultant, EDIFY, will include a brief summary discussion of this information in their presentation at the SC Meeting scheduled for Thursday, August 26, 2010.

Cc: Kevin Kelleher, Interim Director, Human Resources Division
Danielle French, Interim Director, Risk Management Division
Evan Lukic, County Auditor
Adam Katzman, Assistant County Attorney
Mary O'Donnell, Interim Director, Accounting Division
Karen Walbridge, Purchasing Division
Mitch Cohen, Purchasing Division
Norman Taylor, Director, Office of Economic and Small Business Development
Karen Ruh, Employee Benefit Services Manager, Human Resources Division
Howard Gruverman, EDIFY

Broward County Government Summary of Self Funded Clarification Questions

| | Question | Coventry | Aetna | UHC |
|----|--|--|--|---|
| 1. | Clarify if your agg attachment includes the rx claims. | Our Aggregate attachment does not include Rx benefit claims as BCG separately self-funds their Pharmacy claims. | No our aggregate attachment point was calculated utilizing only Medical claim projections. | Pharmacy claims are excluded from our stop loss proposal (individual stop loss [ISL] and aggregate stop loss [ASL]) since pharmacy is carved out with a third party. |
| 2. | Clarify if your agg attachment includes the healthcare reform act lifetime limit elimination or any other impact of healthcare reform. | Please refer to the stop loss quote for lifetime maximums being quoted. Coventry has assigned a dedicated team with the purpose of reviewing and interpreting recently published health care reform laws. Once that review has been completed, Coventry is prepared to share its position on the impact of health care reform. | This proposal does not contemplate the impact of certain health care reform mandates and requirements expected to be effective 9/23/2010 regardless of grandfathered status. We are working aggressively to understand the impact of the legislation, much of which will require additional regulations to be issued that will bring further clarity to the new law. We will determine specific impact to this renewal/proposal, if any, over the next few months. | Confirmed. |
| 3. | Clarify what standard reports are included in the ASO bid and online management tools. | A copy of our standard reports is included in the RLI. | Aetna Health Information Advantage, our new information application software tool created by Aetna Informatics, makes performance experience data available in real time through the Internet. Aetna Health Information Advantage is the ideal tool for benefits managers, placing valuable | We are offering Employer eServices Expanded-level reporting to Broward County Government (the County), which is the highest level of reporting available. Our Expanded-level reporting package provides automated, do-it-yourself online reports for your day-to-day and operational needs, augmented by face-to-face health plan |

| | Question | Coventry | Aetna | UHC |
|--|----------|----------|---|---|
| | | | <p>information right at their fingertips. Interactive data analysis can be performed on topics such as key measures, components of medical trend, medical, high cost claimants, network savings and membership. These topics, called modules, are produced at the customer level by funding arrangement and product type on an incurred basis with a two-month claim lag. The modules offer a high-level view of the current data as well as book of business and prior year comparisons.</p> <p>Each module can be drilled down into more detailed reporting and graphs allowing users to group and refine how they look at the data with options such as time period, products, age, gender, region, clinical, geographic and provider specific detail.</p> <p>Preformatted reports are also available at the customer level by funding arrangement and product type on an incurred claim basis, rolling 12 months with a 2-month claim lag. The reports offer a view of the current year's and the prior year's data, illustrating utilization and financial trends in a concise, graphical format. The reports are available quarterly, within 45 days following the end of the reporting period.</p> <p>The Aetna Health Information Advantage software tool is a standard component of our administrative</p> | <p>consultations, where we will guide you through deep analysis of your overall trend and performance. You will have total transparency and understanding to help you meet your business and financial goals.</p> <p>We provide thoughtful and meaningful reports – each with their own purpose – to drive results and action.</p> <ul style="list-style-type: none"> ■ Self-service online, on-demand Employer eServices plan reporting ■ Full-service Executive Performance Report, Plan Performance Review and Health Plan Performance Report ■ Clinical reporting <p>Self Service: Access Your Plan Performance Information On Demand Through Employer eServices</p> <p>You can gain access to your medical plan information with a simple click of a button by using our electronic online Employer eServices Reporting solution. It's your one-stop shop that makes it easier to analyze the performance of your plan. This all-encompassing reporting tool will help you identify current trends and evaluate your health care utilization and costs—</p> |

| | Question | Coventry | Aetna | UHC |
|--|----------|----------|---|---|
| | | | <p>services through which reports can be downloaded into Microsoft® Excel for review, analysis and electronic communication. Information is encrypted in both systems so the customer's information remains secure. Reports are available to customers with at least 100 covered employees.</p> <p>The standard preformatted report package provides data on the following:</p> <p>Plan performance (including Aetna pharmacy when our medical product is linked to a pharmacy plan) on key financial and utilization metrics, prior and current with some current Aetna book of business comparisons, such as paid per member and per employee, admissions per 1,000 members, bed days per 1,000 members, average length of stay, office visits per 1,000 members, etc.</p> <p>Executive Summary providing quick analysis on plan performance by summarizing the key information from the report package.</p> <p>Medical membership demographics by age bands and gender, prior and current with Aetna book of business comparison and current membership age band buckets by gender with plan paid comparison.</p> <p>Paid claims for medical catastrophic claimants with a dollar threshold of</p> | <p>giving you what you need to make important decisions about your health care benefits and potentially leading to benefits cost savings.</p> <p>Employer eServices Expanded-level access provides greater flexibility in report layouts, permits focused drills to identify cause and effect, and offers a wide variety of report templates to facilitate utilization analysis.</p> <p>The following reports are included in our Expanded-level reporting:</p> <p>FINANCIAL PROGRAM AREA</p> <ul style="list-style-type: none"> ■ Claim Expenses by Size of Payment ■ Claim Lag Study ■ Detail Payment ¹ ■ Large Loss Claim Payment ² ■ Payments by Benefit Type ■ Payments by Month <p>MEDICAL MANAGEMENT PROGRAM AREA</p> <ul style="list-style-type: none"> ■ Costs and Utilization by Procedure ■ Utilization by Diagnosis ■ Inpatient Utilization by Diagnosis ■ Outpatient Utilization by |

| | Question | Coventry | Aetna | UHC |
|--|----------|----------|--|--|
| | | | <p>\$50,000, prior and current reporting periods and current trend with and without these catastrophic claimants. There is an additional detail report showing medical catastrophic claimants with a threshold of \$50,000 that includes inpatient and ambulatory paid amounts and diagnosis code. We mask these reports to protect against individual identification.</p> <p>Detail by Major Diagnostic Category (MDC) including three reports: one total report showing facility and professional claims, one inpatient report and one outpatient report. Each report shows the prior and the current period.</p> <p>Select reports provide a comparison to our product specific book-of-business benchmarks, which are also adjusted for the age and gender of the customer's population.</p> <p>Provider network experience, including discount savings by inpatient, ambulatory, physician and other for prior and current reporting period.</p> <p>Medical cost sharing showing COB, deductible, copays, coinsurance, employee-paid portion and employer-plan paid portion.</p> <p>Trend analysis, utilization and unit cost by medical cost category.</p> | <p>Diagnosis</p> <p>NETWORK PERFORMANCE PROGRAM AREA</p> <ul style="list-style-type: none"> ■ Network Utilization ■ Top Hospitals Ranked by Total Net Paid ■ Top Physicians Ranked by Total Net Paid <p>PLAN PERFORMANCE PROGRAM AREA</p> <ul style="list-style-type: none"> ■ Claim Experience ■ Health Care Cost Management Summary ■ Cost and Utilization Summary ■ Inpatient Utilization and Costs by Admission Type ■ Member Cost Sharing Detail – Confidential ■ Member Cost Sharing Detail – Non-Confidential ■ Bill Count by Month ■ Distribution of Discounts ■ Distribution of Ineligible Charges ■ Distribution of Other Savings ■ Utilization and Costs by Provider Type |

| | Question | Coventry | Aetna | UHC |
|--|----------|----------|---|--|
| | | | <p>Hospital Profile showing the top 25 hospitals ranked by total medical claims paid amounts.</p> <p>Health Profile showing top 25 diseases ranked by paid amounts and listing those diseases under the plan that are part of our disease management programs.</p> <p>Key statistics for Pharmacy by generic, brand single source and brand multi-source if medical plan linked to an Aetna pharmacy plan.</p> <p>The Standard Report package can also be run with variations on time periods, account structure, product combinations, network service area, large claimant threshold and claim basis (incurred versus processed). We update our data monthly.</p> <p>In addition to the product-specific standard reports, we offer a Summary by Product package that provides key information for all medical product lines, pharmacy and dental in one package.</p> | <ul style="list-style-type: none"> ■ Utilization by Age Group ■ HRA Plan Design Status ■ HRA Plan Sponsor Statement of Position ■ HRA Termed Balance <p>MEMBERSHIP PROGRAM AREA</p> <ul style="list-style-type: none"> ■ Membership by Month ■ Membership by Market ■ Membership with Demographic and Geographic Factors <p>Your online reports are available 24 hours a day, seven days a week, with data updates on the 10th business day of every month.</p> <p>Full Service: The Executive Performance Report, Plan Performance Review and Health Plan Performance Report ensure that your plan goals and health care affordability strategies are on track.</p> <p>They are provided annually or on a mutually agreed-upon schedule, highlight trends in experience and suggest opportunities for future cost savings. They include key cost and utilization metrics for medical plans, managed pharmacy and clinical programs, as well as highlights from our proprietary reporting tools, the</p> |

| | Question | Coventry | Aetna | UHC |
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| | | | | <p>Affordability Solutions Index and Consumer Activation Index.</p> <p>Affordability Solutions Index identifies opportunities to improve plan financial return by introducing the right affordability solutions while also balancing corporate benefit strategies with population requirements.</p> <p>Consumer Activation Index identifies areas within the benefit programs that may not be optimally utilized by members, so that strategies that can be developed to promote behavior changes and increase program utilization.</p> <p>Results can be compared to prior experience, book-of-business results, or industry peers, and you may customize the Executive Performance Report to limit or compare your experience to business segments, medical products and actives/retirees, among other options. As an added value, this same data can be reviewed throughout the plan year on a monthly basis by utilizing our Employer eServices Reporting tool.</p> <p>The Health Plan Performance Review provides an intensive consultation with your strategic account executive (SAE), clinical data expert, and other UnitedHealthcare professionals to review the Executive Performance Report and Plan Performance</p> |

| | Question | Coventry | Aetna | UHC |
|--|----------|----------|-------|--|
| | | | | <p>Review to analyze your clinical, financial, and consumer behavior measures, and plan a course of action.</p> <p>Clinical reports focus on delivering a comprehensive integrated reporting solution to you that delivers information in the same synchronized format as our health and wellness programs themselves. This framework provides you with a clear picture of the effectiveness of your clinical programs and the following is a snap shot of the type of clinical reports you can expect to see:</p> <p>Operations Reporting is ROI forecasting based on closed value drivers that focus on linking members with the right providers, the right treatments, the right medications, and the right lifestyle decisions</p> <p>Clinical Activity Report identifies areas within the benefit programs that may not be optimally utilized by members, so that strategies can be developed to promote behavior changes and increase program utilization.</p> <p>Clinical Outcomes and Value Report brings together medical, pharmacy and behavioral cost and utilization data with clinical program engagement. It will show you how we have improved your subscribers'</p> |

| | Question | Coventry | Aetna | UHC |
|--|----------|----------|-------|--|
| | | | | <p>health while reducing your costs.</p> <p>Clinical Executive Summary Report provides high-level, specific analysis of your clinical engagement and categorizes opportunities for improving outcomes.</p> <p>Our Clinical Activity and Clinical Outcomes and Value Reports also provide valuable information on the County's progress with regard to health promotion and disease prevention. In each aspect of our health and wellness solution, we are focused on delivering comprehensive integrated activity reporting solutions for our customers. This enables you to understand the right members have been identified and reached out to for program engagement.</p> <p>Our overall goal is to partner with you to help develop and maintain health care affordability strategies and to provide a better understanding of consumer behavior and health care cost drivers. We want to offer full transparency and insight into your program and help you optimize your health care investment. We then develop and implement solutions that support optimal decision making, cost controls and improved workforce health.</p> <p><i>1 The Detail Payment report is an optional report available to self-funded customers. Customers</i></p> |

| | Question | Coventry | Aetna | UHC |
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| | | | | <p><i>concerned with access to individuals' specific claims information and governing HIPAA guidelines may elect to exclude this report from their standard package or replace it with a non-confidential version that suppresses claimant identity.</i></p> <p><i>2 The Large Loss Claim Payment report is generated in the self-funded customer reporting package when one or more claimants present paid claim amounts for the reporting period in excess of a chosen threshold. This report does not reflect customer-specific stop loss contract provisions and is not intended to support either UnitedHealthcare or external stop loss vendor programs.</i></p> |
| 4. | Clarify if the terminal liability for claims adjudication is included and if there is a limit to the timeframe. | Coventry Health Care of Florida has provided a stop loss quote that includes run-out coverage (12/15 contract quoted, providing 3 months for run-out coverage). Coventry does not offer a Terminal Liability Option on a stop loss policy that already includes run-out coverage. | Terminal liability is not included. The contract quoted is a 12/15 contract. This includes 3 months of run-out coverage in the first policy year. Pooled claims paid out as a result of the run-out period will not accumulate toward the subsequent year's pooling or aggregate limits. Please be advised that all first year policies will be renewed on a paid basis in the second and subsequent policy years. | Please refer to the Stop Loss Terminal Liability exhibits that were included in our original response for costs associated with this coverage. This is an optional service that can be purchased at the time of sale or prior to the beginning of any renewal period, based on a revised rate offer at that future time. A three-month run-out extension period will be added to the last active period for an overall 15 month accumulation period. The additional cost for terminal liability is two months of stop loss premium. |

| | Question | Coventry | Aetna | UHC |
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| 5. | Clarify if there are different platforms used for and between the fully insured and self insured offerings. | Coventry Health Care of Florida uses one claims processing platform for both fully insured and self funded clients. | Yes there are separate and different platforms used between our fully insured and self insured pricing. Our fully insured pricing is for our HMO and PPO products, while our self insured offering was based on Aetna Choice POS II and Aetna Select. | UHC has provided an ASO only quote which is administered on our Unet platform. Unet combines all claim administration elements, including online eligibility, benefit design provisions, notification, physician and other health care professional data, discounts, negotiated rates, claim payment and claim history. |
| 6. | Clarify if there are any outside vendors offering any services or reinsurance with your offering and who would be offering that service. | As it relates to reinsurance, Coventry Health and Life Insurance Company (CHLIC) is a domestic service provider, providing stop loss coverage to ASO clients whose claims administration is provided exclusively by a Coventry Health Plan. | We supplied a reinsurance quote with our proposal response. That service is handled by Aetna. As far as other services; we do subcontract with outside vendors. | <p>We provide most of our core services directly through the UnitedHealth Group family of companies. This allows us to offer affordable solutions through integrated data elements and systems, streamlined implementations and unified account management support.</p> <p>We do work with a variety of external vendors and subcontractors, and have listed some of these third parties and the different capacities in which we interact with them. Due to the broad spectrum of UnitedHealth Group businesses, and variations in the contractual relationships we have with each vendor or subcontractor, this list is subject to change and should not be considered exhaustive.</p> <p><u>VENDORS AND</u></p> |

| | Question | Coventry | Aetna | UHC |
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| | | | | <p><u>SUBCONTRACTORS</u></p> <p>PRESCRIPTION BENEFITS ADMINISTRATION</p> <p>Prescription Solutions is our business partner in the administration of our pharmacy program. We have contracted with Prescription Solutions to outsource general program administration, including retail network management, etc.</p> <p>NETWORK LEASING</p> <p>UnitedHealthcare owns the majority of networks we use for providing health care coverage. However, we use leased or vendor networks where it is not feasible to develop our own network. Vendor networks must comply with the same quality standards we use for our own networks. Vendor network compensation varies based on market demands and the customary practices of the local marketplace. We retain responsibility for claim processing. In addition, we oversee all quality issues, including quality control of the physicians and other health care professionals in the network.</p> <p>PHYSICIAN ADVISORS</p> <p>We utilize a national panel of more than 80 board-certified specialists as physician advisors. Prior to selecting subcontractors, we complete a thorough review of their</p> |

| | Question | Coventry | Aetna | UHC |
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| | | | | <p>qualifications. Subcontractors are also required to meet all of our contractual obligations.</p> <p>OVERPAYMENT IDENTIFICATION VENDORS</p> <p>We contract with a number of vendors to identify overpayments. These vendors perform a variety of audits, including, but not limited to, credit balance, data mining, coordination of benefits (COB), contract audits, DRG audits, workers' compensation and subrogation. Generally, these vendors do not perform collections on the overpayments they identify in an effort to reduce the number of vendors approaching physicians. A collection vendor is assigned to collect these overpayments.</p> <p>OVERPAYMENT COLLECTION VENDORS</p> <p>We contract with a number of vendors to collect overpayments that are identified internally or from an overpayment identification vendor. Overpayment collection vendors are responsible for sending out the initial overpayment notification letter and will follow up with the physician on outstanding balances through phone calls or subsequent recovery letters. These vendors assist with the resolution of physician disputes/appeals.</p> |

| | Question | Coventry | Aetna | UHC |
|--|----------|----------|-------|--|
| | | | | <p>MATERNITY MANAGEMENT</p> <p>We subcontract with Alere (formerly Matria Healthcare) to provide portions of our Healthy Pregnancy Program (HPP). We do use an outside vendor for external review on selected cases.</p> <p>SHARED SAVINGS PROGRAM</p> <p>We use Viant, Three Rivers Physician's Network, First Health Networks and MultiPlan's national network of hospitals, physicians and other health care professionals to provide discounts to our customers for non-network claims through our Shared Savings Program (SSP).</p> <p>DURABLE MEDICAL EQUIPMENT</p> <p>We have a national durable medical equipment (DME) vendor, Apria Healthcare. Apria Healthcare is a large national ancillary supplier of DME and home health/home infusion supplies.</p> <p>EXPATRIATE COVERAGE</p> <p>In conjunction with Bupa International, UnitedHealthcare offers Global Choice, a program that offers network access and health care services for U.S. expatriates and other subscribers living and working outside of their home country. Bupa International is a British organization with more than 30 years of experience in providing</p> |

| | Question | Coventry | Aetna | UHC |
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| | | | | <p>quality health plans to expatriates throughout the world.</p> <p>HEALTH INFORMATION</p> <p>Various internal and external sources provide health content to our member Web site, myuhc.com. Each resource maintains relationships with various health professionals who write, edit and review the content created for the site. We screen each vendor for accuracy and independence of content.</p> <p>SURVEYS</p> <p>We conduct an annual satisfaction survey based upon the HEDIS 3.0 standards.</p> <p>Administration of the CAHPS survey is a joint effort between the Survey Research Studies division of Ingenix (a UnitedHealth Group company) and the Center for the Study of Services (CSS). CSS is certified by NCQA as a CAHPS survey vendor.</p> <p>SOCIAL SECURITY ADVOCACY ASSISTANCE</p> <p>Social Security advocacy assistance is provided through another vendor. Claim specialists are trained to educate, guide and monitor the application process for Social Security disability benefits. We then consider offering assistance through either Doherty and Associates or</p> |

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| | | | | <p>Allsup.</p> <p>ID CARDS</p> <p>Our member medical ID cards are produced by Fiserv Output Solutions, a business unit of Fiserv, Inc. Fiserv, headquartered in Brookfield, Wisconsin, is a provider of business-critical communications to the financial services, health care, telecommunications, investment services and retail markets.</p> <p><u>LEGAL</u></p> <p>We will be responsible for holding our vendors to the same standards and requirements to which we agree. We will accept responsibility to the extent that our subcontracted vendor fails to meet any contractual obligation assumed by us.</p> <p><u>REINSURANCE</u></p> <p>We provide stop loss coverage directly. Our stop loss insurance is underwritten by UnitedHealthcare Insurance Company (UHIC).</p> |
| 7. | Clarify if your bid includes claims fiduciary or the charges for claims fiduciary. | Yes, our bid includes claims fiduciary | Under our fully insured offering Aetna will serve as Claim fiduciary, but currently we've based our self insured offering on Broward County serving as fiduciary. Aetna has shown as an option the cost of having Aetna serve as claim fiduciary on the self insured offering. That cost would be \$1.75 per employee per month. | Fiduciary services can be purchased as an optional service. As identified in our proposal, the additional cost for this service is \$0.55 per employee per month (PEPM). |

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| 8. | Clarify the implementation timeline difference for an ASO program. | A 90 day implementation is desired for a self insured program. Implementations under 90 days are approved only on a case-by-case basis and may result in the need for temporary workaround solutions until all systems and Business Partners have had time to implement the custom plan(s), test banking and electronic feeds that are associated with a self-funded product. Our Fully insured proposal requires a minimum of a 45 day implementation to ensure service standards are met. | The time required to successfully implement a benefit program is dependent upon the spectrum of the products and services selected not the funding type. Recommended lead time for a smooth transition is 90-120 from the business awarded date. | UHC is comfortable with successfully implementing this program based on the timelines included by the County. Please refer to our sample ASO timeline included in the proposal binder. |
| 9. | Clarify ability to integrate rx data or DM from a third party source under an ASO platform and the impact to the rates. | As incumbent, our current fully insured program accepts the Rx data from Walgreens and data is used for medical management on a fully insured basis. The same can be done on a self insured arrangement for an additional fee. We are not clear on what is meant by integrating DM from a third party source. Our proposal includes DM services. We will need more specific regarding what is requested before being able to respond. | <p>We can integrate third-party pharmacy plan data from a freestanding prescription drug program for our disease management programs. By integrating pharmacy data and therapies with care management, we can:</p> <ul style="list-style-type: none"> Promote positive member management outcomes Help contribute to the member's quality of life and productivity Help stabilize overall health plan costs for customers and members Maximize the value of health plan expenditures <p>In order to use third-party pharmacy vendor data for the disease management program, we require that the data be electronically submitted to us in an agreed-upon, compatible Aetna format file on a periodic basis. Submission can be weekly, bi-weekly, monthly or quarterly. Our ActiveHealth Management systems can process data feeds as frequently as weekly, while Aetna Informatics processes data on a monthly basis.</p> | <p><u>PHARMACY</u></p> <p>We are able to accept pharmacy data from a third-party pharmacy benefit manager (PBM) as well as many other external data sources to integrate claims data into our work to identify at-risk members.</p> <p>We collaborate with each customer's PBM to maximize the quality and efficiency of medication therapy. We leverage current and accurate pharmacy claims data in our identification and/or stratification processes. Certain PBMs offer online access for disease managers to use real-time pharmacy claims data to identify treatment gaps and savings opportunities.</p> <p>Typical transfer of data occurs at least every 30 days to coordinate with our predictive model, which also runs every 30 days. The incorporation of pharmacy data into this model ensures robust informatics by integrating clinical and physician data sharing, as well as vastly improved utilization and</p> |

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| | | | <p>There is an additional cost to the customer for third-party pharmacy data integration with our disease management program. The customer can opt to have these charges embedded into our pricing.</p> <p>Some third-party pharmacy vendors we work with include:</p> <ul style="list-style-type: none"> ▪ Medco ▪ Caremark ▪ Express Scripts ▪ Walgreens ▪ Several smaller vendors such as Anthem <p>Some medical carriers we work with to obtain pharmacy data for self-funded plans include:</p> <ul style="list-style-type: none"> ▪ Cigna ▪ Humana ▪ Blue Cross <p>Maintain and Store Data We store and maintain the medical claim data and pharmacy data, where we are the pharmacy benefit manager (PBM), in our data warehouse, which is maintained by Aetna Integrated Informatics. We also receive laboratory data (test and result values) from participating laboratories and store this data in the data warehouse.</p> <p>We send the data via SecureTransport to Health Data</p> | <p>disease management identification.</p> <p>The cost to include pharmacy claims into our predictive model of \$0.36 PEPM was included in our administration fee.</p> <p><u>DISEASE MANAGEMENT</u></p> <p>We have extensive experience integrating with external disease management vendors to provide a continuous member experience and assure overall health management of each member based on needs. We have designed workflows and processes to support these types of integrations during implementation. These workflows and processes allow us to:</p> <ul style="list-style-type: none"> ■ Provide detailed claim information to an external vendor with specific information such as ICD9 codes and initial diagnosis information ■ Conduct initial assessment of members to close immediate gaps in care, then provide referral through online or telephonic methods for ongoing disease management ■ Schedule and conduct bi-weekly conference calls between nurse teams to ensure cases are being handled correctly and established processes are functioning ■ Share information and build |

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| | | | <p>Management Solutions (HDMS), a subsidiary of ActiveHealth Management. We send weekly pharmacy data files, weekly medical claim data files and weekly laboratory results files from the data warehouse to HDMS. Aetna Integrated Informatics extracts and posts the data files from the data warehouse.</p> <p>We also send a monthly membership eligibility file to HDMS.</p> <p>In addition to our data feeds, HDMS receives data feeds directly from external vendors (e.g., PBMs and laboratory services). When a customer utilizes an external PBM, we work with the external PBM to arrange for the transmission of data feeds from the external PBM on a regular basis. The frequency of data feeds sent directly from external vendors to HDMS vary by vendor; however, our goal is to arrange for these feeds to occur at least every two weeks.</p> <p>HDMS prepares the data for use by ActiveHealth Management, an Aetna wholly-owned subsidiary, in the CareEngine for our MedQuery program. MedQuery is a prerequisite for our Aetna Health Connections disease management program, and both programs share common data sources; therefore, there is not a separate data feed for Aetna Health Connections disease management.</p> | <p>relationships between external disease management nurses and our care management nurses to facilitate discussion of immediate health needs, or to facilitate steerage to in-network providers (co-managing each member based on specific needs)</p> <ul style="list-style-type: none"> ■ Conduct staff training with our team to provide online review of member enrollment through the disease management vendor's system ■ Provide information during any type of clinical audit in order to detail past referrals to disease management <p>The additional cost to include disease management from a third party is \$0.08 PEPM.</p> |

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| | | | <p>The cost to integrate Pharmacy data from a third party vendor into our system is \$11,000 per contract period.</p> <p>We can also provide a universal monthly medical claim file to a third party Disease Management vendor for a cost of \$5,500 annually.</p> | |
| 10. | Clarify if the administrative portion of the ASO fee would be impacted based on Disease management being carved out. | No | Our proposal currently assumes that Disease Management programs would be carved out. In our fee exhibit we have shown what the cost would be for any of our Disease Management programs. | Our fee includes Personal Health Support with disease management. Disease management programs include asthma, diabetes, coronary artery disease (CAD) and heart failure. If the disease management components are carved out, we would reduce our fee by \$1.10 PEPM. |
| 11. | Clarify the services included in your disease management program relative to offerings, resources, and ROI calculations. | Please refer to Attachment #I-1 in the RLI ROI- Please refer to Questionnaire response on Disease Management/Wellness Section I-4 | <p>Aetna Health Connections provides disease management of over 35 chronic conditions:</p> <ul style="list-style-type: none"> ▪ A vascular cluster consisting of diabetes (adult and pediatric), congestive heart failure, coronary artery disease, cerebrovascular disease/stroke, hypertension (adult and pediatric), hyperlipidemia (high cholesterol) and peripheral artery disease ▪ A pulmonary cluster consisting of asthma (adult and pediatric) and COPD ▪ A cancer cluster including cancers such as breast, lung, | <p>To supplement more than 50 condition-specific interventions available through our case management program, we offer disease management programs for heart failure, CAD, diabetes and asthma.</p> <p>Each program, based on national guidelines and evidence-based medicine, is designed to improve quality of care, lower costs, ensure a personalized member experience and maximize our customers' investment. We provide a whole-person approach to disease management that includes behavioral health, comorbidity management and prescription drug</p> |

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| | | | <p>prostate, colorectal, lymphoma/leukemia, and general cancer (as a comorbidity)</p> <ul style="list-style-type: none"> ▪ A gastrointestinal cluster consisting of gastro esophageal reflux disease (GERD), peptic ulcer disease, chronic hepatitis, inflammatory bowel disease (Crohn’s disease and ulcerative colitis) ▪ An orthopedic/rheumatologic cluster consisting of osteoporosis, osteoarthritis (as a comorbidity) rheumatoid arthritis, and osteopenia (as a comorbidity) ▪ A neurological/geriatric cluster consisting of geriatrics, migraines, seizure disorders and Parkinsonism ▪ A renal cluster consisting of chronic kidney disease and end stage renal disease ▪ A comprehensive set of other conditions consisting of cystic fibrosis (adult and pediatric), HIV, hypercoagulable state (blood clots), chronic low back pain, weight management (adult and pediatric), sickle cell anemia (adult and pediatric), and depression (as a comorbidity) that vary in prevalence and severity across populations | <p>management. Through improved member self-management and guidance to quality- and efficiency-designated physicians and Centers of Excellence networks, we can reduce variation in clinical quality and cost. In short, our disease management programs provide members and their providers with the information they need to make the best decisions and achieve optimal outcomes.</p> <p>Better Results ...A recent UnitedHealthcare study of high-risk members with a chronic condition showed that consumers who made the “best” decisions reduced the cost of their health care by 10 percent to 15 percent. Disease management interventions are an important factor in this equation—our heart failure program alone has shown a 5 percent year-over-year medical cost savings for congestive heart failure.</p> <p>Each disease management program shares several common components, regardless of condition, that contribute to overall effectiveness and results. These include identifying and engaging members, monitoring treatment plan compliance, supporting needed lifestyle modification changes, evaluating and improving the care received and providing personalized ongoing support to ensure the best possible quality of life for each</p> |

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| | | | <p>Member Engagement We engage members identified for disease management in varying and progressive levels of intensity. The levels depend upon the severity of their condition(s) and the overall opportunity to impact their health status as measured by an opportunity score which uses a set of clinical identification and validation rules, scoring models and stratification algorithms. In addition, the CareEngine's clinical-rules set is continually run against medical claims, pharmacy and laboratory data. This allows us to identify and address new care improvement opportunities and potential medical errors.</p> <p>Engagement levels include:</p> <p>Supportive Monitoring: Members receive a toll-free number to access an Aetna disease management nurse 24/7, use of Aetna Navigator, our secure member website, for self-directed learning and bi-annual newsletters. Members will be assisted by staff to order a glucose meter according to their benefit plan.</p> <p>Active Monitoring: Members receive all of the above, plus an introductory and welcome letter, an invitation to call our toll-free number and speak with an Aetna disease management nurse for personalized education and action plans and educational materials as needed.</p> | <p>participant. In addition to these universal steps, each disease management program also incorporates unique components essential to successful management of the specific condition in question.</p> <p>IDENTIFICATION – FINDING THE RIGHT PEOPLE</p> <p>We use a variety of methods to identify members who would benefit from disease management. Key to the identification process is our eSync technology platform, which includes a predictive model and creates a customized medical summary for every member in a customer's population. Using medical, pharmacy, laboratory and behavioral claims and health assessment data, eSync constantly scans the entire population to identify members who would benefit from outreach—and not just for gaps in care, but where there are opportunities for intervention before a major health event occurs—so we can prevent or mitigate more serious health events. Sixty-five percent of the over 800 value drivers used to identify care management opportunities are proactive in nature—by proactively addressing root cause issues early in the cost curve, we positively impact cost and productivity.</p> <p>We also find members through referrals from case management</p> |

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| | | | <p>Members may also receive peak flow meters and spacers if appropriate.</p> <p>Active Monitoring with Nurse Engagement: Members receive all of the above plus regular outreach by an Aetna disease management nurse for individualized coaching and education at least on a quarterly basis.</p> <p>Single Nurse Approach The Aetna Health Connections disease management program uses our care management system, Aetna Total Clinical View (ATV). ATV enhances our nurses' ability to assist members with multiple conditions due to the member centric view and the information displayed for each individual member. Our nurses use condition specific assessments based on the members' condition(s). The condition specific assessments reflect the most current treatments available and help guide our nurses through the complexity of a medical condition including possible co-morbidities that may affect the individual member. ATV creates a whole-member view, which lets a single nurse interact with each member for all their disease management needs.</p> <p>Aetna Total Clinical View allows our nurses to perform targeted, customized assessments for each individual enrolled in the program. Branching logic built into the system pushes additional questions and</p> | <p>nurses, calls to NurseLine, self-referrals and other resources.</p> <p>STRATIFICATION – DETERMINING THE RIGHT LEVEL OF CARE</p> <p>Once identified for the program, we evaluate the needs of each member and offer them the specific interventions to match their needs. A sophisticated triage tool uses condition-specific criteria to stratify acuity levels and allows us to prioritize interactions and focus on the most critical situations first. We can not only identify which members need the most immediate outreach, we also use each member's medical summary to highlight the specific interventions that would be most impactful. All eligible members with identified conditions are stratified to high-, moderate-, or low-intensity interventions.</p> <p>ASSESSMENT – ASSESSING THE INDIVIDUAL'S NEEDS</p> <p>Assessments allow us to gain detailed insight into the specific care needs of an individual. Our nurses apply a combination of general assessment and chronic disease-specific assessments to identify specific care needs or gaps. It is these gaps that serve as the basis for the development of a care plan.</p> <p>INTERVENTION – CLOSING EVIDENCE-BASED GAPS IN</p> |

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| | | | <p>teaching points for the nurse to communicate to members. The system also prompts the nurse on important questions for each clinical diagnosis and follows up each conversation with a ready-to-be-sent communication to the member detailing any teaching, goals and follow up items, and the date and time of the next follow up call.</p> <p>In addition to having evidence-based information at their fingertips, we have trained our nurses in motivational interviewing techniques and the stages of change, which lets a single nurse to interact with members on both condition management and lifestyle behavior change.</p> <p>ROI The return on investment result for the Aetna Health Connections disease management program is 2:1.</p> <p>Confidential</p> | <p>CARE</p> <p>Once opportunities for intervention and characteristics of member needs are understood, our programs deliver interventions tailored to each individual. For high-risk members, the goal is to address opportunities for intervention telephonically, beginning with the most critical steps. Our experience has shown that by closing identified gaps in care, we can improve the member's health status and quality of life and have a positive impact on reducing unnecessary future utilization of health care resources. For individuals of all acuity levels, we identify, prioritize and address as many gaps in care as possible with the individual or caregiver through a variety of communication modes, including HealtheNotes.</p> <p>HealtheNotes are mail and online evidence-based recommendations, care opportunities and preventive reminders that members and their physicians can use to guide health and wellness decisions. With HealtheNotes, customers have experienced a 20 percent increase in care gap closure.*</p> <p>Our process and innovative supporting platform enable our clinical teams to closely track interventions across the spectrum of care management, optimize the</p> |

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| | | | | <p>clinical outcomes and expand medical cost savings. Individual interventions are tracked and are accessible to all program nurses and clinical staff.</p> <p>RETURN ON INVESTMENT</p> <p>Our disease management programs, based on national guidelines and evidence-based medicine, are designed to improve quality of care, lower costs, ensure a personalized customer experience and maximize our customers' investments.</p> <p>Book-of-business return on investment (ROI) results for our disease management programs are provided below.</p> <ul style="list-style-type: none"> ■ Asthma 1.3:1 to 2:1 ■ CAD 2:1 to 2.5:1 ■ Diabetes 1.7:1 to 2:1 ■ Heart Failure 2.4:1 to 3:1 <p>ROI is reported six months after the close of the year. These rates are for illustrative purposes only and are associated with the "average" disease burden in our commercial book of business. Individual customer rates may vary significantly from those shown based on higher or lower than book prevalence and individual program requirements.</p> <p><i>*Actual results will vary by customer.</i></p> |

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| | | | | <i>Factors driving variation include, but are not limited to, illness burden in customer population, turnover in population, pharmacy claims integration, case and contract size.</i> |
| 12. | Clarify the location of the claims office administering the claims under an ASO. | Sunrise, FL | Our Tampa Service Center located at 4630 Woodlands Corporate Boulevard, Tampa, Florida, will handle claims processing and member services functions. The hours of operation are Monday through Friday, 8:00 a.m. to 6:00 p.m. ET | The County's claims will be processed at our Oldsmar, Florida transaction center. |
| 13. | Clarify percent of admin fees at risk for performance guarantees. | Please refer to Section B, Exhibit #EX-4, Performance Guarantees/Worksheet. As directed in the RLI, fees at risk were indicated in dollar increments, not a percentage of fees. Total annual maximum at risk amount is \$100,000. | Aetna has proposed to place 15% of its self funded administrative fees at risk for performance based guarantees. On our fully insured offering we've proposed a 1% of premium penalty on service related performance guarantees. | We have agreed to custom performance guarantees with 15 percent of base fees (excludes any buy-up services) or \$300,000 at risk. In addition, we have also provided a discount guarantee with 15 percent of base fees (excludes any buy-up services) at risk with a target discount of 65.5 percent for the Miami, Florida, market. |
| 14. | Clarify the service delivery and resource differences between your fully insured proposal and self insured proposal. | The scope of services provided for Fully insured and Self-insured proposal are included in our RLI responses. Additionally, the list of services included in our ASO fee is outlined on exhibit EX 2A of the Financial Rating Exhibits. We can offer the same level of services and resources on a self insured basis as included in our fully insured proposal subject to pricing adjustments as stipulated in the financial rating exhibits Health Fairs, onsite wellness program and activities performed will be billed on a pass through basis. | Fully Insured Our insured arrangements provide full insurance protection to the limits of the plan in exchange for full monthly premiums. Both the customer and Aetna play key roles in providing valuable protection for employees and their dependents through a group benefit plan. Our insured arrangements enable | Not applicable. UHC is only proposing a self funded quote. |

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| | | | <p>customers to meet the following objectives:</p> <ul style="list-style-type: none"> ▪ Insurance protection ▪ Budgetable cash flow ▪ Insurance certificates ▪ Third party determination of benefit payments ▪ ERISA claim fiduciary services ▪ Full services: plan administration, actuarial, underwriting, and field representative services <p>Self Funded Our Administrative Services Only Agreement (ASO) is a financial arrangement which allows customers to self-insure their benefit plan by directly funding benefit payments. A stop loss component is available on an optional basis to provide customers with some protection for catastrophic claims.</p> <p>Under the standard ASO arrangement, we provide the same full range of services available under a conventionally insured plan. An ASO arrangement does not alter the type of services performed by Aetna in the administration and operation of the customer's benefit program. The fundamental difference is that we will no longer assume insurance or financial risk of loss under the plan and we do not standardly assume claim fiduciary responsibilities (although Aetna will assume claim fiduciary responsibility for an appropriate charge). Risk charges</p> | |

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| | | | are eliminated. No state premium taxes are payable in connection with the ASO product. | |
| 15. | Clarify if you are including an aggregating deductible in your proposal. | No, the stop loss proposal as quoted does not include an Aggregating Specific Deductible. Coventry does offer an Aggregating Specific product, as requested, to eligible clients. | Our Stop Loss proposal does not include any aggregating deductible. Once the Individual stop loss limit is reached Aetna is responsible for 100% of each member's claims. | We are not including an aggregating deductible in our proposal. |
| 16. | Clarify the underwriting services that are included in the ASO bid and frequency of these services. | Coventry Health Care's expert staff of underwriters can help you achieve your health plan objectives through benefit plan modeling, budgeting and financial analysis. We offer a wide range of underwriting services, including: > Benefit Plan Consulting - Develop a benefit plan strategy and measure its potential impact on your plan costs. > Medical Claims Projections/Budgeting - Set appropriate health plan cost expectations and budgetary requirements with proactive health plan budgeting. > Premium Rate Equivalents - Evaluate overall cost or "premium equivalent" for your plan for budgeting and to set member contributions. > Employee Contribution Levels - Adjust member contributions appropriately to maintain plan participation and control costs. > Development of Stop Loss Premiums - Control cost and risk with stop loss insurance offered through Coventry Health and Life. Our underwriting staff can complete most of these services within ten business days. | Our fees assume our standard Underwriting services are included. These services include but are not limited to renewal package preparation, annual reconciliations of plan and guarantees, assistance with estimating the cost/savings of plan changes, and assistance with claim reserve recommendations. | <p>We provide a wide range of underwriting services, including overall program accounting, claim projections, projections of the cost impact for benefit design changes, reserve estimates and more.</p> <p>The underwriter assigned to a customer's account management team (AMT) responds to questions pertaining to the financial performance of the case and helps forecast the expected impact of trend, changes in benefit design or demographic changes.</p> <p>We provide a complete renewal package, including claim experience and large loss information.</p> <p>At the close of the year, we will prepare an annual report for the County that illustrates the following:</p> <ul style="list-style-type: none"> ■ Claims paid |

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| | | | | <ul style="list-style-type: none"> ■ Drafts cashed ■ Fees earned ■ Fees paid ■ Interest charges and credits ■ Special charges ■ Results and reconciliation of any operational guarantees in effect <p>This annual year-end reconciliation is provided within 120 days of the end of the contract period. Upon request, we will also provide all information needed to complete Schedule C (Service Provider Information) for IRS Form 5500 (Annual Return/Report of Employee Benefit Plan).</p> |
| 17. | Does this include immediate trigger funding? | <p>Advanced funding of specific stop loss breaches is offered on medical claims as a standard and free component of the stop loss product (excludes pharmacy claims and carve-out claims, such as mental health). Medical claims will be reimbursed at the time of claim payment. Coventry Health and Life Insurance Company (CHLIC) will wire the monies directly into the customer's account within 48 hours of notification from the claims administrator. The policyholder must have on file all current and fully executed documentation, including the Administrative Services Agreement (ASA), Summary Plan Description (SPD) and Stop Loss Policy, in order to be eligible for advance funding and reimbursed for stop loss claims. All breach claims paid by CHLIC by means of advance funding are audited retrospectively,</p> | <p>Our stop loss proposal assumes Individual and Aggregate Stop Loss reimbursements resulting from the inclusion of claims paid during the 3 month run out period will be handled on a delayed year-end reimbursement basis. Medical claims that exceed the Individual Stop Loss Amount or Aggregate Limit during the first twelve months of the policy period will be handled on an immediate/monthly budget reimbursement basis.</p> | <p>Our self-funded arrangements do not include a monthly claim budget feature that provides a cap or limit to the amount of claims issued or cashed monthly. However, we do offer aggregate stop loss policies with an optional monthly accommodation feature.</p> <p>The monthly accommodation feature reimburses the plan if aggregate claims exceed the accumulated year-to-date attachment point. This provides the County with a budgetable, monthly-accumulated, maximum cost. If, in any month, the</p> |

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| | | to confirm eligibility under the stop loss policy. | | <p>accumulated year-to-date attachment point is exceeded, we reimburse the excess amounts for that given month. We recoup these amounts in following months as the accumulated attachment point is increased.</p> <p>Stop loss claim payments are automatically and immediately credited to the County's bank account when the ISL level or the ASL attachment point is exceeded.</p> |
| 18. | Please indicate the exact number of mature months of claims you included in your original quote's contract basis for determining the attachment point. | Our initial submission for stop loss was based on the instructions specified in the RLI namely, 12/15 | Twelve months of mature claims were used in determining the attachment point. | We have included 12 months of mature claims. Under a 12/12 contract we use a 0.85 factor to convert 12 months of mature claims to immature claims this equates to 10.2 months of claims. |
| 19. | Please provide your complete Self-Insured Underwriting Build-up/Worksheet along with this completed set of questions. | See attached file | Attached is a summary of the self insured claim build up utilized to set the aggregate attachment point on the stop loss proposal. | Please refer to the attached Self-Insured Underwriting Build-up/Worksheet |

Broward County Government
Fully Insured Cost Build-up

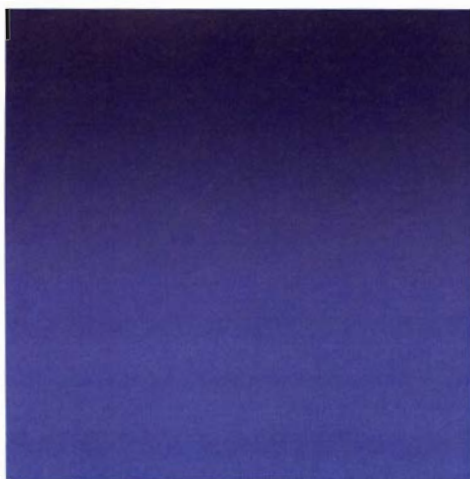
| Vendor Name Plan Design | Current Plan Design | | Current Plan Design | | Aetna | | Coventry | | Coventry | | Coventry | | Coventry | | Coventry | | Coventry | |
|----------------------------------|------------------------|--------------------|-----------------------------|------------------------------|-------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|----------|----------|----------|----------|----------|
| | Coventry Plan EX 3A | Aetna Composite | Aetna Rx - 9 AHF Low HNO | Aetna Rx - 9 AHF High HNO | Aetna Rx - 9 AHF PPO | Coventry Plan EX 3B | Coventry Plan EX 3C | Coventry Plan EX 3D | Coventry Plan EX 3E | Coventry Plan EX 3F | Coventry Plan EX 3G | Coventry Plan EX 3H | Coventry Plan EX 3I | | | | | |
| Current Premium PMPM | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 | \$322.77 |
| Current Members | 9,401 | 9,532 | 2,204 | 6,973 | 355 | 9,401 | 9,401 | 9,401 | 9,401 | 9,401 | 9,401 | 9,401 | 9,401 | 9,401 | 9,401 | 9,401 | 9,401 | 9,401 |
| Incurred Claims PMPM | \$325.61 | \$305.75 | \$295.09 | \$306.71 | \$353.07 | \$325.61 | \$325.61 | \$325.61 | \$325.61 | \$325.61 | \$325.61 | \$325.61 | \$325.61 | \$325.61 | \$325.61 | \$325.61 | \$325.61 | \$325.61 |
| Large Claims | \$14.42 | \$8.54 | \$8.70 | \$8.93 | \$0.00 | \$14.42 | \$14.42 | \$14.42 | \$14.42 | \$14.42 | \$14.42 | \$14.42 | \$14.42 | \$14.42 | \$14.42 | \$14.42 | \$14.42 | \$14.42 |
| Benefit Changes | (\$35.82) | \$0.00 | \$0.00 | \$0.00 | \$0.00 | (\$73.85) | (\$77.64) | (\$86.13) | (\$88.96) | (\$82.05) | (\$85.11) | (\$80.53) | (\$91.56) | | | | | |
| Total Non Pooled Incurred Claims | \$275.37 | \$297.21 | \$286.39 | \$297.78 | \$353.07 | \$237.34 | \$233.55 | \$225.06 | \$222.23 | \$229.14 | \$226.08 | \$230.66 | \$219.63 | | | | | |
| Annual Trend | 12.9% | 13.5% | 13.5% | 13.5% | 13.5% | 12.9% | 12.9% | 12.9% | 12.9% | 12.9% | 12.9% | 12.9% | 12.9% | 12.9% | 12.9% | 12.9% | 12.9% | 12.9% |
| Trend Adjustment | \$68.60 | \$55.45 | \$47.45 | \$53.28 | \$64.03 | \$59.13 | \$58.18 | \$56.07 | \$55.36 | \$57.08 | \$56.32 | \$57.46 | \$54.71 | | | | | |
| # of Months Trended | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | | | | | |
| Age Sex Factor Adjustment | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | | | | | |
| Large Claims Below Pooling Point | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | | | | | |
| Trended Incurred Claims | \$343.97 | \$352.66 | \$333.84 | \$351.06 | \$417.10 | \$296.47 | \$291.73 | \$281.13 | \$277.60 | \$286.22 | \$282.40 | \$288.12 | \$274.34 | | | | | |
| Pooling Level | \$200,000 | Not Supplied | Not Supplied | Not Supplied | Not Supplied | \$200,000 | \$200,000 | \$200,000 | \$200,000 | \$200,000 | \$200,000 | \$200,000 | \$200,000 | | | | | |
| Pooling Charge | \$10.65 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$10.65 | \$10.65 | \$10.65 | \$10.65 | \$10.65 | \$10.65 | \$10.65 | \$10.65 | | | | | |
| Expected Claims | \$354.62 | \$352.66 | \$333.84 | \$351.06 | \$417.10 | \$307.12 | \$302.38 | \$291.78 | \$288.25 | \$296.87 | \$293.05 | \$298.77 | \$284.99 | | | | | |
| Retention % | 9.4% | 10.6% | 11.8% | 10.4% | 8.5% | 9.4% | 9.4% | 9.4% | 9.4% | 9.4% | 9.4% | 9.4% | 9.4% | | | | | |
| Retention \$ | \$36.79 | \$37.38 | \$39.40 | \$36.38 | \$35.60 | \$31.86 | \$31.37 | \$30.27 | \$29.91 | \$30.80 | \$30.41 | \$31.00 | \$29.57 | | | | | |
| HC Reform Impact | \$1.98 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$1.98 | \$1.98 | \$1.98 | \$1.98 | \$1.98 | \$1.98 | \$1.98 | \$1.98 | | | | | |
| Gym Memberships | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | | | | | |
| Needed Premium | \$393.40 | \$390.04 | \$373.24 | \$387.44 | \$452.70 | \$340.97 | \$335.74 | \$324.04 | \$320.14 | \$329.66 | \$325.44 | \$331.75 | \$316.55 | | | | | |
| Calculated Increase | 21.88% | 20.84% | 15.64% | 20.04% | 40.25% | 5.64% | 4.02% | 0.39% | -0.82% | 2.13% | 0.83% | 2.78% | -1.93% | | | | | |
| Proposed Increase | 21.88% | 20.84% | 15.64% | 20.04% | 40.25% | 5.64% | 4.02% | 0.39% | -0.82% | 2.13% | 0.83% | 2.78% | -1.93% | | | | | |

AETNA

Enriching lives. Improving health.

An integrated health management model that fits
Broward County Government





Aetna's Team

- DeFord Smith, Sales Vice President, Public & Labor Sector
- Natalie Gonder Jones, Account Executive, Public & Labor Sector
- Gina Ciccia, Vice President, Client Management, Public Sector
- David Weisman, South Florida Network Manager
- Dr. Valerie Beckles, South Florida Medical Director



Why Aetna?

- Lower premiums
- Network Scope, stability and discounts
- Superior medical management
- Member satisfaction/service excellence
- Consumer expertise/member engagement

Financial Position

| Aetna AHF HNO High | | |
|---------------------------|-------------------|---------------------|
| Coverage Categories | Assumed Employees | Proposed Rates |
| Employee Only | 1,677 | \$444.66 |
| Employee + Spouse | 879 | \$905.03 |
| Employee + Child/ren | 549 | \$772.23 |
| Employee + Family | 565 | \$1,303.43 |
| Monthly Total | 3,670 | \$2,701,608 |
| Annual Total | 3,670 | \$32,419,301 |

| Vista HRA High | | |
|-----------------------|-------------------|---------------------|
| Coverage Categories | Assumed Employees | Proposed Rates |
| Employee Only | 1,677 | \$437.68 |
| Employee + Spouse | 879 | \$941.31 |
| Employee + Child/ren | 549 | \$804.95 |
| Employee + Family | 565 | \$1,376.02 |
| Monthly Total | 3,670 | \$2,780,770 |
| Annual Total | 3,670 | \$33,369,236 |

| Aetna AHF HNO - Low | | |
|----------------------------|-------------------|--------------------|
| Coverage Categories | Assumed Employees | Proposed Rates |
| Employee Only | 573 | \$425.83 |
| Employee + Spouse | 178 | \$866.61 |
| Employee + Child/ren | 184 | \$739.46 |
| Employee + Family | 225 | \$1,248.06 |
| Monthly Total | 1,160 | \$815,131 |
| Annual Total | 1,160 | \$9,781,576 |

| Vista HRA - Low | | |
|------------------------|-------------------|--------------------|
| Coverage Categories | Assumed Employees | Proposed Rates |
| Employee Only | 573 | \$413.70 |
| Employee + Spouse | 178 | \$889.75 |
| Employee + Child/ren | 184 | \$760.84 |
| Employee + Family | 225 | \$1,300.63 |
| Monthly Total | 1,160 | \$828,062 |
| Annual Total | 1,160 | \$9,936,743 |

| Aetna PPO | | |
|----------------------|-------------------|--------------------|
| Coverage Categories | Assumed Employees | Proposed Rates |
| Employee Only | 133 | \$648.62 |
| Employee + Spouse | 38 | \$1,321.11 |
| Employee + Child/ren | 8 | \$1,127.12 |
| Employee + Family | 8 | \$1,903.07 |
| Monthly Total | 187 | \$160,710 |
| Annual Total | 187 | \$1,928,522 |

| Vista PPO | | |
|----------------------|-------------------|--------------------|
| Coverage Categories | Assumed Employees | Proposed Rates |
| Employee Only | 133 | \$547.16 |
| Employee + Spouse | 38 | \$1,176.77 |
| Employee + Child/ren | 8 | \$1,006.27 |
| Employee + Family | 8 | \$1,720.21 |
| Monthly Total | 187 | \$139,301 |
| Annual Total | 187 | \$1,671,617 |

| | | |
|-----------------------------|--------------|---------------------|
| Aetna Annual Premium | 5,017 | \$44,129,399 |
|-----------------------------|--------------|---------------------|

| | | |
|-----------------------------|--------------|---------------------|
| Vista Annual Premium | 5,017 | \$44,977,596 |
|-----------------------------|--------------|---------------------|



Network Strength

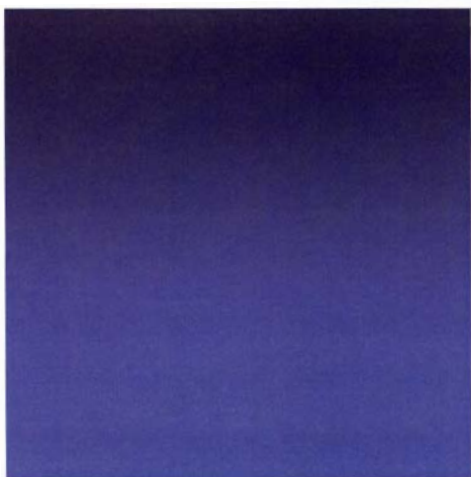
Local Network Management

National Network is seamless and managed exclusively by
Aetna

Contracting strategy focused on quality and total cost
management

Strong charge master increase protection and audit tools

Focused growth and retention strategy, with measurable year-
over-year results



Superior Medical Management

- Guaranteed Savings of \$100 PEPY
- Disease Management covers 50% of medical spend
- Patented CareEngine Technology
- Unmatched Member Engagement



Member Satisfaction

Service Excellence

- **First Call Resolution**
 - 96.6%
- **Member Satisfaction**
 - 92.0%

Dedicated Government & Public Sector Team

| | |
|-----------------------|---|
| Field Sales & Service | <ul style="list-style-type: none">✓ Dedicated and Designated Gov/Public Sector Sales Executives and Account Management teams serving 1.5M Members✓ Onsite Account Managers/Plan Sponsor Liaisons where appropriate |
| Sales Support | <ul style="list-style-type: none">✓ Dedicated Government/Public Sector Team✓ Understanding of Procurement Process, RFP review, Compliance |
| Underwriting | <ul style="list-style-type: none">✓ Dedicated New Business Underwriting Teams✓ Dedicated Renewal Underwriting Teams✓ Regional Focus |
| Customer Service | <ul style="list-style-type: none">✓ Designated Claim, Call and Plan Sponsor Services teams✓ Additional regional dedication/designation in progress |
| Additional Resources | <ul style="list-style-type: none">✓ Dedicated Legal/Compliance, Actuarial, Finance, and Informatics✓ Designated liaisons throughout the organization |



Why Aetna Customer Service Has Been Superior...

Investment in our people

While Aetna has made a capital investment in technology, we still believe that we need the right person with the right training on the other end of the phone

Co-located claims and member services

Calls & claims for a national account customer is the responsibility of one manager / team has a common focus on the customers they serve / drives accountability & quality

Customer service centers / 100% focused on the member experience

Members and providers are different constituencies / they ask for, understand and provide information differently

By separating member calls from provider calls, each constituent gets dedicated service / providers contact our provider service centers

No pended claims / do it right the first time

Is a higher auto-adjudication rate better?

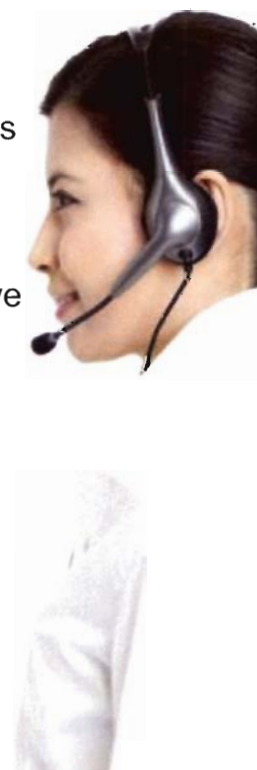
Sometimes it makes more sense to have a processor place a proactive call to obtain information, simply process the claim and eliminate member hassles

Customer service that listens, informs and educates

We take the member out of the middle / we don't give the member an assignment / and we focus on keeping the commitment

First call resolution

Measured by asking the member, we actually make outbound calls to speak to members within 72 hours / as opposed to the practice of relying on call data to make assumptions for FCR



YOUR TEAM

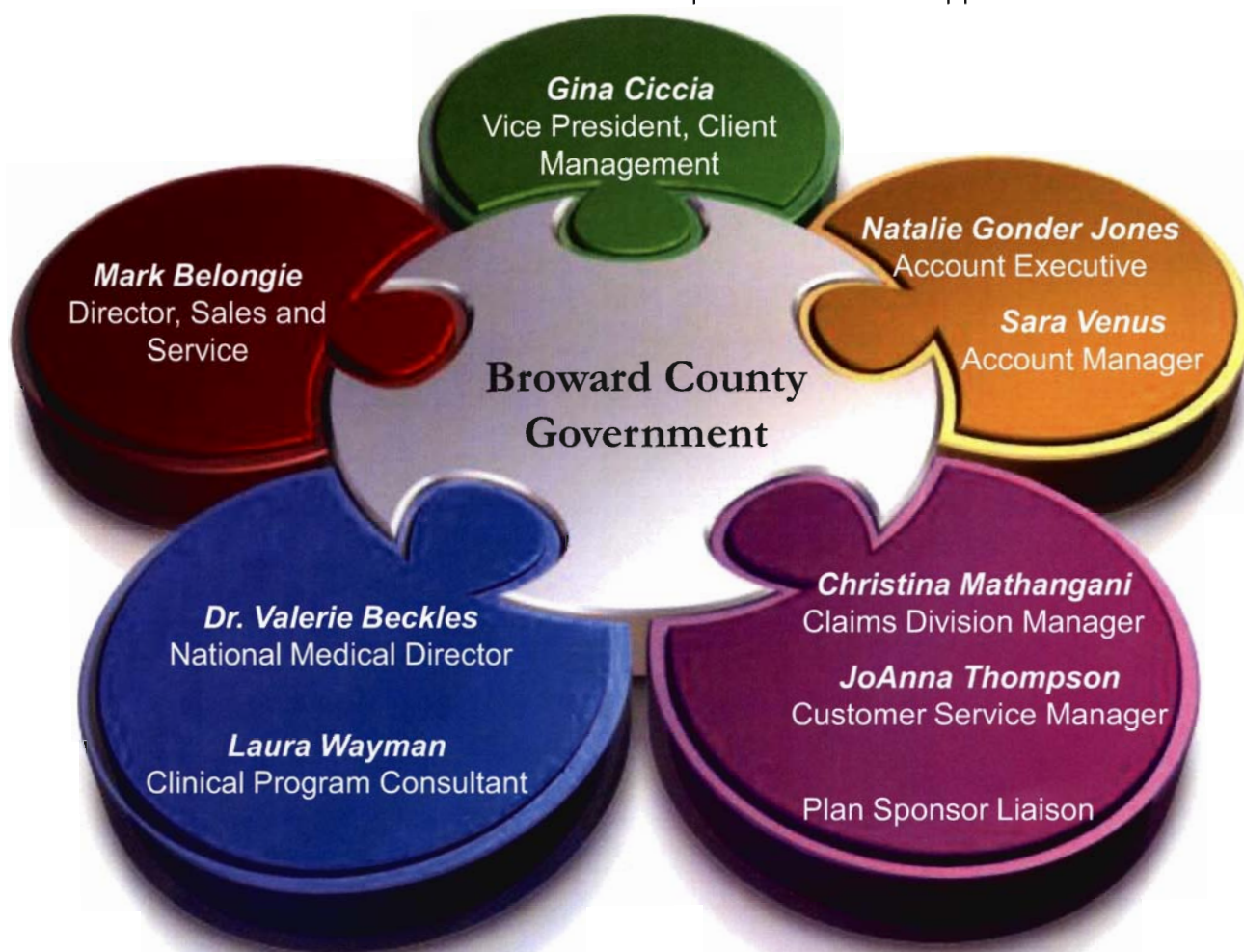
PROVEN LEADERSHIP TO SUCCESSFULLY EXECUTE YOUR VISION

Aetna Account Executive Role

- Overall Aetna Relationship Management
- Strategic Planning
- Utilization Review
- Renewal review / Underwriting Review
- Aetna Industry / Trend Updates

Aetna Account Manager Role

- Day-to-Day Inquiries / Resolution
- Review of Service Contract / Agreements / Summary of Coverage Documents
- Quarterly Reporting / Ad Hoc Reporting
- Operational Oversight
- Internal Aetna Liaison
- Aetna Network Changes
- Open Enrollment Support



Tampa Service Center Site Results

| Metric & Goal | 2008 | 2009 |
|--|------------|-----------|
| Total Calls Answered | 953,856 | 335,592 |
| Abandonment Rate (2.0%) | 0.7% | 0.9% |
| Average Speed of Answer (30 seconds) | 12.30 | 15.80 |
| Telephone Service Factor (80%) | 87.70% | 84.50% |
| Total Claims Processed (manual and Auto-Adjudication) | 10,813,786 | 4,120,021 |
| Financial Accuracy (99.25%) | 99.77% | 99.85% |
| Total Claim Accuracy (96%) | 99.56% | 99.51% |
| Pay Incidence (97%) | 99.76% | 99.74% |
| TAT (80% in 8 days) | 2 days | 2.7 days |

Tampa Customer Service Center & Aetna's Florida Presence

Our Site



- High-quality service since 1958
- National Account client base
- Bilingual capabilities
- Disease Management

Our People



- Over 263 customer service staff
- Average 10.1 years Aetna experience
- Aetna employs more than 3,400 full-time employees in the State of Florida

Our Customers



- Serving 761,460 members
- Focused exclusively on National and Public Sector customers and members
- We service Polk County, Sarasota County, North Broward Hospital District, the City of Jacksonville, and Miami Dade College out of our Tampa Center





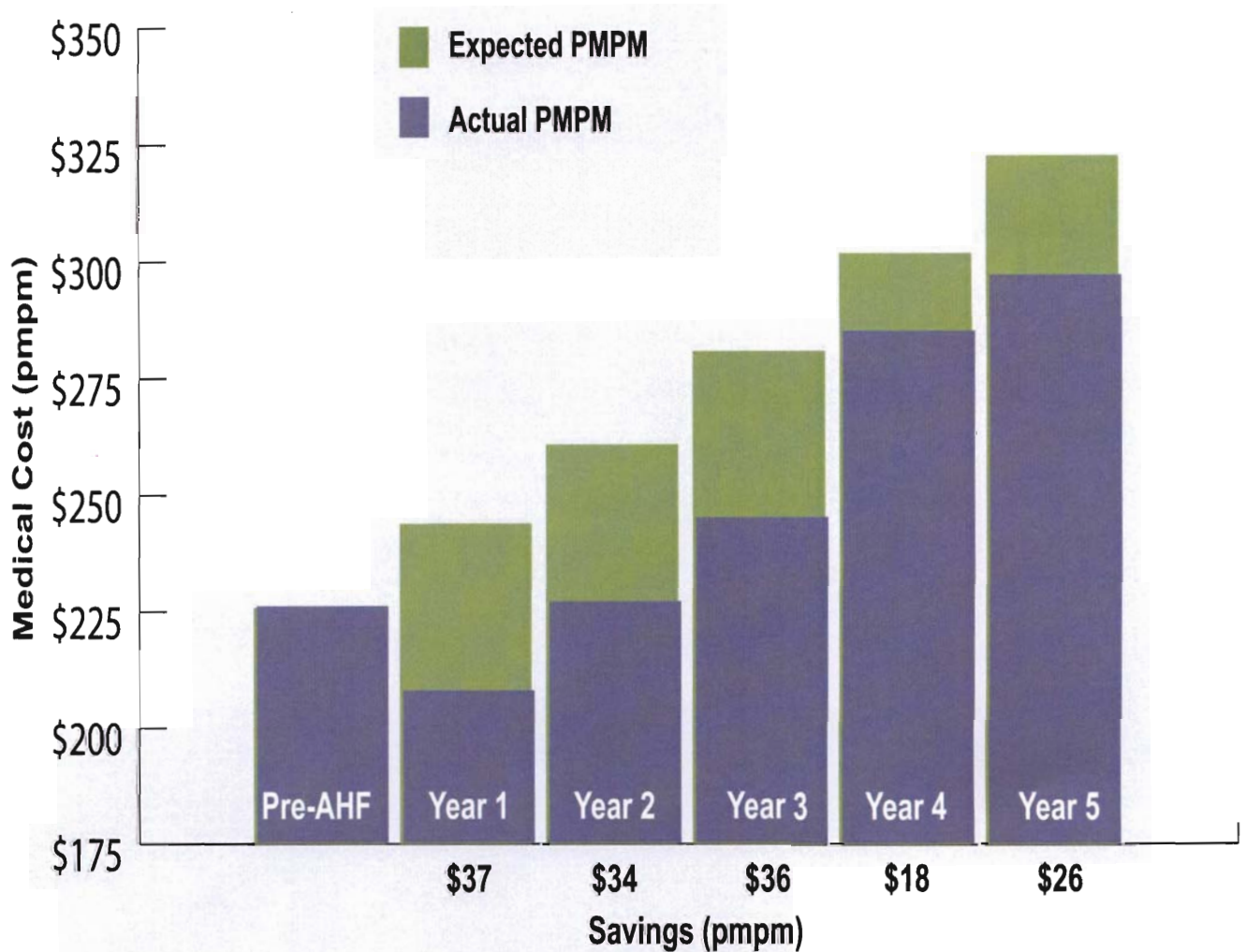
Consumer Expertise and Member Engagement

- Aetna was the first national carrier to offer Consumer-Directed Health Plans (CDHPs)
- CDHP's continues to realize long-term trend reductions and medical cost savings
- CDHP members get the care they need
- CDHP members are more informed and engaged health care consumers
- Execution on strategies impacts results



Full replacement AHF HRA/HSA (Part of CDHP Study)

Resulted in \$18 million in savings per 10,000 members over 5 years* (2003 – 2008)



* Based on allowed claim trends

Aetna Navigator

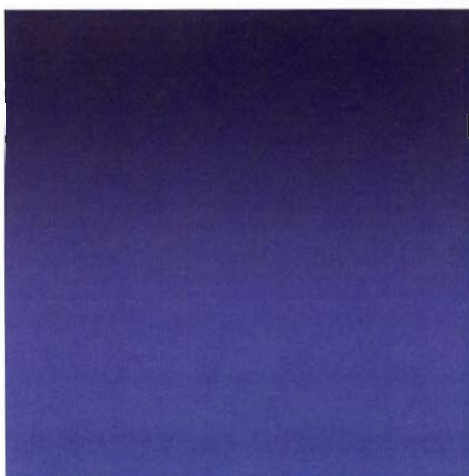
With Aetna's secure member website*, members can better manage their health and benefits with easy online access to:

- Claims, Balances, and eligibility information
- Find a Doctor with DocFind[®]
- Personal Health Record and Health History Report
- Health Assessments through Simple Steps To A Healthier Life^{®**}
- Doctors' Rates, Medical Procedure by Facility Cost Tool, Estimate the Cost of Care
- Hospital Comparison Tool
- Print a Temporary ID Card
- Health information with SmartSource^{**}, Aetna IntelliHealth[®] and Healthwise[®] Knowledgebase
- Health Information Guide

* Available to members with Aetna benefits. An Aetna medical or Aetna dental plan is not required.

** Availability varies by plan

*** Aetna pharmacy required



Why Aetna?

Proven Track Record With Our:

Lower premiums
Network Scope, stability and discounts
Superior medical management
Member satisfaction/service excellence
Consumer expertise/member engagement

External Validation:

Most admired health care insurer

Fortune® Magazine, March 2009

Leader in customer service for both members and clients

UBS Benefit Consultants Survey, October 2008

2008 winner for improving asthma health literacy

Institute for Healthcare Advancement, May 2008

Ranked #1 nationally for how we work with physicians

athenahealth, Inc. 2008 PayerViewSM Rankings

Ranked #1 for providing clear information to doctors

The Verden Group, April 2008

Platinum winner best employer for healthy lifestyles

National Business Group on Health, May 2008

Appendix

Ready Today for the Future of Health Care



Physician's Electronic Medical Records

Lifestyle Coaching

- Tobacco Cessation
- Weight Management
- Stress Reduction
- Referrals to Disease Mgmt



Patient Safety Program ← **CARE ENGINE** → **Condition Management**

Member Outreach

Physician Outreach

Targeted Wellness Reminders



Disease Management

- Single nurse model
- 41 Conditions
- Active Advice Custom Scripting
- Referrals to Lifestyle Coaching



Maternity Management

- Pregnancy Risk Survey
- Case management is available for "Supportive", "At Risk", and "High Risk" members
- Post partum outreach calls to "At Risk" and "High Risk" members



Engagement



We want you to know®

Condition Management 1 Program - 41 Conditions

- 1 program;
41 conditions
- Customized
assessments
and action
plans
- Single Nurse
Model
- Provides
360° view of
100% of
members,
100% of the
time

Vascular Cluster

- Peripheral Artery Disease
- Congestive Heart Failure (CHF)
- Diabetes (adult and pediatric)
- Coronary Artery Disease (CAD)
- Hypertension (high blood pressure)
- Cerebrovascular disease/Stroke
- Hyperlipidemia (high cholesterol)

Pulmonary Cluster

- Asthma (adult and pediatric)
- Chronic Obstructive Pulmonary Disease (COPD)

Orthopedic/Rheumatologic Cluster

- Osteoporosis
- Rheumatoid arthritis
- Osteoarthritis (OA)

GI Cluster

- Gastro Esophageal Reflux Disease (GERD)
- Peptic Ulcer Disease
- Inflammatory Bowel Disease (Crohn's Disease and Ulcerative Colitis)
- Chronic Hepatitis

Neuro-Geriatric Cluster

- Geriatrics
- Migraines
- Seizure Disorders
- Parkinsonism

Oncology

- Cancer (General)
- Breast Cancer
- Lung Cancer
- Lymphoma/Leukemia
- Prostate Cancer
- Colorectal Cancer

Other

- Chronic Kidney Disease
- End Stage Renal Disease
- Hypercoagulable state (blood clots)
- Sickle Cell Disease (adult and pediatric)
- Cystic Fibrosis
- HIV
- Low Back Pain
- Weight Management

MEASURABLE RESULTS

REPORTING CAPABILITIES

Your Aetna team will be accountable for managing your program with a focus on monitoring results, designing solutions and innovating for the future. On a regular basis, your Aetna Account team will meet with you to review and make consultative recommendations based on plan specific information

Utilization Management Reports

- Medical Utilization Reports

Clinical Reports

- Simple Steps To A Healthier Life Health Risk Assessment Aggregate Report
- Aetna Health Connections/MedQuery® Activity Report
- Aetna Health Connections/MedQuery Outcomes Report
- Beginning Right Maternity Management Activity Report
- Aetna Health Connections Case Management Report

Member Utilization Reports

- Informed Health Line, Aetna Navigator Registration and Usage Reports
- Personal Health Record Activity Report
- Informed Activity Report

Financial Reports

- Fund Summary and Funds Request and Receipt Report
- Annual Accounting Package
- Renewal Package
- Periodic Claim Analysis
- National Advantage Savings Report

Performance Metric Reports

- Claim Administration Performance Metrics
- Aetna Value Scorecard
- Other performance based guarantees

Rewards Tracking Reports

- Simple Steps Rewards Tracking Report



Health and Wellness Reporting

Disease Management Activity Report

Member Tracking – Beginning to End of reporting period

- Where you find new members for the reporting period
- Where you find members who opted out during the reporting period (additional detail about these members on page 10)
- Examples of others include : Deceased, Member Denies Condition, Advanced Illness, Transitioned to other program or other program managing.

| Program Track | Disease Management Program Members (24,552) | | |
|--|---|--------------------------|------------------------|
| | Active Monitoring with NE | Active Monitoring w/o NE | Supportive Monitoring |
| | Reporting Period Total | Reporting Period Total | Reporting Period Total |
| Number of Members at the Beginning of the Current Reporting Period | 1,597 | 15,623 | 6,268 |
| New Members During the Reporting Period | 135 | 1,422 | 75 |
| Members who moved to another Program Track | 0 | 0 | |
| Members who Opted Out | 1 | 20 | 1 |
| Lost Eligibility | 3 | 2 | |
| Others | 27 | 299 | 202 |
| Number of Members at the End of the Current Reporting Period | 1,701 | 16,711 | 6,140 |
| Postponed - due to Higher Level Program | 89 | 651 | 154 |

Health and Wellness Reporting

Disease Management Activity Report

Condition Detail

- Top 10 Conditions by member prevalence ranked by Active Monitoring with Nurse Engagement
- Per Member Per Month Cost and Average Opportunity Score
- Total Eligible Population with a Condition is inclusive of DM Program members plus members who have a condition but no open event, postpones, opt outs and members who did not score high enough for DM.
- Members can have more than one condition; therefore, the member, their cost and their opportunity score is included in each condition calculation they are represented in.

| Identified Conditions by Members | | | | | | | | | | | | |
|--------------------------------------|---|--|--------------------|---------------------------|--|--|--------------------|---------------------------------|--|---|--------------------|---------------------------------|
| Top 10 Conditions | Active Monitoring with Nurse Engagement Members | | | | Disease Management Program Population (AM with Nurse, w/o Nurse and Supportive Monitoring) | | | | Total Eligible Population with a Condition | | | |
| | Nurse Engaged Population per Condition | % of Active Monitoring with Nurse Engagement | PMPM Medical Costs | Average Total Opportunity | Disease Management Program Population | % of Disease Management Program Population | PMPM Medical Costs | Average Total Opportunity Score | Total Eligible Population with a Condition | % of Total Eligible population with a condition | PMPM Medical Costs | Average Total Opportunity Score |
| Hypertension - Adult | 829 | 49% | \$285 | 12.61 | 9,951 | 42% | \$178 | 8.01 | 11,195 | 11% | \$189 | 7.86 |
| Cholesterol - Secondary | 733 | 44% | \$279 | 13.44 | 6,728 | 28% | \$185 | 9.75 | 8,024 | 8% | \$193 | 9.43 |
| Diabetes - Adult | 532 | 32% | \$273 | 13.26 | 4,149 | 17% | \$223 | 10.80 | 5,312 | 5% | \$204 | 10.17 |
| Hyperlipidemia - Primary | 437 | 26% | \$95 | 6.66 | 7,201 | 30% | \$76 | 4.26 | 9,433 | 10% | \$72 | 3.52 |
| Weight Management - Adult | 252 | 15% | \$153 | 12.35 | 595 | 2% | \$327 | 11.36 | 1,030 | 1% | \$253 | 8.58 |
| Gastroesophageal Reflux Disease | 227 | 14% | \$442 | 14.01 | 1,823 | 8% | \$262 | 9.50 | 1,946 | 2% | \$284 | 9.36 |
| Cancer | 184 | 11% | \$622 | 12.48 | 1,347 | 6% | \$535 | 9.73 | 1,478 | 2% | \$597 | 9.65 |
| Chronic Low Back Pain | 182 | 11% | \$451 | 12.99 | 1,240 | 5% | \$282 | 9.77 | 2,131 | 2% | \$225 | 7.43 |
| Depression | 168 | 10% | \$464 | 11.07 | 1,250 | 5% | \$286 | 8.11 | 1,251 | 1% | \$285 | 8.11 |
| Coronary Artery disease | 161 | 10% | \$583 | 21.45 | 924 | 4% | \$456 | 18.44 | 1,321 | 1% | \$442 | 16.90 |
| Total Validated Conditions | 4,549 | N/A | N/A | NA | 42,291 | N/A | N/A | N/A | 119,303 | N/A | N/A | N/A |
| Unique Members with a Condition | 1,679 | N/A | \$263 | 10.52 | 23,903 | N/A | \$161 | 6.58 | 97,442 | N/A | \$72 | 5.57 |
| Avg. Validated Conditions per Member | 2.7 | N/A | N/A | NA | 1.7 | N/A | N/A | N/A | 1.2 | N/A | N/A | N/A |

*Because members may validate for more than one condition, the sum of the percentages of conditions will likely be greater than the "Unique Members with a Condition" percentage.

Health and Wellness Reporting


Disease Management Activity Report

Key Metrics

- By Engagement Level with Benchmark
- Member metrics
 - What is % of EE's vs. Members by Engagement Level?
 - What is the avg age, # conditions, and avg AOS by Engagement Level? How does each engagement level compare to each other and to “No Current DM Opportunity” members?
- Care Consideration metrics
 - How does each engagement level compare to each other? To “No Current DM Opportunity”
 - How does CC compliance compare?
- Cost and Utilization metrics
 - Compare cost and utilization by each engagement level to each other.

Dashboard for quick reference...

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Search

Home

Aetna Customer Health Information Portal

Dashboard My HCCs

Your items Search results

ADD MODULE ▾

- Admin & Network Savings
- Behavioral Health
- Clinical View
- Demographics
- Dental Plan Performance
- Disability Utilization Indicators
- High Cost Claimants
- Key Measures
- Medical Trend
- Member Risk Profile
- Pharmacy
- Pharmacy Utilization
- Preventative Care Measures
- Program Participation
- Segmentation & Engagement
- Utilization Indicators

High Cost Claimants x

as of Dec 2007

| | year over year | vs. comparison |
|--------------------------------------|----------------|----------------|
| 587 High Cost Claimants (>\$50k) | 1.9% | |
| 8.5 Claimants per 1,000 Members | | 9.2% |
| \$112,233.00 Average Cost per HCC | 1.5% | |
| 33.3% HCC % to Total Paid | 1.0% | 33.3% |
| 60.5% % HCC in-network | 2.0% | 75.0% |

PRINT | VIEW

Utilization Indicators x

as of Dec 2007

| | year over year | vs. comparison |
|---|----------------|----------------|
| 21.78 musculoskeletal disorders (PMPM) | (13.1)% | 5.4% |
| 13.4 digestive disorders (PMPM) | 12.8% | (11.8)% |
| 12.74 cardiac disorders (PMPM) | 3.5% | 4.1% |

PRINT | VIEW

Demographics x

as of Dec 2007

| | year over year | vs. comparison |
|-----------------------------|----------------|----------------|
| 5094 employees | (9.2)% | |
| 11542 members | (9.8)% | |
| 2.3 members to employees | (0.7)% | 12.5% |
| 42.2 average age | 0.4% | 20.9% |
| 52.3% % female | 2.0% | |

Your alerts

- 52 pregnancy/childbirth days of care is 10% increase over previous quarter
- Number of high claimants up 25% over previous quarter
- Mom-to-Babies participation has decreased 10% versus previous quarter
- ER utilization increased 4% in the last quarter

Your messages

- Upgrading systems this coming weekend, 2/24-2/25, may cause temporary outages. Please plan accordingly.
- The Quarterly Reports for Medical, Dental and Pharmacy are updated and available in Aetna Customer Health Information Portal.

Your reports

Your programs

- Case Management Activity
- Employee Assistance Program (EAP)
- Informed HealthLine Program Activity
- MedQuery
- Mom-to-Babies Maternity Mgt. Program
- National Advantage Program

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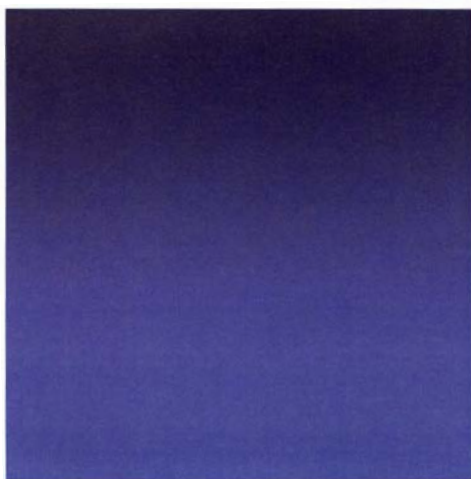
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Employee and Employer Portals:

Aetna's Toolbox





Navigator: Easy registration and log-in

- Accessible anytime, anywhere
- Secure registration process
- Phone support to assist with login or registration questions
- Easy access to information from menus, quick links, related shortcuts and Site Map

The screenshot displays the Aetna Navigator website for a subscriber. At the top, there is a navigation bar with links for Home, Benefits, Claims & Balances, Requests & Changes, and Take Action On Your Health. A sidebar on the left contains 'Welcome to Your Secure Website' and 'Related Shortcuts' such as 'Aetna IntelHealth', 'Claim Explanation of Benefits', and 'ID Card'. The main content area is titled 'SUBSCRIBER' and dated 'October 6, 2008'. It features a 'Messages Just For You' section with links to 'Aetna SmartSource', 'Plan Guide', and 'New! Health Information Guide'. Below this are sections for 'Health Management', 'Cost of Care', and 'Recent Claims'. The 'Recent Claims' section contains a table with columns for Service Date, Name, Birth Date, and Serviced By. At the bottom, there are sections for 'Balances' and 'Benefits', including a 'Who's Covered' table.

| Service Date | Name | Birth Date | Serviced By | Search all claims |
|--------------|------------|------------|--------------------|-------------------------|
| 11/12/2008 | DEPENDENT1 | 03/05/1976 | SMITHS FOOD & DRUG | Details |
| 01/01/2008 | SUBSCRIBER | 03/05/1976 | MARK ANDERSON | Details |
| 01/01/2008 | DEPENDENT1 | 03/05/1976 | MARK ANDERSON | Details |

| | |
|--|-------------------------|
| HealthFund | Details |
| Starting Fund Amt | \$1,225.00 |
| Fund Remaining | \$0.00 |
| Flexible Spending Account - Health Care | Details |
| Amount Remaining - 2008 Plan | \$0.00 |
| Flexible Spending Account - Dependent Care | Details |
| Amount Remaining - 2008 Plan | \$0.00 |

| Who's Covered | Birth Date |
|---------------|------------|
| SUBSCRIBER | 04/28/1975 |
| DEPENDENT1 | 09/12/2007 |
| DEPENDENT2 | 03/05/1976 |

Simple Steps to A Healthier Life

a gateway to member engagement

Health Assessment

The screenshot shows a digital health assessment form. At the top, it says 'My Health Risk Assessment' with sub-sections for 'My Health and Well-Being', 'My Health Insurance', and 'My Insurance Information'. The main section is '1. Health & Lifestyle' with a sub-section '20. Work & Daily Life'. It contains several questions with radio button options. For example, '1. Do you work for pay?' has 'Yes' and 'No' options. '2. During the past 7 days, how many days/minutes did you...?' has 'Excellent', 'Very good', 'Good', 'Fair', and 'Poor' options. '3. During the past 7 days, how many hours/minutes did you...?' has 'None', 'Hours', and 'Minutes' options. '4. During the past 7 days, how many hours/minutes did you...?' has 'None', 'Hours', and 'Minutes' options. '5. During the past 7 days, how much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '6. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '7. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '8. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '9. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '10. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '11. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '12. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '13. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '14. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '15. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '16. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '17. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '18. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '19. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options. '20. How much did your health...?' has 'None', 'A little', 'A moderate amount', and 'A great deal' options.

Your Life.
Live It Well.

Simple Steps To
A Healthier Life®

Simple Steps To A Healthier Life is one way to engage members in their health and wellness journey, by:

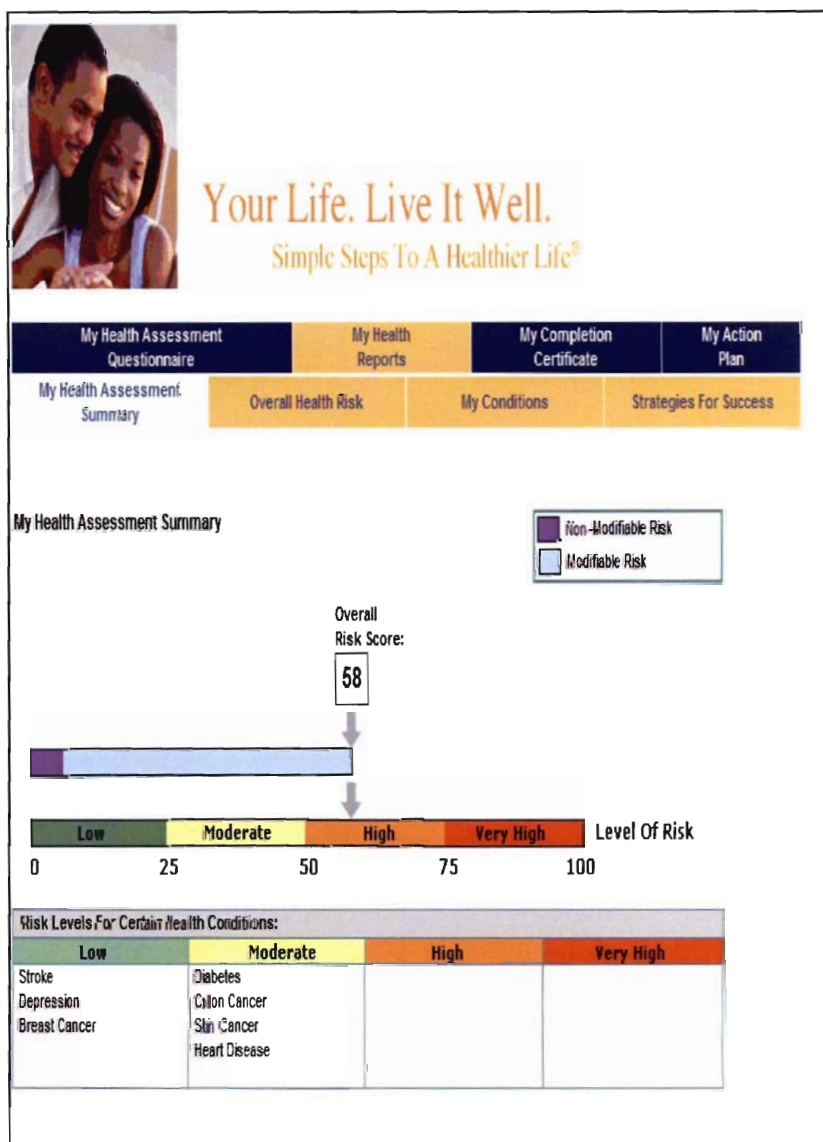
- Helping them **understand** their current health status
- Identifying **opportunities** for them to achieve optimal health
- Providing the tools and resources to help them **achieve** realistic health goals
- Action planning, online behavior change programs, and program referral

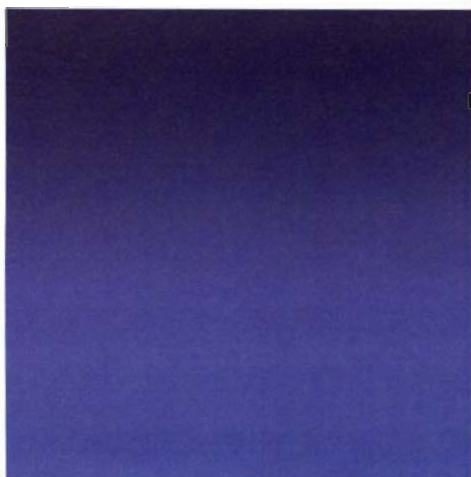


Helping members identify opportunities to achieve optimal health

Personalized health reports, based on results of the Health Assessment, provide:

- Overall health score
- Modifiable health risk factors
- Non-modifiable health risk factors
- Other health recommendations
- Risk levels for diseases and conditions
- Strategies for success





Technology Solutions for Your Employees

Aetna Mobile Web

When mobile device users visit Aetna.com, they see some of our most popular Aetna.com features:

- Simplified for an ideal hand-held user experience
- Customized for each mobile device

The mobile device user has less ‘clicks’ as compared to the desktop/ laptop user. Examples include:

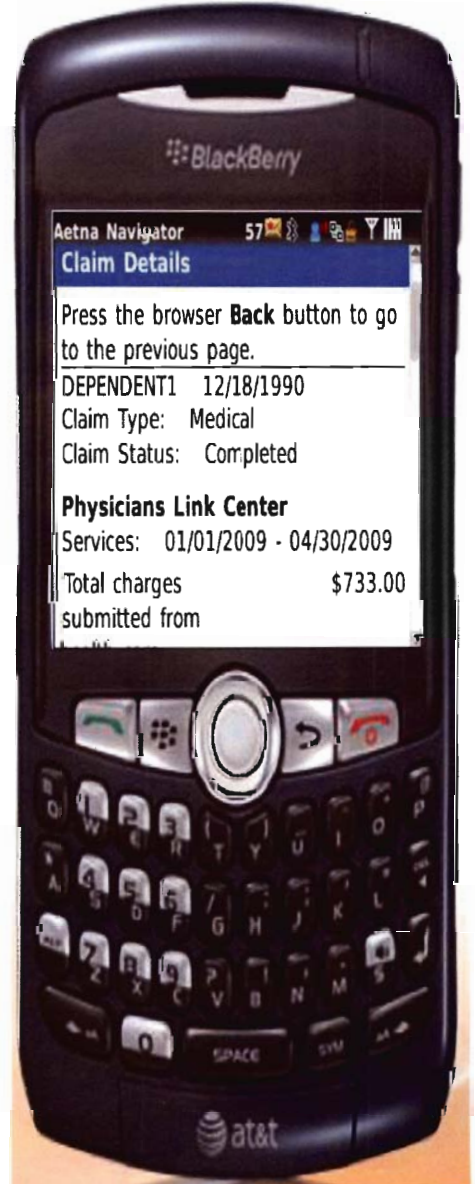
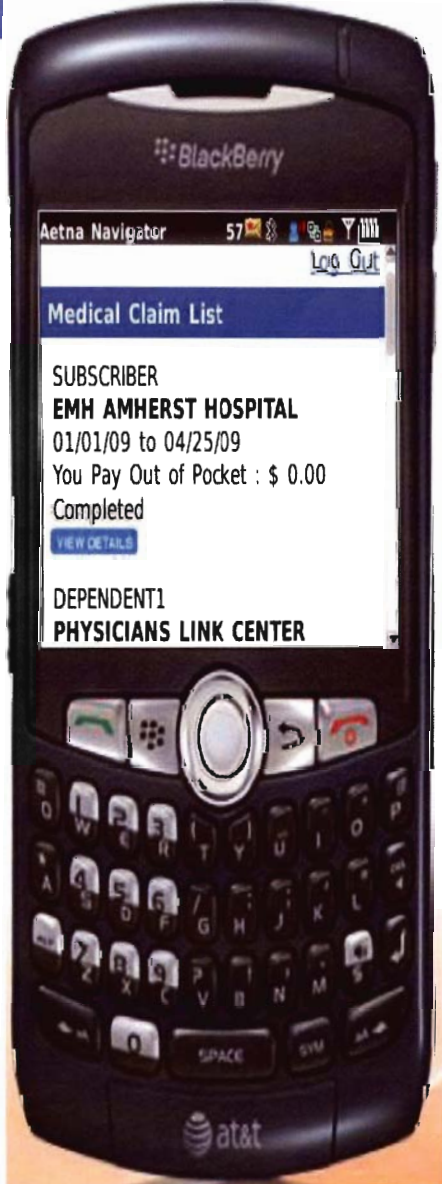
- **Claim search** – their five most recent claims appear as a starting point, with an option to search further.
- **Doctor search** – they are immediately given the option of searching for a specialist.

An application or “app” is downloaded onto a mobile device, or smartphone such as an iPhone or BlackBerry

Apps deliver an engaging user-experience and often use device-specific functions of smartphones such as:

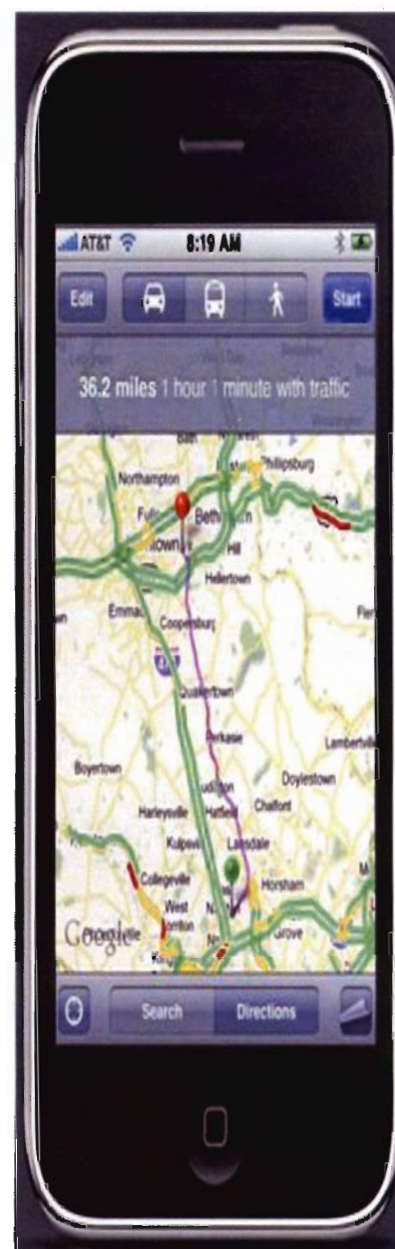
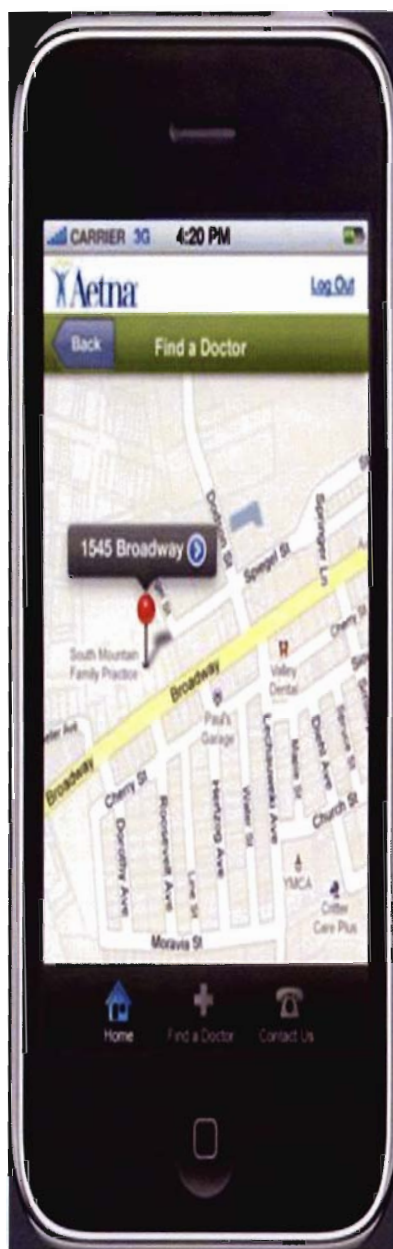
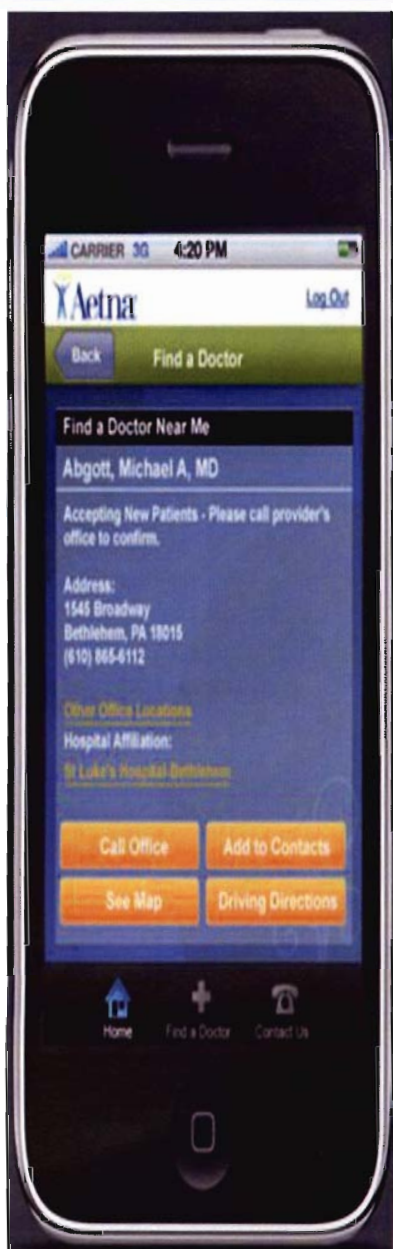
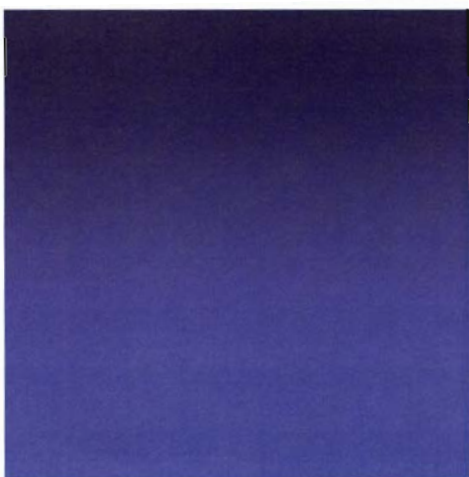
- GPS location awareness for map use and turn-by-turn directions
- Accelerometer for motion controlled functionality
- Integration with other applications on device
- Easier browser navigation

Aetna Mobile Web examples



Using smartphone functions for apps

GPS - location awareness for map use and turn-by-turn directions



Using smartphone functions for apps

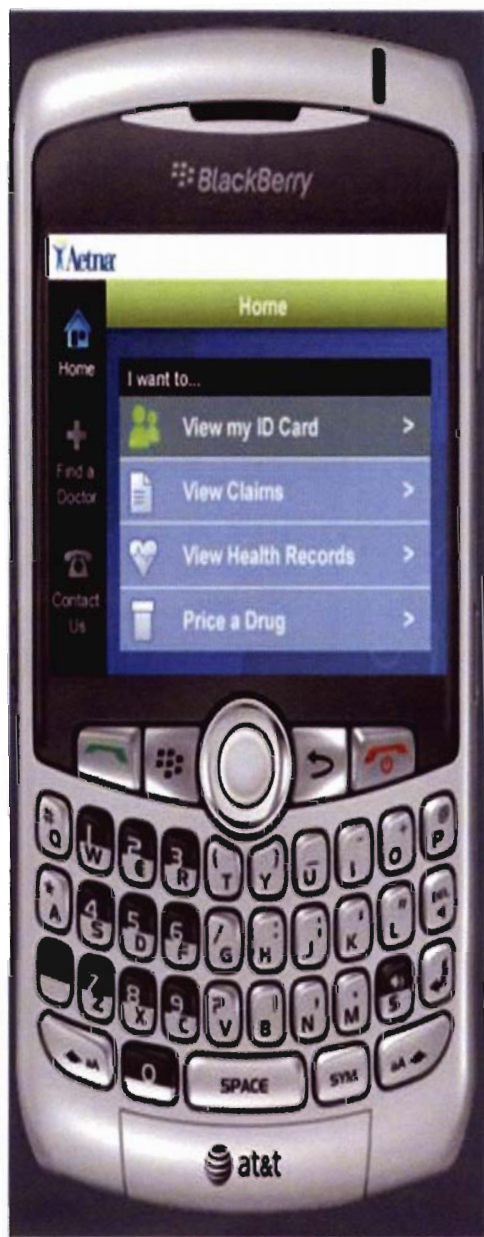
Accelerometer – motion controlled functionality





Using smartphone functions for apps

Easier browser navigation



Equality in Healthcare

Health care disparities, including unequal health care access and outcomes, are a critical challenge to the health care system

- Studies show that racial and ethnic minorities receive lower-quality health care than non-minorities, even when insurance status, income, age and severity of conditions are comparable.
- About 84,000 deaths occur in the United States each year due to the health care gap that separates minorities from non-minorities.
- Private and public sectors are working in concert on initiatives aimed at reducing disparities. Aetna took a leadership position in 2001 when we launched an enterprise-wide initiative to reduce racial and ethnic disparities and improve access to quality health care services for our members.

The Aetna Difference

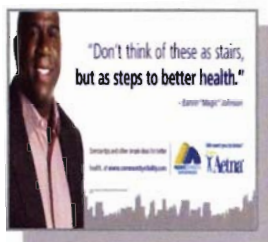
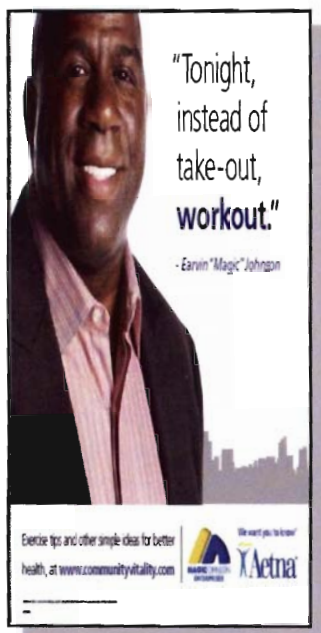
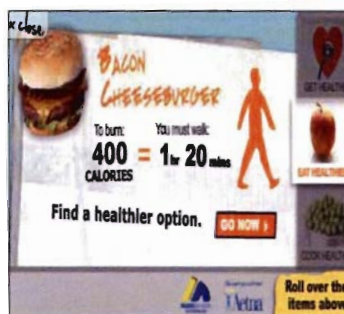
Key to our efforts is the **voluntary provision of self-identified race, ethnicity and language preference data** by our members. More than 6.2 million members have provided this data. By using this data, Aetna is able to understand where the best opportunities exist in its membership to focus targeted interventions in addressing health care disparities and improving quality of care for Aetna's membership



Teaming Up for a Healthy Tomorrow

Local market advertising with “educating” and engaging health literacy content and solutions from Mr. Johnson

- Talk to your doctor
- Empower yourself to take charge
- Ask for more information
- Make a list of your questions
- Understand your medicine; Use your pharmacist
- Plan to learn about your health care needs

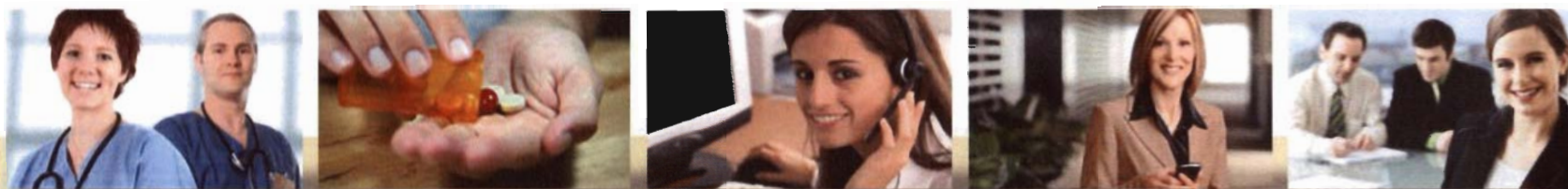


COVENTRY

Coventry Health Care of Florida



The Plan for Better Health







Broward County Government

RLI: R0843005R1

August 26, 2010



Why did BCG decide to solicit RLI?

1. Provide a health plan that is more affordable than the renewal offering 
2. Obtain the best prices in the market for the benefits requested in the RLI 
3. Reduce the County's health care spend to meet budgetary needs 
4. Explore innovative and cost effective benefit options 





The Coventry Difference

Coventry is the only carrier...

- Employing 650 Broward County residents
- Meeting the needs of BCG employees for over 17 years
- Offering a kids plan and a “build-your-own” plan
- Offering on-site account management
- With benefit incentives for low cost facility utilization
- Not providing deviations to current benefits
- Providing preventive vision and dental
- Utilizing only domestic vendors





Fully Insured Financials

| | Coventry Annual Premium | Aetna Annual Premium* | Differential |
|------------------|-------------------------|-----------------------|--------------|
| Plan A (current) | \$43.5M | \$43.1M | \$394,943 |
| Plan B | \$37.7M | \$42.9M | (\$5.2M) |
| Plan C | \$37.1M | \$42.8M | (\$5.7M) |
| Plan D | \$35.8M | \$42.6M | (\$6.8M) |

*Premiums do not include dental, vision and on-site representatives.

Source: 2011 Health Insurance RLI Analysis, Executive Summary, August 26 2010





Fully Insured – Plan A Comparison

| | Coventry | Aetna | Differential |
|--|-----------|--------------|--------------|
| Plan A (current) | \$43.56M | \$43.17M | \$394,943 |
| Dental, Vision, On-site Representatives | \$404,111 | Not included | |
| Comparable Cost | \$43.15M | \$43.17M | (\$9,168) |

Source: 2011 Health Insurance RLI Analysis, Executive Summary, August 26 2010





Fully Insured Pricing Variables

| | Coventry | Aetna |
|----------------|----------|-------|
| Pricing Trend | 12.9% | 13.5% |
| Retention | 9.4% | 10.6% |
| Profit Sharing | Yes | No |

- Lowest health care cost inflation factor
- Most cost effective expense and profit charge
- Opportunity for revenue share





Medical Management Differentiators

Local Medical Management

- Care support by professionals that know the community and medical providers
- Personal understanding of the providers and patients in the market we serve
- Over 50 years of collective experience as clinicians in South Florida with four Medical Directors

Inpatient Daily Review

- Daily concurrent review with on-site nursing staff
- “Every patient, every day”
- Week-end rounds at high-volume hospitals
- Specific focus on readmitted and multiply admitted members
- Weekly case conference on inpatient care
- Tools to strengthen telephonic review when plan is not “on-site”
- Medical team advocates for member in expediting care





Disease/Chronic Care Management

Comprehensive Care Management for all Members

- Dedicated disease management programs
- Multiple admission/transition of care program
- Behavioral health and wellness programs



More Than
Managing
a Disease





Dedicated Clinical Programs

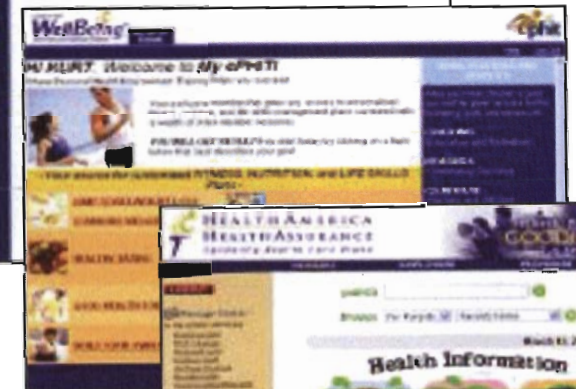
| | |
|--|-------------------------------|
| Congestive Heart Failure (CHF) | Bipolar Disorder |
| Chronic Kidney Disease/End-stage Renal Disease | Childhood ADHD |
| Asthma | Adolescent Suicide Prevention |
| Chronic Obstructive Pulmonary Disease (COPD) | Alzheimer's Disease |
| Hypertension | Domestic Violence Prevention |
| Diabetes | Eating Disorders Prevention |
| High Risk OB | Postpartum Depression |
| Comprehensive Pediatric Care Management | Stress Management |
| Major Depression | Substance Abuse |





Coventry Wellness Programs and more...

- Custom On-Site Health Fairs & Seminars
- On-Site Flu Shot Clinics
- Preventive Vision and Dental
- My ePHIT Online Wellness
- Health Risk Assessment (HRA)
- Biometric Testing
- Wellness Rewards Program
- Fitness Program
- Smoking Cessation Programs
- OTC Nicotine Replacement Therapy (NRT)
- Complementary & Alternative Medicine Discounts
- Discounts on Virtual Scans & LASIK™
- Behavioral Health Prevention





Wellness Engagement

| | |
|---|---|
| On-site Health Fairs and Seminars | Over 4,100 YTD completed \$100,000 annual commitment |
| Health Risk Assessment (HRA) | Over 5,300 HRAs completed YTD (My ePHIT + Summit) |
| My ePHIT | Over 1,700 members registered YTD |
| Preventive Care & Screenings - % of eligible based on criteria | |
| Biometric Screenings | 70.5% |
| Breast Cancer Screenings | 45.6% |
| Cervical Cancer Screenings | 48.9% |
| Prostate Screenings | 55.3% |





Workplace Health Screening Stations

- Proposed Locations
 - BCG East
 - BCG West
 - Aviation
 - Water/Wastewater
 - Port Everglades
 - Mass Transit
- Comprehensive Biometric Measurements
 - Blood Pressure, Heart Rate, Blood Oxygen
 - Weight, Body Mass Index, Body Fat
- Advantages
 - Bi-Lingual
 - Aggregate data compilation and reporting by location
 - Actively engage employees to announce upcoming events
 - Member feedback function to assist in tailoring program to meet employee needs



UNITEDHEALTHCARE

UnitedHealthcare Team Members



Linda Jones

Account Management VP

Dr. Manny Selva

Regional Market Medical Director

Doug Nedobity

Regional Underwriting Director

Tom Moore

Regional VP - Public Sector

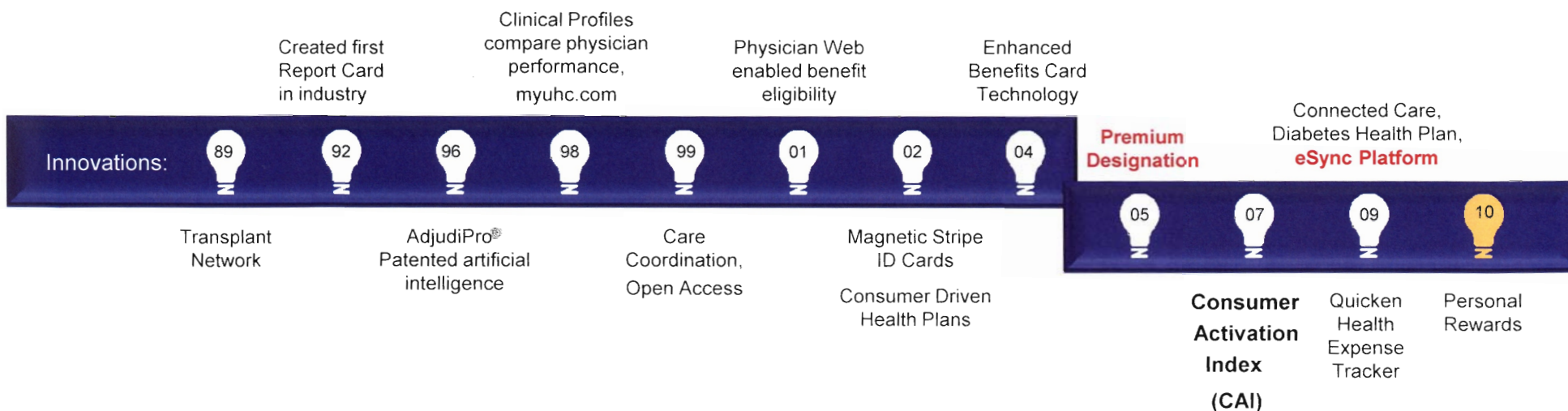
Innovation Solutions

20 years of innovation



UHC mission: *Helping People Live Healthier Lives*

“Consumerism” account-based plans → “Personalization” value-based plans



Innovation Solutions

Focus on behaviors



50% of a person's health status is a result of behavior*

choices we make every day about
our physical and emotional well being

"Should I quit smoking?"

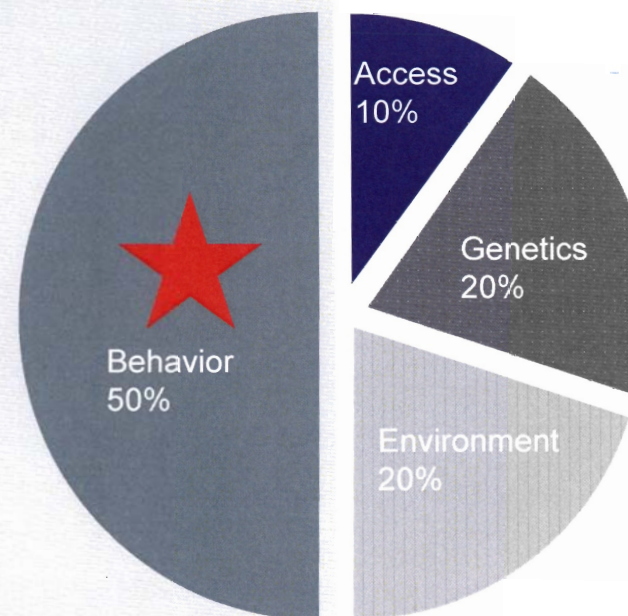
"Let's eat healthy tonight."

*"I'd rather use my non-network
doctor than a Premium provider."*

*"I'd better schedule my
mammogram."*

"Should I test my cholesterol?"

*"I'd like to lose weight, but I'm not
sure how best to start."*



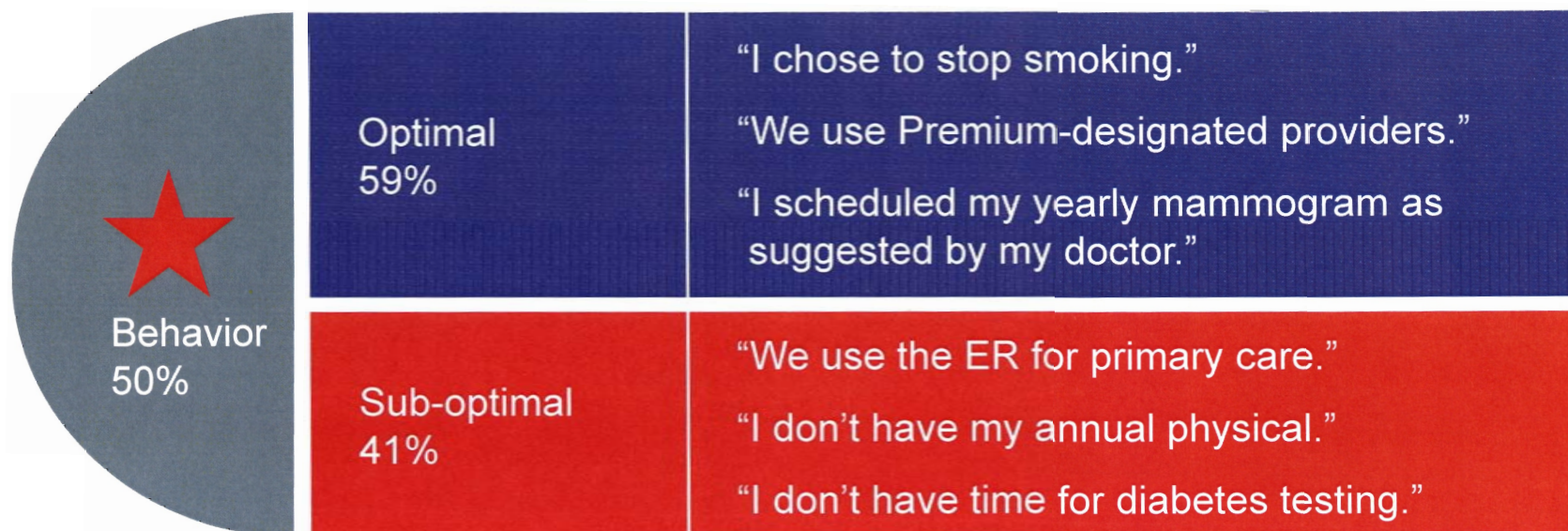
*Centers for Disease Control

Innovative Solutions

Optimal v. sub-optimal



While behavior accounts for 50% of a person's health status
consumers do not make the optimal choice **41%*** of the time



Sub-optimal decisions have the biggest clinical and financial impact

* UnitedHealthcare ASO book of business results measured by CAI through June 2009 (~5m consumers measured)

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Network Access



Better network access and lower costs on a local and national level

- Our network includes over 617,000 doctors and health professionals, 5,000 hospitals and ~1,000 Convenience Care Clinics (CVS, Publix Little Clinic, Walgreens)
 - 83% of all available hospital beds
 - Two out of three available doctors and health professionals
 - 120,000 specialists in our network are designated for quality and efficiency for our UnitedHealth Premium designation program*
- Our focus on fixed-rate contracts helps us better predict and control future costs



**Local access for 98%
of US population**

**Leading discounts in 79% of
the markets we serve help
keep employee out-of-pocket
costs down**

*All eligible physicians in 138 markets are evaluated - 44% meet quality and efficiency standards – an additional 11% meet quality only.

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Source: Mid-Year 2008 Nationally Recognized Third Party Benchmarking Data.

Premium Designation Program

21 Specialty Areas of Focus



Proceduralists

Cardio-thoracic Surgery
Interventional Cardiology
Electrophysiology
Neurosurgery
Orthopaedic Surgery
Spine Surgery
Total Joint Replacement
Sports Medicine



Non-proceduralists

Allergy
Nephrology
Neurology
Pulmonology
Rheumatology
Cardiology (non-interventional)
Endocrinology
Infectious Disease
Family Medicine
Internal Medicine
OB/GYN
Pediatrics



Hospitals

UnitedHealth Premium Specialty Centers

- Cardiac
- Spine Surgery and Total Joint Replacement
- Neonatal Service
- CHD
- Infertility Services

21 Specialty Areas >60% of Medical Spend

Disease Management Return on Investment



Our disease management program is a population based intervention program targeting five conditions – Heart Failure, COPD, CAD, Diabetes and Asthma.

Member and provider outreach are part of the intervention strategy.

Based on stratification, mail and/or telephonic interventions are made.

Members with low and moderate stratification receive mail only; members in high stratification receive telephonic engagement.

Based on our historical claims analysis (medical and pharmacy) our programs have yielded 'returns on investment' (ROI) as shown below. Clinical hierarchy removes overlaps between conditions.

Overall combined ROI is targeted at 1.6:1.0 in year 1 (2007), 2.0:1.0 in year 2 (2008) and 2.1:1.0 in year 3 (projected 2009). There is a diminishing return as the program matures barring high employee turnovers.

Findings are based on 2.93 million lives and 153k diseased members in DM programs between 1/07 – 9/09.

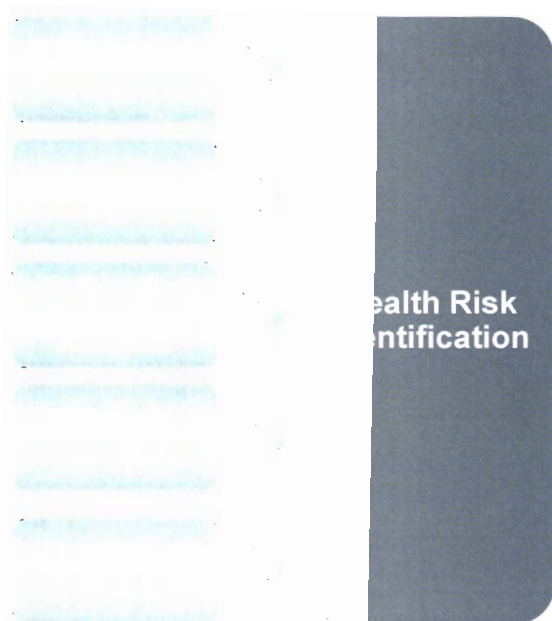
| Clinical Program | Year 1 ROI | Year 2 ROI | Year 3 ROI |
|------------------|------------|------------|------------|
| Heart Failure | 2.4 | 2.7 | 3.0 |
| COPD | 1.2 | 1.5 | 2.0 |
| CAD | 2.0 | 2.4 | 2.5 |
| Diabetes | 1.7 | 1.9 | 2.0 |
| Asthma | 1.3 | 1.7 | 2.0 |
| Total | 1.6 | 2.0 | 2.1 |

These rates are for illustrative purposes only and should be associated with the "average" disease burden in our commercial book of business. Individual customers' rates may vary significantly from those shown (above) based on higher or lower than book prevalence and individual customer program requirements

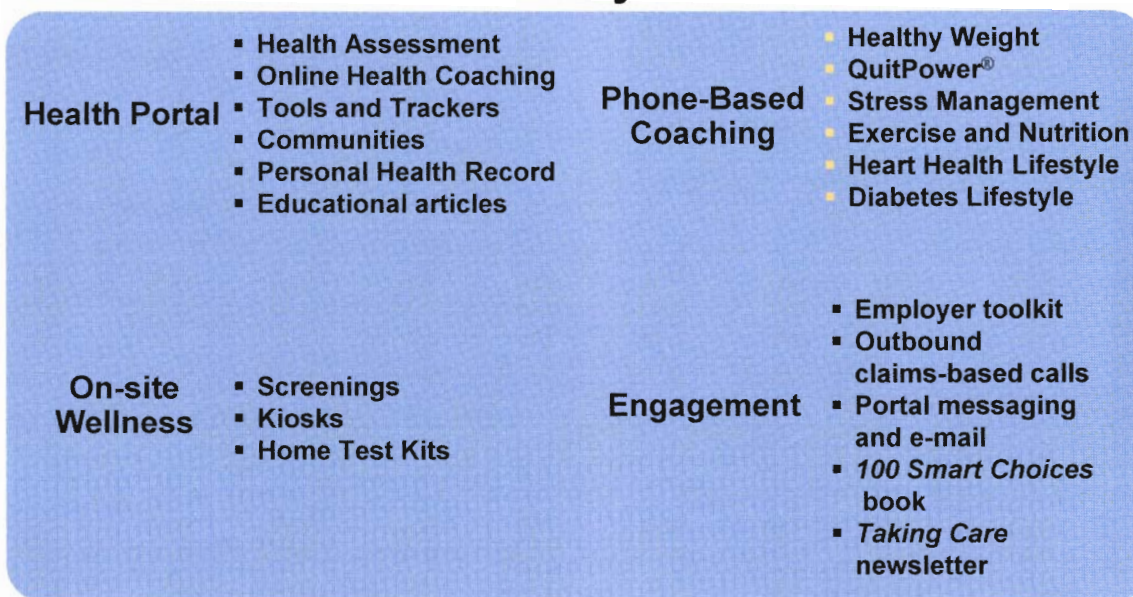
Integrated Wellness Programming



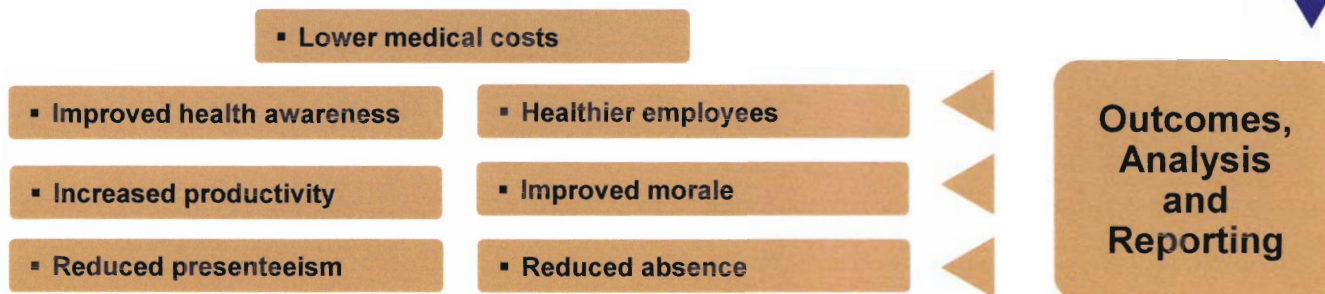
Identification



Delivery Method



Value



Promotion – Awareness – Incentives – Engagement – Health Culture Support

Focus On Service

Designated Support for Rapid Resolution



Trouble-free service supports better engagement and decisions

- **Our San Antonio Customer Care Center is dedicated exclusively to Public Sector clients**
- Overall call center satisfaction of 93.7%¹
- Over 200,000 calls handled monthly
- < 30 second ASA
- < 2% abandoned calls
- High internal and external quality performance
- First Call resolution of 96.2% (Q1 2010)
- **Claims processing located in Oldsmar, Florida**
- 100+ National account clients Serviced
- 325 Claim Processors
- 82% Auto-adjudication Rate
- 94% Claim Turn Time in 10 Business Days
- 99% Dollar Accuracy and Procedural Accuracy



Customer Care satisfaction

93% (2008) 93.7% (2009)

Strong customer care results

1. UnitedHealthcare service data, 2009

UnitedHealthcare service data, October 2009.

Focus On Service Committed to Customer Care



Experienced leadership

- Over 30 years of experience in managing Customer Care
- Seamless implementation & Dedicated Implementation Manager
- Highly experience Public Sector Account Team
 - Tom Moore – Regional VP, Sales
 - Linda Jones – Account Vice President
 - Colleen McGlamry - Strategic Account Manager
 - On Site Service Representative
- Dedicated customer care teams
- Dedicated clinical team for case management and disease management
- Dedicated Wellness Director for strategic program initiatives
- Analytics & Reporting Solutions Director



Why UnitedHealthcare? Principals of our partnership



Value



**Proven
Innovation**



Team



Commitment