

April 22, 2008

Sara R. Wilson  
Director  
Department of Human Resource Management  
Commonwealth of Virginia  
101 N. 14<sup>th</sup> Street  
James Monroe Building, 12<sup>th</sup> Floor  
Richmond, VA 23219

Dear Ms. Wilson:

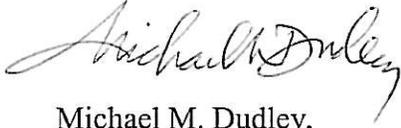
Optima Health, a service of Sentara Healthcare, is pleased to offer the Commonwealth of Virginia (COVA) an innovative proposal designed to meet COVA's goals of improving the health status of COVA employees and reducing the total costs of its spending on benefits. This proposal is in response to Public Notice HOB08-2. Our proposal is based on over 20 years of experience making clinical quality and wellness a priority in Virginia. Our solution for COVA leverages our experience in providing an integrated data repository of medical and behavior information, pharmacy utilization and health risk assessment data with our proven strategies for clinical care services and incentive-based wellness and disease management programs.

This solution will be based on aggregated data and predictive modeling to correctly identify high-risk, high-impact members and enroll them in appropriate health management programs. Optima Health has previously used predictive modeling to enroll members in appropriate health management programs, which produced sustained savings of millions of dollars for our customers. As a Virginia-based, not-for-profit health plan, Optima Health is the ideal partner to provide COVA with reliable, actionable information and to provide your employees with the services they need to improve their health.

By joining with Optima to achieve its stated goals, COVA will enjoy significant improvement in its employee's health status, satisfaction with their benefits and enhanced engagement in their work environment. Moreover, COVA will see a reduction in its cost of providing health benefits to its employees.

Optima is pleased to offer its services to COVA. We look forward to a partnership that is mutually beneficial for years to come.

Sincerely,

A handwritten signature in cursive script, appearing to read "Michael M. Dudley".

Michael M. Dudley,  
President, Optima Health

cc: The Honorable Viola O. Baskerville  
The Honorable Ansh P. Chopra  
The Honorable Marilyn P. Tavenner



## **Proprietary Disclosure Page**

Under the Virginia Freedom of Information Act, trade secrets or proprietary information submitted by an offeror are not subject to public disclosure if the offeror invokes this protection, pursuant to Section 2.2-4342 of the Code of Virginia, prior to or upon submission of the data or other materials. The offeror must identify the specific area or scope of data or other materials to be protected and state the reasons why protection is necessary.

Optima Health has created this separate proprietary exhibit to this proposal. The information and data described in this section is considered proprietary in that it would give competitors an unfair advantage over Optima Health in the general marketplace.

Optima Health calls for redaction of the following section of our proposal submission to the Commonwealth of Virginia PPEA Conceptual Proposal:

◆ III. Project Financing (pages 20-23)

Release of this information in the public realm would cause undo harm to Optima Health's competitive position and provide our competitors with unfair advantage in future competitive bidding. The underwriting data provides information that would allow others to determine how we develop premiums. All other sections provide information in regard to policies and procedures that Optima health has taken years to develop.

This information is the property of Optima Health. It may not be disclosed other than to the employees or duly authorized representatives of the Commonwealth of Virginia for the use of evaluating our proposal without the express written consent of Optima Health.

We appreciate your consideration in regard to this legal request.

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## **EXECUTIVE SUMMARY**

Optima Heath, a Service of Sentara Healthcare (Optima), is pleased to offer the Commonwealth of Virginia (COVA) an innovative proposal designed to meet COVA's goals of improving the health status of COVA employees and reducing the total cost of its spending on health benefits. This proposal is in response to Public Notice OHB08-2.

Executive Orders 42 and 55 call for achieving COVA's goals through innovative application of information technologies designed to provide COVA leadership with actionable information and total transparency of health status of its employees and cost of care provided.

Optima's proposal offers COVA the transparency it seeks through proven information technologies. Optima brings over 20 years of experience with managing large data bases of claims and clinical information, and the ability to extract and analyze the data through predictive modeling software that will provide COVA with greater insight into the health status of its employees and how to improve the health of its employees.

Optima's information technology infrastructure is designed for sophisticated analytics for population identification and segmentation for targeted clinical risk categories. Our demonstrated capability will be used to address COVA's need for and utilization of health care information.

Further, Optima's proposal offers COVA wellness and disease management programs with incentives for COVA employees to become engaged in their own health and wellbeing. Optima's programs have proven to drive down the total cost of care for a defined population.

Optima's *Mission: Health Wellness* program provides employees the opportunity to reduce their annual health premiums based on participation in appropriate interventions identified by our health risk assessment. *Mission: Health Disease Management* program provides financial incentives for employees who engage with a health coach and actively participate in evidence-based guidelines of care. Correctly identifying high-risk, high-impact members and enrolling them in appropriate health management programs has produced sustained savings of approximately 17% over a 5-year period for Optima. Optima will utilize this knowledge and experience to partner with COVA to achieve optimal results.

Optima proposes to implement its program in two phases. In Phase one, Data Aggregation and Employer Reporting, Optima will dedicate a team that will build and populate a Health Care Informatics data warehouse to include medical, behavioral health, lab, and pharmacy benefits. In Phase two, High-Touch Integrated Care Model with Expanded Employer Reporting, Optima will work with COVA to implement an integrated solution of clinical care services and *Mission: Health*, an incentive-based wellness and disease management program. This solution will be based on the aggregated data and predictive modeling developed in Phase one, to correctly identify high-risk, high-impact members and enroll them in appropriate health management programs.

Optima will create the infrastructure required to implement its proposal at no cost to COVA. By joining with Optima to achieve its stated goals, COVA employees will enjoy significant improvement in health status, satisfaction with their benefits and enhanced engagement in their work environment. Moreover, COVA will see a reduction in its cost of providing health benefits to its employees. Optima's return on its investment will follow successful achievement of the objectives.

Optima is pleased to offer its services to COVA. We look forward to a partnership that is mutually beneficial for years to come.

## INTRODUCTION

Optima Health, a service of Sentara Healthcare (Optima), is the ideal partner for the Commonwealth of Virginia (COVA). Optima's mission is to "improve health every day," and the passion behind our mission statement is what drives our team to improve the health of COVA employees every day. This translates into better control of health care costs for COVA. We are in a unique position to provide a quality health plan to COVA employees and their dependents and to work with COVA in a collaborative manner to improve both the health outcomes of COVA employees and reduce COVA's total cost of health benefits. As a Virginia-based, not-for-profit health plan, Optima has an established, well-proven information technology capability that provides for an integrated data repository of medical and behavioral health information, pharmacy utilization, and health risk assessment data. Optima's technology capability will be used to address COVA's need for reliable, actionable information which will provide COVA with increased ability to manage its total cost for health benefits.

### Situation Analysis

According to the U.S. Centers for Disease Control and the Kaiser Family Foundation, as many as 58 percent of all Virginians are overweight or obese, 23 percent do not exercise on a regular basis and an estimated 25 percent of Virginians smoke or use other tobacco products. In fact, obesity in Virginia has jumped 10 percent in just the last decade—more than any other state in the nation.<sup>1</sup> COVA employees may reflect the patterns of the general population, or they may have even higher incidents of obesity and use of tobacco products. In Virginia, lifestyle-related conditions represent about 35 percent of all inpatient hospital costs for the state employee health benefits program; 35 percent of state employees do not exercise regularly, and 20 percent smoke.<sup>2</sup>

After Medicaid, spending on state employees' health benefits is COVA's next-largest health expenditure. In 2006, COVA spent nearly \$570 million in medical, behavioral health and pharmacy costs for approximately 93,000 employees, up 5.8% from the previous year.<sup>3</sup>

To encourage state employees to get and stay healthy, the Healthy Virginians program has implemented wellness programs which include:

- Informational Programs - State employees have access to health programs, special challenges, and other fun health-related initiatives.
- CommonHealth also provides onsite bi-annual health checks which tests an employee's blood pressure, cholesterol and blood glucose.
- Walk 15. State employees are encouraged to use a daily 15-minute break for walking or other exercise.
- Free Online Tracking of Health Routines. State employees are encouraged to participate in the America on the Move™ walking program so they can record individual daily walk and exercise routines at [www.americaonthemove.org](http://www.americaonthemove.org).<sup>4</sup>

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<sup>1</sup> Healthy Virginians Web site, <http://www.healthyvirginians.virginia.gov>.

<sup>2</sup> National Governors Association Center for Best Practices, "State Employee Wellness Initiatives," Issue brief 5/18/05.

<sup>3</sup> Commonwealth of Virginia's Health Benefits Program 2006 Annual Report.

Governor Kaine’s Executive Orders 42 and 55 direct COVA leadership to identify areas where health information technology can lower health care costs for COVA as an employer and health insurer and demonstrate its commitment to health care accountability and transparency. Despite significant wellness programs and initiatives, COVA is still experiencing rising healthcare costs.

COVA is concerned about the annual amount of healthcare expenditures for its employees and striving to minimize the rate at which expenditures are increasing or, better yet, to decrease its healthcare spend. COVA has indicated that a contributing factor in its ability to manage employee healthcare costs more effectively is a lack of information, data analysis and actionable recommendations to help COVA’s leadership understand the drivers behind the healthcare spend. A detailed understanding of the cost drivers is critical in developing a healthy solution to manage costs.

Optima is the ideal partner for COVA to work with to address this problem. Optima has well-established, well proven information technology capabilities that provide for an integrated data repository of medical and behavior information, pharmacy utilization, and health risk assessment data. Optima is also a proven leader in partnering with large employers in the development and implementation of incentive-based programs and providing integrated clinical care services that successfully encourage employees to engage in healthy lifestyles.

Our mission at Optima is to “improve health every day” and the passion behind our mission statement is what drives our team to improve the health of COVA’s employees every day—which translates into better controlled healthcare costs. Optima is in a unique position to provide a quality health solution for COVA employees and to work with COVA in a consultative manner to ensure that we meet your needs. We have extensive experience in managing the healthcare needs of municipal customers. As an organization, we are very skilled, dedicated and able today to provide the services as described within our proposal.

#### Optima’s Solution

Optima’s solution consists of two phases:

Phase I – Data Aggregation and Employer Reporting, in which an Optima team of professionals will be dedicated to COVA to build and populate a Health Care Informatics data warehouse to include medical, behavioral health, lab, and pharmacy utilization.

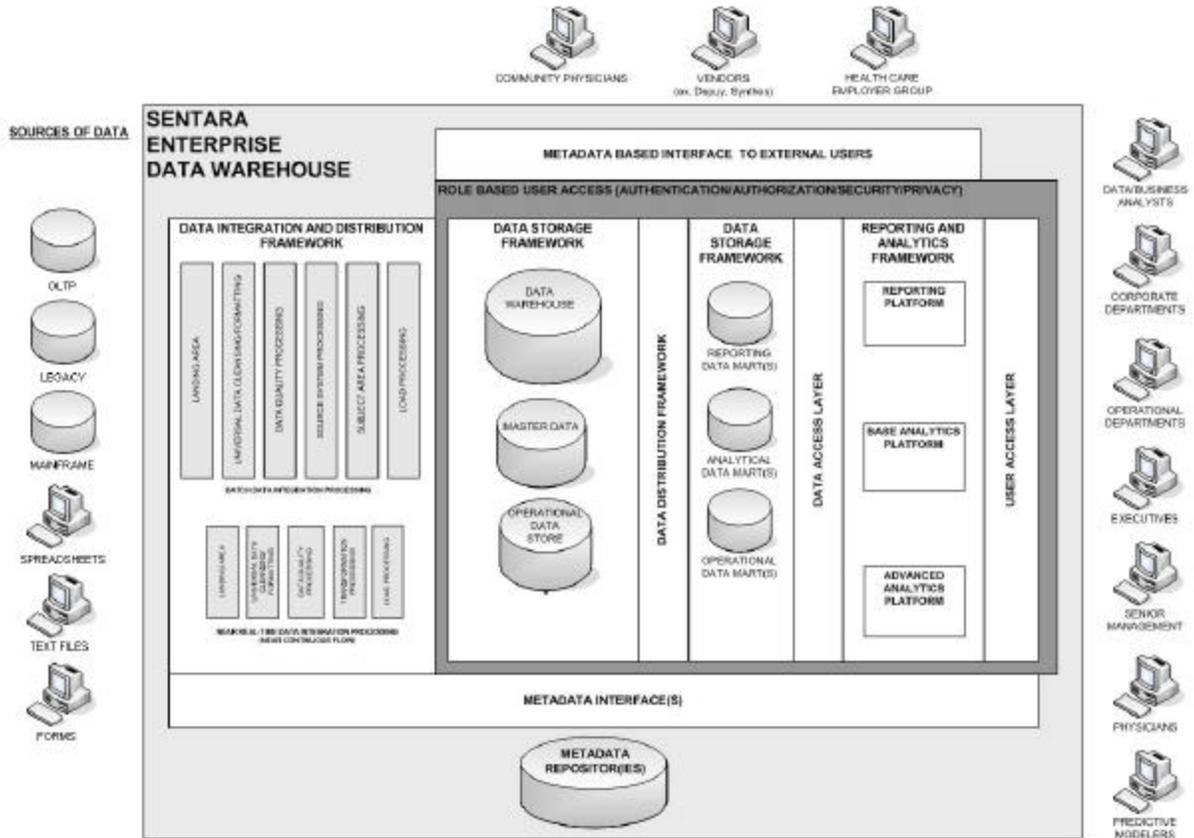
Phase II – High-Touch Integrated Care Model with Expanded Employer Reporting, an integrated solution of clinical care services and incentive-based wellness and disease management program for COVA employees, based on aggregated data and predictive modeling to correctly identify high-risk, high-impact members and enrolling them in appropriate health management programs.

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<sup>4</sup> Healthy Virginians Web site, “Healthy Employees,”  
<http://www.healthyvirginians.virginia.gov/Employees/index.cfm>

The foundation of Phase I of Optima’s proposal is an integrated data repository of medical and behavior health information, lab, and pharmacy utilization. Our established, well documented health information technology provides a robust platform for a unified view of medical history via our secure web portal. Optima’s Health Performance Modeling Analytic Technology is structured for sophisticated analytics for population identification and segmentation of targeted clinical risk categories. Targeting the right population segment with the right interventional strategy is the key to enabling COVA to manage its costs.

**Figure 1**  
**Application Technology Visual Representation**



Optima’s existing repository provides a rich data source for predictive modeling capabilities designed by Optima’s Clinical and Business Intelligence (CBI) division as illustrated above in Figure 1. The predictive capabilities provide a unique approach to identifying new health management outreach programs to engage members earlier to encourage adoption of healthy lifestyles and early prevention opportunities. The analytic toolset, linked together with experienced Health Data Analysts, ensures that, working collaboratively with COVA, we will effectively impact utilization, quality, and health management for COVA’s employees and their dependents.

The aggregated data collected and analyzed in Phase I will be the basis for recommendations that lead to clinical improvement, improved compliance and improved quality for COVA's health benefits program.

During Phase II, Optima will implement an integrated solution of clinical care services and *Mission: Health*, an incentive-based wellness and disease management programs. This solution will be based on the aggregated data and predictive modeling activities resulting from Phase I activities; correctly identifying high-risk, high-impact members and enrolling them in appropriate health management programs.

Outcomes of our proposed collaborative initiative would offer COVA:

- An opportunity to share in profits; we believe this is fully in the spirit of the Public-Private Education Facilities and Infrastructure Act (PPEA)
- A significant savings opportunity for COVA
- An opportunity to offer Optima's Incentive Based Programs to help change behavior of members in the higher risk categories
- Financial commitment from Optima related to our ability to deliver actionable information to COVA leadership as well as disease management programs
- Several Health and Wellness programs, such as, WalkAbout exercise program, self-paced individual wellness programs, continuous direct mail reminders, educational material including Healthwise Handbook, on-site classroom sessions, wellness coordinator training
- Quarterly Clinical Consultation
- Internet resources for members and benefit administrators

Optima's established, well-proven health information technology capabilities and proven approach to clinical care services are well aligned with Executive Orders 42 and 55 and position Optima as a unique partner for COVA. As a result of Optima's innovative integrated approach, there will be higher employee and dependent satisfaction for COVA, improved health status and more affordable health care.

#### Rationale for Our Approach

The need for integrated, coordinated care is well documented. Virginians are living longer due, in part, to advances in medical science and technology, and with an aging population comes increased prevalence of chronic illness. Conditions such as heart disease, diabetes and respiratory illness are now the leading cause of death and disability.<sup>5</sup> Additionally, research indicates that 25% to 40% of outpatient populations have a co-occurring mood, anxiety, somatoform, eating, or alcohol-related disorders<sup>6</sup>. To insure efficacy in the management of such conditions, a multidisciplinary infrastructure is needed to provide a full complement of services.

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<sup>5</sup> Institute of Medicine; Committee on Quality of Healthcare in America. Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century. National Academy Press: 2001.

<sup>6</sup> Kathol, R., Saravay, S., Lobo, A., Ormel, J., Epidemiologic Trends and Costs of Fragmentation. *Med Clin N Am* 90 (2006) 549-572.

The Institute of Medicine recommends patient-centric care, in which support, education and practical skills for success are delivered in a variety of methodologies to impact patient development of good self-management techniques. The cornerstones of patient-centric care are at the core of Optima's Integrated Clinical Care Services Delivery model which include enhanced patient disease self-management, organized delivery system build on evidenced-based support for clinical decisions, secure, user-friendly information technology, and links to community support groups<sup>7</sup>. Quality Improvement activities are employed utilizing the Best Clinical and Administrative Practices (BCAP) Quality Framework<sup>8</sup>, allowing Optima to frequent and consistent evaluation of the ways in which we identify, stratify, outreach, and intervene with our members.

Optima uses predictive modeling to enroll members in appropriate health management programs which produced sustained savings of approximately \$7 million.<sup>9</sup> We will utilize this expertise to identify opportunities for improvement in health and financial outcomes for COVA and its employees.

#### Optima's Organization and Qualifications

For more than 20 years, Optima has made clinical quality and wellness a priority. Our innovative and integrated approach will maximize the value of COVA's health care dollar. Through our efforts, COVA employees will receive best-in-class service and coverage as well as access to numerous programs and discounts that will help guide them toward better health.

Optima Health, a service of [Sentara Healthcare](#), serves more than 355,000 members throughout the state of Virginia, of which 130,000 are Medicaid beneficiaries. Optima offers a full range of high-value commercial health plans including HMO, POS and PPO plans, plus a consumer-driven FourSight<sup>®</sup> plan for small to medium-sized businesses. Approximately 700,000 people are enrolled in the statewide plan for behavioral health services and employee assistance programs.

Optima was named 23<sup>rd</sup> among the top 25 Medicaid managed care programs in 2006 in the first national ranking of health plans by *U.S. News & World Report*. In 2007, Optima remained in the top 25 Medicaid managed care programs and was ranked in the top 50 Best Commercial plans.<sup>7</sup> The rankings are based on a review of 680 health plans, placing Optima among the top 10% of health plans in the nation based on clinical quality, member satisfaction and National Committee for Quality Assurance (NCQA) accreditation scores. Optima offers services that are comparable to large, national health insurance plans. Our recent ranking as the #1 health plan in Virginia by U.S. News & World Report and NCQA "Excellent" accreditation illustrate our commitment to being a high quality provider of health benefits and health information.

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<sup>7</sup> Arvantes, J., "Patient-Centered Medical Home Is Key to Health Care".  
<http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20070514kmantestimony.html>

<sup>8</sup> Center for Health Care Strategies Inc. "A Guide to the BCAP Quality Framework". June 2006

<sup>9</sup> Zimbro, K.S., Mountie, T.W., Addauan-Anderson, C., Bray, K.J., Ingram, B., Rutledge, C.M., "Predictive Modeling: Turning Predictions into Measurable Results." (Pending Publication).

Optima's unique advantage lies in its relationship with Sentara Healthcare, a nationally recognized, integrated healthcare delivery system headquartered in Norfolk, Virginia. Sentara is consistently ranked among the nation's top integrated health care networks by Modern Healthcare. Our focus spans the entire spectrum of care - from preventative and maintenance services to disease and medical management. Optima's vision is to provide services that surpass many of the national and larger managed care organizations by bridging the gap between our services and how they impact healthcare at the local level. We work with local physician partners and providers to know the membership intimately. We strive to provide the highest quality service to our business partners and our members with programs that have been designed to address health needs and customer service to ensure the highest level of satisfaction. Our physician leadership within Optima administration and our Board of Directors provides valuable perspective for the importance of effectively managing chronic conditions using evidence-based and documented methodologies. Underscoring our commitment to customer service, Optima was recently awarded the 2006/07 Customer Care Award by the National Research Corporation (NRC). This annual survey of over 200,000 households across the nation asks consumers to rank health plans. NRC then awards the top health plan for each state.

We believe the most effective strategy for improving health is a collaborative approach. By working together with our customers, Optima members receive the best chance for a healthy lifestyle. A key component of this strategy centers on a strong health and prevention agenda. Optima serves as a resource for our employers to help educate and empower members to make healthy lifestyle choices that keep them well or help them effectively manage their health for optimum quality of life. We provide analysis and support for a number of programs and services, in addition to on-site subject matter experts to support a good working relationship on an ongoing basis.

Organizational components and the key personnel of our organization that will be involved in our proposed solution are described below.

- *Optima* is the health plan division of Sentara Healthcare. Serving 355,000 members in Virginia, Optima Health Plan provider network consists of nearly 15,000 providers and 43 hospitals. For nine consecutive years, Optima has received the highest level of accreditation – Excellent – from the National Committee for Quality Assurance. Optima Health Plan currently offers a variety of commercial health plans including PPO, HMO, POS and HSA/HDHP plans. In addition, Optima offers a Medicaid HMO and a Medicare PPO.
- *Clinical and Business Intelligence (CBI) Division* transforms the volume of data Optima collects and stores into actionable information that can be used in day-to-day activities. Actionable information in accessible reports and analysis gives Optima decision-makers a 360-degree view of all company operations, enabling better and timelier clinical and business decisions. CBI delivers this actionable information through comprehensive, fully integrated clinical and business intelligence solution sets. They also ensure that these solution sets provide the same consistent set of facts,

regardless of which department is using them. More importantly, CBI provides the means to understand the “why” behind clinical and business performance.

- *Michael M. Dudley, President and CEO of Optima:* Prior to joining Optima in 1996, Mr. Dudley served as President of Kaiser Permanente Insurance Company, President of the Northeast Region of Kaiser Permanente in Hartford Connecticut, and President of Kaiser’s Vallejo Medical Center in California. He earned his bachelor’s degree from Brigham Young University and his master’s degree of health administration from the University of Colorado where he was Class Valedictorian and recipient of the Foster G. McGaw Scholarship. He completed Stanford University’s executive management program and is a Fellow of the American College of Health Care Executives. Mr. Dudley serves as a Director on the Boards of America’s Health Insurance Plans (AHIP) – the nation’s principal association of health plans and insurance companies, the Virginia Association of Health Plans, the Preferred Health Partnership in Knoxville, Tennessee, and the Hampton Roads Chamber of Commerce.
- *Darleen S. Anderson, Senior Vice President and Chief Operating Officer:* Ms. Anderson has been with the Sentara Healthcare system for 30 years in a variety of staff, management, and executive administrative positions. She has been a Vice President for hospital services since 1992. Key areas of operational responsibility included surgical services, imaging services, neurosciences, cancer services, emergency services, and liaison to EVMS for Graduate Medical Education Coordination. Prior to joining Optima, Ms. Anderson served as the Vice President and Site Administrator of Sentara Norfolk General Hospital. She earned her bachelor’s degree from Old Dominion University in Norfolk, Virginia, graduating Magna Cum Laude, and her master’s degree in Advanced Adult Nursing and Administration from Hampton University in Hampton, Virginia, completing her thesis research on air-ambulance transport of trauma victims. In support of the Trauma Services and Trauma Center Program, Ms. Anderson served on Virginia State EMS Advisory Board, representing the Virginia Hospital Association from 1992 to 1999. She also served on Tidewater EMS Board of Directors from 1992 to 2004, representing the Regional Council of Hospitals (VHHA).
- *George K. Heuser, MD, CHIE - Vice President, Senior Medical Director:* Dr. Heuser is a native of Virginia Beach and returned to attend medical school in Norfolk after his undergraduate education in Chemical Engineering at the University of Virginia. He attended the Eastern Virginia School of Medicine, and remained there for his internship and residency. He is Board Certified in Internal Medicine. Dr. Heuser began his career with the Veterans Affairs Medical Center in Hampton, VA. There, he developed his interest in Quality Improvement and administrative medicine. While at the VA, he filled the positions of Chief, Spinal Cord Injury Unit and Associate Chief of Staff for Ambulatory Care. He joined Sentara in 1998, spending three years as the Medical Director for Sentara Hampton General Hospital. Currently, R. Heuser is the Vice President and Senior Medical Director for Optima, with programmatic and oversight responsibility for all clinical programs.

- John E. DeGruttola, Senior Vice President for Sales and Marketing:* Mr. DeGruttola has over 22 years of experience in healthcare consulting, sales, marketing, advertising, product development and health plan operations. He earned a bachelor's of science degree from Westminister College, Pennsylvania. Prior to joining Optima Health Plans in December 2006, Mr. DeGruttola was the Central Ohio Executive Leader for UnitedHealthcare. He was responsible for the sales and retention of the small and large group markets. Other prior experiences include various healthcare management positions with Highmark Blue Cross Blue Shield, UPMC Health Plan, and Towers Perrin in Pittsburgh, Pennsylvania. Mr. DeGruttola is responsible for the overall growth of Optima Health. His primary focus is the strategic positioning of Optima Health to include identifying, developing, promoting, and distributing new products and services that produce overall profitable growth.
- Natalie Kaszubowski, MBA, Vice President of Information Services:* Ms. Kaszubowski's responsibilities include managing highly motivated technical and management teams with responsibilities including application development and support for hospital billing and registration, Health Information Services, Financial Services (AP, AR, GL), Human Resources, Materials Management, Systems Integration, Physician Information Services (both owned and community based), Long Term Care, Optima Health Plan, Homecare, and other outpatient related services. In addition, Ms. Kaszubowski is responsible for setting and executing Sentara's web presence and enterprise-wide data strategy. The technologies implemented within Optima Healthcare have been nationally recognized as being innovative and leading edge. Ms. Kaszubowski has over twenty years of experience in managing highly complex technology applications and services. She holds a BS Degree in Industrial & Operations Engineering from The College of Engineering at The University of Michigan, and is currently completing her Masters in Business administration for Old Dominion University.
- Kathie S. Zimbro, Ph.D., R.N., Director of Clinical & Business Intelligence:* Dr. Zimbro leads Optima in planning and implementing enterprise wide information systems to enable both distributed and centralized business and clinical intelligence. She provides technology vision and leadership for developing and implementing information-engineering initiatives that improve clinical and business intelligence, health care service quality, and business development in a rapidly changing, competitive marketplace. Her designs improve integrity of system-wide data repositories for Optima and improve validity and reliability of information assets. She has over 32 years experience in health care and is a certified Six Sigma Black Belt through the Juran Institute. Dr. Zimbro serves as an Adjunct Associate Professor for the College of Health Sciences, Old Dominion University and has published extensively in the area of the use of performance measures in hospitals, physician offices, and managed care settings.

## Organizational Experience

*Information Technology:* Optima's information technology is the result of our 15 year investment in the development of internal performance improvement initiatives. In concert with the Clinical and Business Intelligence (CBI) division, we utilize our information technology capabilities to drive results in its health plan and hospitals. Our infrastructure was built over time, with the addition of staff and technology to focus on quality, safety, length of stay, complications, and financial improvement. In addition, Optima cultivated partnerships with select software firms to develop unique reporting tools and proprietary information databases to enable performance improvement. At the same time, Optima staff have become knowledgeable and experienced at applying these tools. The combination of these skills makes Optima the ideal choice to partner with COVA in performance and quality improvement initiatives.

*Clinical and Business Intelligence (CBI)* – In 1996, Optima chose Risk Navigator Clinical (RNC), provided by MEDai, as our predictive modeling solution. MEDai's predictive modeling process, using artificial intelligence (AI), is relatively new in the healthcare industry<sup>10</sup>. Data used by MEDai's neural net models are more comprehensive than data elements used by rules-based models. The Intelligent Data Cleanup<sup>®</sup> process eliminates noise and misleading data from the member population before forecasts are made. The neural net technology provides strong, precise statistical modeling turning forecasts into measurable results. Through continuous data review, Optima has learned that RNC provides a proactive approach to maximizing the match between available health management resources and provider community to meet needs identified for at-risk populations with actionable disease states.

Over the past six years, the Clinical and Business Intelligence (CBI) division has demonstrated that the RNC model is empirically sound and provides accurate forecasts. Analysis of our predictive model enables Optima to look beyond traditional return on investment criteria to empirically measure RNC's contribution to business effectiveness. Specifically, RNC provides a proactive approach to identifying members at-risk for high health resource use. Optima is able to a) accurately predict high-users, b) identify cost drivers, c) forecast future costs, d) evaluate utilization patterns over time, and e) improve outcomes. Information derived from the RNC model is used in business scorecards. These scorecards currently offer employer groups and Virginia Medicaid an understanding of the overall health risk of their beneficiaries.

*Integrated Clinical Care Health Services* - Optima's many health management programs underlie the organization's focus on teaching its members how to manage chronic diseases. The methods used to identify the "right" members at the "right" time and place them in the "right" health management programs have become more exact over the last ten years through the health plan's use of predictive modeling. This practice is becoming more widely used in the health plan community as an effective way to more accurately predict and to manage large segments of health care consumers.

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<sup>10</sup> Axelrod, R.C. & Vogel, D. Predictive modeling in health plans. *Disease Management Health Outcomes* 2003;11(12),779-787.

Our strong clinical focus is evidenced by our continued recognition by the Disease Management Association of America. Most recently, in December 2006, we were recognized as the Outstanding Medicaid Disease Management Program for our Sickle Cell Disease Management Program. This award recognizes excellence in the design, development, implementation and operation of a disease management program resulting in measurable, favorable outcomes, and the demonstration of a unique level of leadership and innovation in the industry. Additionally, Optima has won awards from the Disease Management Association of America (DMAA) for its LifeCoach Diabetes management program and Partners in Pregnancy, a program to help women with high-risk pregnancies achieve full-term healthy babies. Optima has also won a national award from the Environmental Protection Agency for Asthma management in people's homes.

In 2005 (the last year for which complete data are available) Optima's disease management programs for asthma, diabetes and pregnancy demonstrated significant impact on the health of our members. By providing programs to coach members toward better health, Optima documented reductions in Emergency Department visits and hospitalizations for asthma and diabetes patients. Our Partners in Pregnancy program helped lead to a decrease of NICU admits per 100 babies born from 11.5 to 10.4.

### **PROJECT CHARACTERISTICS**

The foundation of the proposed analytics platform is an established, well-proven data repository of medical and behavioral health information, pharmacy utilization, lab values, and health risk assessment data, which is required to incorporate self reported medical information from a personal health record. This integrated information provides a robust platform for a unified view of medical history via our secure web portal. The same infrastructure is designed for sophisticated analytics for population identification and segmentation for targeted clinical risk categories. Our Health Performance Modeling Analytic Technology is structured for sophisticated analytics for population identification and segmentation of targeted clinical risk categories. Targeting the right population segment with the right interventional strategy is the key to enabling COVA to manage its costs.

Optima's existing data repository provides a rich data source for predictive modeling capabilities designed by Sentara's Clinical and Business Intelligence (CBI) division. The predictive capabilities provide a unique approach to identifying new health management outreach programs to engage members earlier to encourage adoption of healthy lifestyles and early prevention opportunities. The analytic toolset, linked together with experienced Health Data Analysts, ensures that, working collaboratively with COVA, we will effectively impact utilization, quality, and health management for COVA's employees and their dependents.

Our proposal consists of two phases: Phase I – Data Aggregation and Employer Reporting, and Phase II – High-Touch Integrated Care Model with Expanded Employer Reporting.

Phase I – Data Aggregation and Employer Reporting (July 1 – June 30, 2009): In Phase I of our proposed project, a team of Optima professionals will be dedicated to COVA to build

and populate for COVA a Healthcare Informatics data warehouse to include medical, behavioral health lab, values and pharmacy utilization.

*Orientation and System Overview:* Optima leadership and staff will work with COVA staff throughout the initial orientation and product overview. During orientation, we will describe our extensive first-hand experience with the processes used to drive significant improvements in cost structure, quality, and safety of performance improvement. Optima staff will collaborate with COVA's staff on successful methods to establish an internal reporting structure, develop a culture of accountability, plan for success, and celebrate milestones. The initial orientation will focus on the processes and infrastructure needed to maximize results for COVA.

In addition, we will describe the Health Performance Modeling Analytic Technology product portfolio during the orientation session. The portfolio consists of three components and is based on a progressive approach designed to maximize client understanding, implementation, effectiveness, and results. Optima staff will review each component of the portfolio with COVA staff and provide a high level description of the tools used to achieve results and examples of findings from our extensive experience. To help COVA staff better understand technical requirements, key Optima technical personnel will be available to discuss interfaces and data requirements, data base products, and Web access tools to ensure a smooth implementation.

*Performance Review and Data Model Development:* Optima will collaboratively work with COVA and their business partners to define data requirements and will complete a defined implementation plan within 60 days of project approval. We will then begin work according to the identified project milestones to build COVA Health Performance Modeling Analytics Technology data structures. The actual implementation is anticipated to be 120-180 days in duration, and will be structured to include dedicated personnel to:

- Develop and manage project plan and milestones
- Complete a comprehensive file specification document
- Review data validation and re-fresh recommendation
- Identify test plans and verification processes

Working in conjunction with COVA staff, Optima staff will conduct a review of COVA's base (5 year) performance data. This will be accomplished utilizing the three components of our Health Performance Modeling Analytics Technology and the extensive experience of our Clinical and Business Information (CBI) division.

- Data Transfer and Staging will be accomplished through our industry-standard secured file transfer protocol (FTP) service. This will involve operational processing of data transmissions which are then moved into a staging area. The staging will serve as a holding place for validation of complete transmissions and error handling. From the staging area, the ETL (Extraction, Translation, and Load) processes will be run to map and tag data based on COVA-defined business rules. The data will process through person-identity management algorithms to ensure accurate aggregation of disparate data sources.

- Data Aggregation and Analysis will involve loading data into a data repository at which time clinical tagging, segmentation and modeling analytics will be performed. At this point, predictive modeling and trending algorithms will be applied for creation of targeted data cubes.
- Data Presentation and Collaboration will involve utilization of a secure portal by which COVA will access their transformed data. The portal will allow for a sophisticated data presentation, as well as collaboration between Optima and COVA staff. Additional capabilities will include automated notification and alerts for secure e-mail transmissions.

The proposed Health Performance Modeling Analytics Technology platform will be supported by Optima's robust, well-established technology infrastructure and sophisticated call center technology. Staffed 24 hours 7 days a week, our centralized computer facility ensures high availability via built in redundancy, automated alerting, and failover technology. To further ensure high availability, Optima has developed a disaster recovery hot-site, tested annually with a full execution of the disaster recovery policies to ensure timeliness and accuracy of recovery goals. High speed wide-area network service provides secure access to all remote business locations. Redundant Internet Service access and firewall design enable secure transactions for employees, patients, physician, and members authorized access to their information. And Optima's infrastructure is architected to ensure secure and monitored access to appropriate systems and data by only authenticated and authorized users. A fully established Information Security Office works directly with our Chief Privacy Officer to manage Protected Health Information.

Phase I Deliverables will consist of information in the form of an Employer Group Report, a sample of which is included in the Appendix. A Clinical Consultation will also be provided.

The aggregated data collected and analyzed in Phase I will be the basis for recommendations that lead to clinical improvement, improved compliance and improved quality for COVA's health benefits program.

Phase II: High-Touch Integrated Care Model with Expanded Employer Reporting – (beginning July 1, 2009): In Phase II of our proposed activities, Optima will implement an integrated solution of clinical care services and *Mission: Health*, incentive-based wellness and disease management programs. This solution will be based on aggregated data and predictive modeling to correctly identify high-risk, high-impact members and enrolling them in appropriate health management programs. Optima has previously used predictive modeling to enroll members in appropriate health management programs which produced sustained savings of approximately \$7 million.<sup>11</sup> Optima will utilize our expertise to identify opportunities for improvement in health and financial outcomes for COVA and its employees.

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<sup>11</sup> Zimbardo, K.S., Mountie, T.W., Addaun-Anderson, C., Bray, K.J., Ingram, B., Rutledge, C.M., "Predictive Modeling: Turning Predictions into Measurable Results."

At the heart of Optima’s Clinical Care Services Integrated Delivery Model (Figure 2) are the clinicians – nurses, licensed professional counselors and social workers – who are co-located to allow them to manage members in an organized, cross-trained team focus.

**Figure 2**



This means that a member with diabetes and asthma does not have two different case managers. One case manager coordinates all elements of the members health needs. Supporting the clinical staff are Patient Service Coordinators (PSC), who are non-clinicians with training in supporting member behavior change. The PSC helps the member to develop action plans that are achievable to support better self-management of chronic or acute illness.

Clinical Care Services is closely aligned with Health & Prevention and Pharmacy services to insure that medication compliance is achieved, and to communicate and transition to a clinician any member who may have a health risk identified at a screening. Finally, Optima’s Quality Improvement department supports clinical teams to evaluate continuous improvement of the Plan-Do-Check-Act cycles of continuous quality improvement, and the Clinical & Business Intelligence (CBI) department assesses the program on a regular basis to measure clinical and financial success. This model also allows us to offer comprehensive incentive programs to employer groups who wish to offer financial incentives to members for following physician orders, taking medication appropriately, and meeting the evidence-based testing guidelines that can prevent or reduce the burden of chronic illness.

Implementation of Optima’s proposed integrated Clinical Care Services delivery model will involve activities in five categories as illustrated in Figure 3. Description of the model is described below.

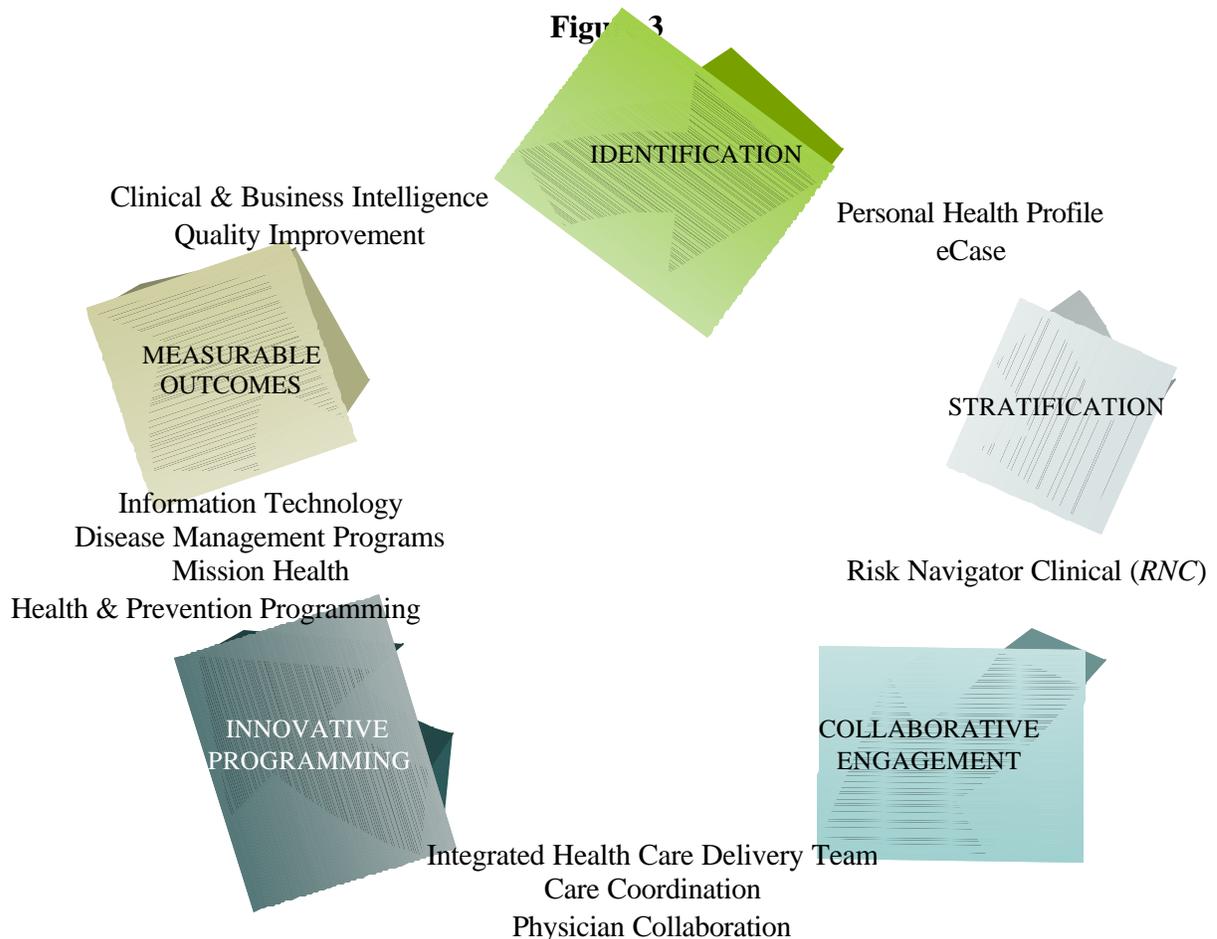
### Identification

The foundation of Optima’s integrated Clinical Care Services delivery model is the development of a health risk appraisal – the Personal Health Profile (PHP) – for each member. Supporting the model is an internally developed clinical record system called eCase.

- *Personal Health Profile:* The initial Personal Health Profile (PHP) assesses member risk status in the areas of biometrics, laboratory results, lifestyle habits, health status and management, chronic conditions, and future disease risk. Members are provided

a report indicating their results, assessed risk level, and national clinical targets for each measure. Subsequent PHP updates allow members to track changes in assessment measures in each category. PHP data populate the clinical database to identify members for targeted programs.

- *eCase*: eCase draws information from claims, lab, pharmacy and authorization data, and functions as an integrated care management documentation system. All clinical staff use eCase to document contacts and interactions with members. A health assessment is completed upon establishing a relationship with the member, and this assessment is updated as necessary to develop a care management plan that includes goals and timelines. Productivity and quality standards are built into the system to insure that members receive appropriate care based on established guidelines and policies.



### Stratification

Optima's uses Risk Navigator Clinical (*RNC*), provided by MEDai, as our predictive modeling solution. *RNC* allows for a proactive approach to identifying members at-risk for high health resource use. To accomplish correct member classification, Optima's predictive modeling experiences have identified five health risk profile categories:

- "Well Members" members have the least risks for developing chronic disease and the best chance for living a healthy life. This group generally makes up 50% of a large population, and accounts for 10% of health care costs.
- "Low Risk" members have some risks for developing chronic disease, but are generally healthy. This group generally makes up 20% of a large population and accounts for 10% of health care costs.
- "Moderate Risk" members may have already developed early chronic illness states, and probably have more than one risk factor. This group generally makes up 25% of a large population and accounts for 25% of health care costs.
- "High Risk, Multiple Diseases" members are at significant risk for developing chronic disease, and may already have done so. They are also likely to have multiple risk factors leading to progression of chronic illness. This group generally makes up 4% of a large population and accounts for 30% of health care costs.
- "Complex and Intensive Care" members have significant illness burden. They generally have multiple disease states, which may rise to a catastrophic level. This group generally makes up 1% of a large population, and accounts for 25% of health care costs.

*RNC* will support COVA's efforts to a) accurately predict high-users, b) identify cost drivers, c) forecast future costs, d) evaluate utilization patterns over time, and e) improve health and financial outcomes.

Collaborative Engagement - Optima's collaborative engagement activities are grounded in the Transtheoretical Model of intentional change theory, working with people 'where they are' in all aspects of their life. This allows staff to assist members in formulating effective plans for their health management and wellness. All activities are implemented by Integrated Health Care Delivery teams comprised of a Health Coach and clinical staff members from medical care management, behavioral health and disease management. Health Coaches are trained to help members navigate complex health systems and to provide education on practical skills to improve personal health behaviors. Team members undergo cross training regarding their various competencies, and, as they are co-located within work units, can easily interact and communicate within the team to discuss and solve member issues. This allows Optima to assign each member only one clinical resource, thus solving the problem of fractured and disjointed care as multiple specialty case managers interact with the member in a disease-centric model. Our model is member-centric, and allows the team to move beyond focusing on the condition or illness to focus on the individual needs of the member.

Care Coordination case management services are provided to members who have patterns of high utilization or utilization that could be provided more efficiently in another setting. Optima's technology allows us to identify members with specific patterns of care, cost or

predicted exacerbation to assign the appropriate support staff. These staff identify needs of the member and the provider and coordinate and facilitate communication to optimize outcomes of care. In addition to acute care coordination, Optima provides high quality disease management programs for chronic-illness populations.

Recognizing that the success of patient-centered, integrated programming depends in large part on becoming a partner in care with the practicing physician, Optima team members are familiar with practicing in a provider-based organization, and have a history of developing strong partnerships with providers. Our staff will work collaboratively with COVA's physician providers to maintain good will and communication which translates into a model of care that facilitates best practices.

Innovative Programming – As previously noted, Optima offers a comprehensive list of health management strategies and resources. We believe that our greatest strength is the integrated provision of information and services by a strong team of clinicians committed to working with members and care providers to improve the quality and cost of healthcare delivery to our members. Programming that would be available to COVA employees and their dependents would include Asthma Disease Management, Cardiovascular Disease Management, COPD Disease Management, Diabetes Disease Management, Partners in Pregnancy. Health and Prevention programming would also be provided to all employees and their dependents including Health Publications, Patient Identification Reminders computer-based direct mail programming, Health Edge Planning magazine, Healthy Pregnancy Self-Care Handbook, and Health Programming offerings such as Get Off Your Butt: Stay Smokeless for Life; Healthy Hear Education and Support, Eating for Life, WalkAbout with Healthy Edge, Flu Patrol, Healthy Heart Express, and Healthy Heart Yoga.

In addition to the programs listed above, Optima's comprehensive wellness and disease management incentive program would also be made available to COVA employees.

*Mission: Health* contains two coordinated programs. *Mission: Health Wellness*, is a wellness program in which employees who participate would be eligible to receive a reduction their annual premiums. *Mission: Health Disease Management*, would be available to employees with any of three conditions: diabetes, coronary artery disease or congestive heart failure. In this program, the employees who actively engage with a health coach, follow evidence-based guidelines of care for physician follow up and testing, and meet medication adherence criteria can receive financial rewards into a Flexible Spending Account or Health Savings Account to help offset the costs of managing their chronic illness.

#### Measurable Outcomes

Optima takes our program metrics and evaluation very seriously. As described in Phase I of our proposal, we have developed a rigorous evaluation methodology using predictive modeling software to evaluate whether the right people were being identified for programs, and whether those programs were effective. Our model demonstrates that we are able to accurately identify high-risk, high-impact individuals and populations and target our programs and interventions. And, those accurate predictions can be traced to the bottom-line through improved management, more focused programs, and better resource decisions. Correctly identifying high-risk, high-impact members and enrolling them in appropriate

health management programs has produced sustained savings of approximately 17% over a 5-year period for Optima. We are committing to utilizing our knowledge and experience to work collaboratively with COVA to attain optimal results.

**PROJECT FINANCING**

REDACTED

Establishing the Baseline

REDACTED

Phase I Financing: Data Aggregation and Employer Reporting

REDACTED

Phase II Financing: High Touch Integrated Care Model with Expanded Employer Reporting

REDACTED

Reward-sharing Arrangement

REDACTED



Charge Structure

REDACTED

Settlement and Payments

REDACTED

Requirements of COVA

REDACTED

Termination/Separation Options

REDACTED

## **PROJECT BENEFITS AND COMPATIBILITY**

For more than 20 years, Optima has made clinical quality and wellness a priority. Our innovative and integrated approach maximizes the value of COVA's health care dollar. Through Optima's aligned efforts, COVA employees will receive best-in-class service and coverage as well as access to numerous programs and discounts that will help guide them toward better health. Optima offers services that are comparable to large industry providers, while bringing the benefit of a local company with intimate knowledge of Virginians and the needs of COVA. In addition to helping COVA manage its healthcare costs, an equally important objective will be achieved: Keeping state employees healthy.

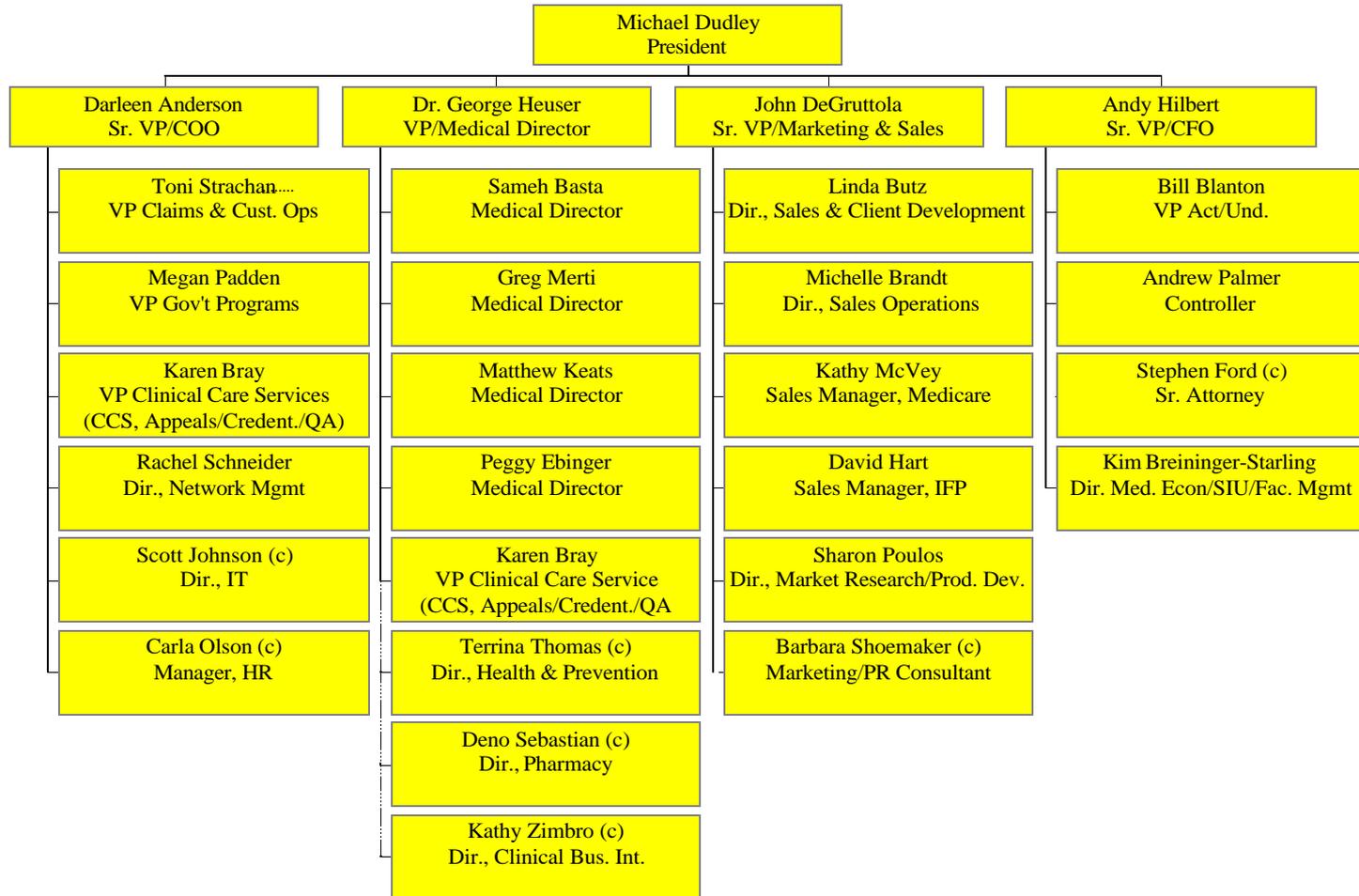
Outcomes of our proposed collaborative initiative would offer COVA:

- An opportunity to share in profits; we believe this is fully in the spirit of the Public-Private Education Facilities and Infrastructure Act (PPEA).
- A significant savings opportunity for COVA
- An opportunity to offer Optima's Incentive Based Programs to help change behavior of members in the higher risk health categories
- Financial commitment from Optima related to our ability to deliver actionable information to COVA leadership as well as disease management programs
- Several Health and Wellness programs, such as, WalkAbout exercise program, self-paced individual wellness programs, continuous direct mail reminders, educational material including Healthwise Handbook, on-site classroom sessions, wellness coordinator training
- Quarterly Clinical Consultation
- Internet resources for members and benefit administrators

With our established, well-proven health information technology capabilities and innovative approach to clinical care services, Optima is well aligned with Executive Orders 42 and 55 and uniquely positioned as a partner for COVA. As a result of Optima's innovative integrated approach, there will be higher employee and dependent satisfaction for COVA, improved health quality and more affordable health care.

# **Organizational Chart**

# Sentara Health Plans Organization Chart



# **Optima's Historic Timeline**



## **Optima Health Historic Timeline 1984 - 2006**

### **1984**

- Optima Health Plan HMO is introduced.

### **1988**

- Sentara purchases Maxicare HMO, later renamed Sentara Health Plan, and expands to the Peninsula.

### **1994**

- Optima Family Care Medicaid HMO is introduced.

### **1995**

- Sentara receives Tricare Prime contract, offering service to CHAMPUS beneficiaries.

### **1997**

- Optima Health receives its first National Committee for Quality Assurance (NCQA) accreditation.

### **1999**

- Optima Health Plan receives the Quality Leader Number One designation among commercial health maintenance organizations in 84 cities, according to a National Research Corporation consumer healthcare study called the Healthcare Market Guide. The study recognized 100 commercial HMO's that were top-rated on overall member satisfaction.
- Sentara receives a full three-year accreditation for Optima Health Plan, Sentara Health Plan and a commendable accreditation for Sentara Family Care.
- Optima Family Care begins offering Children's Medical Security Insurance Plan (CMSIP), which enables families to secure free or low-cost health insurance for children through age 18.
- Optima Family Care begins offering a girl's basketball league in Hampton Roads in an effort to educate at-risk girls about key health and wellness issues while providing them wholesome competition and character-building opportunities.

### **2000**

- Three health plans administered by Optima Health receive the highest level of accreditation from the National Committee for Quality Assurance (NCQA) -

Optima's Commercial HMO, POS Plan, and Sentara Health Plans, Inc.'s Commercial HMO. Optima Health HMO Medicaid product (Sentara Family Care) receives a "Commendable" Accreditation by NCQA.

## **2001**

- Optima Health ranks in the top 10 HMOs with the best-rated pharmacy benefits in a survey by the National Research Council. Optima Health Plan is the highest-ranking Virginia based-plan on the list.
- Four health plans administered by Optima Health receive the highest level of accreditation from the NCQA. Optima Health Plan's Commercial HMO, Commercial POS Plan, Sentara Health Plans, Inc.'s Commercial HMO and Family Care are all awarded an accreditation of "Excellent" by NCQA.

## **2002**

- For the fifth consecutive year, health plans administered by Optima Health receive the highest level of accreditation from the National Committee for Quality Assurance (NCQA).

## **2003**

- Sentara Health Management plans receive the highest level of accreditation from the National Committee for Quality Assurance (NCQA), marking the sixth consecutive year of recognition. Optima Health Plan is Virginia's only commercial HMO to maintain NCQA's highest accreditation status since 1998.
- Optima Family Care girls basketball league expands to offer a fall and summer league. The program was launched in 1999 to help educate at-risk girls about key health and wellness issues while providing character-building opportunities.

## **2004**

- Optima Health's Partners in Pregnancy program to improve prenatal care for women on Medicaid wins a national award from the Disease Management Association of America (DMAA). The program has significantly reduced admissions to neonatal intensive care units (NICUs), in lengths of stay for babies in NICUs and in the costs of hospitalizations.
- Optima Family Care's Girls Summer Basketball League receives a \$35,675 grant from Virginia Tobacco Settlement Foundation (VTSF). The grant along with volunteers from Old Dominion University's urban studies program and nurses from Sentara's Community Health and Prevention Division have been trained to bring important messages to at-risk girls in Norfolk between ages 10 and 13.

## **2005**

- The Optima 'Life Coach' Diabetes Program wins the 2005 "Excellence Award for Best Provider Engagement Initiative" from DMAA Disease Management Association of America (DMAA).
- Optima Health receives it's first-ever award for asthma management from the U.S. Environmental Protection Agency (EPA). The national Environmental Leadership

Award in Asthma Management recognizes Optima's innovative program to control environmental factors in patients' homes that trigger asthma attacks.

- The Disease Management Association of America (DMAA) recognizes Optima's LifeCoach Model for Type 2 Diabetes.
- Optima Health receives its first "A" rating from Weiss Ratings, Inc., one of the most respected health plan ratings agencies in the nation, placing Optima among an elite group of 98 HMOs representing the top 19 percent of health plans.
- For the eighth straight year, all commercial HMO products administered by Optima Health earn the highest accreditation from the National Committee for Quality Assurance, (NCQA).
- Optima Health begins offering group insurance to the Richmond area.

## **2006**

- Optima Health introduces Optima Medicare Preferred, a program for Medicare recipients through the Virginia-based Optima Health.
- Optima Health launches the *Choose Generics* campaign among members and the public statewide. The campaign urges physicians to authorize generics and consumers to ask for them.
- Optima Health Insurance Company and Optima Family Care are ranked in the top 100 health plans by *U. S. News & World Report's* first national ranking of health plans.
- Optima Health Plans rank 50<sup>th</sup> among the nation's top health plans in the second national survey by *U.S. News & World Report* and NCQA. Six hundred and eighty four plans from across the nation are surveyed. Optima Family Care also places 25<sup>th</sup> among Medicaid products in a national survey. The *U.S. News & World Report* web site and magazine reference the ranking.
- Optimahealth.com receives the URAC Health Web Site Accreditation. The seal of approval means that Optima Health's website is a trusted source of health content and services. The site was evaluated against 50 standards for content, privacy, security and quality oversight.
- The Disease Management Association of America (DMAA) awards Optima Health and Sentara Home Care Services a national award for the home-based Sickle Cell treatment program for preventing Sickle Cell crises and sharply reducing ED visits and hospitalizations.
- Optima Family Care holds a regional basketball challenge for the Optima Family Care Central versus the Hampton Roads girl's basketball league. The annual challenge is between the Central Virginia League (Richmond, New Kent County, Petersburg, Charles City, Fluvanna County, Emporia and Williamsburg) and the Hampton Roads League (Norfolk, Portsmouth, Newport News, Chesapeake, Hampton, Virginia Beach and Suffolk). The program, which has reached more than 5,000 girls in Virginia, includes a mandatory health education class before each game. The league has recently expanded to include a Southside Regional League (Halifax County, Danville Parks and Recreation, Danville Boys and Girls Club, South Boston and Charlotte Courthouse Virginia.)

# **Financial Statements**



**OPTIMA HEALTH PLAN**

Statutory Financial Statements

December 31, 2006 and 2005

(With Independent Auditors' Report Thereon)



**KPMG LLP**  
2100 Dominion Tower  
999 Waterside Drive  
Norfolk, VA 23510

## **Independent Auditors' Report**

The Board of Directors  
Optima Health Plan:

We have audited the accompanying statutory statements of admitted assets, liabilities, and capital and surplus of Optima Health Plan (the Corporation) as of December 31, 2006 and 2005, and the related statutory statements of revenue and expenses, changes in capital and surplus, and cash flows for the years then ended. These financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As described more fully in note 2 to the financial statements, the Corporation prepared these financial statements using accounting practices prescribed or permitted by the Bureau of Insurance of the Commonwealth of Virginia, which practices differ from U.S. generally accepted accounting principles. The effects on the financial statements of the variances between the statutory basis of accounting and U.S. generally accepted accounting principles also are described in note 2.

In our opinion, because of the effects of the matter discussed in the preceding paragraph, the financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of Optima Health Plan as of December 31, 2006 and 2005, or the results of its operations or its cash flows for the years then ended.

Also, in our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities and capital and surplus of Optima Health Plan as of December 31, 2006 and 2005, and the results of its operations and its cash flows for the years then ended, on the basis of accounting described in note 2.



Our audits were made for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplementary information included in the supplementary summary investment schedule (schedule 1) and the schedule of supplemental investment risks interrogatories (schedule 2) is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the audits of the basic financial statements, and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken as a whole.

KPMG LLP

May 25, 2007

## OPTIMA HEALTH PLAN

### Statutory Statements of Admitted Assets, Liabilities, and Capital and Surplus

December 31, 2006 and 2005

Admitted Assets	<u>2006</u>	<u>2005</u>
Admitted current assets:		
Cash	\$ 23,423,995	23,129,830
Short-term investments (note 3)	186,834,256	169,440,693
Uncollected premiums in the course of collection (note 12)	8,170,605	7,498,746
Healthcare receivables (note 4)	3,367,284	1,654,611
Investment income due and accrued	386,561	365,042
Amounts due from parent, subsidiaries and affiliates	<u>6,764</u>	<u>730</u>
Total admitted current assets	222,189,465	202,089,652
Bonds (note 3)	34,699,751	30,702,254
Equipment, net (note 6)	<u>718,929</u>	<u>807,516</u>
Total admitted assets	<u>\$ 257,608,145</u>	<u>233,599,422</u>
<b>Liabilities, and Capital and Surplus</b>		
Current liabilities:		
Claims unpaid (note 7)	\$ 64,614,588	63,028,324
Unpaid claims adjustment expenses	1,342,772	1,222,443
Aggregate health policy reserves	254,048	870,068
Aggregate health claim reserves (note 7)	1,586,502	1,422,146
Accrued incentive pool and bonus amounts (note 8)	250,000	500,000
Premiums received in advance	802,403	1,302,072
Amounts due to parent, subsidiaries and affiliates	5,161,213	3,712,105
Other current liabilities	<u>704,716</u>	<u>106,585</u>
Total current liabilities	<u>74,716,242</u>	<u>72,163,743</u>
Capital and surplus:		
Gross paid-in and contributed surplus	13,000,000	13,000,000
Unassigned surplus	<u>169,891,903</u>	<u>148,435,679</u>
Total capital and surplus	182,891,903	161,435,679
Commitments and contingencies (notes 9, 10 and 11)		
Total liabilities and capital and surplus	<u>\$ 257,608,145</u>	<u>233,599,422</u>

See accompanying notes to statutory financial statements.

## OPTIMA HEALTH PLAN

### Statutory Statements of Revenue and Expenses

Years ended December 31, 2006 and 2005

	2006	2005
<b>Revenue:</b>		
Premium, net of reinsurance expense (notes 10 and 12)	\$ 780,625,658	695,955,775
Net investment income earned	11,099,756	6,417,684
Net realized capital losses	(63,314)	(102,390)
Change in aggregate health policy reserves	616,020	(47,350)
Other revenue	432,668	411,109
Total revenue, net	792,710,788	702,634,828
<b>Expenses:</b>		
Medical benefits, net (notes 4, 5, 7 and 9):		
Hospital and medical benefits	479,341,102	411,768,994
Outside referrals	294,069	201,108
Emergency room and out-of-area	39,456,544	33,536,008
Other medical and hospital expenses	9,916,112	13,158,320
Prescription drugs, net	123,091,625	110,308,991
Incentive pool and withhold adjustments	925,246	1,427,506
Reinsurance recoveries (note 10)	(2,719,127)	—
Total medical benefits, net	650,305,571	570,400,927
Claims adjustment expenses	11,091,025	8,837,201
General administrative expenses (notes 2, 5, 6, 9 and 11)	51,520,921	41,061,574
Total expenses	712,917,517	620,299,702
Net income	\$ 79,793,271	82,335,126

See accompanying notes to statutory financial statements.

**OPTIMA HEALTH PLAN**

Statutory Statements of Changes in Capital and Surplus

Years ended December 31, 2006 and 2005

Balance at December 31, 2004	\$ 139,452,928
Change in nonadmitted assets	(397,315)
Dividends (note 5)	(60,000,000)
Miscellaneous changes	44,940
Net income for the year ended December 31, 2005	<u>82,335,126</u>
Balance at December 31, 2005	161,435,679
Change in nonadmitted assets	1,616,925
Dividends (note 5)	(60,000,000)
Miscellaneous changes	46,028
Net income for the year ended December 31, 2006	<u>79,793,271</u>
Balance at December 31, 2006	<u>\$ 182,891,903</u>

See accompanying notes to statutory financial statements.

## OPTIMA HEALTH PLAN

### Statutory Statements of Cash Flows

Years ended December 31, 2006 and 2005

	2006	2005
Cash flows from operations:		
Premiums collected, net of reinsurance	\$ 779,689,519	695,462,463
Benefit and loss related payments	(648,804,951)	(566,724,132)
Commissions and administrative expenses paid	(62,491,617)	(49,731,332)
Net investment income	11,156,257	6,766,080
Miscellaneous income	432,668	411,109
Net cash provided by operations	79,981,876	86,184,188
Cash flows from investments:		
Proceeds from investments sold, matured or repaid	14,218,734	13,262,884
Cost of investments acquired	(18,357,567)	(14,674,646)
Net cash used in investments	(4,138,833)	(1,411,762)
Cash flows from financing and miscellaneous sources:		
Dividends paid	(60,000,000)	(60,000,000)
Change in amounts due to and due from parent, subsidiaries and affiliates	1,443,074	4,373,266
Other sources provided (applied), net	401,611	(2,785,467)
Net cash used in financing and miscellaneous sources	(58,155,315)	(58,412,201)
Net increase in cash and short-term investments	17,687,728	26,360,225
Cash and short-term investments at beginning of year	192,570,523	166,210,298
Cash and short-term investments at end of year	\$ 210,258,251	192,570,523

See accompanying notes to statutory financial statements.

## OPTIMA HEALTH PLAN

### Notes to Statutory Financial Statements

December 31, 2006 and 2005

#### (1) Corporate Organization

Optima Health Plan (the Corporation) is a nonprofit, nonstock corporation organized under the laws of the Commonwealth of Virginia (the Commonwealth). Sentara Healthcare (SHC), a separate tax-exempt corporation, is the parent holding company and "sole member" of the Corporation. As a sole member, SHC has those rights and powers prescribed by law, the Articles of Incorporation and Bylaws of the Corporation, including the power to approve any alteration, amendment or repeal of the Articles of Incorporation, the Bylaws or the adoption of new bylaws.

The Corporation is licensed to operate as a health maintenance organization (HMO) in the Commonwealth of Virginia, in accordance with Section 38.2 of the Virginia Code. The Corporation serves commercial members, federal employees under an experience-rated contract with the Office of Personnel Management (OPM), and Medicaid recipients under the terms of a contract with the Commonwealth of Virginia Department of Medical Assistance Services (DMAS).

#### (2) Basis of Presentation and Summary of Significant Accounting Policies and Practices

##### (a) Basis of Presentation

The accompanying statutory financial statements have been prepared on the statutory basis of accounting, in accordance with the accounting practices adopted by the National Association of Insurance Commissioners (NAIC) codification project (Codification), as prescribed or permitted by the Bureau of Insurance of the Commonwealth of Virginia (BOI). These practices differ in some respects from U.S. generally accepted accounting principles (GAAP).

For statutory purposes, certain assets are accorded no value and thus reduce statutory capital and surplus. Also, for statutory purposes, negative goodwill is not recognized on the statutory statements of admitted assets, liabilities, and capital and surplus. Short-term investments and bonds are recorded at amortized cost for statutory purposes which differs from GAAP whereby short-term investments and bonds are recorded at fair value. Equipment is depreciated over a period not to exceed three years for statutory purposes. The presentation of the direct method statutory statements of cash flows under Codification is different from what would be presented under GAAP.

The Codification was adopted by the BOI, with an effective date of January 1, 2001, except that it has retained the prescribed practice of requiring that the value of certain prohibited investments and other investments that exceed certain limits established by the Virginia Code be treated as a reduction in admitted assets. There is no impact of the prescribed difference from Codification in accounting for investments as of December 31, 2006 and 2005. In addition, the BOI has the right to permit other specific practices that may deviate from prescribed practices.

## OPTIMA HEALTH PLAN

### Notes to Statutory Financial Statements

December 31, 2006 and 2005

The following table illustrates the differences between net assets under GAAP and statutory capital and surplus at December 31, 2006 and 2005:

	2006	2005
GAAP net assets	\$ 181,840,349	160,414,926
Adjustments:		
Nonadmitted receivables	(798,612)	(2,705,396)
Nonadmitted equipment	(797,296)	(507,437)
Remove negative goodwill pushed down from parent company, SHC	2,886,800	4,330,200
Investments to amortized cost	239,402	287,667
Accumulated depreciation	(352,418)	(338,253)
Other	(126,322)	(46,028)
Statutory capital and surplus	\$ 182,891,903	161,435,679

The following table illustrates the differences between excess of revenues over expenses under GAAP and statutory net income for the years ended December 31, 2006 and 2005:

	2006	2005
GAAP excess of revenues over expenses	\$ 81,377,158	83,824,847
Adjustments:		
Amortization of negative goodwill	(1,443,400)	(1,443,400)
Depreciation expense	(14,165)	(293)
Other	(126,322)	(46,028)
Statutory net income	\$ 79,793,271	82,335,126

**(b) Cash Equivalents**

The Corporation considers all highly liquid temporary investments with original maturities of three months or less to be cash equivalents. The Corporation had no cash equivalents as of December 31, 2006 and 2005.

**(c) Short-Term Investments and Bonds**

Short-term investments and bonds as of December 31, 2006 and 2005, consist of money market mutual funds, government and agency notes and bonds, asset-backed securities and corporate bonds, which are recorded at amortized cost, adjusted for the amortization or accretion of premiums or discounts as an adjustment to yield using the effective-interest method. A decline in the market value of any security below cost that is deemed other than temporary results in a reduction in carrying value to fair value. The impairment is charged to earnings, and a new cost basis for the security is established. Interest income is recognized when earned.

## OPTIMA HEALTH PLAN

### Notes to Statutory Financial Statements

December 31, 2006 and 2005

**(d) Equipment**

Equipment is stated at cost, less accumulated depreciation. Depreciation on equipment is calculated on the straight-line method over the estimated useful lives of the assets, primarily three years. Furniture and equipment, leasehold improvements and a portion of electronic data processing (EDP) equipment are considered nonadmitted assets under Codification (see note 6).

**(e) Premium Revenue**

Contract premiums are recognized as income during the coverage period of the applicable subscriber agreement. Premium billings are billed to subscribers in the month preceding the coverage period and are recorded as premiums received in advance to the extent received in advance of the coverage period. Premiums are due monthly and are recognized as revenue during the period in which the Corporation is obligated to arrange for service to subscribers.

**(f) Aggregate Health Policy Reserves**

Aggregate health policy reserves consist of unearned premium reserves recorded by the Corporation. The Corporation recorded unearned premium reserves of \$254,048 and \$870,068 as of December 31, 2006 and 2005, respectively, for amounts paid in advance of the period in which the Corporation is obligated to provide service to members for groups that pay their annual premiums over a 10-month period.

**(g) Claims Unpaid and Unpaid Claims Adjustment Expenses**

Claims unpaid for inpatient hospital, outpatient surgery, emergency room, specialist, pharmacy and ancillary medical claims include amounts billed and not paid and an estimate of costs incurred for unbilled services provided. The liabilities for estimated costs incurred for unbilled services provided are based principally on historical payment patterns using actuarial techniques. Unpaid claims adjustment expenses are accrued based on an estimate of the costs necessary to process unpaid claims. Claims unpaid are reviewed and adjusted periodically and, as adjustments are made, differences are included in current operations.

**(h) Pension Plan**

Employees of the Corporation participate in SHC's corporate pension plan, the cost of which is paid for by the Corporation. Past service costs of this plan are funded over a 30-year period and normal costs are paid annually.

**(i) Risk-Based Capital**

Risk-based capital (RBC) was developed by the NAIC as a method of measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. A company's RBC is calculated by applying certain factors to various asset, premium and reserve items. Four action levels of RBC have been defined to set industry standards for regulatory intervention. The Commonwealth of Virginia requires all health maintenance organizations to maintain statutory capital and surplus of at least 200% of the Authorized Control Level, or the Company Action Level. As of December 31, 2006 and 2005, the Corporation was in compliance with this requirement.

**OPTIMA HEALTH PLAN**

Notes to Statutory Financial Statements

December 31, 2006 and 2005

**(j) Income Taxes**

The Corporation has been recognized by the Internal Revenue Service as tax exempt under Section 501(c)(3) of the Internal Revenue Code of 1986 (the Code) and as a public charity under Sections 509(a)(1) and 170(b)(1)(A)(viii) of the Code.

**(k) Use of Estimates**

Management of the Corporation has made a number of estimates and assumptions relating to the reporting of admitted assets and liabilities and the disclosure of contingent assets and liabilities to prepare these statutory financial statements in conformity with accounting practices prescribed or permitted by the BOI. Actual results could differ from those estimates.

**(3) Short-Term Investments and Bonds**

The amortized cost, gross unrealized holding gains, gross unrealized holding losses and fair value for short-term investments and bonds as of December 31, 2006 and 2005 are as follows:

	December 31, 2006			Fair value
	Amortized cost	Gross unrealized holding gains	Gross unrealized holding losses	
Money market mutual funds	\$ 186,834,256	—	—	186,834,256
Government and agency notes and bonds:				
Maturing between one year and five years	22,042,986	—	(133,496)	21,909,490
Asset-backed securities:				
Maturing between one year and five years	7,049,116	27,425	(71,724)	7,004,817
Maturing between five years and ten years	475,237	920	—	476,157
Maturing after ten years	398,083	1,491	(1,825)	397,749
Corporate bonds:				
Maturing between one year and five years	4,734,329	484	(62,677)	4,672,136
	221,534,007	\$ 30,320	(269,722)	221,294,605
Less short-term investments	186,834,256			
Bonds	\$ 34,699,751			

**OPTIMA HEALTH PLAN**

Notes to Statutory Financial Statements

December 31, 2006 and 2005

	December 31, 2005			Fair value
	Amortized cost	Gross unrealized holding gains	Gross unrealized holding losses	
Money market mutual funds	\$ 169,440,693	—	—	169,440,693
Government and agency notes and bonds:				
Maturing between one year and five years	18,537,903	5,411	(134,842)	18,408,472
Asset-backed securities:				
Maturing between one year and five years	5,385,506	1,947	(81,053)	5,306,400
Maturing between five years and ten years	315,753	49	—	315,802
Maturing after ten years	390,129	113	(651)	389,591
Corporate bonds:				
Maturing between one year and five years	6,072,963	6,434	(85,075)	5,994,322
	<u>200,142,947</u>	<u>\$ 13,954</u>	<u>(301,621)</u>	<u>199,855,280</u>
Less short-term investments	<u>169,440,693</u>			
Bonds	<u>\$ 30,702,254</u>			

As a condition for licensure by the BOI to operate health maintenance organizations, the Corporation is required to maintain on deposit certain funds with the BOI. Accordingly, as of December 31, 2006 and 2005, \$2,892,229 and \$2,814,208, respectively, of government and agency notes and bonds, at amortized cost, are on deposit and are included in bonds in the accompanying statutory statements of admitted assets, liabilities, and capital and surplus.

At December 31, 2006, the Corporation had five government and agency notes and bonds, twelve asset-backed securities and twelve corporate bonds with fair values of \$19,215,851, \$4,836,822 and \$4,321,755, respectively, with temporary declines in value of \$133,496, \$73,549 and \$62,677, respectively. Of these securities, four government and agency notes and bonds, six asset-backed securities and eleven corporate bonds with fair values of \$16,466,003, \$1,868,723 and \$4,020,196, respectively, with temporary declines in value of \$119,410, \$21,833 and \$58,122, respectively, have been in a continuous unrealized loss position for more than 12 months.

At December 31, 2005, the Corporation had five government and agency notes and bonds, eleven asset-backed securities and fifteen corporate bonds with fair values of \$13,864,431, \$4,376,588 and \$5,138,495, respectively, with temporary declines in value of \$134,842, \$81,704 and \$85,075, respectively. Of these securities, three government and agency notes and bonds, six asset-backed securities and six corporate bonds with fair values of \$7,531,012, \$2,259,796 and \$2,314,141, respectively, with temporary declines in value of \$82,592, \$30,504 and \$57,136, respectively, have been in a continuous unrealized loss position for more than 12 months.

## OPTIMA HEALTH PLAN

### Notes to Statutory Financial Statements

December 31, 2006 and 2005

These temporary declines in value as of December 31, 2006 and 2005 are primarily due to fluctuations in market interest rates.

#### (4) Pharmaceutical Rebates

The Corporation estimates pharmaceutical rebates based on a per member, per month calculation developed by reviewing historical payment patterns of the drug manufacturers. Pharmaceutical rebates are recorded as health care receivables on the accompanying statutory statements of admitted assets, liabilities, and capital and surplus and as a reduction to medical benefits, net, in the accompanying statutory statements of revenue and expenses. Pharmaceutical rebates receivable are considered admitted assets to the extent invoiced to the drug manufacturers within two months of recording the estimate and then collected within 90 days of the invoice date in accordance with statutory accounting principles. The following table represents approximate pharmaceutical rebates as recorded in the Corporation's statutory filings for each of the four quarters in the years ended December 31, 2006, 2005 and 2004, along with amounts invoiced and cumulatively collected subsequent to the reporting dates:

	Quarter ended			
	December 31, 2006	September 30, 2006	June 30, 2006	March 31, 2006
Estimated pharmaceutical rebates as recorded	\$ 3,367,000	2,871,000	2,523,000	1,801,000
Pharmaceutical rebates as invoiced	—	3,139,000	2,960,000	2,853,000
Actual rebates collected within 90 days of invoicing	—	284,000	827,000	2,109,000
Actual rebates collected between 91 to 180 days of invoicing	—	—	1,492,000	353,000
Actual rebates collected more than 180 days after invoicing	—	—	—	274,000

## OPTIMA HEALTH PLAN

### Notes to Statutory Financial Statements

December 31, 2006 and 2005

	Quarter ended			
	December 31, 2005	September 30, 2005	June 30, 2005	March 31, 2005
Estimated pharmaceutical rebates as recorded	\$ 1,655,000	1,402,000	1,876,000	1,357,000
Pharmaceutical rebates as invoiced	2,326,000	2,632,000	2,599,000	2,545,000
Actual rebates collected within 90 days of invoicing	1,754,000	1,689,000	1,633,000	1,427,000
Actual rebates collected between 91 to 180 days of invoicing	775,000	648,000	531,000	883,000
Actual rebates collected more than 180 days after invoicing	6,000	213,000	372,000	253,000

	Quarter ended			
	December 31, 2004	September 30, 2004	June 30, 2004	March 31, 2004
Estimated pharmaceutical rebates as recorded	\$ 1,303,000	994,000	2,438,000	1,469,000
Pharmaceutical rebates as invoiced	2,314,000	2,038,000	1,957,000	1,966,000
Actual rebates collected within 90 days of invoicing	1,784,000	1,574,000	1,336,000	975,000
Actual rebates collected between 91 to 180 days of invoicing	594,000	471,000	679,000	963,000
Actual rebates collected more than 180 days after invoicing	20,000	17,000	56,000	38,000

#### (5) Transactions with Parent, Subsidiaries and Affiliates

During the years ended December 31, 2006 and 2005, the Corporation incurred expenses of approximately \$11,485,000 and \$9,351,000, respectively, for data processing services and other administrative and financial support services provided by SHC.

Certain benefits under the health policies are paid to hospitals and physician groups affiliated with SHC. Total claims expenses for services performed at SHC-affiliated hospitals and physician groups during the years ended December 31, 2006 and 2005 approximated \$121,568,000 and \$115,232,000, respectively, which are included in medical benefits, net, in the accompanying statutory statements of revenue and expenses.

## OPTIMA HEALTH PLAN

### Notes to Statutory Financial Statements

December 31, 2006 and 2005

The Corporation contracts with Sentara Behavioral Health Services (SBHS), a third-tier subsidiary of SHC, to provide mental health services to plan members. Under the terms of a capitated contract, the Corporation pays SBHS fixed rates per member per month to cover the cost of these services. Total capitation expenses to SBHS approximated \$19,617,000 and \$17,942,000 during the years ended December 31, 2006 and 2005, respectively, which are included in medical benefits, net, in the accompanying statutory statements of revenue and expenses.

During the years ended December 31, 2006 and 2005, the BOI approved \$60,000,000 each year in dividends to the Corporation's sole member, SHC.

#### (6) Equipment, Net

The cost basis, accumulated depreciation and nonadmitted assets for the following categories of equipment, net, as of December 31, 2006 and 2005 are as follows:

		2006			
		Furniture and equipment	EDP equipment and software	Leasehold improvements	Total
Cost basis	\$	2,272,102	4,383,784	1,015,671	7,671,557
Less accumulated depreciation		1,808,813	3,664,855	681,664	6,155,332
		463,289	718,929	334,007	1,516,225
Less nonadmitted assets		463,289	—	334,007	797,296
Admitted assets	\$	—	718,929	—	718,929
		2005			
		Furniture and equipment	EDP equipment and software	Leasehold improvements	Total
Cost basis	\$	1,950,960	3,998,653	848,153	6,797,766
Less accumulated depreciation		1,696,221	3,191,137	595,455	5,482,813
		254,739	807,516	252,698	1,314,953
Less nonadmitted assets		254,739	—	252,698	507,437
Admitted assets	\$	—	807,516	—	807,516

Depreciation expense was \$672,518 and \$590,223 for the years ended December 31, 2006 and 2005, respectively, and is included in general administrative expenses in the accompanying statutory statements of revenue and expenses.

**OPTIMA HEALTH PLAN**  
Notes to Statutory Financial Statements  
December 31, 2006 and 2005

**(7) Claims Unpaid and Aggregate Health Claim Reserves**

As of December 31, 2006 and 2005, claims unpaid and aggregate health claim reserves were as follows:

	<u>2006</u>	<u>2005</u>
Claims unpaid	\$ 64,614,588	63,028,324
Aggregate health claim reserves	1,586,502	1,422,146
	<u>\$ 66,201,090</u>	<u>64,450,470</u>

A summary of the activity for claims unpaid and aggregate health claim reserves is as follows:

	<u>2006</u>	<u>2005</u>
Balance at January 1	\$ 64,450,470	60,848,706
Incurred related to:		
Current year	657,696,801	575,701,224
Prior years	(5,597,349)	(6,727,803)
Total incurred	<u>652,099,452</u>	<u>568,973,421</u>
Paid related to:		
Current year	591,862,114	512,034,090
Prior year	58,486,718	53,337,567
Total paid	<u>650,348,832</u>	<u>565,371,657</u>
Balance at December 31	<u>\$ 66,201,090</u>	<u>64,450,470</u>

The Corporation uses actuarial techniques based principally on historical payment patterns to estimate incurred claims. Changes in payment patterns and claims trends can result in adjustments to prior years' claims estimates and are recorded in current operations. Changes in estimates of incurred claims for prior years recognized in 2006 and 2005 were attributable to lower than anticipated utilization and costs of medical services.

**(8) Accrued Medical Incentive Pool and Bonus Amounts**

The Corporation maintains contracts with area providers to supply inpatient, outpatient and other medical services on either a per-case, per-diem or discounted fee-for-service basis. Estimated accrued medical incentive pools and bonus amounts under the aforementioned contracts were \$250,000 and \$500,000 as of December 31, 2006 and 2005, respectively.

## OPTIMA HEALTH PLAN

### Notes to Statutory Financial Statements

December 31, 2006 and 2005

#### (9) Employee Benefit Plans

##### (a) *Deferred Compensation Savings Plan*

The Corporation's employees have the option to participate in a deferred compensation plan sponsored by SHC. Substantially all full-time employees of the Corporation may elect to participate in this plan. This plan is exempt from income taxes under Section 401(k) of the Internal Revenue Code. Under the plan, participants may contribute certain amounts of compensation, subject to maximum federal and plan limits. The Corporation matches one-half of the participant's annual contribution, limited to 2.5% of the participant's annual compensation. For the years ended December 31, 2006 and 2005, the Corporation's expense related to the plan approximated \$333,000 and \$292,000, respectively, and is included in general administrative expenses in the accompanying statutory statements of revenue and expenses.

##### (b) *Pension Plan*

SHC sponsors a noncontributory defined benefit pension plan (the Plan), which covers substantially all employees of SHC and certain of its subsidiaries, including the Corporation. The legal obligation of the Plan is the responsibility of SHC. Net pension expense, which is allocated to the Corporation by SHC based on the number of employees of each SHC affiliate, was approximately \$1,394,000 and \$1,514,000 for the years ended December 31, 2006 and 2005, respectively, and is included in general administrative expenses in the accompanying statutory statements of revenue and expenses. The Plan conforms to the requirements of the Employee Retirement Income Security Act of 1974. It is not possible to present separately the actuarial present value of benefit obligations or the net assets available for benefits of the Corporation because no determination has been made of the allocation of such amounts between SHC and the Corporation.

#### (10) Insurance

##### (a) *Reinsurance Coverage*

The Corporation purchases reinsurance coverage for hospital medical expense through Optima Health Insurance Company (OHIC), a wholly owned subsidiary of Sentara Health Plans (SHP), a second-tier subsidiary of SHC. The policy limits reinsurance coverage to \$1,000,000 of covered expenses for an individual member per policy year, subject to a \$500,000 deductible. This reinsurance coverage does not relieve the Corporation of its primary obligation to the policy members. Reinsurance coverage expense of \$1,521,098 and \$1,423,547, respectively, for the years ended December 31, 2006 and 2005 is netted with premium revenue in the accompanying statutory statements of revenue and expenses. As of December 31, 2006 and 2005, there were no reinsurance amounts recoverable from OHIC. Reinsurance recoveries from OHIC during 2006 were \$2,719,127 and are recorded in medical benefits, net in the accompanying statutory statement of revenue and expenses. There were no reinsurance recoveries during 2005.

## OPTIMA HEALTH PLAN

### Notes to Statutory Financial Statements

December 31, 2006 and 2005

**(b) General Liability and Malpractice Insurance**

The Corporation, along with SHC and its subsidiaries, insure their professional, general and managed care liability risks through comprehensive claims-made insurance policies issued by Lexington Insurance Company (Lexington). Under the Lexington policies, the policy limits are \$2,000,000 per occurrence and \$23,000,000 in the aggregate for professional and managed care liability and \$1,000,000 per occurrence for general liability. The Lexington policies are reinsured by SHC's wholly owned captive insurance company, Bay Primex Insurance Company Ltd. The sole activity of Bay Primex Insurance Company, Ltd. is reinsurance, on a facultative basis, of the claims-made professional, comprehensive general and managed care professional liability insurance policies issued by Lexington. All SHC entities are covered by the same claims-made excess liability policy through two independent carriers. Annual coverage limits are \$40,000,000 per occurrence and \$40,000,000 in the aggregate for amounts exceeding the primary coverage limits. The professional liability policies are on a claims-made basis and must be renewed or replaced with equivalent insurance if claims incurred during their term but asserted after their expiration are to be insured.

**(11) Minimum Lease Payments**

SHP entered into an operating lease for office space, part of which is occupied by the Corporation. The Corporation has agreed to share proratably, based on membership, in the responsibility for this lease with certain other wholly owned subsidiaries of SHP. SHP's total future minimum lease payments as of December 31, 2006 are as follows:

2007	\$	939,464
2008		949,127
2009		969,374
2010		867,092
2011		359,580
	\$	<u>4,084,637</u>

The Corporation's share of total expense relating to this operating lease approximated \$930,000 and \$888,000 for the years ended December 31, 2006 and 2005, respectively.

**(12) Concentration of Business and Credit Risk**

The Corporation provides subscriber benefits to OPM under the Federal Employees Health Benefits Program. As of December 31, 2006 and 2005, the Corporation had uncollected premiums in the course of collection from OPM of approximately \$3,890,000 and \$3,283,000, respectively. Premium revenue generated from insurance contracts with OPM was approximately 8% of total premium revenue for each of the years ended December 31, 2006 and 2005.

## **OPTIMA HEALTH PLAN**

### **Notes to Statutory Financial Statements**

**December 31, 2006 and 2005**

In addition, the Corporation provides benefits to Medicaid recipients through a contract with DMAS. As of December 31, 2006 and 2005, the Corporation had uncollected premiums in the course of collection from DMAS of approximately \$406,000 and \$141,000, respectively. Premium revenue generated from the contract with DMAS was approximately 48% and 49% of total premium revenue for the years ended December 31, 2006 and 2005, respectively.

## OPTIMA HEALTH PLAN

## Supplementary Summary Investment Schedule

December 31, 2006

Investment holdings	Admitted assets as reported in the statutory financial statements	
	Amount	Percentage
Bonds:		
U.S. Treasury securities	\$ 19,224,349	8%
U.S. Government agency and corporate obligations (excluding mortgage-backed securities – issued by U.S. Government sponsored agencies)	2,820,000	1%
Mortgage-backed securities (including residential and commercial mortgage-backed securities):		
Pass-through securities:		
Issued or guaranteed by FNMA and FHLMC	6,656,337	3%
All other	135,730	0%
CMOs and REMICs:		
Issued or guaranteed by GNMA, FNMA or FHLMC or VA	276,382	0%
Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by GNMA, FNMA or FHLMC or VA	850,000	0%
Other debt and other fixed income securities (excluding short term) – unaffiliated domestic securities (including credit tenant loans rated by the SVO)	4,736,953	2%
Equity interests:		
Investments in mutual funds	186,834,256	76%
Cash	23,423,995	10%
Total invested assets	<u>\$ 244,958,002</u>	<u>100%</u>

Note: At December 31, 2006, there are no differences between gross investment holdings and admitted asset values.

See accompanying independent auditors' report.

**OPTIMA HEALTH PLAN**  
 Supplemental Investment Risks Interrogatories  
 Year ended December 31, 2006

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. \$ 257,608,145

2. Ten largest exposures to a single issuer/borrower/investment.

1	2	3	4
Issuer	Description of exposure	Amount	Percentage of total admitted assets
2.01 SAGA Funds	Money market	\$ 391,539	0.2%
2.02 Bank One Issuance Trust	Bond	850,000	0.3
2.03 General Elect Cap Corp	Bond	599,829	0.2
2.04 Merrill Lynch & Co	Bond	501,023	0.2
2.05 Morgan Stanley Group	Bond	499,820	0.2
2.06 BankAmerica Corp	Bond	474,033	0.2
2.07 Caterpillar Financial Sacs	Bond	448,454	0.2
2.08 American General Finance Corp	Bond	349,854	0.1
2.09 International Lease Fin Corp	Bond	322,433	0.1
2.10 Bank New York Inc	Bond	321,720	0.1

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIF rating.

Bonds	1 Amount	2 Percent	Preferred stocks	1 Amount	2 Percent
3.01 NAIC-1	\$ 221,534,007	86.0%	3.07 P/RP-1	\$ —	—%
3.02 NAIC-2	—	—	3.08 P/RP-2	—	—
3.03 NAIC-3	—	—	3.09 P/RP-3	—	—
3.04 NAIC-4	—	—	3.10 P/RP-4	—	—
3.05 NAIC-5	—	—	3.11 P/RP-5	—	—
3.06 NAIC-6	—	—	3.12 P/RP-6	—	—

4. Assets held in foreign investments:

1 Amount	2 Percent
4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X] No [ ]
4.02 Total admitted assets held in foreign investments	\$ — —%
4.03 Foreign-currency-denominated investments	— —
4.04 Insurance liabilities denominated in that same foreign currency	— —

If response to 4.01 above is yes, responses are not required for interrogatories 5 – 10.

5. Aggregate foreign investment exposure categorized by NAIF sovereign rating:

NAIF Sovereign Rating	1 Amount	2 Percent
5.01 Countries rated NAIC-1	\$ —	—%
5.02 Countries rated NAIC-2	—	—
5.03 Countries rated NAIC-3 or below	—	—

6. Two largest foreign investment exposures in a single country, categorized by NAIF sovereign rating:

1 Amount	2 Percent
Countries rated NAIC-1:	
6.01	\$ — —%
6.02	— —
Countries rated NAIC-2:	
6.03	— —
6.04	— —
Countries rated NAIC-3 or below:	
6.05	— —
6.06	— —
<b>1</b>	<b>2</b>

**OPTIMA HEALTH PLAN**  
 Supplemental Investment Risks Interrogatories  
 Year ended December 31, 2006

Schedule 2

7. Aggregate unheeded foreign currency exposure \$ — —%

8. Aggregate unheeded foreign currency exposure categorized by the country's NAIF sovereign rating:

NAIF Sovereign Rating	1 Amount	2 Percent
8.01 Countries rated NAIC-1	\$ —	—%
8.02 Countries rated NAIC-2	—	—
8.03 Countries rated NAIC-3 or below	—	—

9. Two largest unheeded foreign currency exposures to a single country, categorized by the country's NAIF sovereign rating:

	1 Amount	2 Percent
Countries rated NAIC-1:		
6.01	\$ —	—%
6.02	—	—
Countries rated NAIC-2:		
6.03	—	—
6.04	—	—
Countries rated NAIC-3 or below:		
6.05	—	—
6.06	—	—

10. Ten largest no sovereign (i.e. nongovernmental) foreign issues:

1 Issuer	2 NAIF Rating	3 Amount	4 Percent
10.01		\$ —	—%
10.02		—	—
10.03		—	—
10.04		—	—
10.05		—	—
10.06		—	—
10.07		—	—
10.08		—	—
10.09		—	—
10.10		—	—

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unheeded Canadian currency exposure.

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes  No   
 If response to 11.01 is yes, details is not required for the remainder of interrogatory 11.

Description	1 Amount	2 Percent
11.02 Total admitted assets held in Canadian Investments	\$ —	—%
11.03 Canadian-currency-denominated investments	—	—
11.04 Canadian-denominated insurance liabilities	—	—
11.05 Unheeded Canadian currency exposure	—	—

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes  No   
 If response to 12.01 is yes, responses are not required for the remainder of interrogatory 12.

1 Contractual sales restrictions	2 Amount	3 Percent
12.02 Aggregate statement value of investments with contractual sales restrictions	\$ —	—%
12.03 Largest 3 investments with contractual sales restrictions:		
12.04	—	—
12.05	—	—

**OPTIMA HEALTH PLAN**  
**Supplemental Investment Risks Interrogatories**  
Year ended December 31, 2006

Schedule 2

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

- 13.01 Are assets held in equity interest less than 2.5% of the reporting entity's total admitted assets Yes  No   
If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.

1 Name of issuer	2 Amount	3 Percent
Assets held in equity interests:		
13.02	\$ —	—%
13.03	—	—
13.04	—	—
13.05	—	—
13.06	—	—
13.07	—	—
13.08	—	—
13.09	—	—
13.11	—	—

14. Amounts and percentages of reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

- 14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes  No   
If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

1 Investment category	2 Amount	3 Percent
14.02	\$ —	—%
Aggregate statement value of investments held in nonaffiliated, privately placed equities		
Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03	—	—
14.04	—	—
14.05	—	—

15. Amounts and percentages of reporting entity's total admitted assets held in general partnership interests:

- 15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? Yes  No   
If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

1 Investments in general partnerships	2 Amount	3 Percent
15.02	\$ —	—%
Aggregate statement value of investments held in general partnership interests		
Largest 3 investments in general partnership interests:		
15.03	—	—
15.04	—	—
15.05	—	—

16. Amounts and percentages of reporting entity's total admitted assets held in mortgage loans:

- 16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes  No   
If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

1 Type (Residential, Commercial, Agricultural)	2 Amount	3 Percent
Total admitted assets held in mortgage loans		
16.02	\$ —	—%
16.03	—	—
16.04	—	—
16.05	—	—
16.06	—	—
16.07	—	—
16.08	—	—
16.09	—	—
16.10	—	—
16.11	—	—

**OPTIMA HEALTH PLAN**  
Supplemental Investment Risks Interrogatories  
Year ended December 31, 2006

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

Description	Loans	
	2 Amount	3 Percent
16.12 Construction loans	\$ —	—%
16.13 Mortgage loans over 90 days past due	—	—
16.14 Mortgage loans in the process of foreclosure	—	—
16.15 Mortgage loans foreclosed	—	—
16.16 Restructured mortgage loans	—	—

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

Loan to value	Residential		Commercial		Agricultural	
	1 Amount	2 Percent	3 Amount	4 Percent	5 Amount	6 Percent
17.01 Above 95%	\$ —	—%	\$ —	—%	\$ —	—%
17.02 91% to 95%	—	—	—	—	—	—
17.03 81% to 90%	—	—	—	—	—	—
17.04 71% to 80%	—	—	—	—	—	—
17.05 Below 70	—	—	—	—	—	—

18. Amounts and percentages of reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported in less than 2.5% of the reporting entity's total admitted assets? Yes  No   
If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Description	1	2	3
	Amount	Percent	Percent
Largest 5 investments in any one parcel or group of contiguous parcels of real estate:			
18.02	\$ —	—%	—%
18.03	—	—	—
18.04	—	—	—
18.05	—	—	—
18.06	—	—	—

19. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

Description	At year-end		At end of each quarter		
	1	2	3 1st Quarter	4 2nd Quarter	5 3rd Quarter
	Amount	Percent	Amount	Amount	Amount
19.01 Securities lending agreements (do not include assets held as collateral for such transactions)	\$ —	—%	\$ —	—	—
19.02 Repurchase agreements	—	—	—	—	—
19.03 Reverse repurchase agreements	—	—	—	—	—
19.04 Dollar repurchase agreements	—	—	—	—	—
19.05 Dollar reverse repurchase agreements	—	—	—	—	—

20. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

Description	Owned		Written	
	1 Amount	2 Percent	3 Amount	4 Percent
20.01 Hedging	\$ —	—%	\$ —	—%
20.02 Income generation	—	—	—	—
20.03 Other	—	—	—	—

**OPTIMA HEALTH PLAN**  
 Supplemental Investment Risks Interrogatories  
 Year ended December 31, 2006

21. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

Description	At year-end		At end of each quarter		
	1 Amount	2 Percent	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
21.01 Hedging	\$ —	—%	\$		
21.02 Income generation	—	—			
21.03 Replications	—	—			
21.04 Other	—	—			

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

Description	At year-end		At end of each quarter		
	1 Amount	2 Percent	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
22.01 Hedging	\$ —	—%	\$		
22.02 Income generation	—	—			
22.03 Replications	—	—			
22.04 Other	—	—			

See accompanying independent auditors' report.



**OPTIMA HEALTH INSURANCE COMPANY**

Statutory Financial Statements

December 31, 2006 and 2005

(With Independent Auditors' Report Thereon)



KPMG LLP  
2100 Dominion Tower  
999 Waterside Drive  
Norfolk, VA 23510

## Independent Auditors' Report

The Board of Directors  
Optima Health Insurance Company:

We have audited the accompanying statutory statements of admitted assets, liabilities, and capital and surplus of Optima Health Insurance Company (the Corporation) as of December 31, 2006 and 2005, and the related statutory statements of revenue and expenses, changes in capital and surplus, and cash flows for the years then ended. These financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As described more fully in note 2 to the financial statements, the Corporation prepared these financial statements using accounting practices prescribed or permitted by the Bureau of Insurance of the Commonwealth of Virginia, which practices differ from U.S. generally accepted accounting principles. The effects on the financial statements of the variances between the statutory basis of accounting and U.S. generally accepted accounting principles also are described in note 2.

In our opinion, because of the effects of the matter discussed in the preceding paragraph, the financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of Optima Health Insurance Company as of December 31, 2006 and 2005, or the results of its operations or its cash flows for the years then ended.

Also, in our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities and capital and surplus of Optima Health Insurance Company as of December 31, 2006 and 2005, and the results of its operations and its cash flows for the years then ended, on the basis of accounting described in note 2.



Our audits were made for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplementary information included in the supplementary summary investment schedule (schedule 1) and the schedule of supplemental investment risks interrogatories (schedule 2) is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the audits of the basic financial statements, and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

KPMG LLP

May 25, 2007

**OPTIMA HEALTH INSURANCE COMPANY**

Statutory Statements of Admitted Assets, Liabilities, and Capital and Surplus

December 31, 2006 and 2005

<b>Admitted Assets</b>	<u>2006</u>	<u>2005</u>
<b>Admitted current assets:</b>		
Cash	\$ 624,494	471,570
Short-term investments (note 3)	17,902,358	19,087,320
Uncollected premiums in the course of collection	1,166,115	—
Healthcare receivables (note 4)	273,652	126,213
Investment income due and accrued	104,780	122,033
Amounts due from parent, subsidiaries and affiliates (note 5)	2,527,669	411,093
Deferred tax asset (note 8)	563,000	253,000
Total admitted current assets	<u>23,162,068</u>	<u>20,471,229</u>
Bonds (note 3)	10,637,937	9,378,416
Equipment, net (note 6)	66,516	58,282
Total admitted assets	<u>\$ 33,866,521</u>	<u>29,907,927</u>
<b>Liabilities, and Capital and Surplus</b>		
<b>Current liabilities:</b>		
Claims unpaid (note 7)	\$ 8,230,345	5,722,374
Unpaid claims adjustment expenses	155,909	116,679
Aggregate health policy reserves	14,362	146,547
Aggregate health claim reserves (note 7)	94,541	111,372
Premiums received in advance	816,786	958,725
Amounts due to parent, subsidiaries and affiliates (note 5)	738,787	86
Other current liabilities (note 9)	1,166,552	2,700,715
Ceded reinsurance payable	37,160	—
Accrued incentive pool and bonus amounts	554,275	334,416
Total current liabilities	<u>11,808,717</u>	<u>10,090,914</u>
<b>Capital and surplus:</b>		
Common capital stock, par value \$1,000 per share. Authorized 5,000 shares; issued and outstanding 1,040 shares	1,040,000	1,040,000
Gross paid-in and contributed surplus	25,960,000	25,960,000
Reserved surplus – reinsurance (note 9)	(514,464)	(2,678,273)
Unassigned deficit	(4,427,732)	(4,504,714)
Total capital and surplus	<u>22,057,804</u>	<u>19,817,013</u>
Commitments and contingencies (notes 9, 10 and 11)		
Total liabilities and capital and surplus	<u>\$ 33,866,521</u>	<u>29,907,927</u>

See accompanying notes to statutory financial statements.

**OPTIMA HEALTH INSURANCE COMPANY**

Statutory Statements of Revenue and Expenses

Years ended December 31, 2006 and 2005

	2006	2005
<b>Revenue:</b>		
Premium (note 9)	\$ 75,778,449	50,574,003
Change in aggregate health policy reserves	132,185	2,696
Net investment income earned	1,371,845	824,018
Net realized capital losses	(20,139)	(30,289)
Total revenue, net	77,262,340	51,370,428
<b>Expenses:</b>		
Medical benefits, net (notes 4, 5 and 7):		
Hospital and medical benefits	50,096,447	32,160,255
Emergency room and out-of-area	1,687,977	1,201,942
Prescription drugs, net	10,822,610	7,597,847
Other medical and hospital expenses	216,049	155,608
Incentive pool and withhold adjustments	478,953	394,491
Total medical benefits, net	63,302,036	41,510,143
Claims adjustment expenses	1,052,603	2,058,554
General administrative expenses (notes 5, 6, 10 and 11)	12,695,699	7,796,379
Total expenses	77,050,338	51,365,076
Income before federal income taxes	212,002	5,352
Federal income tax expense (benefit) (note 8)	472,670	(275,553)
Net income (loss)	\$ (260,668)	280,905

See accompanying notes to statutory financial statements.

**OPTIMA HEALTH INSURANCE COMPANY**  
Statutory Statements of Changes in Capital and Surplus  
Years ended December 31, 2006 and 2005

Balance at December 31, 2004	\$ 14,286,585
Change in nonadmitted assets	(16,567)
Change in deferred tax asset (note 8)	(173,000)
Change in reserved surplus-reinsurance (note 9)	(535,116)
Paid-in capital and surplus	6,000,000
Miscellaneous changes	(25,794)
Net income for the year ended December 31, 2005	<u>280,905</u>
Balance at December 31, 2005	19,817,013
Change in nonadmitted assets	128,222
Change in deferred tax asset (note 8)	319,000
Change in reserved surplus-reinsurance (note 9)	2,163,809
Miscellaneous changes	(109,572)
Net loss for the year ended December 31, 2006	<u>(260,668)</u>
Balance at December 31, 2006	<u>\$ 22,057,804</u>

See accompanying notes to statutory financial statements.

**OPTIMA HEALTH INSURANCE COMPANY**

Statutory Statements of Cash Flows

Years ended December 31, 2006 and 2005

	2006	2005
Cash flows from operations:		
Premiums collected, net of reinsurance	\$ 74,507,554	50,943,983
Benefit and loss related payments	(60,591,037)	(41,272,527)
Commissions and general administrative expenses paid	(13,709,072)	(9,863,254)
Net investment income	1,420,568	952,772
Federal taxes recovered (paid)	(472,670)	275,553
Net cash provided by operations	1,155,343	1,036,527
Cash flows from investments:		
Proceeds from investments sold, matured or repaid	3,874,272	4,324,159
Cost of investments acquired	(5,230,570)	(4,813,148)
Net cash used in investments	(1,356,298)	(488,989)
Cash flows from financing and miscellaneous sources:		
Paid-in capital and surplus	—	6,000,000
Change in amounts due to and due from parent, subsidiaries and affiliates	(1,377,875)	(1,780,773)
Other sources provided (applied), net	546,792	(423,695)
Net cash provided by (used in) financing and miscellaneous sources	(831,083)	3,795,532
Net increase (decrease) in cash and short-term investments	(1,032,038)	4,343,070
Cash and short-term investments at beginning of year	19,558,890	15,215,820
Cash and short-term investments at end of year	\$ 18,526,852	19,558,890

See accompanying notes to statutory financial statements.

## OPTIMA HEALTH INSURANCE COMPANY

Notes to Statutory Financial Statements

December 31, 2006 and 2005

### (1) Corporate Organization

Optima Health Insurance Company (the Corporation) is a for-profit stock corporation organized under the laws of the Commonwealth of Virginia. The Corporation is a wholly owned subsidiary of Sentara Health Plans (SHP) and is licensed to operate as an accident and health insurer in the Commonwealth of Virginia, in accordance with Section 38.2 of the Virginia Code. SHP is a wholly owned subsidiary of Sentara Holdings, Inc (SHI), which is a wholly owned subsidiary of Sentara Healthcare (SHC), which is also the parent company of several health care provider organizations, including Sentara Hospitals, Sentara Enterprises, Sentara Life Care Corporation and Sentara Medical Group. In addition, SHC is the sole member of Optima Health Plan (Optima), a health maintenance organization.

### (2) Basis of Presentation and Summary of Significant Accounting Policies and Practices

#### (a) Basis of Presentation

The accompanying statutory financial statements have been prepared on the statutory basis of accounting, in accordance with the accounting practices adopted by the National Association of Insurance Commissioners (NAIC) codification project (Codification), as prescribed or permitted by the Bureau of Insurance of the Commonwealth of Virginia (BOI). These practices differ in some respects from U.S generally accepted accounting principles (GAAP).

For statutory purposes, certain assets are accorded no value and thus reduce statutory capital and surplus. Also, short-term investments and bonds are recorded at amortized cost for statutory purposes which differs from GAAP whereby short-term investments and bonds are recorded at fair value. Deferred taxes under Codification are only recorded for federal income tax purposes and deferred tax assets and liabilities arise from timing differences between the statutory bases of assets and liabilities and their respective tax bases. Further, changes in deferred taxes are recorded directly to capital and surplus. Equipment is depreciated over a period not to exceed three years for statutory purposes. The presentation of the direct method statutory statement of cash flows under Codification is different from what would be presented under GAAP.

The Codification was adopted by the BOI, with an effective date of January 1, 2001, except that it has retained the prescribed practice of requiring that the value of certain prohibited investments and other investments that exceed certain limits established by the Virginia Code be treated as a reduction in admitted assets. There is no impact of the prescribed difference from Codification in accounting for investments as of December 31, 2006 and 2005. In addition, the BOI has the right to permit other specific practices that may deviate from prescribed practices.

**OPTIMA HEALTH INSURANCE COMPANY**

Notes to Statutory Financial Statements

December 31, 2006 and 2005

The following table illustrates the differences between stockholder's equity under GAAP and statutory capital and surplus at December 31, 2006 and 2005:

	<u>2006</u>	<u>2005</u>
GAAP stockholder's equity	\$ 22,602,376	22,470,954
Adjustments:		
Nonadmitted receivables	(43,914)	(205,993)
Nonadmitted equipment	(80,462)	(55,605)
Premium receivable allowance due to a a timing difference in recording an entry for statutory reporting purposes	167,782	191,224
Deferred tax asset	(125,918)	(47,534)
Reinsurance	(514,464)	(2,678,273)
Investments to amortized cost	75,891	96,129
Accumulated depreciation	(21,605)	(40,019)
Other	(1,882)	86,130
Statutory capital and surplus	<u>\$ 22,057,804</u>	<u>19,817,013</u>

The following table illustrates the differences between net income (loss) under GAAP and statutory net income (loss) for the years ended December 31, 2006 and 2005:

	<u>2006</u>	<u>2005</u>
GAAP net income (loss)	\$ 111,184	(7,130)
Adjustments:		
Premium revenue due to a timing difference in recording an entry for statutory reporting purposes	(23,442)	(23,703)
Deferred tax expense (benefit)	(388,384)	186,239
Depreciation expense	18,414	15,665
Other	21,560	109,834
Statutory net income (loss)	<u>\$ (260,668)</u>	<u>280,905</u>

**(b) Cash Equivalents**

The Corporation considers all highly liquid temporary investments with original maturities of three months or less to be cash equivalents. The Corporation had no cash equivalents as of December 31, 2006 or 2005.

**(c) Short-Term Investments and Bonds**

Short-term investments and bonds as of December 31, 2006 and 2005, consist of money market mutual funds, government and agency notes and bonds, asset-backed securities and corporate bonds, which are recorded at amortized cost, adjusted for the amortization or accretion of premiums or discounts as an adjustment to yield using the effective-interest method. A decline in the market value

## OPTIMA HEALTH INSURANCE COMPANY

### Notes to Statutory Financial Statements

December 31, 2006 and 2005

of any security below cost that is deemed other than temporary results in a reduction in carrying value to fair value. The impairment is charged to earnings, and a new cost basis for the security is established. Interest income is recognized when earned.

**(d) Equipment**

Equipment is stated at cost, less accumulated depreciation. Depreciation on equipment is calculated on the straight-line method over the estimated useful lives of the assets, primarily three years. Furniture and equipment, leasehold improvements and a portion of electronic data processing (EDP) equipment are considered nonadmitted assets under Codification (see note 6).

**(e) Premium Revenue**

Contract premiums are recognized as income during the coverage period of the applicable subscriber agreement. Premium billings are billed to subscribers in the month preceding the coverage period and are recorded as premiums received in advance to the extent received in advance of the coverage period. Premiums are due monthly and are recognized as revenue during the period in which the Corporation is obligated to arrange for service to subscribers.

**(f) Claims Unpaid and Unpaid Claims Adjustment Expenses**

Claims unpaid for inpatient hospital, outpatient surgery, emergency room, specialist, pharmacy and ancillary medical claims include amounts billed and not paid and an estimate of costs incurred for unbilled services provided. The liabilities for estimated costs incurred for unbilled services provided are based principally on historical payment patterns using actuarial techniques. Unpaid claims adjustment expenses are accrued based on an estimate of the costs necessary to process unpaid claims. Claims unpaid are reviewed and adjusted periodically and, as adjustments are made, differences are included in current operations.

**(g) Aggregate Health Policy Reserves**

Aggregate health policy reserves consist of advance premiums received by the Corporation. The Corporation recorded advance premiums of \$14,362 and \$146,547, respectively, as of December 31, 2006 and 2005 for amounts paid in advance of the period in which the Corporation is obligated to provide service to subscribers.

**(h) Pension Plan**

Employees of the Corporation participate in SHC's corporate pension plan, the cost of which is paid for by the Corporation. Past service costs of this plan are funded over a 30-year period and normal costs are paid annually.

**(i) Income Taxes**

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating losses and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary

## OPTIMA HEALTH INSURANCE COMPANY

### Notes to Statutory Financial Statements

December 31, 2006 and 2005

differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized as a change in capital and surplus in the period that includes the enactment date.

For federal income tax purposes, the Corporation's taxable income or loss is reported in the consolidated federal income tax returns filed by SHI. Under Codification, net deferred tax assets may be admitted if they meet certain admissibility criteria (see note 8).

**(j) Risk-Based Capital**

Risk-based capital (RBC) was developed by the NAIC as a method of measuring the minimum amount of capital appropriate for an accident and health insurer to support its overall business operations in consideration of its size and risk profile. A company's RBC is calculated by applying certain factors to various asset, premium and reserve items. Four action levels of RBC have been defined to set industry standards for regulatory intervention. The Commonwealth of Virginia requires that all accident and health insurers maintain statutory capital and surplus of at least 200% of the Authorized Control Level, or the Company Action Level. As of December 31, 2006 and 2005, the corporation was in compliance with this requirement.

**(k) Use of Estimates**

Management of the Corporation has made a number of estimates and assumptions relating to the reporting of admitted assets and liabilities and the disclosure of contingent assets and liabilities to prepare these statutory financial statements in conformity with statutory accounting practices prescribed or permitted by the BOI. Actual results could differ from those estimates.

**OPTIMA HEALTH INSURANCE COMPANY**

Notes to Statutory Financial Statements

December 31, 2006 and 2005

**(3) Short-Term Investments and Bonds**

The amortized cost, gross unrealized holding gains, gross unrealized holding losses, and fair value for short-term investments and bonds as of December 31, 2006 and 2005 are as follows:

	December 31, 2006			Fair value
	Amortized cost	Gross unrealized holding gains	Gross unrealized holding losses	
Money market mutual funds	\$ 17,902,358	—	—	17,902,358
Government and agency notes and bonds -				
Maturing between one year and five years	6,201,976	462	(39,921)	6,162,517
Asset-backed securities:				
Maturing between one year and five years	2,491,085	9,590	(24,890)	2,475,785
Maturing between five years and ten years	111,037	215	—	111,252
Maturing after ten years	150,726	506	(752)	150,480
Corporate bonds -				
Maturing between one year and five years	1,683,113	207	(21,308)	1,662,012
	<u>28,540,295</u>	<u>10,980</u>	<u>(86,871)</u>	<u>28,464,404</u>
Less short-term investments	17,902,358			
Bonds	<u>\$ 10,637,937</u>			

**OPTIMA HEALTH INSURANCE COMPANY**

Notes to Statutory Financial Statements

December 31, 2006 and 2005

	December 31, 2005			
	Amortized cost	Gross unrealized holding gains	Gross unrealized holding losses	Fair value
Money market mutual funds	\$ 18,543,451	—	—	18,543,451
Government and agency notes and bonds:				
Maturing within one year	543,869	—	—	543,869
Maturing between one year and five years	5,209,997	1,995	(44,070)	5,167,922
Asset-backed securities:				
Maturing between one year and five years	1,878,473	136	(28,593)	1,850,016
Maturing between five years and ten years	105,251	16	—	105,267
Maturing after ten years	111,939	—	(108)	111,831
Corporate bonds -				
Maturing between one year and five years	2,072,756	2,712	(28,217)	2,047,251
	28,465,736	\$ 4,859	(100,988)	28,369,607
Less short-term investments	19,087,320			
Bonds	\$ 9,378,416			

As a condition for licensure by the BOI to operate health maintenance organizations, the Corporation is required to maintain on deposit certain funds with the BOI. Accordingly, as of December 31, 2006 and 2005, \$543,988 and \$543,869, respectively, of government and agency notes and bonds, at amortized cost, are on deposit and are included in short-term investments in the accompanying statutory statements of admitted assets, liabilities, and capital and surplus.

At December 31, 2006, the Corporation had four government and agency notes and bonds, thirteen asset-backed securities and twelve corporate bonds with fair values of \$5,514,455, \$1,722,481 and \$1,511,857, respectively, with temporary declines in value of \$39,921, \$25,642 and \$21,308, respectively. Of these securities, three government and agency notes and bonds, six asset-backed securities and twelve corporate bonds with fair values of \$4,589,684, \$641,254 and \$1,511,857, respectively, with temporary declines in value of \$35,176, \$8,037 and \$21,308, respectively, have been in a continuous unrealized loss position for more than 12 months.

At December 31, 2005, the Corporation had five government and agency notes and bonds, twelve asset-backed securities and fifteen corporate bonds with fair values of \$4,482,619, \$1,671,657 and \$1,694,820, respectively, with temporary declines in value of \$44,070, \$28,701 and \$28,217, respectively. Of these securities, three government and agency notes and bonds, four asset-backed securities and five corporate bonds with fair values of \$2,559,760, \$583,708 and \$764,349, respectively, with temporary declines in value of \$27,573, \$17,138 and \$18,621, respectively, have been in a continuous unrealized loss position for more than 12 months.

**OPTIMA HEALTH INSURANCE COMPANY**

Notes to Statutory Financial Statements

December 31, 2006 and 2005

These temporary declines in value as of December 31, 2006 and 2005 are primarily due to fluctuations in market interest rates.

**(4) Pharmaceutical Rebates**

The Corporation estimates pharmaceutical rebates based on a per member, per month calculation developed by reviewing historical payment patterns of the drug manufacturers. Pharmaceutical rebates are recorded as health care receivables on the accompanying statutory statements of admitted assets, liabilities, and capital and surplus and as a reduction to medical benefits, net, in the accompanying statutory statements of revenue and expenses. Pharmaceutical rebates receivable are considered admitted assets to the extent invoiced to the drug manufacturers within two months of recording the estimate and then collected within 90 days of the invoice date in accordance with statutory accounting principles. The following table represents approximate pharmaceutical rebates as recorded in the Corporation's statutory filings for each of the four quarters in the years ended December 31, 2006, 2005 and 2004, along with amounts invoiced and cumulatively collected subsequent to the reporting dates:

	<b>Quarter ended</b>			
	<b>December 31, 2006</b>	<b>September 30, 2006</b>	<b>June 30, 2006</b>	<b>March 31, 2006</b>
Estimated pharmaceutical rebates as recorded	\$ 274,000	295,000	234,000	155,000
Pharmaceutical rebates as invoiced	—	266,000	238,000	225,000
Actual rebates collected within 90 days of invoicing	—	24,000	66,000	167,000
Actual rebates collected between 91 to 180 days of invoicing	—	—	120,000	28,000
Actual rebates collected more than 180 days after invoicing	—	—	—	22,000

**OPTIMA HEALTH INSURANCE COMPANY**

Notes to Statutory Financial Statements

December 31, 2006 and 2005

	Quarter ended			
	December 31, 2005	September 30, 2005	June 30, 2005	March 31, 2005
Estimated pharmaceutical rebates as recorded	\$ 126,000	102,000	125,000	90,000
Pharmaceutical rebates as invoiced	180,000	191,000	175,000	165,000
Actual rebates collected within 90 days of invoicing	135,000	122,000	110,000	93,000
Actual rebates collected between 91 to 180 days of invoicing	60,000	47,000	36,000	57,000
Actual rebates collected more than 180 days after invoicing	—	15,000	25,000	16,000

	Quarter ended			
	December 31, 2004	September 30, 2004	June 30, 2004	March 31, 2004
Estimated pharmaceutical rebates as recorded	\$ 121,000	91,000	245,000	142,000
Pharmaceutical rebates as invoiced	215,000	205,000	200,000	203,000
Actual rebates collected within 90 days of invoicing	166,000	158,000	136,000	101,000
Actual rebates collected between 91 to 180 days of invoicing	55,000	47,000	69,000	100,000
Actual rebates collected more than 180 days after invoicing	2,000	2,000	6,000	4,000

**(5) Transactions with Parent, Subsidiaries and Affiliates**

During the years ended December 31, 2006 and 2005, the Corporation incurred expenses of approximately \$514,000 and \$381,000, respectively, for data processing services and other administrative and financial support services provided by SHC.

Certain benefits under the health policies are paid to hospitals and physician groups affiliated with SHC. Total medical benefits expenses for services performed at SHC-affiliated hospitals and physician groups during the years ended December 31, 2006 and 2005 approximated \$14,766,000 and \$10,060,000, respectively, which are included in medical benefits, net, in the accompanying statutory statements of revenue and expenses.

**OPTIMA HEALTH INSURANCE COMPANY**

Notes to Statutory Financial Statements

December 31, 2006 and 2005

The Corporation also contracts with Sentara Behavioral Health Services (SBHS), a subsidiary of SHP, to provide mental health services to subscribers. Under the terms of a capitated contract, the Corporation pays SBHS fixed rates per member per month to cover the costs of these services. Total capitation expenses to SBHS approximated \$1,274,000 and \$914,000 in 2006 and 2005, respectively, which are included in medical benefits, net, on the accompanying statutory statements of revenue and expenses.

Amounts due from Parent, subsidiaries and affiliates of \$2,527,669 at December 31, 2006 represent an amount owed to the Corporation by Optima due to the timing of the settlement of various intercompany accounts. Amounts due from Parent, subsidiaries and affiliates of \$411,093 at December 31, 2005 represent an amount owed to the Corporation by SHP for overpayment of administrative expenses paid by SHP on behalf of the Corporation.

Amounts due to Parent, subsidiaries and affiliates represent amounts owed to SHP for administrative expenses paid by SHP on behalf of the Corporation.

**(6) Equipment, Net**

The cost basis, accumulated depreciation and nonadmitted assets for the following categories of property and equipment, net, as of December 31, 2006 and 2005 are as follows:

	2006			
	<u>Furniture and equipment</u>	<u>EDP equipment and software</u>	<u>Leasehold improvements</u>	<u>Total</u>
Cost basis	\$ 177,984	519,394	102,020	799,398
Less accumulated depreciation	133,061	452,878	66,481	652,420
	44,923	66,516	35,539	146,978
Less nonadmitted assets	44,923	—	35,539	80,462
Admitted assets	\$ —	66,516	—	66,516

	2005			
	<u>Furniture and equipment</u>	<u>EDP equipment and software</u>	<u>Leasehold improvements</u>	<u>Total</u>
Cost basis	\$ 146,322	481,423	85,504	713,249
Less accumulated depreciation	119,271	423,141	56,950	599,362
	27,051	58,282	28,554	113,887
Less nonadmitted assets	27,051	—	28,554	55,605
Admitted assets	\$ —	58,282	—	58,282

Depreciation expense was \$53,058 and \$63,462 for the years ended December 31, 2006 and 2005, respectively, and is included in general administrative expenses in the accompanying statutory statements of revenue and expenses.

**OPTIMA HEALTH INSURANCE COMPANY**

Notes to Statutory Financial Statements

December 31, 2006 and 2005

**(7) Claims Unpaid and Aggregate Health Claim Reserves**

As of December 31, 2006 and 2005, claims unpaid and aggregate health claim reserves were as follows:

	<u>2006</u>	<u>2005</u>
Claims unpaid	\$ 8,230,345	5,722,374
Aggregate health claim reserves	<u>94,541</u>	<u>111,372</u>
	<u>\$ 8,324,886</u>	<u>5,833,746</u>

A summary of the activity for claims unpaid and aggregate health claim reserves is as follows:

	<u>2006</u>	<u>2005</u>
Balance at January 1	\$ 5,833,746	5,750,546
Incurred related to:		
Current year	63,952,565	42,442,918
Prior years	<u>(1,129,482)</u>	<u>(1,327,266)</u>
Total incurred	<u>62,823,083</u>	<u>41,115,652</u>
Paid related to:		
Current year	55,655,705	36,667,978
Prior years	<u>4,676,238</u>	<u>4,364,474</u>
Total paid	<u>60,331,943</u>	<u>41,032,452</u>
Balance at December 31	<u>\$ 8,324,886</u>	<u>5,833,746</u>

The Corporation uses actuarial techniques based principally on historical payment patterns to estimate incurred claims. Changes in payment patterns and claims trends can result in adjustments to prior years' claims estimates and are recorded in current operations. Changes in estimates of incurred claims for prior years recognized in 2006 and 2005 were attributable to lower than anticipated utilization and costs of medical services.

**(8) Federal Income Taxes**

The Corporation and SHI are members of an affiliated group that files a consolidated federal income tax return. The other members of that group are SHP, OHG, SBHS, Sentara Ventures, Inc. and Hampton Services Corporation, all subsidiaries of SHI. The consolidated federal income tax liability is allocated among the members of the group under the provisions of a tax sharing agreement entered into by the members of the group. The Corporation's federal income tax expense (benefit) was \$472,670 and \$(275,553) for the years ended December 31, 2006 and 2005, respectively.

**OPTIMA HEALTH INSURANCE COMPANY**

Notes to Statutory Financial Statements

December 31, 2006 and 2005

The components of the deferred tax asset for the Corporation as of December 31, 2006 and 2005 are as follows:

	2006	2005
Claims unpaid, a portion of which is deductible as paid for tax purposes	\$ 61,000	46,000
Unearned revenue, included in income as received for tax purposes	58,000	71,000
Allowances for doubtful accounts, net of non-admitted assets, and deductible as written off for tax purposes	22,000	72,000
Property and equipment, due to timing differences in depreciation and non-admitted assets	38,000	29,000
Accrued expenses, deductible as paid for tax purposes	422,000	64,000
	601,000	282,000
Less non-admitted asset	38,000	29,000
Admitted deferred tax asset	\$ 563,000	253,000

The increase (decrease) in deferred tax asset of \$319,000 and \$(173,000) for the years ended December 31, 2006 and 2005, respectively, is recorded as an increase (decrease) to statutory capital and surplus. For the years ended December 31, 2006 and 2005, the Corporation's federal income tax expense (benefit) is different from the computed expected tax expense (benefit) of 35% of income (loss) before federal income taxes due to the effects of nondeductible expenses for tax return purposes and changes in estimates resulting from filing prior year tax returns.

**(9) Insurance**

**(a) Reinsurance**

The Corporation provides reinsurance coverage to Optima and an unaffiliated company. The policies limit reinsurance coverage to \$1,000,000 of covered expenses for an individual member per policy year, subject to deductibles of \$500,000. The Corporation had reinsurance premium revenue of \$1,893,903 (\$1,521,098 of which related to Optima) and \$1,423,547 (all of which related to Optima) during the years ended December 31, 2006 and 2005, respectively, which was recognized as premium revenue. As prescribed by the BOI, the Corporation recorded liabilities of \$514,464 and \$2,678,273 at December 31, 2006 and 2005, respectively, within other current liabilities along with a corresponding reserve against capital and surplus as reserved surplus-reinsurance in the accompanying statutory statements of admitted assets, liabilities, and capital and surplus. The liability and reserved surplus are increased each year by the premiums collected, net of premium tax. The liability and reserved surplus are released either as claims are incurred that are covered under the reinsurance policies or after a two-year period passes. For the year ended December 31, 2006, Optima incurred claims that exceeded the deductibles of \$2,719,127. No claims were filed during 2005.

## OPTIMA HEALTH INSURANCE COMPANY

Notes to Statutory Financial Statements

December 31, 2006 and 2005

### **(b) *General Liability and Malpractice Insurance***

The Corporation, along with SHC and its subsidiaries, insure their professional, general and managed care liability risks through comprehensive claims-made insurance policies issued by Lexington Insurance Company (Lexington). Under the Lexington policies, the policy limits are \$2,000,000 per occurrence and \$23,000,000 in the aggregate for professional and managed care liability and \$1,000,000 per occurrence for general liability. The Lexington policies are reinsured by SHC's wholly owned captive insurance company, Bay Primex Insurance Company Ltd. The sole activity of Bay Primex Insurance Company, Ltd. is reinsurance, on a facultative basis, of the claims-made professional, comprehensive general and managed care professional liability insurance policies issued by Lexington. All SHC entities are covered by the same claims-made excess liability policy through two independent carriers. Annual coverage limits are \$40,000,000 per occurrence and \$40,000,000 in the aggregate for amounts exceeding the primary coverage limits. The professional liability policies are on a claims-made basis and must be renewed or replaced with equivalent insurance if claims incurred during their term but asserted after their expiration are to be insured.

### **(10) Employee Benefit Plans**

#### **(a) *Deferred Compensation Savings Plan***

The Corporation's employees have the option to participate in a deferred compensation plan sponsored by SHC, which is exempt from income taxes under Section 401(k) of the Internal Revenue Code. Substantially all full-time employees may elect to participate in this plan. Under the plan, participants may contribute certain amounts of their compensation, subject to maximum federal and plan limits. The Corporation matches one-half of the participant's annual contribution limited to 2.5% of the participant's annual compensation. In 2006 and 2005, the Corporation's expense related to the plan was approximately \$38,000 and \$28,000, respectively.

#### **(b) *Pension Plan***

SHC sponsors a noncontributory defined benefit pension plan (the Plan), which covers substantially all employees of SHC and certain of its subsidiaries, including the Corporation. The legal obligation of the Plan is the responsibility of SHC. Net pension expense, which is allocated to the Corporation by SHC based on the number of employees of each SHC affiliate, was approximately \$173,000 and \$157,000 for the years ended December 31, 2006 and 2005, respectively. The Plan conforms to the requirements of the Employee Retirement Income Security Act of 1974. It is not possible to present separately the actuarial present value of benefit obligations or the net assets available for benefits of the Corporation because no determination has been made of the allocation of such amounts between SHC and the Corporation.

## OPTIMA HEALTH INSURANCE COMPANY

### Notes to Statutory Financial Statements

December 31, 2006 and 2005

#### (11) Minimum Lease Payments

SHP entered into an operating lease for office space, part of which is occupied by the Corporation. The Corporation has agreed to share proratably, based on number of subscribers, in the responsibility for this lease with Optima and certain other subsidiaries of SHP. SHP's total future minimum lease payments as of December 31, 2006 are as follows:

2007	\$	939,464
2008		949,127
2009		969,374
2010		867,092
2011		359,580
	\$	<u>4,084,637</u>

The Corporation's share of total expense relating to this operating lease was approximately \$76,000 and \$61,000 for the years ended December 31, 2006 and 2005, respectively.

## OPTIMA HEALTH INSURANCE COMPANY

## Supplementary Summary Investment Schedule

December 31, 2006

Investment holdings	Admitted assets as reported in the statutory financial statements	
	Amount	Percentage
Bonds:		
U.S. Treasury securities	\$ 6,198,888	21%
Mortgage-backed securities (including residential and commercial mortgage-backed securities):		
Pass-through securities:		
Issued or guaranteed by GNMA	58,050	0%
Issued or guaranteed by FNMA and FHLMC	2,307,756	8%
CMOs and REMICs:		
Issued or guaranteed by GNMA, FNMA or FHLMC or VA	98,007	0%
Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by GNMA, FNMA or FHLMC or VA	290,000	1%
Other debt and other fixed income securities (excluding short term) – unaffiliated domestic securities (including credit tenant loans rated by the SVO)	1,685,236	6%
Equity interests – investments in mutual funds	17,358,370	60%
Cash and short term investments	1,168,482	4%
Total invested assets	<u>\$ 29,164,789</u>	<u>100%</u>

Note: At December 31, 2006, there are no differences between gross investment holdings and admitted asset values.

See accompanying independent auditors' report.

**OPTIMA HEALTH INSURANCE COMPANY**  
**Supplemental Investment Risks Interrogatories**  
Year ended December 31, 2006

Schedule 2

The Investment Risk Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U. S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. \$ 33,866,521
2. Ten largest exposures to a single issuer/borrower/investment.

1	2	3	4
Issuer	Description of exposure	Amount	Percentage of total admitted assets
2.01	SSGA Funds	\$ 145,047	0.4
2.02	Bank One Issuance Trust	290,000	0.9
2.03	General Electric Cap Corp	199,943	0.6
2.04	Merril Lynch & Co	175,413	0.5
2.05	Morgan Stanley	149,946	0.4
2.06	American General Finance	149,937	0.4
2.07	Caterpillar Finance Serv Corp	149,558	0.4
2.08	Bank of New York Co Inc	107,478	0.3
2.09	Goldman Sach Group Inc	107,240	0.3
2.10	Wal-Mart Stores	159,065	0.5

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

NAIC Rating	Amount	Percentage of total admitted assets
<b>Bonds:</b>		
3.01 NAIC-1	\$ 28,540,295	84.3
3.02 NAIC-2	—	—
3.03 NAIC-3	—	—
3.04 NAIC-4	—	—
3.05 NAIC-5	—	—
3.06 NAIC-6	—	—
<b>Preferred Stocks:</b>		
3.07 P/RP-1	\$ —	—
3.08 P/RP-2	—	—
3.09 P/RP-3	—	—
3.10 P/RP-4	—	—
3.11 P/RP-5	—	—
3.12 P/RP-6	—	—

4. Assets held in foreign investments:

1	2
Amount	Percent
4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X] No [ ]
4.02 Total admitted assets held in foreign investments	\$ —
4.03 Foreign-currency-denominated investments	—%
4.04 Insurance liabilities denominated in that same foreign currency	—

If response, to 4.01 above is yes, responses are not required for interrogatories 5 – 10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

NAIC Sovereign Rating	1	2
NAIC Sovereign Rating	Amount	Percent
5.01 Countries rated NAIC-1	\$ —	—%
5.02 Countries rated NAIC-2	—	—
5.03 Countries rated NAIC-3 or below	—	—

**OPTIMA HEALTH INSURANCE COMPANY**  
 Supplemental Investment Risks Interrogatories  
 Year ended December 31, 2006

Schedule 2

6. Two largest foreign investment exposures to a single country, categorized by NAIC sovereign rating:

NAIC Sovereign Rating	1 Amount	2 Percent
Countries rated NAIC-1		
6.01	\$ —	—%
6.02	—	—
Countries rated NAIC-2		
6.03	\$ —	—%
6.04	—	—
Countries rated NAIC-3 or below		
6.05	\$ —	—%
6.06	—	—

Description	1 Amount	2 Percent
7. Aggregate unhedged foreign currency exposure	\$ —	—%

8. Aggregate unhedged foreign currency exposure categorized by the country's NAIC sovereign rating:

NAIC Sovereign Rating	1 Amount	2 Percent
8.01 Countries rated NAIC-1	—	—%
8.02 Countries rated NAIC-2	—	—
8.03 Countries rated NAIC-3 or below	—	—

9. Two largest unhedged foreign currency exposures to a single country, categorized by the country's NAIC sovereign rating:

NAIC Sovereign Rating	1 Amount	2 Percent
Countries rated NAIC-1		
9.01	\$ —	—%
9.02	—	—
Countries rated NAIC-2		
9.03	\$ —	—%
9.04	—	—
Countries rated NAIC-3 or below		
9.05	\$ —	—%
9.06	—	—
Canadian currency exposure.		

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

1	2	3	4
Issuer	NAIC Rating	Amount	Percentage of total admitted assets
10.01 SSGA Funds		\$ —	—%
10.02 Bank One Issuance Trust		—	—
10.03 General Electric Cap Corp		—	—
10.04 Merrill Lynch & Co		—	—
10.05 Morgan Stanley		—	—
10.06 American General Finance		—	—
10.07 Caterpillar Finance Serv Corp		—	—
10.08 Bank of New York Co Inc		—	—
10.09 Goldman Sach Group Inc		—	—
10.10 Wal-Mart Stores		—	—

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure.

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]  
 If response to 11.01 is yes, details is not required for the remainder of interrogatory 11.

Description	1 Amount	2 Percent
11.02 Total admitted assets held in Canadian Investments	—	—%
11.03 Canadian-currency-denominated investments	—	—
11.04 Canadian-denominated insurance liabilities	—	—
11.05 Unhedged Canadian currency exposure	—	—

**OPTIMA HEALTH INSURANCE COMPANY**  
 Supplemental Investment Risks Interrogatories  
 Year ended December 31, 2006

Schedule 2

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes  No   
 If response to 12.01 is yes, responses are not required for the remainder of interrogatory 12.

1	2	3
Contractual Sales Restrictions	Amount	Percent
12.02 Aggregate statement value of investments with contractual sales restrictions	—	—%
Largest 3 investments with contractual sales restrictions		
12.03	—	—
12.04	—	—
12.05	—	—

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interest less than 2.5% of the reporting entity's total admitted assets? Yes  No   
 If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.

1	2	3
Name of issuer	Amount	Percent
13.02 Assets held in equity interests:	—	—%
13.03	—	—
13.04	—	—
13.05	—	—
13.06	—	—
13.07	—	—
13.08	—	—
13.09	—	—
13.10	—	—
13.11	—	—

14. Amounts and percentages of reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes  No   
 If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

1	2	3
Investment Category	Amount	Percent
14.02 Aggregate statement value of investments held in nonaffiliated, privately placed equities	—	—%
Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03	—	—
14.04	—	—
14.05	—	—

15. Amounts and percentages of reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? Yes  No   
 If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

1	2	3
Investment in General Partnerships	Amount	Percent
15.02 Aggregate statement value of investments held in general partnership interests	—	—%
Largest 3 investments held in general partnership interests:		
15.03	—	—
15.04	—	—
15.05	—	—

**OPTIMA HEALTH INSURANCE COMPANY**  
 Supplemental Investment Risks Interrogatories  
 Year ended December 31, 2006

## 16. Amounts and percentages of reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

1 Type (Residential, Commercial, Agricultural)	2 Amount	3 Percent
Total admitted held in Mortgage Loans		
16.02	—	—
16.03	—	—
16.04	—	—
16.05	—	—
16.06	—	—
16.07	—	—
16.08	—	—
16.09	—	—
16.10	—	—
16.11	—	—
Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:		
16.12	—	—
16.13	—	—
16.14	—	—
16.15	—	—

## 17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

Loan to value	Residential		Commercial		Agricultural	
	1 Amount	2 Percent	3 Amount	4 Percent	5 Amount	6 Percent
17.01 Above 95%	—	—%	—	—%	—	—%
17.02 91% to 95%	—	—	—	—	—	—
17.03 81% to 90%	—	—	—	—	—	—
17.04 71% to 80%	—	—	—	—	—	—
17.05 Below 70%	—	—	—	—	—	—

## 18. Amounts and percentages of reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported in less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

1 Description	2 Amount	3 Percent
Largest 5 investments in any one parcel or group of contiguous parcels of real estate:		
18.02	\$ —	—%
18.03	—	—
18.04	—	—
18.05	—	—
18.06	—	—

## 19. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

Description	At year-end		At end of each quarter		
	1	2	3 1st Quarter	4 2nd Quarter	5 3rd Quarter
19.01 Securities lending agreements (do not include assets held as collateral for such transactions)	\$ —	—%	\$ —	—	—
19.02 Repurchase agreements	—	—	—	—	—
19.03 Reverse repurchase agreements	—	—	—	—	—
19.04 Dollar repurchase agreements	—	—	—	—	—
19.05 Dollar reverse repurchase agreements	—	—	—	—	—

## OPTIMA HEALTH INSURANCE COMPANY

## Supplemental Investment Risks Interrogatories

Year ended December 31, 2006

20. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

Description	Owned		Written	
	1 Amount	2 Percent	3 Amount	4 Percent
20.01 Hedging	\$ —	—%	\$ —	—%
20.02 Income generation	—	—	—	—
20.03 Other	—	—	—	—

21. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

Description	At year-end		Amount at end of each quarter		
	1 Amount	2 Percent	3 1st Quarter	4 2nd Quarter	5 3rd Quarter
21.01 Hedging	\$ —	—%	\$ —	—	—
21.02 Income generation	—	—	—	—	—
21.03 Replications	—	—	—	—	—
21.04 Other	—	—	—	—	—

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

Description	At year-end		Amount at end of each quarter		
	1	2	3 1st Quarter	4 2nd Quarter	5 3rd Quarter
22.01 Hedging	\$ —	—%	\$ —	—	—
22.02 Income generation	—	—	—	—	—
22.03 Replications	—	—	—	—	—
22.04 Other	—	—	—	—	—

See accompanying independent auditors' report.

**Sample  
Employer Group Report**

## Health Profile Group Summary

Sample Group- Annual Report includes 1/01/07 thru 12/31/07

This report summarizes the health risk profile based on Optima's predictive modeling software.

People identified as "Well Members" in the chart below have the least risks for developing chronic disease and the best chance for living a healthy life. People in this category may benefit from preventative screenings, health education, and reinforcement of healthy behaviors. This group generally makes up 50% of a large population, and accounts for 10% of health care costs.

People who are "Low Risk" in the chart below have some risks for developing chronic disease, but are generally healthy. People in this category may benefit from optimization of health benefits and resources, and may occasionally require support with acute episodes of care. This group generally makes up 20% of a large population and accounts for 10% of health care costs.

People who are at "Moderate Risk" in the chart below may have already developed early chronic illness states, and probably have more than one risk factor. People in this category may benefit from disease management education, risk avoidance management and coaching. This group generally makes up 25% of a large population and accounts for 25% of health care costs.

People who are identified as "High Risk, Multiple Diseases" are at significant risk for developing chronic disease, and may already have done so, as well as likely having multiple risk factors leading to progression of chronic illness. People in this category may benefit from episodic care management and coordination, comprehensive disease management education and lifestyle change. This group generally makes up 4% of a large population and accounts for 30% of health care costs.

People who are identified as "Complex and Intensive Care" have significant illness burden. They generally have multiple disease states, which may rise to a catastrophic level. People in this category may benefit from total integration of care coordination with a multidisciplinary health care team. This group generally makes up 1% of a large population, and accounts for 25% of health care costs.



### Sample Group % Costs

1.3%	3.6%	7.5%	17.0%	70.6%
10% Cost	10% Cost	25% Cost	30% Cost	25% Cost
<b>Well Members</b>	<b>Low Risk Members</b>	<b>Moderate Risk Members</b>	<b>High Risk, Multiple Diseases</b>	<b>Complex &amp; Intensive Care</b>
Prevention and Education	Optimize Resources in Acute Episodes of Care, Population Care	DM and Education, Risk Avoidance	Episodic Care Mgmt, Clinical Guidelines, High Risk DM	Total Care Integration
50% Members	20% Members	25% Members	4% Members	1% Members

### Sample Group % Members

39.8%	20.2%	19.5%	14.3%	6.3%
<b>Sample Group Number of Members Actively Engaged with Health Coach</b>				
621	818	962	1,477	1296
3.2%	8.3%	10.1%	21.2%	42.1%

Source:

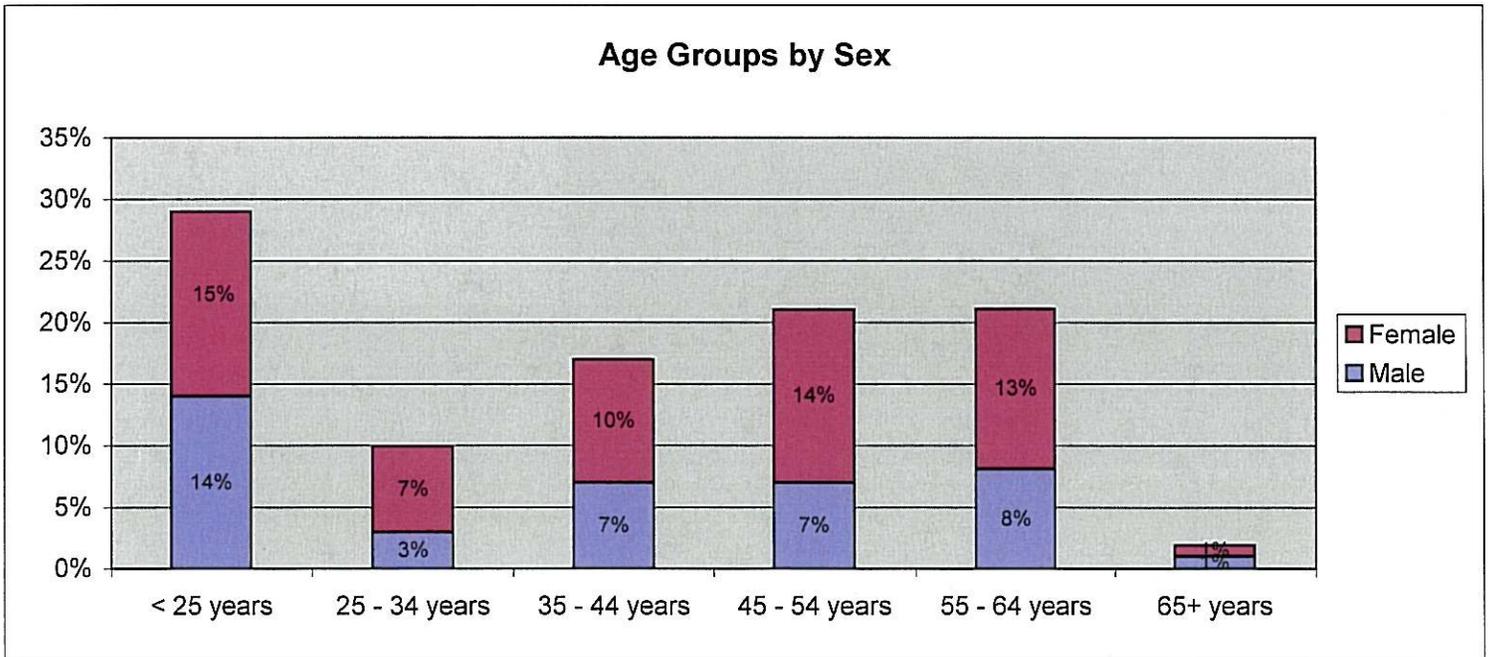
S. Nussbaum, Reflection on the Future of Disease Management, Disease Management Colloquium, 2004.

## Demographics

The chart below describes Group by age, gender and employee/spouse/dependent subgroups.

Although older people face increasingly higher risks of death and disease, young people are also affected by smoking, unhealthy diet and lack of regular exercise.

Habits become ingrained during the younger years—long term physical damage accumulates as well. Although young people have relatively less risk from major killers such as heart disease and cancer in the short run, they can substantially reduce their lifetime risks by modifying unhealthy behaviors as soon as possible.



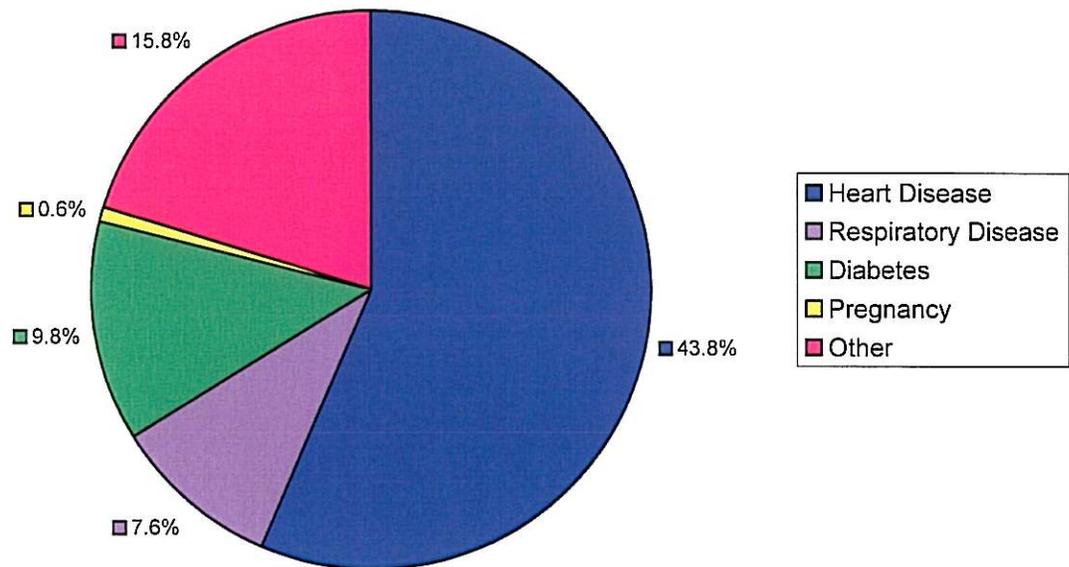
	Number of Members
<b>Employee</b>	26,394
<b>Spouse</b>	7,820
<b>Dependent</b>	14,663
<b>Total</b>	48,877

## Risk Factors in this Group

Risk factors are conditions that shape the odds for early death and disability. The following health risks were evaluated based on individual claims, pharmacy and lab data, as well as individual responses during care management discussion. Lifestyle and habits play a significant role in employees' overall health, and employees' willingness to change impacts their ability to lower their health risks.

Nationally, one person in three has high blood pressure, and nearly half are unaware, 17% of people over age 20 have high blood cholesterol, and 37% of adults report having two or more risk factors for heart disease and stroke. (CDC, 2005)

**Health Risk Factors/Presence of Chronic Illness Identified for Sample Group**



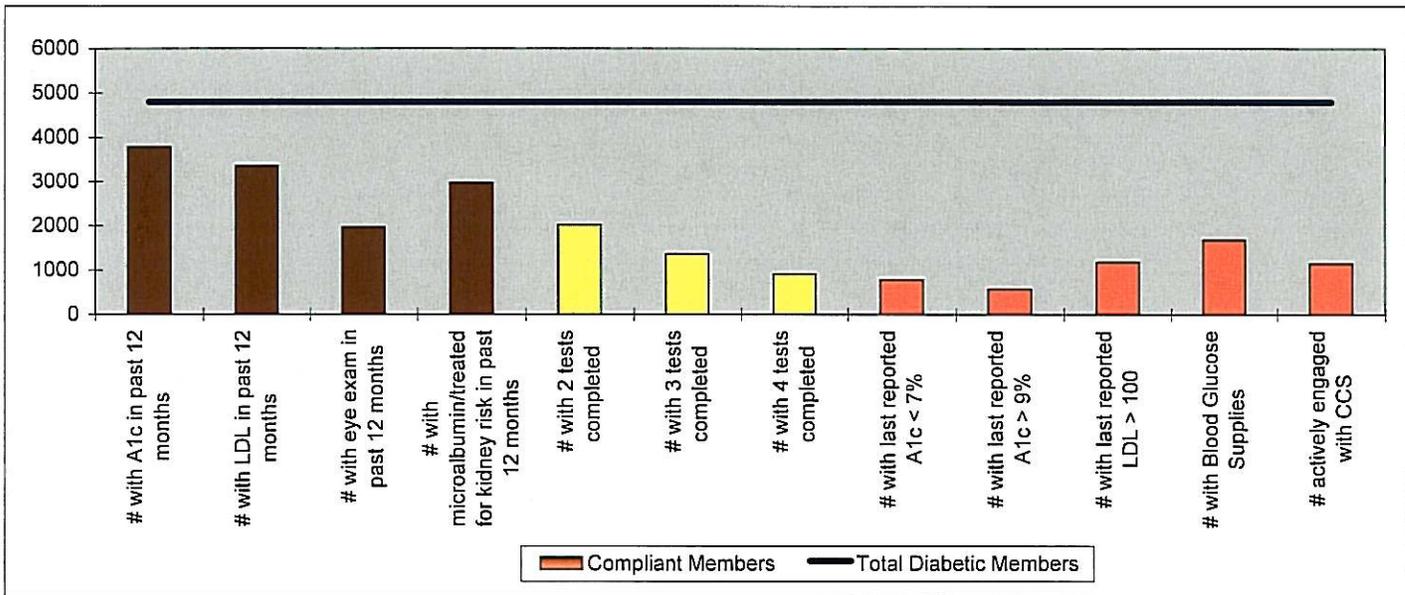
Category	Risk Factor	Number of Members	% of Members
Heart Disease	Acute Cardiac Event	195	0.4%
Heart Disease	Hyperlipidemia/HLD	10264	21.0%
Heart Disease	Hypertension/HTN	10948	22.4%
Respiratory Disease	Asthma	3030	6.2%
Respiratory Disease	COPD	684	1.4%
Diabetes	Diabetes	4790	9.8%
Pregnancy	Pregnancy	274	0.6%
Other	Drug Use Recorded	18	0.0%
Other	Tobacco Use Recorded	136	0.3%
Other	BMI > 25 and < 30 Recorded	3128	6.4%
Other	BMI > 30 Recorded	3910	8.0%
Other	Depression Screening Positive	12	0.1%

# Diabetes

Diabetes and its associated complications is increasing in the United States. Diabetes increases the risk of heart disease and stroke, is the leading cause of non-traumatic amputation, blindness among working age adults, and end-stage renal disease. These realities are especially disturbing given the validated efficacy and economic benefit of prevention of complications and management of diabetes.

9.6% of people age 20 and older have diabetes. At least one-third of those do not know they have the disease. (CDC, 2005).

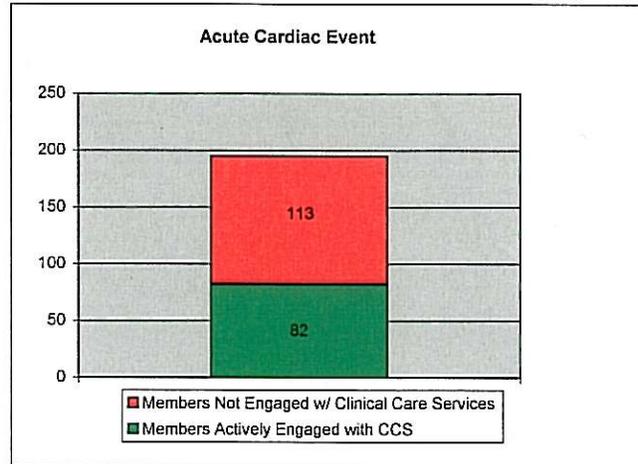
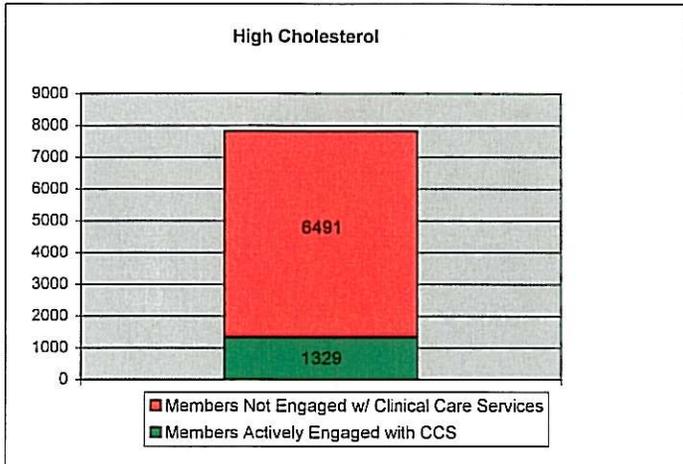
The American Diabetes Association estimates that 22.6% of overweight adults have prediabetes.



Compliant Measures	Number of Members	% Diabetics
# with A1c in past 12 months	3784	79.0%
# with LDL in past 12 months	3353	70.0%
# with eye exam in past 12 months	1964	41.0%
# with microalbumin/treated for kidney risk in past 12 months	2969	62.0%
# with 2 tests completed	2018	42.1%
# with 3 tests completed	1360	28.4%
# with 4 tests completed	910	19.0%
# with last reported A1c < 7%	776	16.2%
# with last reported A1c > 9%	575	12.0%
# with last reported LDL > 100	1178	24.6%
# with Blood Glucose Supplies	1677	35.0%
# actively engaged with CCS	1149	24.0%
# Members with ER Visit in past 12 months	43	0.9%
# Members with IP Admissions in past 12 months	58	1.2%

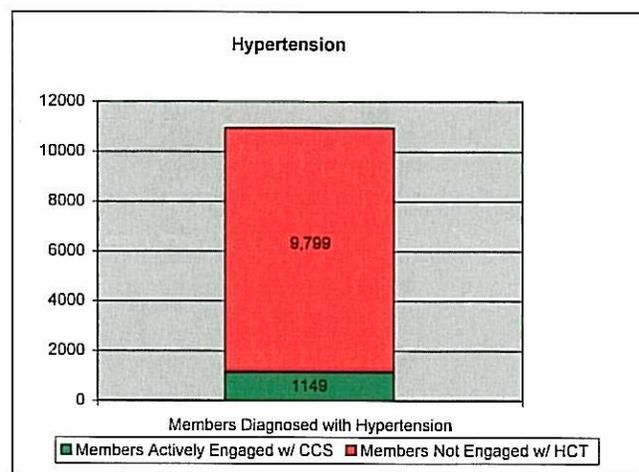
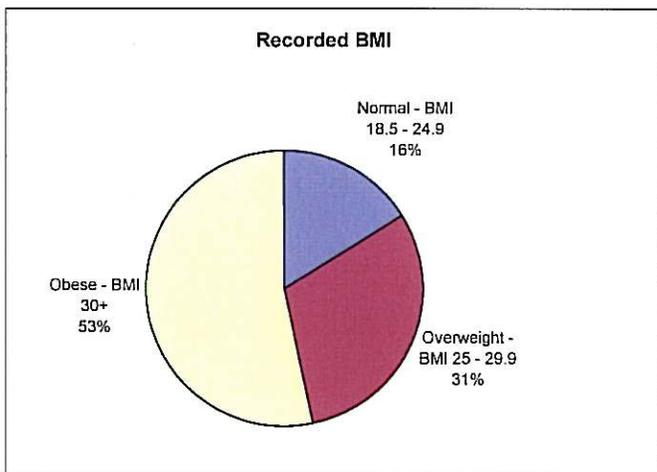
# Heart Disease

Heart disease is the leading cause of death for all people in the United States. Stroke is the third leading cause of death. Heart disease and stroke continue to be major causes of disability and significant contributors to increases in health care costs in the United States. Epidemiologic and statistical studies have identified a number of factors that increase the risk of heart disease and stroke. In addition, clinical trials and prevention research studies have demonstrated effective strategies to prevent and control these risk factors and thereby reduce illnesses, disabilities, and deaths caused by heart disease and stroke.



Cholesterol Measures	Number of Members	% of Members
Members w/ Last Recorded LDL > 130	7820	
Members Actively Engaged with CCS	1329	17.0%

Acute Cardiac Event Measures	Number of Members	% of ACE Members
Members with Acute Cardiac Event	195	
Members Actively Engaged with CCS	82	42.1%

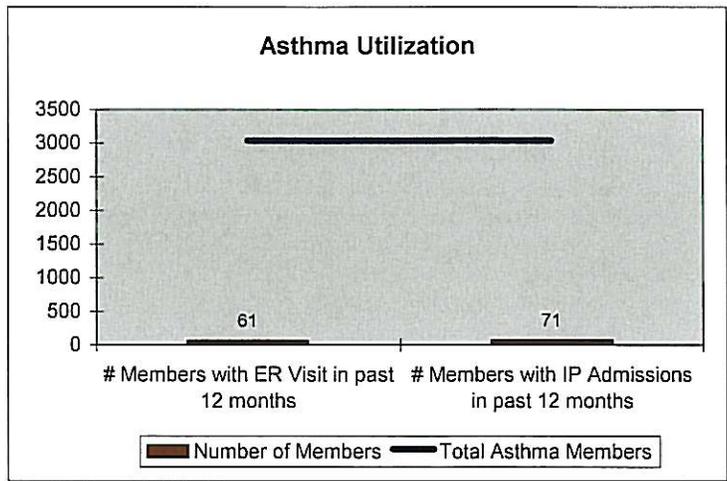
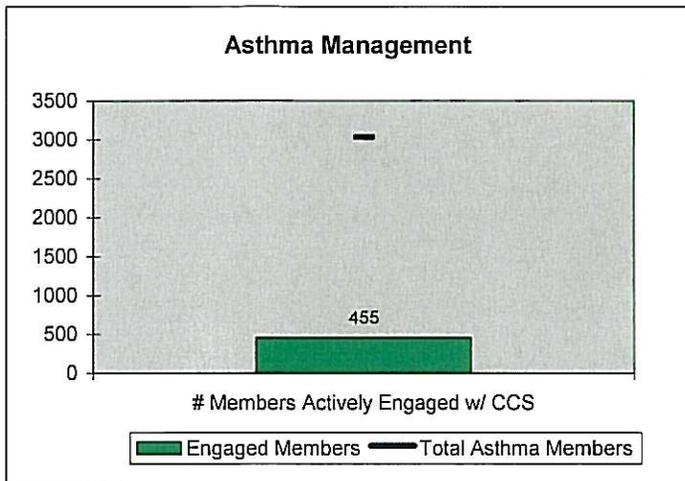


Recorded BMI Measures	Number of Members	% of Members w/ BMI
Total Members w/ BMI	5279	
Normal - BMI 18.5 - 24.9	848	16.1%
Overweight - BMI 25 - 29.9	1622	30.7%
Obese - BMI 30+	2809	53.2%

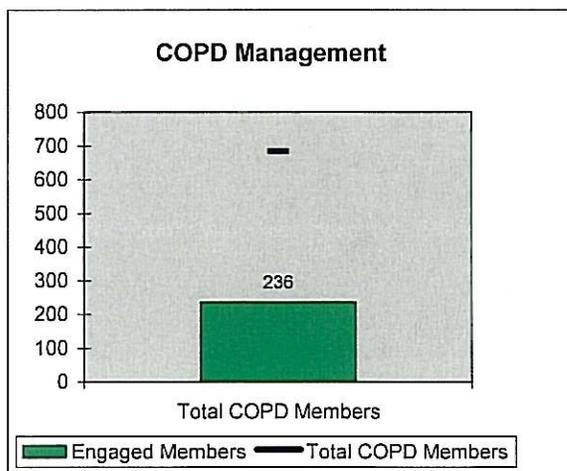
Acute Cardiac Event Measures	Number of Members	% of ACE Members
Total Members w/ Hypertension	10948	
Members Actively Engaged w/ CCS	1149	10.5%

# Asthma and COPD

Respiratory illness is a serious and growing problem. Yet much of the morbidity and mortality of respiratory illness can be averted if patients and health care providers managed the illness according to established guidelines. Effective management comprises four areas: reduction of exposure to environmental triggers, appropriate medications, monitoring lung function, and training patients to become good self-managers.



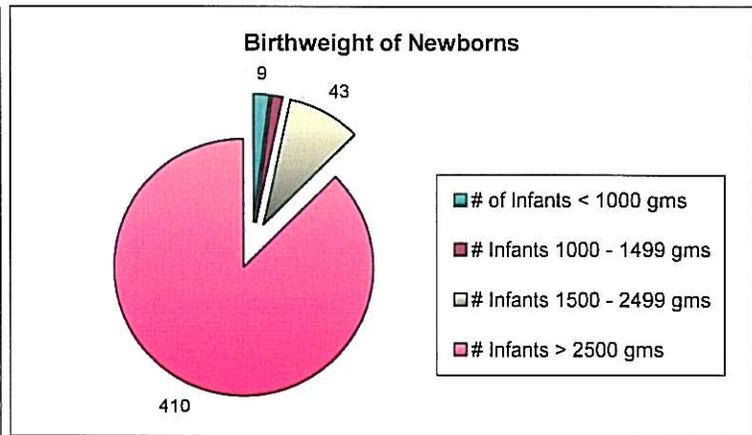
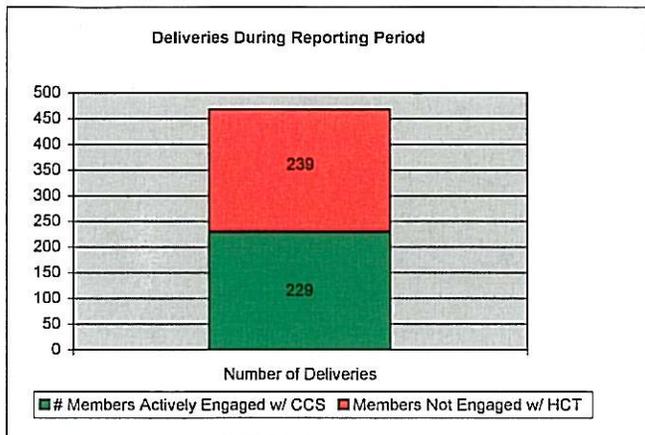
Asthma Measures	Number of Members	% of Asthma Members
Total Number of Members with Asthma	3030	
# Members Compliant with Asthma Medications	2636	87.0%
# Members Actively Engaged w/ CCS	455	15.0%
# Members with ER Visit in past 12 months	61	2.0%
# Members with IP Admissions in past 12 months	71	2.3%



COPD Measures	Number of Members	% of COPD Members
Total Number of Members with COPD	684	
# Members Actively Engaged w/ CCS	236	34.5%

## Partners in Pregnancy

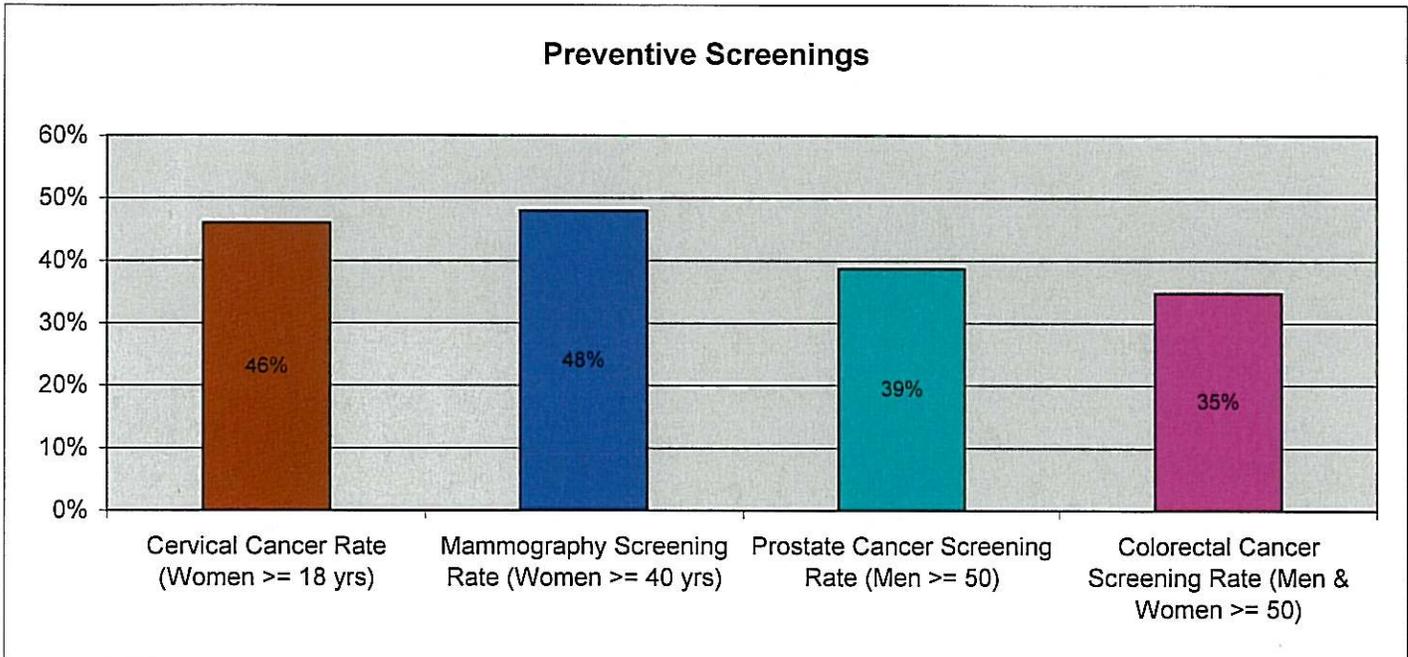
Premature birth and low birth weight (LBW) are the leading causes of neonatal death and disability. Risk factors include maternal LBW, prior history of LBW, cigarette smoking, multiple births and low pregnancy weight gain. However, these risk factors only account for one third of preterm births. Evidence supports that good prenatal care and health practices improve the risk of premature birth.



OB Measures	Number of Members	% of Deliveries	Members Engaged w/ Clinical Care Services
Number of Deliveries	468		
# of Infants < 1000 gms	9	1.9%	0
# Infants 1000 - 1499 gms	6	1.3%	0
# Infants 1500 - 2499 gms	43	9.2%	4
# Infants > 2500 gms	410	87.6%	47
Total Number of Members Engaged w/ Clinical Care Services	229	48.9%	

## Preventive Screenings

Preventative screenings to assess cancer risk are important for early detection. Studies show that early detection of cervical, breast, prostate and colon cancer greatly increase survival rates. The graph below indicates the percentage of eligible members in your group receiving these important screenings annually.



Preventive Screening	# Members with Screening	# Members in Age Group	% of Members
Cervical Cancer Rate (Women >= 18 yrs)	14389	31282	46%
Mammography Screening Rate (Women >= 40 yrs)	6569	13686	48%
Prostate Cancer Screening Rate (Men >= 50)	2081	5376	39%
Colorectal Cancer Screening Rate (Men & Women >= 50)	4082	11731	35%