

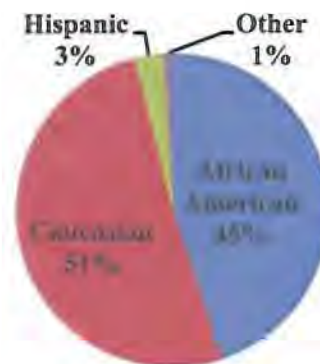
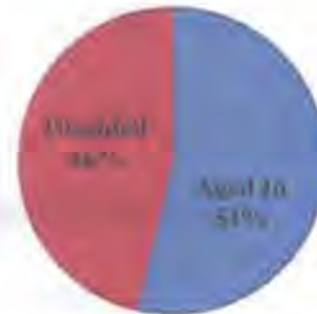
Membership Profile

In Medicare, *about 50% of beneficiaries account for only 4% of spending. In contrast, the costliest 25%, the majority of whom are chronically ill or disabled, account for an astonishing 84% of spending* – spending that in most cases is the result of poor access to care, poor quality providers, the demographics of the population, the absence of coordination of care, and the healthcare system’s indifference to the needs of the chronically ill. Yet it is this very population – older, poorly educated chronically ill seniors living in rural, medically underserved areas – which often benefit the most from managed care, care coordination and disease management.

The following “snapshot” of XLHealth’s Medicare membership as of the first half of 2010 provides a better understanding of this population and helps define the scope of the services we provide:

Select Demographics:

- 45% of our members are “permanently disabled” (e.g., blind, amputees, kidney failure)
- The average age of our non-disabled member is over 76
- 70% of members have not completed high school
- Most of our members have low “health literacy” (ability to understand and retain medical instructions)
- 61% of our members live at or near the poverty line - many are not enrolled in available federal and state-level assistance programs.
- 48% of our members are African American or Hispanic, many with language barriers



Clinical Characteristics:

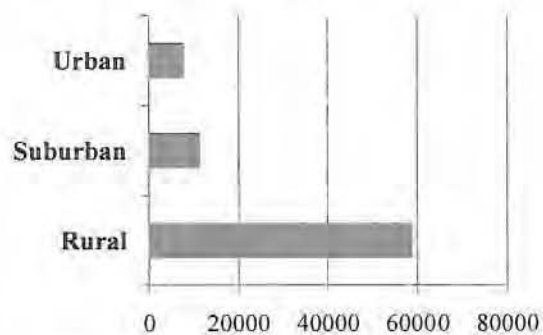
- Approximately 43% of our members have diabetes, and 27% have heart failure
- 25% of our members are clinically depressed (but only 1 in 10 have been diagnosed)

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- Each member sees an average of 11 different doctors each year (yet 1 out of 3 are “medically homeless”)
- Our members have an average of 500 hospital admissions per 1000 within the 1st year of enrollment (2 to 3 times the average Medicare rate)
- 89% of our hospital admissions occur through emergency rooms
- Our members take 8 to 11 unique prescriptions
- End of life planning is underutilized among our membership

Geographic Characteristics:

- More than 75% of our members reside in rural counties



- Most of our counties have an undersupply of primary care physicians and of key specialists; many of our regions are Federally-designated “Medically Underserved Areas”

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Unique Programs and Success Stories Under the XLHealth Model of Care

XLHealth's core business -- Care Improvement Plus -- is the leading provider of Medicare health plans uniquely designed for beneficiaries with diabetes and/or heart failure, many of whom are dual eligible.

Model of Care

Through a comprehensive and innovative model of care, Care Improvement Plus provides high quality benefits and services to make sure members receive the best care for their individual health needs.

- With the support of free Care Improvement Plus services and programs, members are able to better manage their health and improve their quality of life -- lowering their risk of future health complications. In fact, **94 percent of members say Care Improvement Plus helped them get more involved in their health care.**

PharmAssist Program

- Through our PharmAssist program, members receive personalized, private counseling sessions with specialty-trained plan pharmacists.
- In addition to carefully monitoring for potential errors, Care Improvement Plus pharmacists provide members with a detailed review of their medications, alerting them of lower-cost alternatives when available, and teaching them how to use each medication to best support their health.
 - ✦ During a recent PharmAssist counseling session, it was uncovered that Bill Williams*, a Care Improvement Plus member from San Angelo, Texas was unknowingly taking two overlapping medications to treat his high blood pressure – a potentially dangerous and costly duplication. The Care Improvement Plus pharmacist contacted Bill's primary care provider to discuss her concerns, and was able to have his prescriptions adjusted. The pharmacist then called Bill back to review the changes the primary care doctor had made to his medication schedule.

Nurse Care Management

- Care Improvement Plus' care management approach includes ongoing support for members from plan nurses including a 24/7 nurse hotline.
- Members receive personalized care and education during regular nurse coaching calls. In addition, care management nurses work directly with the members' doctors and specialists, coordinating care to make sure members see the right providers at the right time.
 - ✦ Mitch Pruitt*, a Care Improvement Plus member with diabetes from Savannah, Ga. had an open wound on his foot that was not healing properly. Mitch had been told by his podiatrist to wait three weeks before following up – upon hearing this, his Care Improvement Plus nurse care manager contacted the doctor's office to recommend that he be referred to a home health provider to provide wound care support. The nurse then contacted the home health provider to give them a heads up on the pending

* Indicates where identifying information has been changed to protect privacy

referral, and followed up to make sure the referral was received from the doctor's office. The nurse spoke with Mitch's daughter to review his medications and make sure that he had an appointment scheduled for wound care. On the most recent call, Mitch's daughter reports that wound care has helped improve the wound.

HouseCalls Program

- Through our HouseCalls program, members receive annual in-home visits with a physician or nurse practitioner who performs a thorough clinical assessment.
- During the HouseCalls visit, members receive personalized care, visiting with a health care provider that will spend time answering their health related questions, alert them to any potentially urgent health issues, educate them on how to manage their health conditions, and provide advice as to what issues they might want to discuss with their primary care doctor.

✳ Jane Hernandez*, a member from Greensboro, Ga. recently received a HouseCalls visit. Jane had not been feeling well lately and shared this with the nurse conducting the visit. After finding that Jane's legs were abnormally swollen, the nurse was concerned that Jane might have a pulmonary embolism, and told her to go to the emergency room right away. At the hospital, the doctors confirmed Jane's embolism and were able to treat it with medication before anything more serious could happen. Jane is now resting comfortably at home, and is thankful for her HouseCalls nurse's care – knowing that the visit may have potentially saved her life.

Social Service Coordinators

- Care Improvement Plus has partnered with Social Service Coordinators to help plan members access federal, state, and community level programs that provide assistance with health care costs and daily living needs.
- Social Service Coordinators helps members apply for valuable assistance programs they may not otherwise know about - such as Medicaid or Low Income Subsidy – providing incredible savings to ease the burden of health care costs and aspects of daily living they might not be able to afford otherwise.

✳ Sandra and Wally Jones*, who live in Sikeston, Mo. joined Care Improvement Plus' Gold Rx plan because of their diabetes. Unfortunately, the couple was struggling to afford their medications – between the two of them; they took more than 22 prescriptions regularly. Social Service Coordinators contacted the Joneses, and was able to help them qualify for the Missouri state prescription assistance program, which provided them with a check for \$1500 to help with the cost of their medications.

Transitions of Care Program

- Care Improvement Plus' Transitions of Care program provides transitional support through plan nurses and social workers to members and their caregivers as their individual needs change when discharged from the hospital or moving to a new care setting.
- Care Improvement Plus' Transitions of Care program bridges gaps in treatment as members move from one care setting to another — helping to ensure continuity of care, prevent hospital readmissions, and keeping physicians and caregivers informed of member's health status.

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Cecilia Santos*, a member with diabetes from South Carolina was admitted to the hospital for an infected foot wound. After receiving a hospitalization alert, Cecilia's Care Improvement Plus nurse care manager contacted the hospital to review her condition and care needs. The hospital physician placed an order for Cecilia to receive home health visits upon returning home, but unfortunately, the company would not travel to her neighborhood. After contacting Cecilia for a post-discharge assessment, the Care Improvement Plus nurse set up an appointment on her behalf with a new home health provider, and scheduled transportation services to bring Cecilia to follow up appointments with a podiatrist and her primary care doctor. In addition, the care management nurse arranged for a home monitoring device to be sent to Cecilia to help her monitor her feet for temperature "hot spots" to prevent future wounds.

Member Support Services

- Care Improvement Plus' Member Support Services program proactively outreaches to members to educate them on important health issues and help them understand how to get the most from their Care Improvement Plus benefits.
- Members receive important reminders concerning their health care, as well as thoughtful guidance and assistance from plan staff to help them navigate their benefits and make sure they understand how to use their coverage to best support their health.

★ When Hurricane Ike struck south Texas in 2008, the Member Support Services division was called upon to contact members in the storm impact zone. In less than four days, Care Improvement Plus staff made more than 4,000 phone calls and spoke directly to 2,200 members and/or caregivers in the impact zone. Calls included coordinating with local emergency services departments to assist with obtaining battery packs to maintain life-saving medical equipment and providing additional guidance on how to access prescriptions and other necessary medical care.

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Company Background

Founded in 1997, XLHealth has a proud history as an industry leader in improving the quality of care for chronically ill seniors. Over the past four years, the company has evolved from an outsourced provider of disease management services to become the owner and operator of Care Improvement Plus – a Medicare health plan focused on the unique needs of underserved and chronically ill beneficiaries.

Today, Care Improvement Plus and its suite of Special Needs Plans serve more than 85,000 Medicare beneficiaries across six states -- providing care management-focused health care coverage to those with chronic conditions such as diabetes and heart failure, as well as those with both Medicare and Medicaid.

XLHealth has been at the forefront of chronic care management innovations since its inception and the company's unique approach has resulted in positive healthcare outcomes while lowering healthcare costs. XLHealth's chronic care management model goes beyond the more customary approach of telephone or direct mail communications with patients. The company's approach is based upon the belief that support services must be customized for each individual across the spectrum of their healthcare needs. The company is a recognized pioneer in its delivery of care management services in a personal, "high touch" way that supports physicians by increasing the quality of care for their patients and eliminating unnecessary barriers to preventive treatment.

XLHealth's programs emphasize the critical importance of the role primary care physicians have in the healthcare equation. In fact, the premise upon which XLHealth is predicated is that care management services and support programs are most effective when they establish strong ties with the local healthcare community.

Across both the Medicare fee-for-service and Medicare Advantage programs, XLHealth is arguably the most prominent chronic care management company participating in initiatives to improve quality of care for chronically ill beneficiaries.

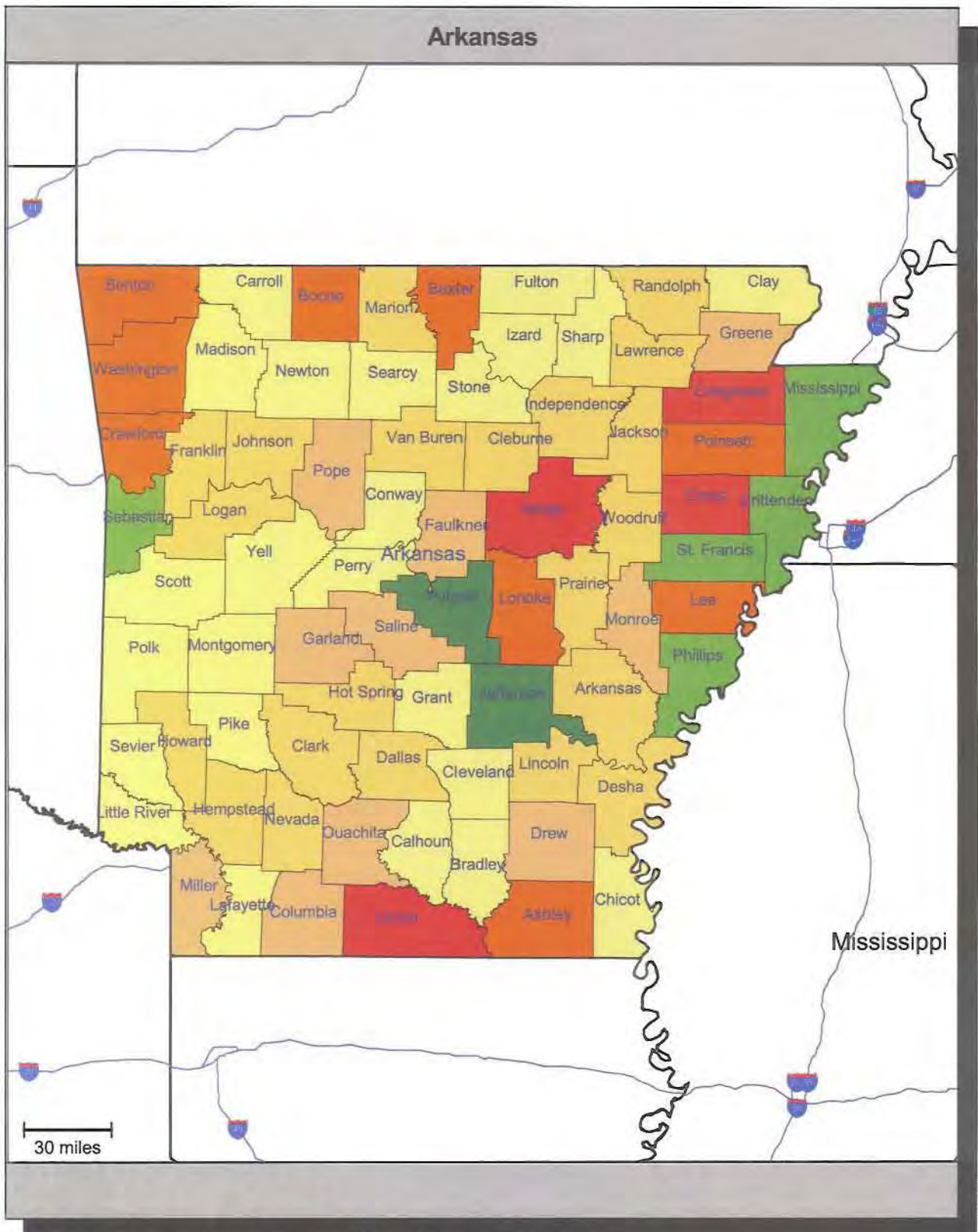
In 2003, the Centers for Medicare & Medicaid Services (CMS) awarded XLHealth one of three demonstration projects that, at the time, constituted the largest initiative in the nation to test whether disease management services would improve the care of chronically ill Medicare beneficiaries. In 2004, CMS selected XLHealth to administer one of eight Medicare Health Support pilot programs – a project which represented CMS' first attempt to offer nation-wide care management services for chronically ill Medicare beneficiaries participating in the fee for service program.

Within the Medicare Advantage industry, in 2006 XLHealth launched Care Improvement Plus, originally as a chronic condition Special Needs Plan and then additionally as a dual eligible Special Needs Plan in 2009. Approximately 1.5 million Medicare beneficiaries in Arkansas, Georgia, Maryland, Missouri, South Carolina and Texas are eligible to join a Care Improvement Plus Special Needs Plan, which combines traditional Medicare coverage with a comprehensive Medicare Part D prescription drug benefit and care management services.

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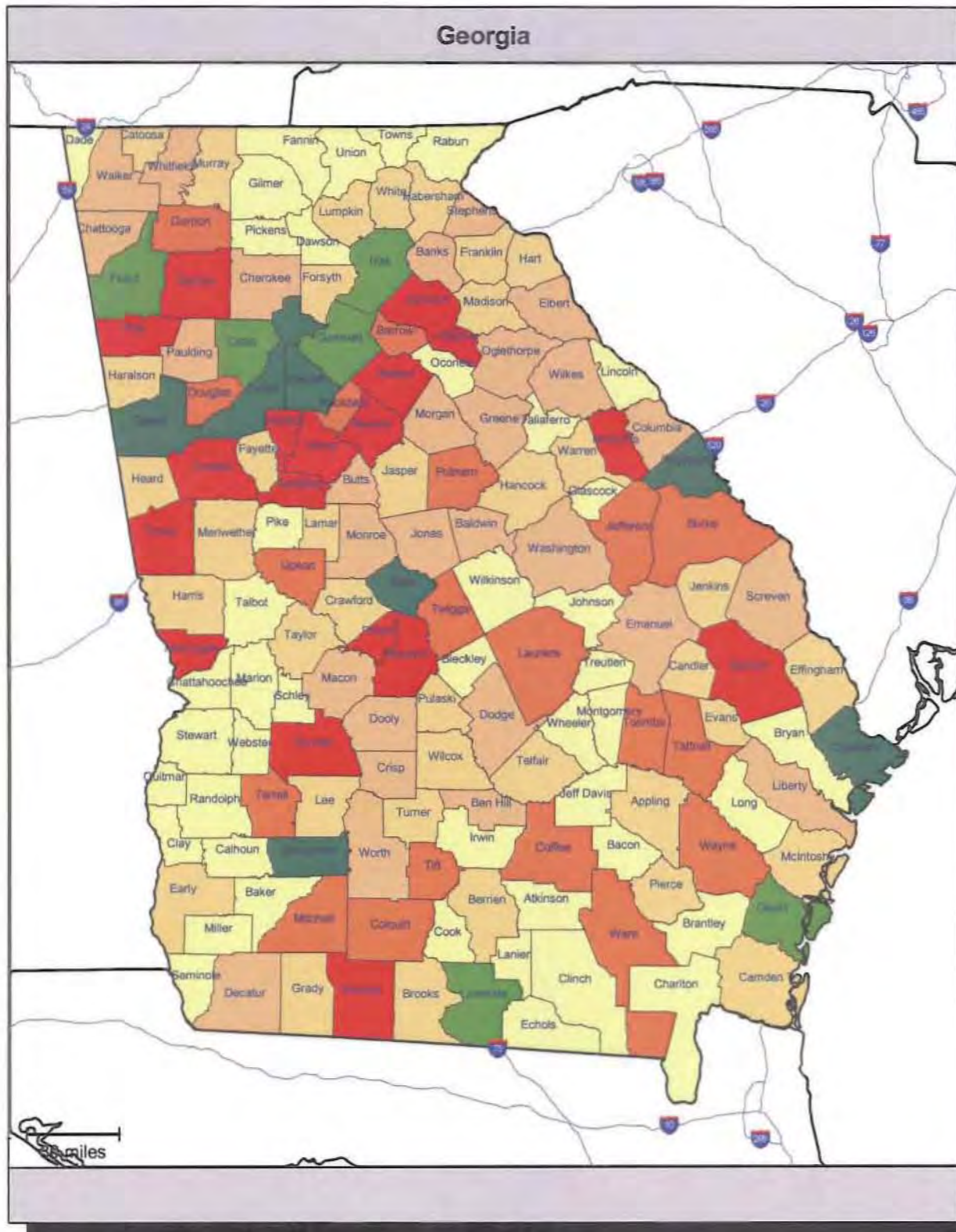
With a core business of providing care management services to Medicare beneficiaries with heart failure and diabetes, XLHealth is a key leader in forming an effective model to manage the approximately 25% of Medicare beneficiaries that represent nearly 80% of Medicare expenditures – beneficiaries with manageable chronic conditions for whom increased quality will result in decreased costs.

Active Membership Volumes by County



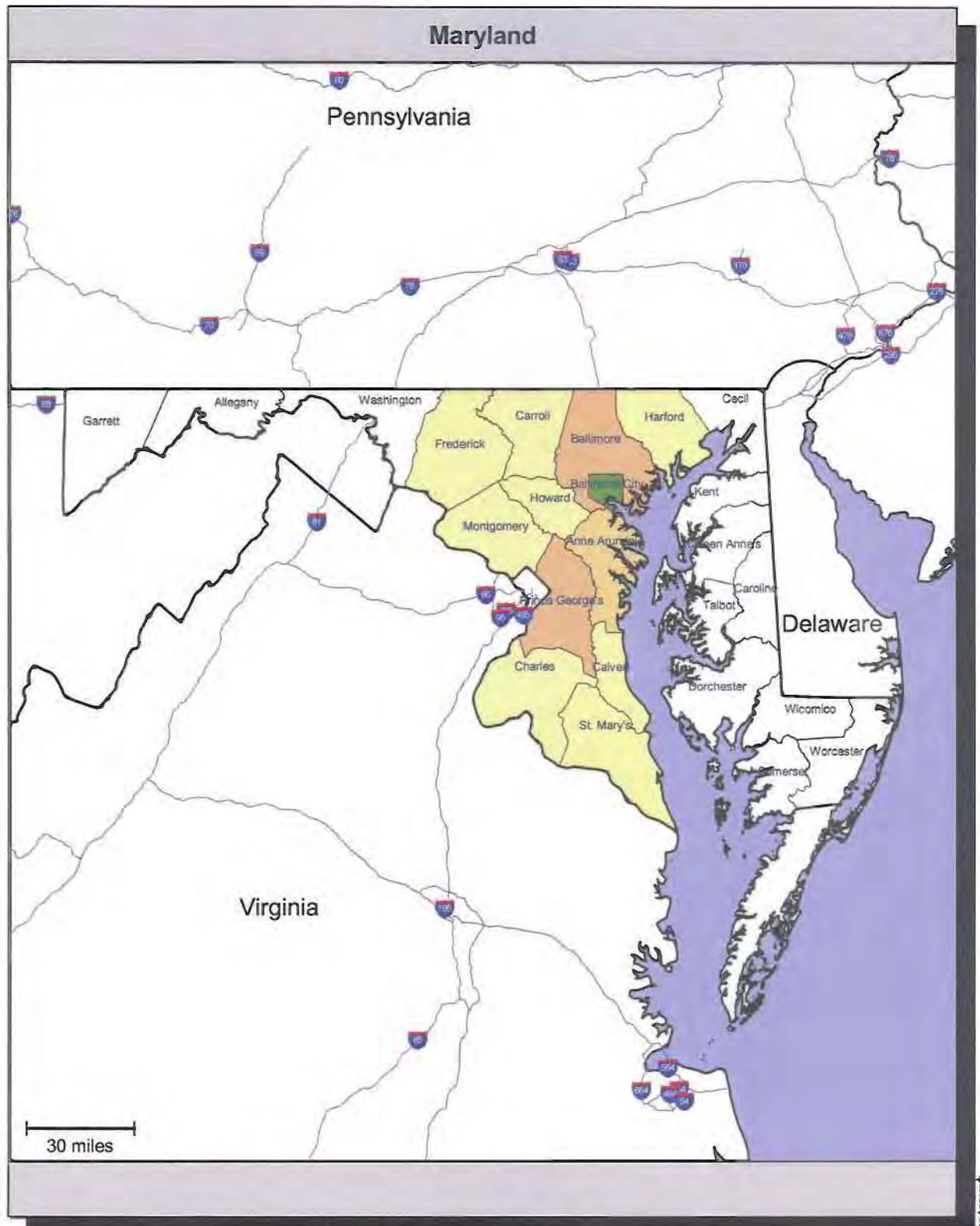
- 1-49 Members (24 counties)
- 50-99 Members (21 counties)
- 100-149 Members (10 counties)
- 150-199 Members (9 counties)
- 200-300 Members (4 counties)
- 300-500 Members (5 counties)
- 500+ Members (2 counties)

Active Membership Volumes by County



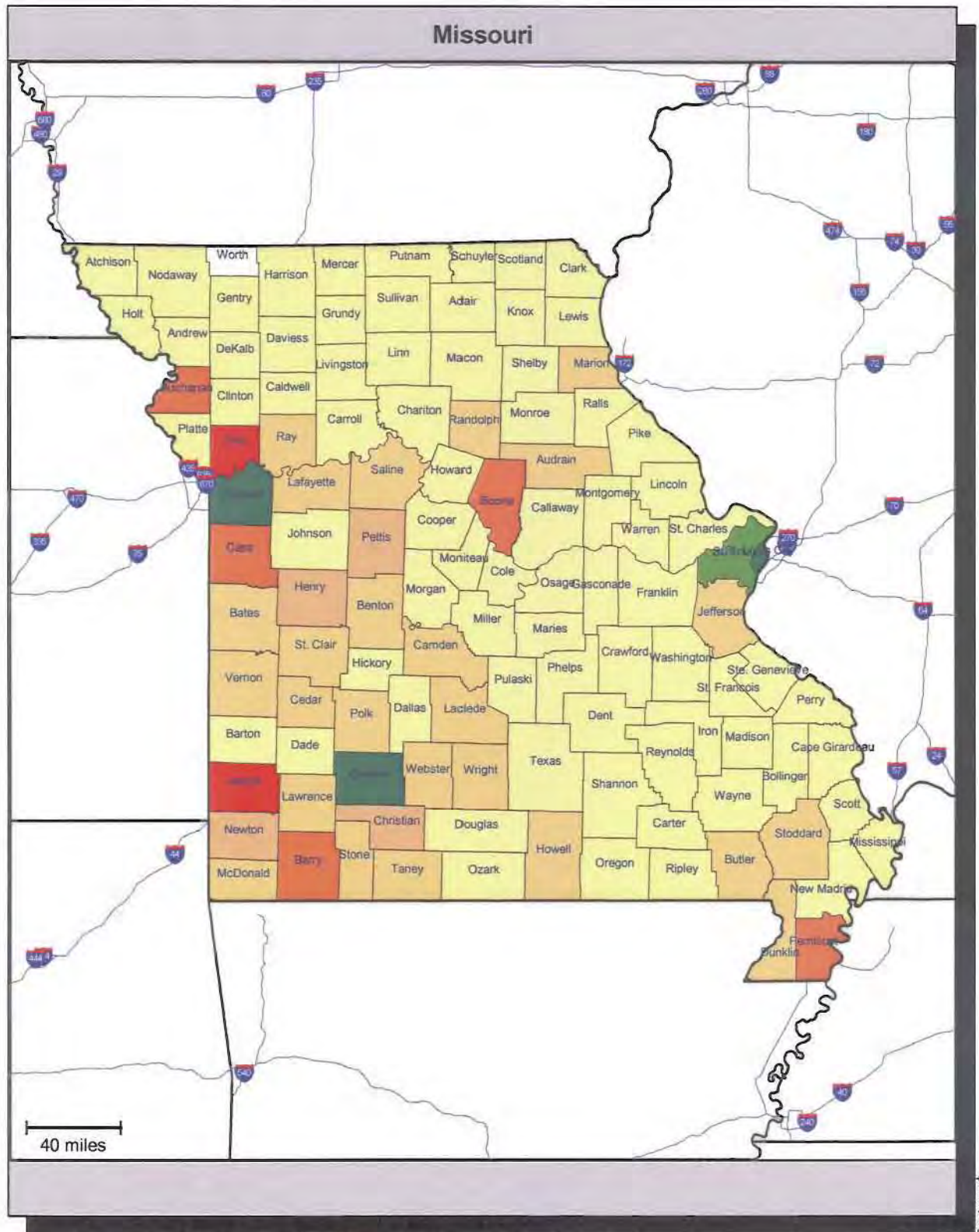
- 1-49 Members (44 counties)
- 50-99 Members (37 counties)
- 100-149 Members (28 counties)
- 150-199 Members (19 counties)
- 200-300 Members (18 counties)
- 300-500 Members (6 counties)
- 500+ Members (7 counties)

Active Membership Volumes by County

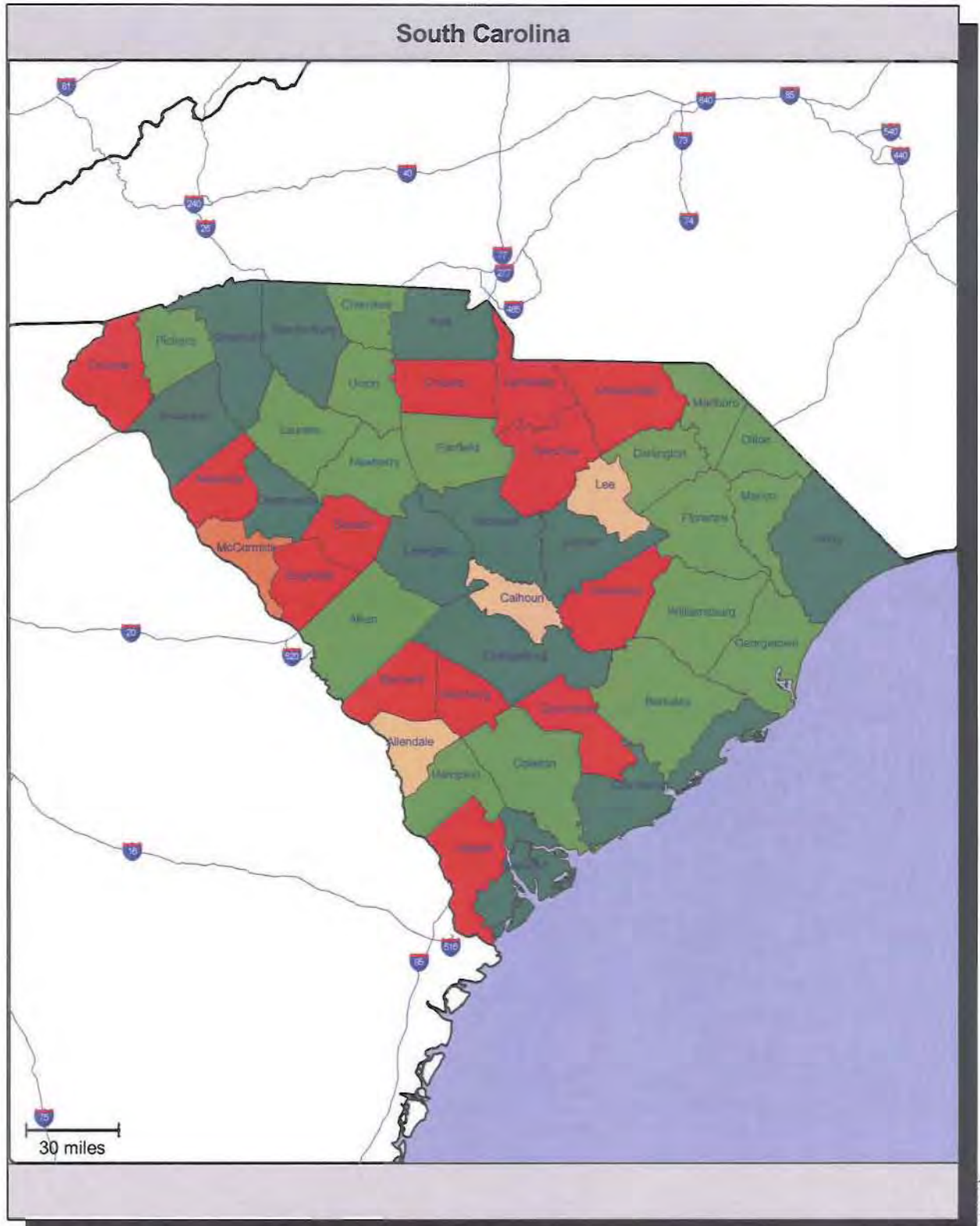


- 1-49 Members (8 counties)
- 50-99 Members (1 counties)
- 100-149 Members (2 counties)
- 150-199 Members (0 counties)
- 200-300 Members (0 counties)
- 300-500 Members (1 counties)
- 500+ Members (0 counties)

Active Membership Volumes by County

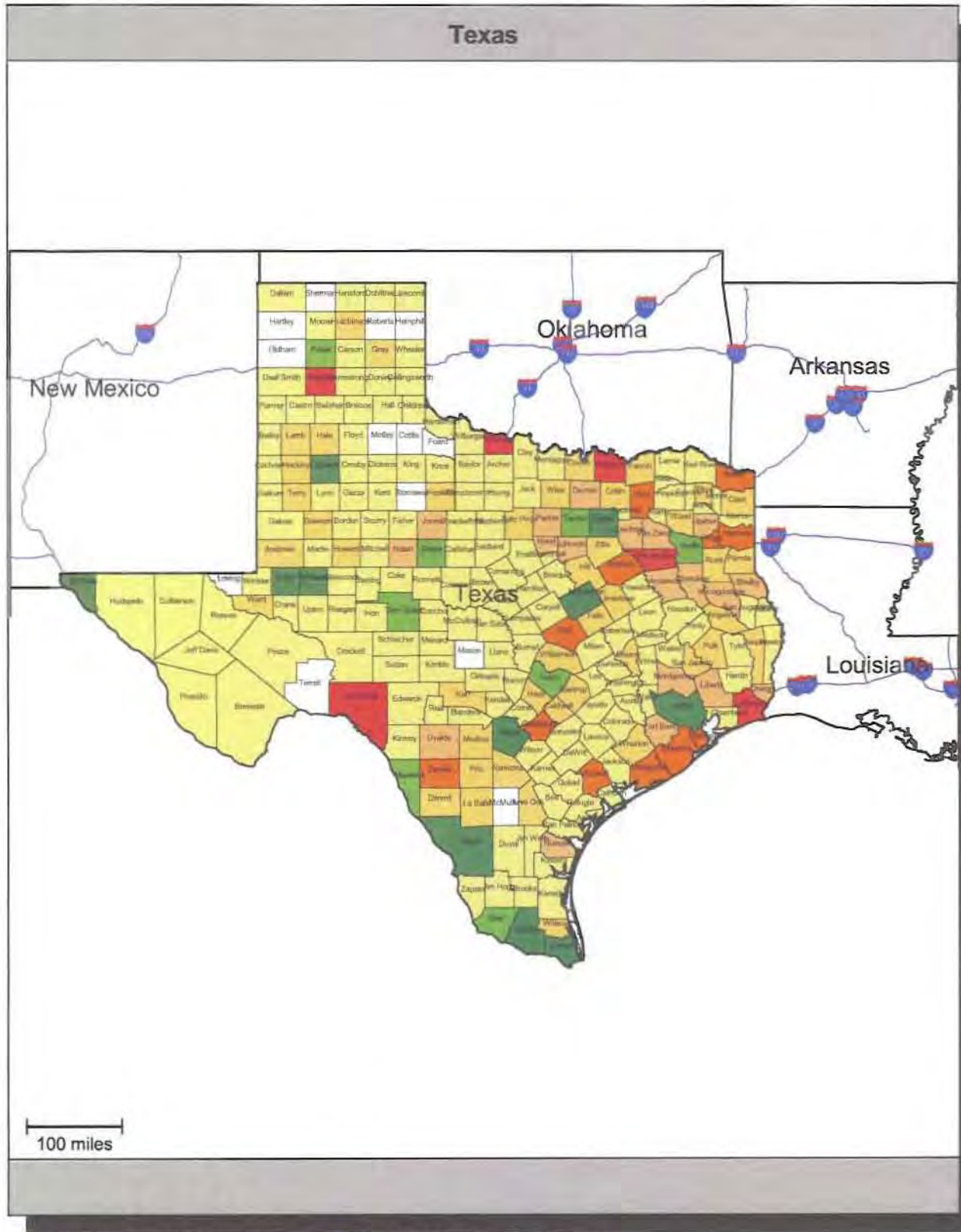


Active Membership Volumes by County



- | | |
|-------------------------------|-------------------------------|
| 1-49 Members (0 counties) | 300-500 Members (17 counties) |
| 50-99 Members (0 counties) | 500+ Members (12 counties) |
| 100-149 Members (3 counties) | |
| 150-199 Members (1 counties) | |
| 200-300 Members (13 counties) | |

Active Membership Volumes by County



- 1-49 Members (142 counties)
- 50-99 Members (43 counties)
- 100-149 Members (19 counties)
- 150-199 Members (12 counties)
- 200-300 Members (6 counties)
- 300-500 Members (8 counties)
- 500+ Members (11 counties)

A Contrast in Beneficiary Experience

Medicare Managed Care's Ability to Support Chronically Ill Beneficiaries

"The special needs I have with my health mean that I have to have some help getting the services I need. Without my care manager, I would be lost. I'm so glad I have someone to talk to who can help me."

— O. Mercer, South Carolina Care Improvement Plus Member

XLHealth
Member. Empower. Excel.

The healthcare costs of the chronically ill continue to increase under fee-for-service (FFS) Medicare. As the Congressional Budget Office has observed, the current FFS system is reactive, generally waiting for an acute event such as a hospitalization before engaging healthcare providers. Medicare managed care plans, or "coordinated care plans," represent a practical alternative, providing care coordination, access to medical homes, and chronic care management services aimed at reducing wasteful spending and improving quality of care.

One beneficiary's story¹

The following profile contrasts the experience of a chronically ill Medicare beneficiary in a Medicare "coordinated care plan" with the same member's likely experience in FFS Medicare.



Angela Garcia, 75, struggles with the ongoing management of her diabetes and heart failure. On a daily basis, she has to keep track of over eight medications, and without family members close by to provide transportation, she has difficulty keeping her doctor appointments. Ms. Garcia has a primary care doctor that has been helping to manage her conditions. Last December, Ms. Garcia woke up in intense pain due to a wound that had recently developed on her left foot which was becoming infected. At the urging of her doctor's office, she took an ambulance to the emergency room where she was visited by a Hospitalist Primary Care Physician (PCP), diagnosed with an infection, and admitted to have her infection treated.

The current FFS system is reactive, generally waiting for an acute event such as a hospitalization before engaging healthcare providers.

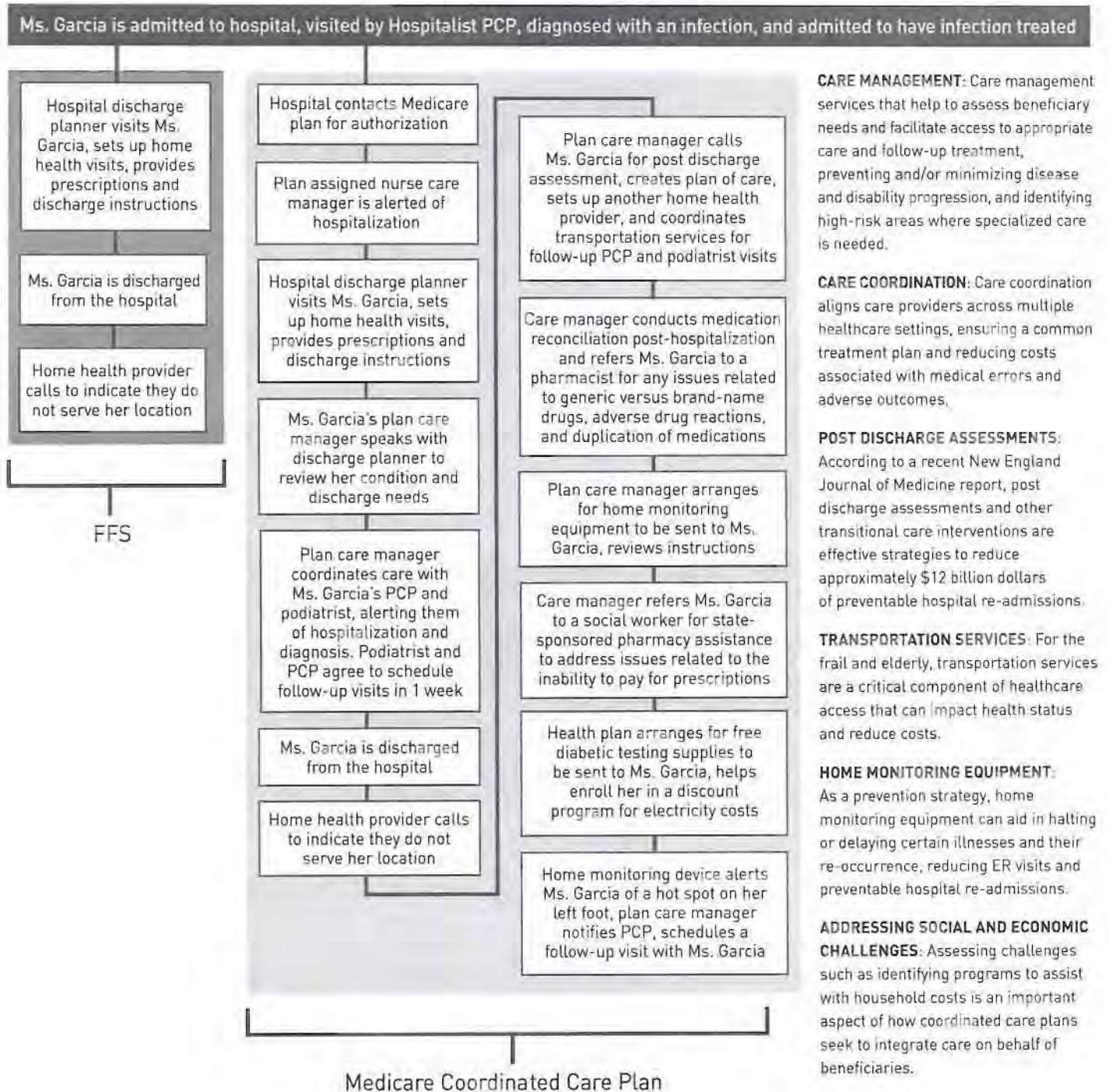
¹ Based on actual events. Identifying information has been changed to protect privacy.

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A Contrast in Beneficiary Experience

Medicare Managed Care's Ability to Support Chronically Ill Beneficiaries

The following table illustrates the likely services and follow-up that Ms. Garcia would experience under the current Medicare FFS program, contrasted with her experience as a member of a Medicare coordinated care plan (a Special Needs Plan in this instance).¹



¹ Based on actual events. Identifying information has been changed to protect privacy.

Chronic Condition Special Needs Plans

A Valuable Option for Medicare's Most Costly



A Unique Option within Medicare Advantage

Unlike fee-for-service (FFS) Medicare and more traditional Medicare Advantage (MA) plans, Chronic Condition Special Needs Plans (C-SNPs) are uniquely dedicated to improving care coordination and quality of care, and reducing the costs for treating Medicare beneficiaries with chronic conditions such as diabetes, heart failure, chronic obstructive pulmonary disease and end stage renal disease.

Operating at the Center of Medicare Reform Issues and Innovations

- **A platform to control spending for Medicare's most costly:** More than 75% of high-cost Medicare beneficiaries are diagnosed with one or more chronic conditions.¹ C-SNPs have an intense focus on customized care management support and added benefits that serve as the ideal platform for controlling costs associated with Medicare's chronically ill. The coordinated care models that C-SNPs employ can improve quality and reduce costs, with a focus on rationalizing care delivery and improving health outcomes.
- **Overcoming barriers to establishing a medical home:** As part of ongoing efforts to coordinate care and establish a more stable "medical home" for chronically ill members, C-SNPs provide services such as an annual home-visit from a licensed, specially trained local healthcare provider to review their medical needs, answer health-related questions, and identify gaps in care to address with their doctor. If no doctor relationship exists, plans work with members to identify a local doctor to be the members' ongoing source of primary care.
- **Focusing on care transitions:** To maintain continuity of care following hospitalizations and prevent re-admissions, plans conduct member assessments and develop plans of care to coordinate community-based services and follow-up appointments with primary care providers. Similar efforts have effectively reduced re-admissions by as much as 30%.²
- **Coordinating benefits with Medicaid and other support systems:** C-SNPs serve a disproportionately high number of poor, rural, and minority beneficiaries. To address social support issues prevalent in these populations, C-SNPs employ programs that seek to connect members with community-based programs to meet their individual needs. In addition, coordinated efforts ensure that qualifying members are actively accessing extra help resources and prescription drug assistance available to them through Medicaid.
- **Bringing high-quality care to those that need it the most:** C-SNP members have more complex care needs—the average SNP member has over 60% more HCC diagnoses than the estimated Medicare-wide average.³ Programs within C-SNPs focus on member education and empowerment, specialized care system expertise, and the use of interdisciplinary teams to direct treatment and identify interventions when necessary.

Recent independent research shows that SNPs on average reduced hospitalization rates 30% below a comparable group of chronically ill beneficiaries in FFS Medicare.

Rising to the Challenge: Early Evidence of C-SNP Value

Increased scrutiny brought forth through the 2008 MIPPA Act and subsequent regulations issued by Centers for Medicare & Medicaid Services (CMS) are evolving requirements such that all C-SNPs must further differentiate themselves from traditional Medicare Advantage plans with robust models of care and high performance on quality measures.

C-SNPs, while still relatively new, are already rising to these challenges and proving to have significant value for participating beneficiaries:

- A recent independent research report shows that SNPs on average reduced hospitalization rates 30% below a comparable group of chronically ill beneficiaries in FFS Medicare.⁴
- High levels of member and physician satisfaction: 94% of members were satisfied with the plan overall, and 91% of members were likely to recommend the plan to other Medicare beneficiaries with chronic illnesses.
- Recent data from large C-SNPs that have now operated for over 2 years show substantial reductions in the medical costs of the chronically ill through innovative combinations of care coordination, chronic care management and additional managed care tools.
 - Over one year, hospital admission rates for high-risk members with diabetes decreased by over 30%, and amputation rates decreased by almost 50%.⁴
 - Over the same time period, total medical expenses decreased by 24% for members diagnosed with end stage renal disease (ESRD).⁴

¹Congressional Budget Office (2005) "High-Cost Medicare Beneficiaries"

²Jack, B, et al. (2009) "A reengineered hospital discharge program to decrease rehospitalization" *Annals of Internal Medicine* 150(3): 178-187

³The Lewin Group (2008) "SNP Alliance profile and advanced practice report"

⁴Care Improvement Plus, 2008/2009 plan dashboard data