

ADDENDUM NO. 1 TO AMENDMENT NO. 1 TO FORM A

**STATEMENT REGARDING THE ACQUISITION
OF CONTROL OF OR MERGER WITH DOMESTIC INSURERS:**

**HIGHMARK INC.,
a Pennsylvania nonprofit corporation licensed to operate a hospital plan and a professional
health services plan**

**FIRST PRIORITY LIFE INSURANCE COMPANY, INC.,
a Pennsylvania stock insurance company**

**GATEWAY HEALTH PLAN, INC.,
a Pennsylvania business corporation and licensed health maintenance organization**

**HIGHMARK CASUALTY INSURANCE COMPANY,
a Pennsylvania stock insurance company**

**HIGHMARK SENIOR RESOURCES INC.,
a Pennsylvania stock insurance company**

**HM CASUALTY INSURANCE COMPANY,
a Pennsylvania stock insurance company**

**HM HEALTH INSURANCE COMPANY,
d/b/a HIGHMARK HEALTH INSURANCE COMPANY,
a Pennsylvania stock insurance company**

**HM LIFE INSURANCE COMPANY,
a Pennsylvania stock insurance company**

**HMO OF NORTHEASTERN PENNSYLVANIA, INC.,
d/b/a FIRST PRIORITY HEALTH,
a Pennsylvania nonprofit corporation and licensed health maintenance organization**

**INTERCOUNTY HEALTH PLAN, INC.,
a Pennsylvania nonprofit corporation licensed to operate a professional health services plan**

**INTERCOUNTY HOSPITALIZATION PLAN, INC.,
a Pennsylvania nonprofit corporation licensed to operate a hospital plan**

**KEYSTONE HEALTH PLAN WEST, INC.,
a Pennsylvania business corporation and licensed health maintenance organization**

**UNITED CONCORDIA COMPANIES, INC.,
a Pennsylvania stock insurance company**

**UNITED CONCORDIA DENTAL PLANS OF PENNSYLVANIA, INC.,
a Pennsylvania business corporation and licensed risk-assuming PPO**

**UNITED CONCORDIA LIFE AND HEALTH INSURANCE COMPANY,
a Pennsylvania stock insurance company**

BY

**UPE,
a Pennsylvania nonprofit corporation**

**Filed with the Insurance Department
of the Commonwealth of Pennsylvania**

August 24, 2012

INTRODUCTION

On November 7, 2011, UPE submitted a Form A filing to the Pennsylvania Insurance Department (Department) in which it requested that the Department authorize a change in control of Highmark Inc. (Highmark) to UPE. As set forth in the Form A, UPE proposed the change in control as part of a strategy to implement an integrated delivery network (IDN). The Form A included an “Overview of Highmark’s Strategic Vision” (see attached Exhibit A) which identified the case for change in the Western Pennsylvania health care market and a plan of action to create the necessary change. A principal component of the IDN strategy is the proposed affiliation of Highmark with West Penn Allegheny Health System, Inc. (WPAHS).

SUMMARY OF STRATEGIC VISION

The purpose of UPE/Highmark’s IDN strategy is to preserve and promote choice and competition in the Western Pennsylvania health care market. The strategy involves a multi-faceted approach including: securing access to a “full-service” network of lower-cost, high quality, highly efficient care providers; building platforms to support care redesign and cost reduction; promoting the introduction of innovative care models and lower-cost sites of treatment; focusing on improved coordination of care; re-aligning provider incentives through new reimbursement models; and developing new insurance product designs that create incentives for value conscious decision-making by consumers, coupled with access to the next generation of cost and quality transparency tools. The strategy contemplates that the IDN will develop support services, such as physician practice management capabilities, information technology capabilities and group purchasing capabilities, to help providers lower their costs and improve the quality of the care they provide. The strategy also contemplates that the IDN will develop and enhance relationships with independent physicians and community hospitals, which will complement the IDN’s overall goals and activities. All of these elements of the strategy remain unchanged.

PROPOSED HIGHMARK-WPAHS AFFILIATION

As indicated above, a principal component of the UPE/Highmark IDN strategy is the proposed affiliation between Highmark and WPAHS. As has been well documented, WPAHS has a recent history of financial challenges.

In the spring of 2011, Highmark engaged Alvarez & Marsal Healthcare Industry Group, LLC (A&M) to assist it in assessing the anticipated affiliation with WPAHS and to develop a turnaround strategy for the system. The turnaround plan which A&M developed focused on specific initiatives or areas at WPAHS requiring attention, such as clinical integration, the physician organization, corporate services, capital investments and growth and revitalization plans for each hospital within the system. A summary of the A&M turnaround plan, as it existed in the fall of 2011, is included as Exhibit B.

In November 2011, A&M was engaged by WPAHS to assume interim management responsibility for WPAHS. Since assuming that role, A&M has begun to execute on plans in several of the areas noted in the turnaround plan it developed while engaged by Highmark, including plans for the reopening of emergency department services at West Penn Hospital, facility improvements at Forbes Regional Hospital, physician recruitment and alignment of corporate services.

To date, Highmark has advanced over \$200 million to WPAHS in accordance with the terms of the definitive affiliation agreement. These advances did not require Department approval.

DEVELOPMENTS SINCE FILING OF FORM A

On July 13, 2012, UPE filed an amendment to the Form A to reflect a number of developments which had occurred since the filing of the Form A. Certain of these developments are described below.

Change in UPE/Highmark CEO

On July 17, 2012, William R. Winkenwerder, Jr., M.D., M.B.A., was named as President and Chief Executive Officer of UPE and Highmark, succeeding Kenneth R. Melani, M.D., who previously held the positions. Dr. Winkenwerder is a leading national health care executive with experience in medical care delivery, health insurance operations and national health policy. He is board certified in internal medicine and has practiced as a primary care physician. He served as Assistant Secretary of Defense for Health Affairs in the U.S Department of Defense and special assistant to the administrator for the agency that oversees Medicare and Medicaid for the Department of Health and Human Services. Dr. Winkenwerder also served as a director of Quality Assurance at Kaiser Permanente and vice president and chief medical officer for Prudential Health Care's Southern operations. Since assuming his offices at UPE and Highmark, Dr. Winkenwerder has expressed his commitment to the strategic vision outlined in the Form A, as the strategy has been modified with the passage of time as described below.

UPMC Contract

On May 2, 2012, Highmark and UPMC announced that they had reached an agreement in principle, and on July 3, 2012, the parties agreed to final terms on an agreement which assures continued access by Highmark policyholders/subscribers to all UPMC hospitals and physicians through December 31, 2014, and to certain UPMC facilities and services thereafter. At the time the Form A was filed, it was anticipated that contracts between Highmark and certain UPMC hospitals would be terminated effective June 30, 2012, with a one-year runout period. This termination would have left Highmark policyholders/subscribers without in-network access to the

affected hospitals after the indicated date.

The contract extension between Highmark and UPMC enables Highmark to retain policyholders/subscribers it otherwise might have lost during the start-up phase. Conversely, projected volumes at WPAHS will be negatively impacted by the extension as Highmark policyholders/subscribers continue to have the choice of UPMC during this phase. Based on the terms of the new contract with UPMC, however, Highmark intends to focus on implementing products that provide policyholders/subscribers with the ability to differentiate the care they seek based on quality and value, which Highmark projects will result in incremental volume at WPAHS. This will have the effect of mitigating, at least in part, some of the volume that otherwise would be lost.

The Highmark-UPMC contract extension does not, however, diminish the need for UPE/Highmark to proceed with implementation of the IDN strategy. While Highmark intends to pursue a further extension of the applicable UPMC contracts for the period following December 31, 2014, UPMC has publicly stated that it does not intend to renew the contracts, and there is no assurance that such renewals can or will be forthcoming. Moreover, the need to preserve consumer choice in the Western Pennsylvania market remains an imperative which the contract extension does not address.

Proposed Affiliation Between Highmark and Jefferson Regional Medical Center

On June 11, 2012, Highmark announced that it had reached an agreement in principle with respect to a proposed affiliation with Jefferson Regional Medical Center (JRMC), a hospital system in southern Allegheny County. On August 14, 2012, the parties executed a definitive agreement with respect to this proposed affiliation.

As part of the JRMC affiliation, Highmark will contribute \$75 million to a foundation to serve community needs in the southern region of Western Pennsylvania. In addition, Highmark will assure the completion by JRMC of several important capital projects by providing funding, in an amount not to exceed \$100 million, to cover the costs of the projects to the extent JRMC cash

flows are insufficient to do so. Highmark also will guarantee that JRMC is able to satisfy its current liabilities, including debt and pension, currently estimated at \$200 million. This guarantee will have no impact on Highmark's GAAP financial statements. However, Highmark will be required to establish a liability on its statutory financial statements in an amount equal to 15% to 20% of the amount guaranteed (i.e., \$30 - \$40 million).

The affiliation between Highmark and JRMC is not an alternative to the proposed Highmark-WPAHS affiliation. If the proposed affiliation with JRMC is consummated, JRMC will become another core component of the IDN envisioned by Highmark for Western Pennsylvania. It will complement the proposed affiliation between Highmark and WPAHS as WPAHS does not currently have full service provider capabilities in the geographic area served by JRMC. Thus, a Highmark-JRMC affiliation will fill a potential gap in Highmark's IDN and enhance WPAHS through the development of clinical partnerships that will benefit WPAHS' tertiary services.

The JRMC affiliation is not dependent on the Department's approval of the pending Form A, and Highmark intends to consummate the JRMC transaction regardless of whether the Form A is approved. The definitive agreement with JRMC contemplates that, as in the case of WPAHS, if the current Form A filing is approved, UPE Provider Sub, the sole member of which is UPE, will become the sole member of JRMC. (See attached Exhibit C.) If the Form A filing is not approved, Highmark, or an affiliate of Highmark, will become the sole member of JRMC.

Other Recent Developments

Since the filing of the Form A, Highmark has announced affiliations with a number of large physician practices, including Premier Medical Associates and Orthopedic Associates of Pittsburgh, and with a number of other smaller groups and individual physicians. To date, Highmark has secured relationships with over 100 physicians who will participate directly in the IDN envisioned by Highmark. Highmark also has formed Promedix LLC d/b/a ProMed Xchange, a physician practice management company (MSO), and Protoco Supply Chain Services LLC, a

group purchasing organization (GPO), to provide support services for physician practices and community hospitals.

Highmark introduced new physician reimbursement methodologies to the market in 2011, through pilot programs to support the patient centered medical home care model. Highmark anticipates that it will introduce accountable care reimbursement models to the market in late 2012. Products to promote value conscious decision-making on the part of the consumer are in development. These products will be supported by transparency tools that also will be implemented in the market later in 2012.

Leadership of the IDN and WPAHS

During the pendency of the Form A filing, Highmark has taken steps to develop a team of experienced individuals to run the provider component of the IDN. IDN operations will be led by John W. Paul, a Pittsburgh health care executive with over 30 years of experience in provider and payor operations. Mr. Paul served as UPMC's chief financial officer and chief operating officer for many years, and oversaw the 20 hospitals within the UPMC health system, as well as the development of UPMC's health plan.

Mr. Paul has been actively engaged in building a team of individuals to manage various aspects of the IDN. Among the persons identified to play a role in this regard are the following:

INDIVIDUAL NAME	CURRENT POSITION	PRIOR EXPERIENCE
Patricia (Pat) Liebman	Executive Vice President, Highmark Integrated Delivery System	More than 35 years of industry experience, including as CEO, Managed Health Services of Indiana; founding CEO of UPMC Health Plan; Senior Vice President, Blue Cross of Western Pennsylvania; Senior Manager, Saint Margaret and Presbyterian University Hospitals

Thomas Kerr	Executive Vice President, Highmark Integrated Delivery System	More than 29 years of experience with Highmark, including senior management positions overseeing communications, product development and marketing
Daniel J. Lebish	Executive Vice President, Highmark Integrated Delivery System	Executive Vice President of Subsidiary Business, Highmark; Senior Vice President of Business Development, Highmark; Executive Vice President, HealthAmerica; Chief Financial Officer and Vice President of Administrative Services, Magee-Womens Hospital
Bonnell Irvin	Vice President of Medical Mall Operations, Highmark	Vice President of Provider Contracts and Relations, Highmark; Vice President of Provider Affairs and Marketing, Gateway Health Plan
Jacqueline A. Dailey	Chief Information Officer, Highmark Provider Division	Vice President for IT Solutions, UPMC; Vice President and CIO, Children's Hospital of Pittsburgh of UPMC
Paul Sikora	Chief Technology Officer, Highmark Provider Division	More than 30 years of healthcare technology experience including as Vice President of Information Technology and Transformation, UPMC

Mr. Paul currently is recruiting for executive level leadership to replace the interim management team at WPAHS following closing of the proposed affiliation with Highmark. UPE anticipates

that a permanent executive management team will be in place within 90 days following closing of the affiliation.

The IDN and Community Hospitals

UPE/Highmark understand the value of community hospitals. Such hospitals play a critical role in the IDN strategy. Community hospitals provide quality care at a lower cost than tertiary hospitals. Today, too much care that could be provided in the community hospital setting is being unnecessarily diverted to higher cost settings. The IDN strategy is intended to reverse this situation and to keep care in the community in which it originates whenever possible. UPE intends to accomplish this objective through insurance product design (Highmark) and enhancements in clinical operations (provider side operations). It is expected that this not only will provide patients with more convenient care; it will reduce the cost of care while also enhancing the operations of the community hospitals.

As UPE implements the IDN strategy, it will strive to achieve an important balance between maintaining convenient access to high-quality facilities, physicians and other care professionals for patients and avoiding duplication of existing services that drive up demand and the cost of health care for the community.

The outpatient and ambulatory settings that UPE is planning to develop are aimed at filling gaps in outpatient care in the community. UPE's plan is to work with community hospitals and a broad spectrum of providers to identify opportunities to develop more innovative ways (such as additional outpatient care facilities) to deliver cost-effective care in the most appropriate settings – building on existing resources in the community wherever possible.

Second Amended and Restated Bylaws of Highmark Inc.

Draft proposed Second Amended and Restated Bylaws of Highmark Inc. are attached as Exhibit D. Section 3.3.2 of these Bylaws sets forth the powers that are proposed to be reserved to UPE as the sole corporate member of Highmark following closing of the change of control transaction contemplated by the Form A. This section generally provides that the powers set forth therein and listed as reserved to UPE will be exercised by UPE as the sole corporate member of Highmark rather than by the Board of Directors of Highmark. This is a common construct in an integrated health care system. Under the draft Bylaws, the Board of Directors of Highmark will retain the powers that must be exercised by a board of directors of a Pennsylvania-domiciled insurance company under Pennsylvania law.

The proposed Second Amended and Restated Bylaws of Highmark, including the provisions dealing with UPE's reserved powers, are subject to approval by the UPE and Highmark Boards of Directors. Such approval will be sought and is expected to be obtained shortly prior to or contemporaneous with closing of the proposed change of control transaction.

MODIFICATIONS TO FORM A

As originally envisioned, the total UPE/Highmark IDN strategy was estimated to be approximately \$750 million, of which amount \$475 million related to the WPAHS affiliation. As the strategy has been refined and portions of it have been implemented, this estimate has been revised, and UPE/Highmark now estimate that implementation will be approximately \$1 billion. The increase is due primarily to updated cost estimates for physician practice and community hospital alignment activities and an increase in the estimated cost to enhance outpatient care delivery. The table below sets forth the currently anticipated allocation of expenditures by purpose. (Note: precise allocations are subject to change over time as developments warrant.)

PURPOSE	ESTIMATED EXPENDITURE (dollars in millions)
WPAHS	\$475
JRMC	\$120
Expansion of provider network (physicians, community hospitals and medical malls)	\$364
Infrastructure development (MSO, GPO)	\$41
TOTAL	\$1,000

To date, Highmark has expended or committed to expend approximately \$740 million of the amount it anticipates to spend on the IDN strategy. With the exception of the \$275 million of the remaining commitment under the existing WPAHS Affiliation Agreement, none of the expenditures/commitments are contingent upon approval of the Form A filing by the Department.

In its amendment to the Form A filing, UPE has proposed that any portion of the \$1 billion Highmark has committed to the IDN strategy but not yet expended at the time of closing of the change of control (currently estimated to be approximately \$365 million) be transferred to UPE so that it can continue implementation of the IDN strategy. UPE also has proposed that Highmark contribute any provider assets that have been accumulated by it under its subsidiary, HMPG Inc., to UPE's subsidiary, UPE Provider Sub. While this is not a critical element of the strategy, UPE/Highmark believe that these transfers will simplify implementation and oversight of the IDN strategy as all provider activities thereafter will be held on the provider side of UPE.

Following the closing of the change of control transaction contemplated by the Form A, future transactions between Highmark and UPE, UPE Provider Sub and their various subsidiaries will be subject to regulation by the Department in accordance with the provisions of the Pennsylvania Insurance Holding Company Law.

FINANCIAL PROJECTIONS

As a supplement to its amendment to the Form A, UPE/Highmark provided the Department with certain confidential information showing the projected financial effects of recent developments on the IDN strategy, UPE, Highmark and WPAHS. The following is a summary of the assumptions and considerations that were factored into the projections, as well as a summary of the conclusions.

Assumptions and Considerations

Several major assumptions and considerations are reflected in the financial projections:

- **Highmark's contracting position with UPMC** – The contract extension between Highmark and UPMC referred to above requires Highmark to pay higher contracting rates than it had been paying in order to secure in-network access to UPMC facilities and UPMC physicians through December 2014. As set forth above, although Highmark intends to continue to pursue a longer term agreement with UPMC, UPMC has publicly stated that it does not intend to renew the contracts. Accordingly, the projections assume that UPMC will not renew the contracts, and access to certain UPMC facilities will be terminated, effective December 31, 2014.
- **Highmark's competitive position** – As indicated above, the contract extension with UPMC enables Highmark to maintain parity with its competitors (in the form of access to UPMC) in the short term while the IDN, including Highmark's affiliation with WPAHS, is in its early stages and is building the capabilities necessary to enable it to deliver a differentiated product and customer/patient experience. The projections assume that, by 2016, Highmark will be able to offer a product that is favorably priced as compared with competitor products through benefit and reimbursement designs that incent consumers to use and providers to provide appropriate care in an appropriate setting, with the necessary effect of significantly increasing the patient volume at WPAHS. The projections also assume the

avoidance of the higher reimbursement rates that would be associated with a market dominated by a single large provider IDN.

- The cost of the IDN strategy to Highmark – As was previously mentioned, Highmark’s assumed total investment in the IDN strategy is currently expected to be approximately \$1 billion.
- The turnaround of WPAHS – Highmark engaged Grant Thornton LLP (GT) to complete financial projections for WPAHS. These projections, which are discussed in more detail in Exhibit E, differ from those described in the A&M summary set forth in Exhibit B and take into account the recent developments described above, as well as the additional assumptions and considerations listed in Exhibit E.

The financial projections further assume the corporate structure outlined in the Form A filing, as amended. (See discussion above and Exhibit D.) The projections also assume that UPE and UPE Provider Sub will become operational on September 1, 2012; that all provider activity that was initiated at Highmark through HMPG will be transferred to UPE Provider Sub; and that Highmark also will contribute any portion of the \$1 billion currently allocated to the IDN strategy from Highmark to UPE; all as described above.

Conclusions

Based on the above assumptions and considerations:

- UPE - UPE is projected to have a loss in 2012, due to costs associated with implementation of the IDN strategy. The projections for 2013 through 2016 reflect positive net income that increases over time due in part to the anticipated turnaround of WPAHS and continued increases in the returns associated with investments made as part of the IDN strategy. Summary financial projections for UPE are provided as Exhibit F.

- **Highmark** – The projections through 2016 indicate that net income is sufficient to keep Highmark’s risk-based capital (RBC) in the range deemed sufficient by the Department, which is 550-750%. Management also completed stress testing on Highmark’s financial results, assuming various negative factors, and determined that, in these cases, Highmark’s financial strength would not be materially diminished.
- **WPAHS** – See Exhibit E for information regarding the financial projections with respect to WPAHS.

ALTERNATIVE CASE – NO AFFILIATION BETWEEN HIGHMARK AND WPAHS

At the request of the Department, UPE/Highmark also completed financial projections to estimate the impact to UPE, UPE Provider Sub and Highmark if the affiliation with WPAHS is not consummated (no affiliation scenario).

Assumptions and Considerations

The no affiliation scenario projections assume that Highmark continues to pursue the same corporate structure proposed in the PID filed scenario, which includes the formation of UPE and UPE Provider Sub, and that this structure becomes operational on September 1, 2012. The no affiliation scenario also assumes that Highmark proceeds with the JRMC transaction, with JRMC becoming a subsidiary of Highmark.

In the no affiliation scenario, Highmark’s total investment in the IDN strategy is projected to remain at approximately \$1 billion. Funds that remain to be spent on WPAHS are assumed to be redirected to other activities that will provide Highmark with the opportunity (albeit a lesser opportunity) to lower the cost of care in the inpatient and outpatient settings. Similar to the affiliation scenario, all provider activity that was initiated at Highmark is assumed to be transferred to UPE Provider Sub as part of this scenario, and all remaining funds to be directed to the IDN strategy, which are estimated at \$640 million, are assumed to be transferred to UPE.

Conclusions

In the no affiliation scenario, the projected pre-tax income of UPE is projected to be lower than in the affiliation scenario between 2012-2016. In addition, Highmark is projected to have fewer policyholders/subscribers by 2016 in the no affiliation scenario, as a result of not having WPAHS as part of the IDN and as a result of Highmark's inability to provide a more highly differentiated product in the market.

More important, however, in a scenario involving no affiliation with WPAHS, choice in the provider market will be limited. The provider market will be dominated by one large provider, UPMC, which will be unchecked in its ability to set the price for access to its network. Highmark's weakened competitive position, reduced enrollment and inability to create a differentiated, value oriented product will adversely impact healthcare consumers' ability to make value conscious decisions and to mitigate UPMC's higher costs. The price of Highmark's products will be driven upward by contract increases with limited opportunity to achieve the savings that were initially projected in the scenario involving an affiliation with WPAHS and a more robust provider network. Highmark projects that the average annual cost of health care for a family of four in the Western Pennsylvania market will be nearly \$3,000, or 13%, higher by 2016 in the no affiliation scenario as compared with the affiliation scenario.

Signature and Certification

Pursuant to the requirements of Section 1402 of the Act, UPE has caused this Addendum No. 1 to Amendment No. 1 to the Form A to be duly signed on its behalf in the City of Pittsburgh and Commonwealth of Pennsylvania on the 24th day of August, 2012.

(SEAL)

APPLICANT

By: Nanette P DeTurk Title: Treasurer
Nanette P. DeTurk

Attest:

By: Thomas L. VanKirk Title: Secretary
Thomas L. VanKirk

CERTIFICATION

The undersigned deposes and states that she has duly executed the attached Addendum No. 1 to Amendment No. 1 to the Form A dated August 24, 2012, for and on behalf of Applicant; that she is the Treasurer of such company; and that she is authorized to execute and file such instrument. Deponent further states that she is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of her knowledge, information and belief.

Signature: Nanette P DeTurk
Typed Name: Nanette P. DeTurk

EXHIBIT A

OVERVIEW OF HIGHMARK'S STRATEGIC VISION

For nearly 75 years, Highmark's mission has been to provide ready access to high-quality, affordable health care services for the communities it serves. Several forces at work today, emerging principally over the last decade, threaten Highmark's ability to sustain both the affordability and the access components of this mission.

With the advent of federal health reform legislation nearly two years ago, Highmark began a series of initiatives seeking to restore affordability to health insurance. Specifically, Highmark began to undertake an effort to transform market dynamics, from a market where the price and volume of services are determined by how much market power a provider could exercise to one where price and volume of services are determined by how much value a provider delivers. Highmark has already launched at least two programs in support of this transformation. One, a pilot, tests the concept of an accountable care organization, where providers assume more accountability for managing the cost of care. The other, a program called Quality Blue, has been in the market for a number of years and seeks to link clinical quality to reimbursement for provider services. Approximately three percent of Highmark's reimbursements are linked to several quality metrics at the present time.

Highmark's vision is simple and compelling: structure reimbursements to providers on the basis of how well providers perform these services, measured by quality and customer satisfaction: Do providers adhere to the best evidence available? Is the clinical outcome favorable? Did the patient have a satisfying experience? This reimbursement structure, known in the industry as "pay for performance" or "P4P," is intended to be combined with a set of tools providing the consumer with the knowledge, transparency, and freedom needed to make well-informed decisions regarding whether, and from whom, to obtain health services. Accordingly,

Highmark no longer intends to simply negotiate prices with providers, but rather intends to create the market conditions for a much more efficient exchange of dollars for services. These new market conditions, once developed, are intended to empower both physicians and consumers to make much better decisions, to focus on the rapidly growing area of outpatient services (now close to 80% of all costs in the commercial population), to sharpen the vital role of the secondary acute care hospitals, and to restore positive choice at the tertiary acute care level.

Consistent with this strategy, Highmark approached UPMC, the single largest provider system in western Pennsylvania, in early 2010 with a proposal to engage it in a contract based principally on the terms described above: linking payments to a demonstrated ability to deliver high-quality services and to create an exceptional customer experience for Highmark's policyholders and subscribers. UPMC refused to entertain the proposal and, instead, demanded a 20% increase covering its entire revenue base (including physician fees and hospital fees for both commercial and Medicare Advantage products). This demand would translate into a 40% increase for the subset of UPMC facilities with contracts currently up for renewal (Magee, Presbyterian-Shadyside, Passavant, McKeesport, Northwest, Horizon, Bedford and St. Margaret), or an increase of approximately \$400 million per year by Highmark's calculation. If Highmark were to meet this demand, it believes that employers and individuals in western Pennsylvania would experience an approximately 7% increase in commercial premiums solely attributable to the UPMC contract position.

While Highmark attempted to engage UPMC in a new reimbursement structure, the only other health system in the region with comparable tertiary services, West Penn Allegheny Health System, Inc. ("WPAHS"), was experiencing growing financial troubles. WPAHS's bond ratings were downgraded and Highmark became concerned that WPAHS was approaching the point

where it would violate its bond covenants. WPAHS also announced that it would close one of the largest acute care facilities in the region. In light of these developments, Highmark began to consider ways that it could assist WPAHS.

Upon becoming aware of discussions between Highmark and WPAHS, UPMC announced that it would no longer contract with Highmark. UPMC has accumulated provider assets and physicians in western Pennsylvania over the last decade and now controls over 55% of all healthcare provider capacity in Allegheny County by Highmark's count. UPMC's position creates a fundamental issue of access to UPMC facilities for Highmark. Highmark needs to take action to assure that its policyholders and subscribers will have access to lower cost, high quality providers in the event UPMC is no longer in the Highmark network.

Having witnessed the disruption that a major Chapter 11 bankruptcy filing had on providers, policyholders and subscribers, and the overall community a decade ago, and in light of the threat by UPMC that it will not enter into new contracts for hospital and physician services, Highmark now faces a situation where over 59% of its inpatient provider network capacity (UPMC and WPAHS) in southwestern Pennsylvania (Allegheny, Beaver, Butler, Westmoreland, Washington Counties) is at risk. In some locations within the region, the percentage of Highmark inpatient provider network capacity at risk is even higher; for example, where a UPMC or WPAHS facility is the only hospital in reasonable proximity to a policyholder/subscriber. It is in this context that Highmark is seeking approval to affiliate with WPAHS as part of a broader strategy to preserve and assure for the future long-term access to affordable, high-quality health care including both hospital and physician services for its policyholders and subscribers.

Highmark provided \$50 million in funding support to WPAHS in June 2011. This intervention, however, only preserved a fragile financial status quo for a limited time. Highmark needs to affiliate with WPAHS now to stabilize the situation more permanently and in so doing to preserve WPAHS as an essential choice in the market and as the anchor to a higher-performing network based on the efficient market principles described above: pay for performance, transparency, and value-based exchange of services for dollars. When the affiliation with WPAHS is complete and other elements of the strategy are in place, Highmark policyholders and subscribers in western Pennsylvania will see four major benefits.

- *Lower Premiums.* A vibrant WPAHS will give Highmark's policyholders and subscribers access to high-quality healthcare services built around a commercial product that will be less expensive than any product that includes UPMC at the contract rates it demanded. Implementation of Highmark's strategic plan, including improvements in the care delivery model to assure better quality and better patient experience, should result in an ability to control the healthcare costs which drive premium increases.
- *More transparency and, ultimately, higher quality.* WPAHS and other community hospitals already have agreed to engage in a quality-based reimbursement system linking payments directly to quality health care provision. This new payment system, the quality metrics of which will be broadly available to every policyholder and subscriber for evaluation, will induce providers, including community hospitals, to adhere to the highest standards of medicine and to ensure that the policyholder/subscriber knows much more precisely what he or she is consuming and what the cost of services will be.
- *More choice of, and access to, providers.* Preserving the financial integrity of WPAHS will permit policyholders and subscribers and patients from all insurance carriers (not just Highmark) to have greater access and choice in western Pennsylvania. Aetna, Cigna and United Health, for example, also have contracts with WPAHS.
- *More integrated care and better subscriber experience.* By creating a system which can coordinate health insurance and health provision and by introducing reimbursement structures that reward care coordination and the patient's experience, Highmark will create an organization that improves the overall satisfaction and clinical outcomes of its policyholders and subscribers when they seek care.

Even if UPMC were to change its contracting posture toward Highmark, the need to maintain provider choice in the western Pennsylvania market will remain, not only for Highmark's policyholders and subscribers, but for the benefit of all other insurers (e.g.,

Medicaid, Medicare, national carriers) and their policyholders and subscribers. This balance is essential to a well performing health services market. For reasons presented below, only a direct affiliation between Highmark and WPAHS will provide the degree of structure necessary to turn around WPAHS's financial condition, improve the WPAHS care model, and restore a basic level of choice in the western Pennsylvania provider market on a timely basis.

A. The imperative for change in the western Pennsylvania delivery system and Highmark's vision and strategy for promoting this change.

The growing costs of health care in western Pennsylvania have made health insurance increasingly unaffordable for a larger percentage of individual and employer populations resulting in a growing number of uninsured. In the last decade alone, health insurance premiums in western Pennsylvania have increased at a rate greater than 6% per year while wages and salaries have only increased 2-3% per year. Highmark believes that this unsustainable growth in healthcare costs has several root causes: the exercise of market power on the part of providers leading to steep reimbursement increases; reimbursement methodologies encouraging overutilization of health services and encouraging the use of higher cost, not lower cost, settings of care; provider system strategies leading to redundant overinvestment in physical assets and clinical technology; and benefit structures that do not encourage value-conscious consumption of services on the part of policyholders and subscribers.

Highmark's vision and strategy for addressing these issues has two critical elements:

- For providers, Highmark envisions a multi-pronged approach to achieve a positive impact on practice patterns. Four provider imperatives constitute Highmark's provider network strategy:

1. Re-aligning physician incentives through new reimbursement models.

2. Securing access to a “full-service” network of lower-cost, higher quality, highly efficient care providers that both share in the vision of improving the care model and are willing to enter into alternative contract relationships and make investments, where appropriate, to promote the adoption of new protocols and/or alter care offerings.
3. Promoting the introduction of innovative care models and lower-cost sites of treatment.
4. Building platforms to support care redesign and cost reduction within the provider community.

All of these imperatives will need to be addressed in order for Highmark to fully achieve its vision of affordable access for its policyholders and subscribers.

- For policyholders and subscribers, Highmark will develop products that create incentives for value conscious decision-making and will support policyholders and subscribers in making these decisions by providing access to the next generation of cost and quality transparency tools.

Highmark believes that these actions, taken together, will help to control costs, increase quality, maintain continued choice and access, and improve the overall policyholder/subscriber experience. Specifically, Highmark believes that policyholders and subscribers will benefit ultimately in several ways:

- Highmark will avoid the approximately 7% increase in commercial premiums which Highmark calculates would have resulted from UPMC’s contract positions, thus improving affordability of health insurance. Premiums may still increase, but they will increase less than had Highmark met UPMC’s contract demands.

- Consumers will have more provider choices overall in the marketplace and improved access to providers regardless of the health insurer they choose.
- Consumers will benefit over the longer term from a market transformation. They will be less likely to face premium increases driven by providers with market power and they will be permitted to make informed choices about which provider offers the greatest value.

B. Why this change needs to happen now.

The urgency behind the decision to affiliate with WPAHS is a function of three recent events.

- UPMC's posture in recent rate negotiations and its threat to withdraw from Highmark's network is discussed above. Either possibility (substantially increased reimbursements leading to higher premiums for policyholders and subscribers or withdrawal from the network), combined with the specter of a financially troubled WPAHS, could compromise Highmark's ability to fulfill its mission, by either increasing premium costs beyond affordability, disrupting access, or both.
- WPAHS has expressed a willingness and desire to engage in new reimbursement and transparency practices that will help to control costs, enhance quality, and improve customer satisfaction, thereby accelerating the transformation of the market.
- National healthcare reform will be fully implemented whereby Highmark will need to offer products costing less, through a state-based exchange in

two years. Consumers in other states like Massachusetts, which has implemented a similar set of reforms, have demonstrated that they prefer insurance products that are 10-15% less expensive even if the provider network excludes several hospitals and doctors.

C. Why Highmark's affiliation with WPAHS is the most effective way to accomplish this change.

- Highmark has the tools necessary to ensure a robust turnaround for WPAHS without resorting to reimbursement increases (e.g., ability to realign reimbursement incentives, align independent physicians, deploy shared service platforms, etc.).
- WPAHS has asserted its willingness and eagerness to engage in Highmark's new approach to reimbursement, consumer engagement, choice and transparency.
- A direct affiliation reduces traditional barriers to speedy and effective implementation of these changes.

**THE IMPERATIVE FOR CHANGE AND
HIGHMARK'S VISION FOR THE FUTURE**

The need for a new approach to the market and Highmark's decision to pursue the affiliation with WPAHS stem from Highmark's conviction that the current market structure, the recent pattern of provider consolidation and the current model of care delivery are increasingly in conflict with the mission of ensuring policyholders and subscribers, employers, and the broader patient community long-term access to an open network of affordable, high-quality providers. The impending changes in the environment induced by healthcare reform will exacerbate these

challenges by altering the means by which health insurance is underwritten, priced, and distributed. Accordingly, Highmark believes a fundamental change in the role of the provider (delivering value, not just volume) and the consumer (making informed decisions about who delivers the best value) is necessary.

A. Why the Current System Needs to Change

As the national debate over healthcare has highlighted, the current fee-for-service reimbursement methodology has led to perennial increases in provider costs without a corresponding increase in quality or positive consumer experience. A recent study by Milliman, for example, showed that the percentage of a family's income spent on health care in the Pittsburgh metropolitan area is the highest of twelve comparable areas across the nation. Highmark believes that many well-documented reasons for this result have been identified, including the incentives for utilization that fee-for-service creates, the fragmented nature of the delivery system, the lack of transparency and information for patients and policyholders and subscribers, and the need on the part of providers to subsidize lower-paying patients.

Highmark believes that similar structural factors are making insurance increasingly unaffordable in western Pennsylvania. In the last 5 years, Highmark has experienced an annual trend of medical cost increases of 6.6% (versus 2-3% increase in the Consumer Price Index) despite efforts to manage utilization and negotiate lower provider rate increases. Highmark believes this is a typical result in a market dominated by a large provider which can lead to behaviors such as overutilization, movement of services to higher reimbursement locations, building of unnecessary facilities, and requests for unreasonable reimbursement increases. UPMC has been an active consolidator in the last 10 years (largely through hospital acquisitions, employment of thousands of physicians, and extension of key clinical specialties like oncology

into the community in ways that promote dependency even on the part of the remaining “independent hospitals”). This consolidation, in Highmark’s view, has resulted in market power that in turn leads to excessive reimbursement demands, which would result in much higher premiums for Highmark’s policyholders and subscribers.

Highmark also believes that there are three other, less obvious, reasons for the escalation of health care cost increases:

1. Provider overutilization and inappropriate settings of care

The fee for service reimbursement structure defining the industry for decades is one of the major contributors to this utilization pattern. Most providers benefit financially from performing additional services. Highmark estimates, for example, that for services such as clinical laboratory diagnostics and radiology, its policyholders and subscribers utilize up to 65% more services than comparable, risk adjusted regions in the mid-Atlantic area.

In addition, many decisions about the location at which a patient receives care are made without a full understanding of the cost and quality implications. For many services, Highmark believes that the setting can be a major determinant of the cost. For example, ambulatory surgery services performed in a hospital are typically 50% more expensive than the same services performed in a stand-alone center; diagnostic imaging is 45% less expensive when performed in a free-standing imaging center compared to a hospital; urgent care is delivered at roughly half the cost in an urgent care setting compared to a hospital emergency room. Approximately 17% of all emergency room visits can be addressed by a free-standing care facility, which is typically two-thirds less costly than hospital-based emergency rooms.

In the future, Highmark intends to design products with cost sharing incentives to encourage value-conscious decision-making by policyholders and subscribers. Highmark will

engage in a pay-for-performance reimbursement system with WPAHS and other willing providers that considers both utilization rates and cost differences between hospitals and other settings. Through its transparency tools, Highmark will give policyholders and subscribers information to help them determine the best value when choosing providers. By providing actionable data on both quality performance and cost of a provider, they will have the opportunity to choose the highest value providers. These providers will also likely benefit from higher patient volume, as they become recognized as being associated with delivering higher quality at lower cost. In addition, Highmark estimates that medical costs can be reduced by 2-6% simply by redirecting to appropriate, lower cost settings, while assuring quality and likely improving the patient experience.

2. Overinvestment in physical assets and clinical technology

Highmark believes that, in a market where supply is not value-driven and consumption is not value conscious, the providers with the greatest market power can charge higher prices and use the surplus from these high prices to “overinvest” in unnecessary physical assets, which, in turn, causes them to require even higher reimbursement levels. Hospital systems often invest in the latest technology, even if that new technology does not lead to improved outcomes justifying this cost. In turn, those hospitals and the physicians they employ have an incentive to utilize this new equipment, effectively increasing utilization and overall service costs. Input costs to the system (e.g., drugs and medical devices) often follow similar patterns, with continued innovation and patent protections leading to accelerated inflation relative to other sectors. These costs represent sources of inflation that do not create value for policyholders and subscribers or the broader patient community, meaning that insurers can mitigate inflation without negative impact. For example, Highmark’s information indicates that orthopedic implants nationally account for

approximately 20% of episode costs for total knee replacement, and vary by up to 33% across knee implant types. Inappropriate matching of implants is estimated to cost the healthcare system in the U.S. \$200 million per year. Encouraging physicians to utilize more cost-effective though comparable quality implants and appropriately match the implant to the clinical situation should reduce episode costs considerably.

3. Lack of value-conscious consumption

Consumers have not historically been given the tools to make informed, value-conscious decisions about whether, and from whom, they will procure health services. The basic benefit designs embedded within health insurance products have also failed to encourage proper evaluation on the part of the consumer, and this raises costs for all policyholders and subscribers. Accordingly, Highmark is now combining efforts to engage the consumer more deeply, introduce much greater transparency into the market for provider services, and develop products that financially reflect the differences in value in the marketplace. Under Highmark's strategic plan, consumers will be offered products at a more economical price point resulting from incentives to consumers to use the highest value providers.

Highmark already has several tools in the marketplace or under development to accomplish this goal: (1) "Provider Search" permitting a policyholder/subscriber to conduct side by side comparisons of providers and to identify which tier of cost a provider is in; (2) "Patient Experience Review" giving policyholders and subscribers access to other patients' reviews and comments of specific providers and institutions; (3) "Out of Pocket Cost Estimator" permitting patients to clearly understand the personal financial obligations and quality tradeoffs associated with going to one provider versus another. Other, related tools are under development as well.

At no time will Highmark force a consumer to select one provider over another. Rather, Highmark intends to enhance choice based on value.

B. Highmark’s Strategy to Address Affordability and Access Issues

Highmark understands these issues and has developed a comprehensive strategy to address these dynamics. This strategy includes changing the delivery of care via a new reimbursement approach that encourages providers to use the most cost-effective venue for care, adhere to evidence-based standards of care, and deliver superior outcomes by reducing such issues as unnecessary re-admissions and post-surgical infections. Highmark’s strategy is focused on driving value for the consumer; that is, assuring high quality at an affordable price. From a policyholder/subscriber perspective, the strategy includes providing transparency regarding differences among providers with respect to cost, quality, patient experience, and overall value so that policyholders and subscribers can make informed choices around their healthcare services. This strategy should enable Highmark to deliver a lower cost, higher quality product in the marketplace for its policyholders and subscribers when the strategy is fully implemented.

CONCLUSION

A Highmark-WPAHS affiliation will represent the coming together of two organizations dedicated to common goals and objectives, including changing the way in which health care is delivered to their customers and patients. Both are committed to improving the quality and affordability of health care and enhancing the patient experience through collaborative relationships with physicians and operational excellence. Highmark believes that an affiliation with WPAHS will result in a stable integrated health system which will be a valuable community asset offering high quality, lower cost health services across the continuum of care.

EXHIBIT B

WEST PENN ALLEGHENY HEALTH
SYSTEM, INC.

Proposed Turnaround Plan

LEADERSHIP • PROBLEM SOLVING • VALUE CREATION



November 4, 2011

Submitted to:

HIGHMARK.

**Redacted
Turnaround Plan
May 1, 2012**

Submitted by:

**Alvarez & Marsal Healthcare
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Report Limitations

This redacted report (this "Report") was prepared and made available at the explicit request of the Pennsylvania Insurance Department. This Report is a redacted version of the original report (the "Original Report") prepared by Alvarez & Marsal Healthcare Industry Group (A&M) for Highmark, Inc. ("Highmark") on November 4, 2011 (the "Report Date") pursuant to the terms of engagement between A&M and Highmark. This report has not been reviewed, adopted or endorsed by West Penn Allegheny Health System. It is solely and exclusively a Highmark report. Each reviewer of this Report must note that this Report does not contain all of the contents of the Original Report and A&M provides no representation or assurance that the information removed from the Original Report does not result in a material omission the inclusion of which would make the statements contained in this Report not misleading.

In addition, A&M has not updated any of the Information contained herein to take into account any developments since the Report Date or any other facts or assessments that may have changed or been found to have been inaccurate since the Report Date.

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This report is based on information that has been provided by West Penn Allegheny Health System ("WPAHS", "the System" or the "Company") and A&M has relied, and is relying, on the accuracy and validity of the information supplied by the Company without seeking to independently verify that information. In the course of preparing this report, A&M had limited access to WPAHS senior management and facilities.

The nature of the transaction, due to certain regulatory factors, restricts the ability of the parties to collaborate in an effective manner and therefore much of the desired information could not be exchanged. Since the related Affiliation Agreement was under negotiation while this report was being prepared, the further limited information sharing between the parties pre-closing was expected. Although changes dictated by health care reform were considered, their impact is not fully known at this time.

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Executive Summary

A turnaround of the West Penn Allegheny Health System is possible through an affiliation with Highmark – an entity equally dedicated to the not-for-profit and community missions of WPAHS and a commitment to a change in the way health care is delivered. Highmark has the vision, capital and resources to invest immediately.

An affiliation provides an opportunity for WPAHS to benefit from the current integrated delivery network strategy and investments Highmark has independently decided to make across the region. While the financial and delivery system innovation investments Highmark is prepared to make will give WPAHS the opportunity it requires, commitment, action and meticulous follow through by WPAHS will also be required for these benefits to be realized and sustained. Short-term tactical decisions must be made to support long-term strategy.

The suggested plan contained herein recommends a top-line revenue and capacity focus, while containing costs. Activities and initiatives with longer-term focus are strongly suggested to be temporarily placed on hold so that the entire organization can get aligned behind a turnaround plan, and understand and address “burning platform” issues which support the longer-term strategy. Limited and easily understandable goals and measurement criteria should be defined and made transparent to all key stakeholders.

A prioritization of immediate steps (first 100 days) and then longer-term (first year and then beyond) is recommended. As there will be some period of time between the signing of the Affiliation Agreement and closing, WPAHS should address key issues in the best interest of the System for short-term viability and building towards long-term sustainability. Such issues could include:

- Commencing “facelift” projects at Forbes Regional Hospital (FRH)
- Aligning cost structure and finalizing re-opening plan of West Penn Hospital (WPH)
- Developing and implementing action plans for financial, operational, physician alignment and reporting issues within the Physician Organization (PO) and across the System
- Finalizing clinical service line development plans across the System
- Completing master facility and “stacking” plans at Allegheny General Hospital (AGH)

As more is learned during the regulatory review period, additional strategies and tactics should be developed to put WPAHS on a course to be a financially viable and high quality, lower cost health care resource to the community. Critical components should include:

- Corporate Organization: Implementation of expense reduction opportunities
- Physician Organization: Rebuild infrastructure
- AGH: Preparation for growth
- WPH: Renovation and recapitalization to reopen
- FRH: Addressing the competitive threat
- Allegheny Valley Hospital (AVH): Aligning with local employers
- Canonsburg General Hospital (CGH): Rebuilding primary care base

The momentum that can be gained by the immediate action steps and planning during the period after signing of the Affiliation Agreement will be critical for the turnaround of WPAHS. Through commitments made in the Affiliation Agreement, both WPAHS and Highmark are fully dedicated to turnaround WPAHS.

The two parties should, simultaneous to WPAHS turnaround efforts, undertake an intensive post-acquisition integration planning exercise. Such planning should include WPAHS system-wide reconfiguration of clinical service lines to meet strategy affiliation objectives, corporate organization strategy and joint recruitment and integrated delivery system strategies.

Background

Context for Assessment

As part of their integrated delivery system planning process, Highmark engaged A&M on February 10, 2011 to conduct a high-level assessment of WPAHS. Understanding the value of a robust, financially viable and high quality health system to its integrated delivery system, Highmark tasked A&M to develop a prototype turnaround plan for WPAHS. A&M used market and volume projections developed by Highmark and their engaged professional consultants as placeholder data within the turnaround plan. These combined efforts are contained within this document for Highmark's use in deliberating the structure and extent of a potential relationship with WPAHS.

The A&M Approach

For more than 25 years, A&M has been at the forefront of restructuring, turnaround and performance improvement. Our teams have worked on high profile restructuring, turnaround, and interim management engagements. Members of our Healthcare Industry Group are experienced in leading, advising and providing interim management to health systems during turnaround, restructuring and acquisition transition periods. As Chief Restructuring Officers and interim management at multiple clients, current A&M professionals have stabilized the situation and organized asset management, while developing and implementing consensual turnaround plans to rebuild smarter, leaner organizations with revitalized balance sheets and long-term vision for sustainability and growth.

Turnaround engagements are different than restructuring in that they occur before financial conditions have triggered lender action or such that the organization has come to a decision point of declaring bankruptcy or closing. Generally speaking, a turnaround plan is undertaken when warning signs of financial and operational performance challenges persist and there is recognition that the approaches and solutions of the past will not be sufficient to right the organization for a sustainable future. They are a preventive step to avoid restructuring or closure, but are often no less encompassing in the depth and breadth of change undertaken. The A&M approach to turnaround engagements involves establishing an unbiased fact-base at the start, yielding pragmatic recommendations and implementation plans that enable clients to affect positive, sustainable change. We believe identification of immediate actions and goals builds momentum and stability, while simultaneously developing next steps and stakeholder buy-in. The pace is unrelenting in the initial phases of a turnaround, creating a sense of urgency and difference from the past. Our dedicated team of executives brings a commercial approach to health care services while understanding and respecting the needs and demands of patients, physicians, caregivers, and their communities.

Successful turnaround efforts share many of the same characteristics: prioritization, communication, accountability, and leadership. In order to make an impact in a short period of time, the organization must recognize it can only focus on and achieve a limited set of key priority objectives. The initial focus should be on the areas resulting in the greatest leakage of value. The plan must be easy to communicate at all levels and include objectives, responsibilities, timing and key metrics. Each stakeholder (physician, employee, board member, etc.) must understand their role in contributing to the success of the turnaround. Clear lines of authority, progress reporting and communications are balanced for efficiency and effectiveness. Care must be given to not get bogged down in reporting, tracking and the minutiae of project management. Finally, a clear chain of command in which communication, accountability and responsibility are shared across the organization facilitates unambiguous deadlines, deliverables and targets; all driving towards results.

A&M recommends the characteristics of a successful turnaround be implemented at WPAHS to prepare for a sustainable future, with or without Highmark.

Situation Analysis

WPAHS has a strong community mission, accomplished clinical history and dedication to medical education and research. The System also has a history of financial struggles which has not improved during the past ten years, despite initiatives by various leadership and management teams. The WPAHS Board recognizes that the challenges being faced today: declining volumes, changing physician relationships and lack of infrastructure and programmatic investment can only be overcome by a strategic affiliation with an entity equally dedicated to preserving access to quality health care in southwestern Pennsylvania. This affiliation cannot be an effort to restore WPAHS to a glorified version of its past; it must embrace the changing landscape of health care delivery systems and reimbursement mechanisms and become a recognized innovator of integrated, quality care.

Despite the challenges, WPAHS has key strengths indicating it is a system worth reinvigorating for the benefit of Highmark policyholders and subscribers and the communities of southwestern Pennsylvania. This System, out of tradition and necessity, has maintained quality and service on par with or better than local competitors, at a lower cost structure.

As an example, Press Ganey (April 2011) reports that WPAHS as a whole enjoys higher patient satisfaction ratings than that of the largest competitor in the market, UPMC. Both organizations, however, have room for improvement.

Similarly, the Core Measures and readmission data from both systems show they are below national average, but for the cost structure, WPAHS is delivering comparable care at a lower

cost. A goal of the affiliation and the turnaround of WPAHS is to continue to raise the quality of care while maintaining lower cost.

An affiliation between Highmark and WPAHS must address the challenges of the System head-on while reinforcing its strengths.

1. Limited Investments

WPAHS has been able to make only limited capital improvements to the physical plant of the five hospitals over the last ten plus years. Important projects like the renovations of the Emergency Departments (ED) at CGH, FRH and AVH were only possible as opportunities for public funding or philanthropy presented themselves. A small number of strategic projects like the intensive care unit (ICU) projects at AGH and façade repairs at AVH have been undertaken with very limited capital. Use of funds from Highmark could bring facilities back up to competitive standards and enhance facilities to accommodate new/different services.

Lack of resources has also resulted in limited advertising and marketing. The lack of investment in creating a marketing presence is a significant factor in the System's image and brand equity in the marketplace not matching the quality and breadth of services that it offers. A WPAHS/Highmark partnership could provide a vehicle by which an accurate message regarding the quality and services offered can be distributed.

2. Physician Organization

Similar to WPAHS, the physician organization represents the coming together of five organizations. The integration of these organizations has been a slow process, hindered by a change in leadership and a lack of infrastructure systems. Preparation for an affiliation with Highmark spurred WPAHS to bring interim leadership into the PO. This team was charged with assessing and addressing financial, operational and personnel issues. Highmark and the PO interim leadership are coordinating the development of a strategy and investment efforts, to the extent possible in the current environment.

3. Debt

WPAHS is highly leveraged relative to its net asset position, with over \$800M in long-term debt. Long-term debt to total assets ratio is more than twice the S&P benchmark median¹. However, \$750M in Allegheny County 2007A revenue bonds are at fixed rates ranging from 5.000% to 5.375% and a manageable annual level of debt service of about \$50M annually.

¹ S&P Not-For-Profit Healthcare Median Ratios

The System also has floating rate restructuring certificates (“FRRC”), an obligation originating from the AHERF bankruptcy settlement. This indenture has no required principal or interest payments unless cash levels over 105 days are achieved (105 days translates to greater than \$450M of unrestricted cash based on FY 11 daily operating expense). The total FRRC liability is approximately \$48M as of April 2011, including contingent accrued interest.

Days cash on hand (DCOH) was 60.5 as of June 30, 2011, down from 70.9 at June 30, 2010, with 2.15 debt service coverage (DSC).

Through increased volumes and other initiatives resulting from a partnership with Highmark, improved financial performance should strengthen WPAHS’s ability to service its debt.

4. Capital Expenditures (CAPEX)

Capital investment was underfunded between 2005 and 2010, with WPAHS spending on average approximately \$66M per year or about 100% of depreciation on CAPEX (see table below). Capital spending was stronger in FY 11 at \$108M or approximately 180% of depreciation². This larger than normal expenditure was enabled in part by utilizing much of the remaining project funds from the 2007 bond issue primarily for AGH and information technology requirements supporting compliance with Medicare/Medicaid “meaningful use”³.

Year	Capital Expenditures	Depreciation Expense	CAPEX as % of Depreciation	S&P Rating	CAPEX as % of Depreciation
(\$000s)					
FY 05	54,823	63,329	87%	AA+ to AA-	144.8%
FY 06	65,384	61,667	106%	A+ to A-	134.2%
FY 07	81,605	62,450	131%	BBB+ to BBB-	108.9%
FY 08	94,017	67,319	140%	Speculative	83.6%
FY 09	46,551	74,273	63%		
FY 10	55,981	74,286	75%		
FY 05 - 10	398,361	403,324	99%		
FY 11	108,312	60,507	179%		

Historic capital spending was not consistent or strategic, with many infrastructure and equipment replacement and maintenance needs deferred.

² Table sources: WPAHS Audited and Internal Financial Statements and Standard & Poor’s Not-for-Profit Healthcare Median Ratios 2010.

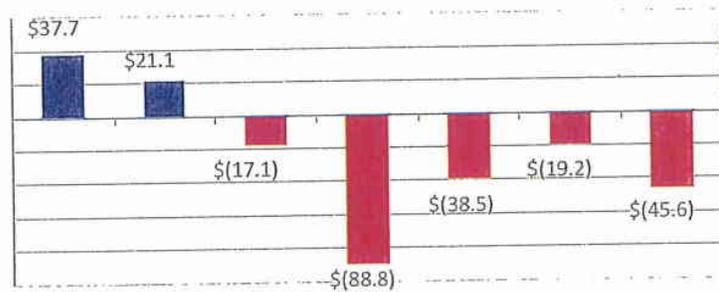
³ The American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use: 1) The use of a certified electronic health records (EHR) in a meaningful manner, such as e-prescribing. 2) The use of certified EHR technology for electronic exchange of health information to improve quality of health care. 3) The use of certified EHR technology to submit clinical quality and other measures.

As part of Highmark's provider initiatives, platforms in health information exchange (HIE), electronic health records (EHR) and electronic medical records (EMR) are being developed for use within its integrated delivery network. WPAHS could both benefit from and support these platforms, providing seamless information exchange, efficiency, and opportunities for enhanced quality of care.

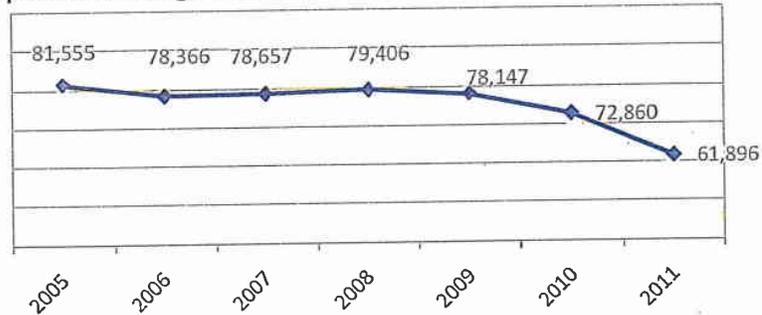
WPAHS Financial Performance

The chart that follows shows WPAHS financial results trended negatively from 2005 through 2008, including a significant downward restatement of patient revenues in 2008. WPAHS Management retained a professional consulting firm in 2008 with the charge of assisting them in pursuing labor productivity, supply chain and revenue cycle improvement initiatives.⁴

Operating Income Trend ⁴



Inpatient Discharge Trend



By 2010, the System had succeeded in improving labor productivity and reducing its cost structure, but volume continued to trend down in large part due to physician attrition. Despite

⁴ Operating Income Trend and Inpatient Discharge Trend Source: FY 05 – FY 10 Audited Financial Statements, FY 11 internal financial statements. WPAHS internal statistics.

lower patient volumes, the labor and cost reduction initiatives enabled the System to generate approximately \$96M in EBIDA and trim its operating loss to about \$20M in FY 10.

In August 2010 services were significantly reduced at WPH as part of the Urban Consolidation Plan undertaken by WPAHS. The ED closed on December 31, 2010. The objective was to shift a large portion of the WPH market share to AGH, but the volume loss as a result of the service consolidations exceeded projections. As programs at WPH closed, the odd mix of services that remained were unrelated and non-synergistic. Inpatient discharges dropped 15% between 2010 and 2011, from 72,860 to 62,095. The large volume decline was a significant contributor to the increased operating loss in FY 11. The loss was most significant in the PO.

Looking at the period from FY 08 forward, recognizing the concerted effort of management in FY 08 and FY 09 to reverse the downward trend of financial performance, the statement of profit and loss (P&L) demonstrates the improved operating performance in FY 09 and FY 10. Related to the volume trends described above, net patient revenue grew from FY 08 through FY 10, but declined between FY 10 and FY 11 primarily due to reduced service offerings at WPH and the loss of key physician practices across the System. The strategy appears to have been inadequate to put the System on a viable financial track for the long-term.

Focus and Approach to WPAHS Turnaround

A&M was engaged by Highmark to conduct a financial and operational assessment of WPAHS during the time leading up to signing of the term sheet, and later the Affiliation Agreement between the two parties. A&M assessed WPAHS's baseline performance, studied major liabilities and identified underlying factors driving key challenges and successes (as previously discussed). Interviews with some stakeholders within the WPHAS organization were conducted, a high-level operations assessment was undertaken, and financial projections were built and stress-tested. Findings and recommendations regarding the potential affiliation were vetted with Highmark leadership. This groundwork provides the basis for the prototype turnaround plan presented herein.

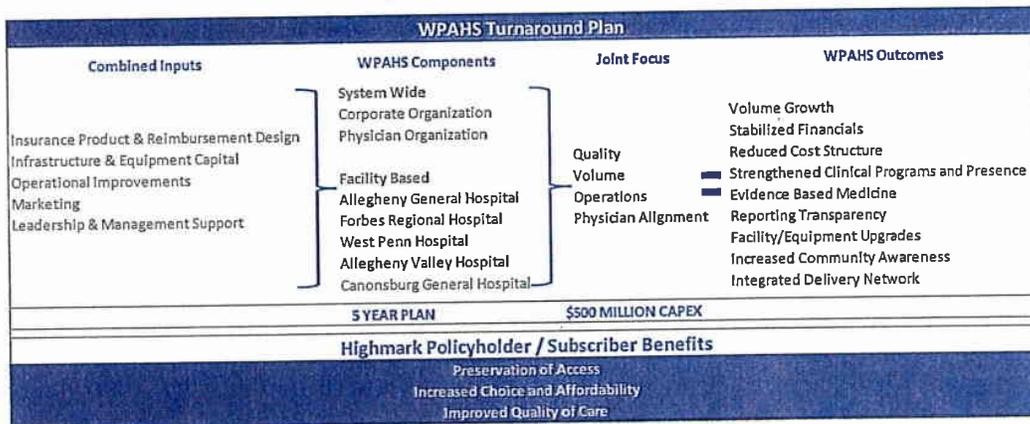
Highmark has committed to affiliating with WPAHS as one part of Highmark's product and network strategy to preserve access, choice, affordability, and improve the quality of care for its policyholders and subscribers through evidence-based medicine and an integrated delivery system. Long-term goals for WPAHS in concert with Highmark's provider initiative have been established, which need to be finalized and implementation plans developed by representatives of the respective companies. Highmark recognizes the time sensitive nature of the actions needed to stabilize WPAHS for financial viability and continued access to quality health care and choice in the southwestern Pennsylvania region.

The design used for this turnaround plan is meant to stimulate WPAHS's growth and ability to compete in the regional market, moving away from its current trajectory of contraction and retrenchment. This would be a fundamental change in strategic direction, one that was considered overwhelming and beyond reach by the leadership of WPAHS without intervention by a third party. Highmark was deemed by WPAHS's leadership to offer access to capital and patients as well as innovation to the integration of delivery networks with a mission focus that other organizations would not be able to provide. With a direct relationship between Highmark and WPAHS, system accountability for high-quality care while reducing the unnecessary use of resources could be coordinated and implemented in a streamlined effort.

In A&M's view, Highmark and WPAHS must be absolutely aligned in the need to:

- Maintain and grow volume at all WPAHS locations
- Invest in programmatic development and capacity, while reducing the overall cost of care, especially in "shared services"
- Stabilize the leadership and align with physicians to establish WPAHS as a provider of choice

These needs represent the focus of this prototype turnaround plan and will be addressed to varying degrees in each of its seven components (see graphic below). Timing of efforts need to be prioritized based on their estimated contribution to volume growth and financial stability.



While long-term sustainability will require the significant changes possible after closure of the affiliation, A&M has concluded that immediate action to address financial challenges will be required by WPAHS during the regulatory review period. These steps include significant infrastructure investment and major physician alignment efforts which WPAHS should implement regardless of the future status of the Highmark affiliation. Joint planning between Highmark and WPAHS should also occur to the extent possible.

The WPAHS PO was identified during the assessment to require a greater level of intervention (i.e. restructuring), for its long-term success and that of the System. Leading up to the Affiliation Agreement, WPAHS chose to act and install interim management within the PO as of September 1, 2011, as an immediate step toward defining responsive leadership and building trust within the provider community. This interim management team is currently conducting a thorough review of the organization.

Goals for a turnaround of WPAHS have already been established by both parties: long-term financial stability and sustainable volume growth. The next steps from analysis to action to stabilization to return on investment will be a long-term evolving process. Building a foundation of clear vision, unified and effective leadership and transparent processes will be required as part of meeting these goals. Communication plans should be an integral component of all initiatives, updating the patient, employer and provider market of WPAHS's strengths and service offerings on an on-going basis.

Volume growth could be achieved through inputs by both Highmark and WPAHS. Current gaps in facility capabilities and services throughout WPAHS should be addressed to meet consumer need and complement the integrated distribution network strategy of Highmark. WPH should be reinvigorated with needed medical and surgical specialties. Investments will need to be made in FRH infrastructure and services to mitigate competitor advances into its primary service area long-term. Reopening of WPH is reportedly critical due to its location and importance for the broader Highmark network. WPAHS is expected to be able to leverage impact from Highmark consumer choice product design and brand for increased volumes. Targeted capital investments should be made and focused on expanding ambulatory capability and improving inpatient technology. WPAHS corporate shared services should be reassessed against best practices, and information technology initiatives by WPAHS and Highmark should be prioritized toward achieving federal meaningful use incentives to WPAHS. Management service organization (MSO) offerings should be further developed and deployed by Highmark for employed provider use as well as for leasing to other independent provider partners to serve as a common platform for better integration, managing information, improving quality and outcomes and lowering cost.

Longer-term strategies for WPAHS should focus on maintaining and continually improving high-quality care and stabilization of financial footing so that regular investments are made in infrastructure and programmatic services to meet the evolving needs of the market.

The prototype turnaround plan presented has limitations. Implementation is the key to success of any plan. The success of the plan will be based on leadership and active day-to-day management of initiatives supporting the plan. The skills and competencies of various management personnel will be as important as the resources provided for successful

implementation and should be bolstered as needed. Senior leadership at WPAHS should be engaged to help refine the final components of an adopted plan to gain acceptance and their alignment in implementation. Responsibilities should be assigned and a timeline finalized. Implementation should commence commensurate with a deeper dive into the operational and financial status and needs of each component of the System.

In summary, Highmark plans to invest \$400M in unrestricted payments and loans to WPAHS over five years within strategic components of the System with the goal of preserving and transforming health care services for policyholders and subscribers. Simultaneously, Highmark will invest in and build an integrated delivery network across southwestern Pennsylvania – of which WPAHS will be one component of a multi-pronged strategy.

The following description provides additional detail of the prototype system-wide initiatives and facility specific plans that could be implemented (or are underway) to address stability and sustainability needs and to integrate WPAHS into Highmark's broader strategy.

Turnaround Plan
"100 Day Plan"

Stabilization – The First 100 Days

Purpose of a “100 Day” Plan

A “100 Day” Plan is an approach to get an organization aligned behind a set of goals over a short period of time (goals and strategic framework are necessarily identified prior to this period). The first 100 days of any transition, whether a turnaround or restructuring, merger or acquisition or integration, is crucial to establish a prioritization of both short- and long-term tactics, organize efforts during a period of uncertainty and identify the needed path beyond this timeframe. By implementing this process, it creates a greater sense of urgency throughout the organization for collaboration and rapid action. Planning of this type shortens the time to decision-making and focuses resources on “quick wins” to promote confidence in the overall strategy. A “rapid response team” can be considered as part of the implementation process to ensure that there is a method to quickly respond to requests for capital, approvals to proceed with change, barriers, and other opportunities which may present across WPAHS. Through continuous communication, implementation of “100 Day” Plans improves transparency in goals, tactics and reporting for buy-in and commitment by key stakeholders. By having a clear focus for the first three months, time is protected to finalize and socialize plans for sustainable change and integration beyond this initial period. Success of a “100 Day” Plan is based on visible leadership, consistent communication, active management and resources to support the plan.

A Sample WPAHS “100 Day” Plan

Highmark has separately outlined its provider initiative framework and the role WPAHS plays in the success of that strategy. While the more common merger between two hospitals or integration of one hospital into a health system focuses on building the infrastructure and consolidating the operational and functional activities, the affiliation process between insurer (Highmark) and health system (WPAHS) is focused on strategic alignment. Because this strategic alignment is dependent on the successful turnaround of WPAHS and capitalizing on any financial improvements and performance efficiencies that can be made both within the System and through the affiliation, the “100 Day” plan and longer-term strategies should fuse these foci.

Highmark management and Board have expressed their commitment to the financial and operational turnaround of this System. The potential priorities identified to date for a “100 Day” plan should be both system-wide and component specific. System-wide, service line planning and quantification of potential impact of each service line should be accelerated and completed. The capacity of the care delivery system should be determined and right-sized,

resulting in a matching of resources and facilities to system needs. Tactics to improve performance of and achieve expense reductions in shared services should be identified and implemented. Performance and savings estimates can be quantified during the first 100 days.

This prototype turnaround plan (including the first 100 days and long-term) can be organized around key aspects of WPAHS:

- Physician Organization
- Clinical Integration
 - System-wide
 - Allegheny General Hospital
 - West Penn Hospital
 - Forbes Regional Hospital
 - Allegheny Valley Hospital
 - Canonsburg General Hospital
- Corporate Organization
- Long-Term Planning

Physician Organization

Within the PO, internal and external financial and operational performance benchmarking should be completed during the first 100 days after the signing of the Affiliation Agreement. Gaps in organizational support structure should be filled (to the extent possible) in order to increase accountability and effectiveness. Ongoing losses should be stemmed as part of efforts to restore physician confidence in leadership. An assessment of System expenses applied to the PO should be undertaken for an accurate understanding of the overall financial status of the PO. Reporting tools should be developed, with the first metrics and results distributed within the first 100 days. The restructuring of the PO, along with the development of a physician strategy and aligned primary care providers should be key priorities.

Clinical Integration

Across WPAHS, the service line strategy should be completed during the first 100 days after both parties have signed the Affiliation Agreement (system-wide and facility specific). Delivery system capacity should be determined, matching resources and facilities to clinical needs. The going forward plan for consolidation and/or exit of service lines across the System should be finalized, with first steps taken at first opportunity.

Opportunities to lower the overall cost of care by driving down unit costs should be identified and developed into actionable plans, as appropriate. Methods by which improved service and

access can be achieved, with concierge level standards as the goal, should be reviewed. Importantly, existing quality dashboards for core measures, re-admission rates and the like should be revised for standardization across the System, for ease of completion and use and transparency. Several tools can be used for these purposes, creating an efficiency in which key data is reviewed for timely resolution of issues. First, a cost per unit of service assessment, utilizing different metrics for nursing and non-nursing services, can drive efficiencies down to the cost center and procedural level. A daily monitoring and floor report by service can track daily, weekly and monthly activity, forecasting against actual. Finally, a plan should be created for every new initiative proposed. Such plans include the various steps of the recommendation, a timeline, and a financial review for return on investment. Each facility should implement these tools for local and system wide tracking.

Among the facilities, the top priorities for the first 100 days should include the finalization of the reorganization plan of each to meet the overall delivery system needs.

- At AGH, this should include completing the master facility "stacking" plan to fully transition the facility befitting a quaternary service provider and preparing to accommodate the additional volume from a Highmark network without UPMC.
- At WPH, the cost structure should be aligned with the long-term role/vision for this facility within WPAHS. The operational plan to reopen WPH should be fully developed, vetted, budgeted and communicated to key stakeholders.
- For FRH, the internal and external "facelift" project should commence immediately to ensure completion by June 2012, in anticipation of the opening of the UMPC East facility.

Corporate Organization

The identification of a cost-effective model for shared services as well as efficiency opportunities should be undertaken. During the first 100 days, an assessment of centralized processes across WPAHS should be conducted. Outsourcing and in-sourcing potential for any contracts to manage or supply support services should be explored. Any resulting plans to right size and place services should be socialized among key WPAHS managers and physician leadership.

Long-Term Planning

Development of longer-term tactics should be ongoing. System-wide, plans should be developed to tackle key areas such as: operations, infrastructure, personnel and integration with Highmark and other components of the Highmark strategy. Within operations, plans to increase patient volume at the most appropriate sites of care and to address any capacity constraints should be examined. Longer-term tactics related to infrastructure should include

refinement of facility and service line capital investment plans. Personnel foci in the long-term strategy should include recruitment of permanent leadership and management aligned with the integrated provider network at Highmark.

Working groups should be established early in the 100 days, with accountability beginning simultaneously. These working groups will have clear lines of reporting both up to leadership and downstream to key stakeholders. Progress towards goals should be monitored regularly.

*Turnaround Plan –
Long-Term*

*System Wide
Components*

Longer-Term Strategy

The following component descriptions of a turnaround plan represent the disclosed current thinking on potential longer-term strategies for each, recognizing their interrelatedness. Loosely, longer-term strategies of a turnaround plan represent months four through twelve (following the first 100 days). While the plans outlined are a potential course of action, as the project gets underway, plans will be necessarily subject to change with the ultimate goal (beyond the initial twelve month period) of system-wide financial viability, quality care and compatibility with the Highmark integrated delivery system in mind. Assessment and progress made during the first 100 days should inform longer-term strategies and tactics for each component.

System-wide components, such as a physician organization or a corporate organization, can require additional planning, extensively coordinated implementation and usually take longer to recognize lasting benefit due to the complex relationships across the system and affiliation impacting success. Potential areas of focus for these components in the four to twelve months following the signing of the Affiliation Agreement are discussed below.

Physician Organization

As previously noted, WPAHS engaged interim management on September 1, 2011 to help administer the Physician Organization in concert with existing WPAHS leadership. With WPAHS' permission, the early findings and actions within this organization are included in this document.

The WPAHS PO currently employs approximately 550 physicians and 1,700 support staff. A strong physician base is critical to the future success of the WPAHS and as such, steps should be taken to ensure and enhance the viability of this investment.

The turnaround of the PO should be a vital part of the larger plan to reinvigorate WPAHS. A PO should be expected to support a robust and viable continuum of care, build trust in the physician leadership, and ensure alignment of employed and community physicians with WPAHS. Tactical plans focusing on enhancing professional leadership, improving financial diligence, understanding the operating losses, analyzing physician compensation models, evaluating revenue cycle management, expanding information technology, and exploring business development opportunities should be prioritized.

Enhance Professional Leadership

The management team has committed to providing open and frequent communication with physician leadership regarding financial results and building adequate infrastructure for a

\$400M enterprise. The organizational chart will be revised to create PO-specific reporting relationships which interface with WPAHS leadership, and create accountability for functions such as Accounting, Finance, Revenue Cycle and Operations. Business Development functions will be created to work closely with the aligned community hospitals for WPAHS to provide needed practitioners and to extend certain clinical capabilities to the Highmark network. Working groups have been formed with representatives from each service line to coordinate and strengthen clinical programs and to help channel tertiary/quaternary referrals.

Improve Financial Diligence

Through turnaround efforts, more discipline should be built into the process of budgeting and the development of financial projections. This includes proper allocation of hospital costs versus PO costs (i.e. medical directorships, teaching responsibilities, and other related responsibilities in service to the hospitals). The process should ensure that there are clear explanations and justification for revenue and cost allocations (including PO administrative and system-wide services).

The financial reporting process needs to be robust and more transparent so that physicians and administrators can access financial and operational performance data and trends through the Allscripts Sunrise EPSi solution in real time. The increased availability of information and data should provide an important perspective to physicians and business leadership on key performance indicators such as productivity.

Understand Sources of Losses

Understanding the underlying causes of the ongoing operating losses is critical to a PO turnaround. Once the sources of the losses are better understood, specific action plans should be created to address the issues. The goal for implementation of these plans is to lay the groundwork for developing a culture of continuous improvement within the PO. Regular, structured meetings can provide an opportunity for management and physicians to more formally collaborate on performance improvement initiatives, whether in the form of revenue improvement opportunities or cost reductions.

The CARTS method (i.e. Clinical, Administrative, Research, Teaching and Service) of analyzing time consumption should be implemented to ensure proper compensation for clinical services provided to the System and other agreed upon duties.

Consideration should be given in the development of revised compensation models to balance productivity, service, and quality measures that incent behavior and actions required for WPAHS success and alignment with Highmark's delivery network strategy. The success of any new model is dependent on parallel execution of a transparent reporting plan, described

earlier. Management must provide regular interval and cumulative data. The increased visibility gives physicians a perspective on projected compensation levels based on current activity.

Increased transparency, improved communication, better management and aligned productivity/compensation are intended to inspire and motivate the physician community. Leadership's espoused goals are to instill the culture of teamwork with the physicians (both employed and independent), to remove as many obstacles as quickly as possible and to deliver the highest quality, most cost efficient health care available. The PO is critical to the success of the WPAHS/Highmark affiliation and the initiatives presented have been designed to strengthen and enhance the organization.

Corporate Organization

A&M does not have the benefit of an insider perspective to contribute to the development of an action oriented turnaround plan for the corporate organization of WPAHS. A final turnaround plan for the complete WPAHS organization will benefit from the first 100 day - activities to obtain such detail. The information that follows is based on key stakeholder interviews, data provided by WPAHS staff and prior experience in other health system turnaround environments.

Under prior management, extensive system-wide (shared) services were created with the goal of consolidating operations and leveraging these services over a larger platform. Volume contraction at the facilities does not appear to have triggered an appropriate sizing of shared services.

A review of the shared services model for each function should be explored during the first 100 days. The level of local versus corporate control and the level of required standardization drive decisions related to centralization versus decentralization. Based on a thorough assessment, the most cost-efficient and effective delivery model should be designed and/or redesigned to ensure adequate levels of support are delivered to the entities of WPAHS without redundancy.

With in-depth analysis of each of the corporate organization areas completed, implementation plans for maximizing efficiency and effectiveness of the corporate organization should be developed for roll-out during the fourth through twelve months following the signing of the Affiliation Agreement.

*Turnaround Plan –
Long-Term*

*Facility Specific
Components*

Facility Specific Components

The discussion that follows provides an outline for consideration of longer-term efforts to turn around WPAHS in keeping with the identified goals: system-wide financial viability, quality care and compatibility with the Highmark integrated delivery system. The following information reflects potential efforts based on high level assessment and experience in other turnaround situations. Each turnaround is unique, and the long-term plans appropriate for WPAHS can only be developed with full cooperation and engagement of WPAHS leadership and management for a thorough assessment during the first 100 days following execution of the Affiliation Agreement.

Allegheny General Hospital Growth Plan

An immediate long-term plan for AGH should be to reduce the hospital's cost structure. The hospital should develop strategic clinical programs, and medical and surgical inpatient services worthy of increased referrals. A plan should focus on promoting AGH's capable service offerings within the community by marketing existing services, recruiting additional physicians who offer new services, developing referral networks and continuing to improve clinical quality.

Long-term goals for AGH should include adoption of evidence-based medicine practices, strengthened integration with the broader WPAHS and Highmark provider community, further improvements to clinical services through physician recruitment, full utilization of health information exchange opportunities and continuous performance improvement.

Capacity and Utilization Improvements

Capital investment at AGH should primarily be used to renovate and expand capacity for additional patients and high acuity programs. A master facility plan for AGH needs to be completed in order to prepare to accommodate the anticipated additional volume while at the same time reorganizing operations for shifting service lines and maximum efficiency. Simple cosmetic renovations for enhanced patient satisfaction should also be prioritized.

Focused Clinical Services

AGH currently serves both low and high acuity patients, who compete for beds and ancillary services. Costs of care for lower acuity services are greater when sharing the infrastructure and staffing needs of high acuity services. Through the turnaround, AGH needs to complete the transition to being a regional quaternary facility. Non-quaternary services such as ambulatory surgery, breast imaging and diagnostics, minimally invasive surgery, etc. may need to be redistributed to lower cost facilities and providers within the WPAHS network as AGH volume

grows. Patient flow, throughput processes and administrative functions at AGH can then be refocused on high acuity patient needs, patient safety and infection control, reducing duplication and “dual track” services.

Expansion of quaternary services should include a redesign of the ED and development of an urgent care track to help improve throughput. “Treat and release” patients can be identified and appropriately referred at triage as a streamlining initiative. Patients arriving with low acuity, but inpatient needs could be treated and transferred accordingly – based upon protocols and census. Quaternary services should be enhanced by the development of specialty clinics for diseases such as adult congenital heart disease and hypertrophic cardiomyopathy.

The Western Pennsylvania Hospital Reopening Plan

The reopening of WPH should be a critical component of Highmark’s commitment to revitalizing the System. The reopening of the ED and returning selected medical/surgical programs to WPH can provide additional access and an alternative for Highmark subscribers in the area.

The initial goal of a WPH turnaround plan should be to “stem the bleeding” with an immediate focus to improve the financial and operational performance of the hospital. This could include the redeployment of unused resources, right-sizing the cost structure, physician recruitment and positioning the Women’s and Infants’ service line for future growth. The obstetrical unit and NICU will need to be expanded to accommodate additional deliveries, which should further increase if UPMC is out of network. For the longer-term, WPH should be a fully functioning community hospital. This community hospital should include an ED, general medical/surgical inpatient units, easily accessible ambulatory surgery, and centers of excellence in breast and inflammatory diseases, and other low to moderate acuity clinical activities.

Forbes Regional Hospital Revitalization Plan

The revitalization of FRH should be another critical component of Highmark’s commitment to a turnaround of the System.

A plan should present a blueprint for the immediate future as well as a long-term strategy geared to ensure the viability of FRH in a competitive market.

Potential Immediate Steps to Ensure a Competitive Edge

FRH has filed an application for Level II Trauma designation. FRH should be fully dedicated to reaching this objective in action and committing resources to this end. The capabilities this

designation represents will help to ensure FRH remains uniquely positioned in the market. The Level II Trauma designation should also heighten awareness of the FRH capabilities and services within the greater community.

A turnaround plan should also include a priority of a “facelift” to refresh the campus.

Long-Term Service Distinction

Over the long-term, after-hours and weekend clinical diagnostic and support services should be augmented to reaffirm FRH as a full service provider of ambulatory services. This could differentiate FRH and create additional relationships with Highmark subscribers in the community.

Specialty clinics in heart failure, cardio-metabolic disease and women’s heart disease are currently under consideration for development as another differentiation tactic and to further augment the continuum of care in core services. Trauma and residency programs could be augmented (as needed) to advance FRH tertiary capabilities.

Alle-Kiski Medical Center Integration Plan (*dba Allegheny Valley Hospital*)

AVH is a profitable facility within WPAHS and could become more so in a Highmark relationship. Inpatient services include psychiatric care as well as geriatric psychiatry, cardiology, orthopedics and oncology. AVH provides a moderate intensity of services with a focus toward employer-related programs. Efforts at AVH should aim to increase ambulatory programs and volume in primary and secondary markets, supporting a more robust and respected WPAHS reputation and long-term viability.

A WPAHS turnaround plan should include development of ambulatory services linked to AVH, expansion of the occupational medicine program at this facility and increasing market awareness of these programs.

Over the long-term, AVH could be coordinated with Highmark to align its clinical service offerings to meet the needs of consumers looking for limited, but high quality and convenient coverage - often the “self-insured” market. Such alignment is also expected to be attractive to future enrollees of the insurance exchange.

Facility Upgrades

AVH currently has the largest inpatient market share within a primary market of any of the WPAHS facilities at 37.9%.⁵ WPAHS has already begun to renovate the facility’s facade. The

⁵ WPAHS Decision Support, Source: Pennsylvania Health Care Cost Containment Council 2010 (Thomson - Reuters)

interior is also in need of a facelift to remain competitive and to attract both providers and patients. Inpatient and operating room should be addressed to handle the potential increase in volume.

Catering to the Ambulatory Service Population

A predominant focus of a turnaround plan for AVH should be to enhance ambulatory services, with the intent to improve patient experience and lower costs for both the patient and the provider. Currently, greater than 60% of AVH admissions come from the ED. A full analysis of referral patterns and community demand should be undertaken, with consideration of resources across the integrated Highmark network. Changes to existing and future services should be implemented accordingly. WPAHS has plans to develop a vascular service line for this specific market, complimenting the quaternary cardiac services under development at AGH. The occupational medicine program is also slated to be expanded and promoted at AVH.

Promotion of Existing Services

AVH services include an underutilized Joslin Diabetes Clinic, which is currently not marketed. As part of the future ambulatory emphasis at AVH, this nationally recognized clinic should be promoted to and made available through the Highmark network of physicians and policyholders/subscribers.

Canonsburg General Hospital

CGH is the smallest inpatient facility within the WPAHS network, and considered to provide “low intensity” services which include a 16 bed rehabilitation unit. The facility has a strong focus on health education and preventative care that reflects a commitment to wellness and health improvement. Local market payor mix characteristics for CGH are among the best for all of the WPAHS facilities. CGH needs refinement around service line focus and capacity in order to take advantage of this fortuitous positioning. Turnaround efforts at CGH could be developed after the initial strategies at other facilities are underway.

Alignment of Clinical Services

Long-term goals for CGH should focus on aligning services offered at this facility with other locations within the Highmark network. Operational improvements which could be considered in order to promote increased volumes could include expanding anesthesia services to support the additional sub-specialty surgeries, orthopedic and neurosurgery inpatient procedures. Additional physicians would be needed to bolster gynecologic services at CGH.

Together with Highmark and WPAHS, CGH could benefit from enhancing and expanding the primary care network through both affiliation and employment. Alignment of additional

primary care physicians should drive volume to the conveniently located CGH. With a strong payor mix, a service line analysis should be undertaken to ensure the future use of this facility meets and attracts consumer demand.



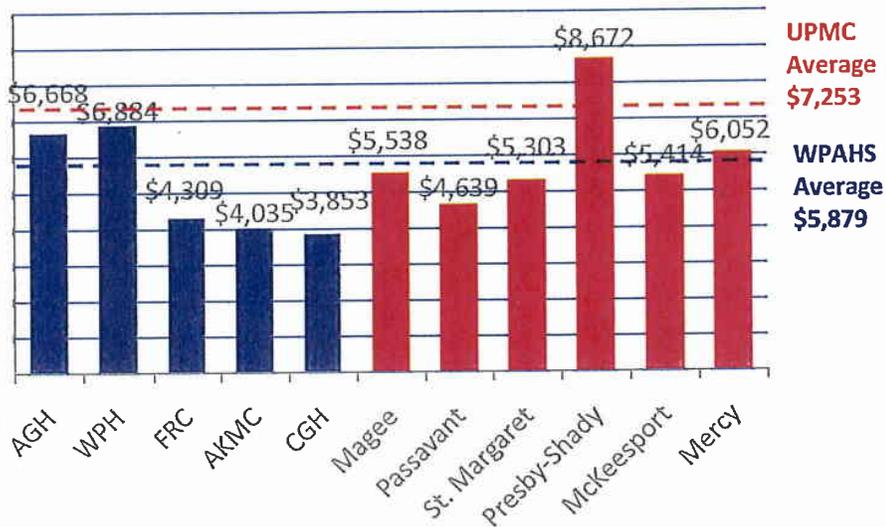
*Financial
Investments*

Highmark Strategy and Expected Volume

As previously described, increased volume is the most critical component of a WPAHS turnaround plan. Hospitals and hospital systems are all capital intensive and have high fixed costs that account for a large share of total expenses. Therefore, a relatively small change in volume up or down can have a significant impact upon unit costs and incremental profitability. WPAHS' historical focus on improved productivity and ratcheting down its cost structure has been a difficult challenge in the face of continually declining volumes, as few health systems can react quickly enough to maintain profitability in this environment.

The System is well positioned to generate stronger margins through the anticipated increase in patient volume that would result from a Highmark relationship and a well defined turnaround plan. As the major payor in the region, Highmark has a unique interest in offering products that provide consumers with choice, transparency tools and leverage WPAHS' lower cost advantage. The chart below provides a comparison of the average cost per inpatient discharge adjusted for relative outpatient activity and case mix index. It shows that WPAHS had an overall cost advantage in FY 10 compared with UPMC of about \$1,374 or 23%, and its quaternary institution AGH had a cost advantage over Presbyterian / Shadyside of approximately \$2,004 or 30%⁶.

Cost per Discharge (CMI & OP Adjusted, 2010)



⁶ Data sources: Medicare FY 2010 cost reports and CMS FY 2010 Final Rule Case Mix Index

Incremental volume growth could be expected to come from several initiatives, including but not limited to:

- Consumer Choice – subscriber and physician incentives through product, benefit and reimbursement design that would provide a greater value proposition (higher quality, lower cost and better service) than the competition.
- Reinvigorated West Penn Hospital – restoring targeted clinical services and reopening the ED would offer a community hospital alternative to residents living or working in areas of urban revitalization (e.g. East End neighborhoods).
- Strategic Execution – focused investment in marketing high quality programs/services and facility/equipment upgrades that would make the hospitals more attractive and competitive (i.e. FRH facelift and upgrades).
- Physician Alignment – strategies that could return former WPAHS physicians to the System and offer independent physicians an alternative practice environment. These tools could help to better align subscriber and physician interests, promote health and wellness, allow sharing of critical medical information and prevent unnecessary utilization of health care services.

Success in generating enhanced market share through the volume-related initiatives described above is projected to generate improved financial performance within the hospitals and PO of WPAHS. Detailed financial analytics were prepared (and submitted to the PID) to estimate the improved profitability of the organization resulting from additional operating revenues, expenses and capital investments. Sensitivity analyses were prepared to understand the potential range in outcomes of financial performance that could occur at varying levels of success. The financial projections assume that promoting, enhancing and developing the quality, cost and customer service advantages at WPAHS will lead to an improved patient experience for Highmark subscribers and all other patients. The financial projections also assume that success in accomplishing this important goal is imperative to restoring market share and improving financial performance at WPAHS.

Capital investment is an important aspect of accomplishing the goal of providing world class quality and customer service. Highmark has made a substantial financial commitment to this plan of \$400M over four years. The financial projections include strategic infrastructure improvements, equipment additions and information technology investments designed to enhance the patient experience, enhance capability and improve quality and efficiency of service delivery.

EXHIBIT C

Proposed Corporate Structure

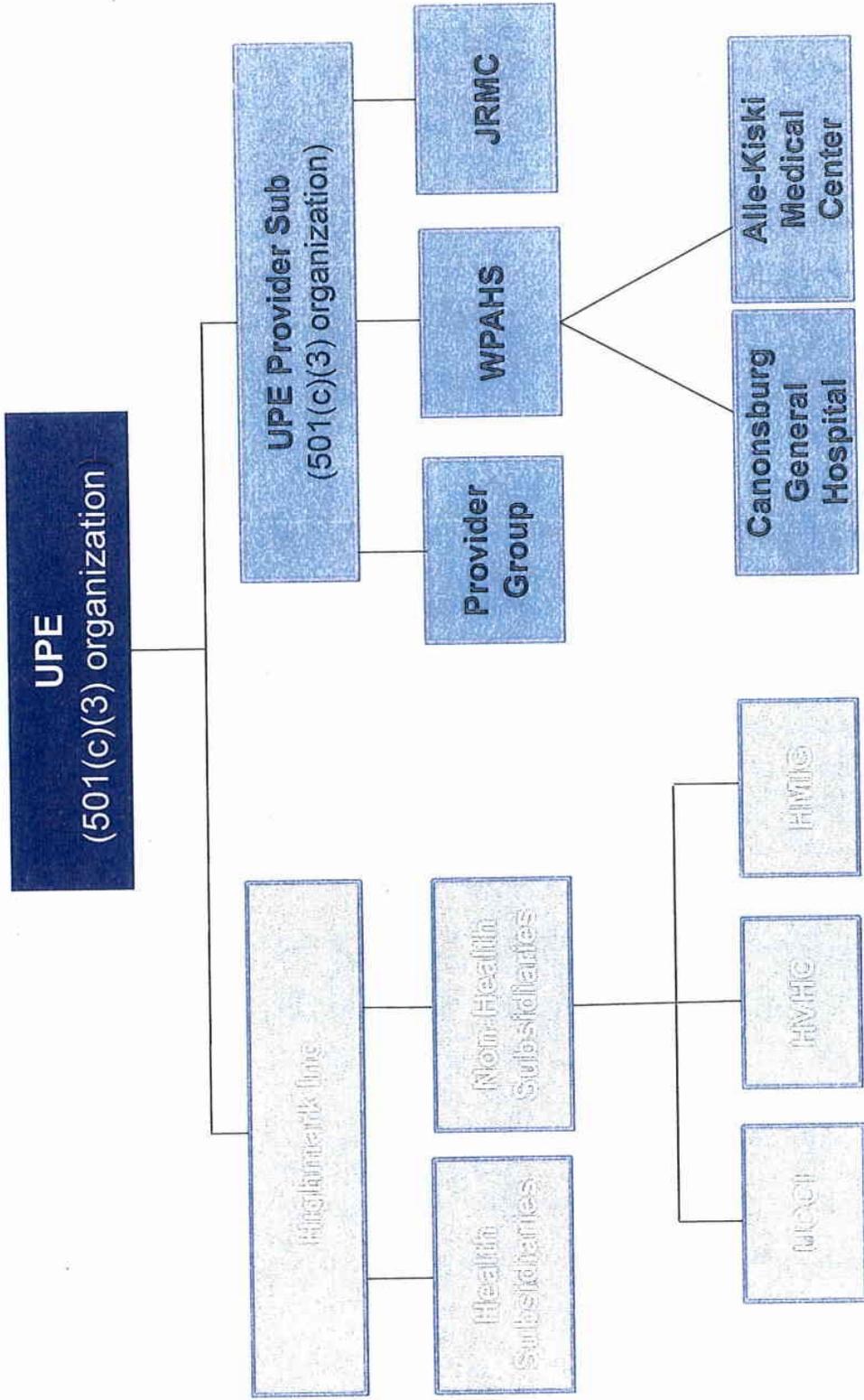


EXHIBIT D

7/30/12

**SECOND AMENDED AND RESTATED
BYLAWS
OF
HIGHMARK INC.**

(Adopted _____, 201)

UPE-0013713

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SECOND AMENDED AND RESTATED
BYLAWS
OF
HIGHMARK INC.

ARTICLE I

Name

1.1 **Name**. The name of the corporation is Highmark Inc. (the "Corporation"). The Corporation may do business under such other names as may be determined by the Board of Directors.

ARTICLE II

Offices

2.1 **Registered Office**. The registered office of the Corporation shall at all times be within the Commonwealth of Pennsylvania at such address as may be established by the Board of Directors.

2.2 **Business Offices**. The Corporation may have business offices at such places permitted by law as the business of the Corporation may require.

ARTICLE III

Members

3.1 **Members**. The members of the Corporation shall consist of two classes, namely (i) [Ultimate Parent Entity], a Pennsylvania nonprofit corporation (hereinafter, the "Corporate Member"); and (ii) the persons who from time to time constitute the Board of Directors (hereinafter, the "Director Members"). ~~The Corporate Member shall be the sole members of the Corporation for all intents and purposes, with voting member of the Corporation on all matters other than matters which are the subject of Section 3.3.1. The Director Members shall be nonvoting members except with respect to the matters which are the subject of Section 3.3.1. In all other respects, the Corporate Member shall have all rights, powers and duties afforded such members by it under these Bylaws and applicable law.~~ The as a "member" as such term "member," as used herein, shall have the meaning assigned to such term is used in Section 5103 of the Pennsylvania Nonprofit Corporation Law of 1988 (15 Pa.C.S.A. § 5101 et seq.), as amended (the "Nonprofit Corporation Law"). A person who ceases to be a director automatically shall cease to be a Director Member.

3.2 **Meetings and Actions**.

3.2.1 To the extent that, as ~~a matter of law set forth in these Bylaws~~, any actions may or are required to be taken by ~~director members~~ Director Members, Board of Director meetings or actions taken in lieu of such meetings, as the case may be, shall be deemed to be ~~membership~~ meetings or actions of the ~~director members~~ Director Members.

3.2.2 The Chief Executive Officer of the Corporate Member shall be entitled to vote on behalf of the Corporate Member in accordance with the authority granted to the Chief Executive Officer of the Corporate Member unless the Corporate Member notifies the Corporation in writing that another officer is authorized to vote on behalf of the Corporate Member.

3.3 Powers.

3.3.1 ~~Reserved Powers of Director Members. The director members shall have the right. The sole power and duty authority of the Director Members shall be to determine the requisites for persons of low income eligible for benefits under the Corporation's health care plans, subject to approval by the Insurance Commissioner of the Commonwealth of Pennsylvania. A person who ceases to be a director automatically shall cease to be a Director Member. To the extent that, as a matter of law, any actions may or are required to be taken by the director members, Board of Director meetings or actions taken in lieu of such meetings, as the case may be, shall be deemed to be meetings of the director members or actions of the director members.~~

3.3.2 Reserved Powers of the Corporate Member. The following rights and powers shall be reserved to the Corporate Member and be exercised in accordance with these Bylaws:

~~{To be determined by Highmark prior to the Closing}~~

(a) Subject to Section 4.2.1, to determine the number of directors that will comprise the Board of Directors of the Corporation;

(b) Subject to Section 4.3.1, to elect the directors of the Corporation;

(c) To remove any of the directors of the Corporation and to replace any such director for the unexpired portion of his or her term;

(d) To approve the election, re-election and removal of the Chief Executive Officer;

(e) To amend, revise or restate the Corporation's Articles of Incorporation and Bylaws or to approve any such amendment, revision or restatement which may be proposed by the Board of Directors; provided, however, that the Corporate Member shall have no power to amend, revise or restate this Section 3.3.2 (or any provision of the Corporation's Articles of Incorporation to the same effect), and such Section (or corresponding provision of the Articles of Incorporation) may be amended, revised or restated only by the Board of Directors as set forth in Section 13.1 of these Bylaws, subject to approval by the Corporate Member;

(f) To (1) dissolve, divide, convert or approve the liquidation of the Corporation, (2) consolidate or merge the Corporation with or into another corporation or entity, (3) approve the Corporation's sale or other disposition of assets, or its acquisition of assets, in any case whether in a single transaction or series of transactions, where the aggregate consideration exceeds three percent (3%) of the Corporation's consolidated total assets;

(g) To approve the annual consolidated capital and operating plan and budget of the Corporation and the subsidiaries, and any amendments thereto or significant variances therefrom:

(h) To approve the selection and appointment of auditors and the fiscal year of the Corporation and the subsidiaries; and

(i) To give such other approvals and take such other actions as are specifically reserved to members of Pennsylvania nonprofit corporations under the Nonprofit Corporation Law.

Except as otherwise may be required by the Nonprofit Corporation Law or provided herein, the Corporate Member shall have the right both to initiate and to approve action in furtherance of such reserved powers, as well as the authority to directly bind the Corporation on such matters. Subject to any provision of the Nonprofit Corporation Law or these Bylaws to the contrary, Any action in this regard taken by the Corporate Member shall be sufficient to finally approve and adopt such actions, and no action of the Board of Directors or other governing body or officer with respect to such action shall be necessary with respect thereto.

ARTICLE IV

Board of Directors

4.1 Powers and Duties. Subject to Section 3.3 of these Bylaws, all powers of the Corporation shall be vested in the Board of Directors, which shall have charge, control and management of the property, business, affairs and funds of the Corporation and shall have the power and authority to perform all necessary and appropriate functions not otherwise inconsistent with these Bylaws, the Articles of Incorporation or applicable law. Subject to Section 3.3 of these Bylaws, and without limiting the generality of the foregoing and except as otherwise may be provided in these Bylaws, the Board of Directors shall have full power and the duty:

4.1.1 To set policies and provide for carrying out the purposes of the Corporation;

4.1.2 To make rules and regulations for its own governance and for the governance of the committees appointed by the Board of Directors as provided herein; and

4.1.3 To adopt and amend from time to time such rules and regulations for the conduct of the business of the Corporation as may be appropriate or desirable.

4.2 Number/Qualifications.

4.2.1 The Board of Directors shall consist of such number of persons as the Corporate Member may determine, but in no case less than twenty-one (21) or more than thirty-six (36), including the individual then serving as the Chief Executive Officer of the Corporation, who shall be a director during his or her term of office (the "Ex-Officio Director").

4.2.2 No individual may be elected to the Board of Directors unless the individual is eligible to serve on the Board of Directors pursuant to applicable law, the Articles of Incorporation and these Bylaws. Each director shall be a natural person of at least 18 years of age and a resident of the Commonwealth of Pennsylvania.

4.2.3 At no time shall the Board of Directors be less than 50% subscribers who have coverage under contracts issued by the Corporation and who are generally representative of broad segments of subscribers covered under contracts issued by the Corporation, whose background and experience indicate that they are qualified to act in the interests of such subscribers and who (or whose spouse) does not derive substantial income from the delivery or administration of health care.

4.2.4 The directors shall be divided equally into three (3) classes so that one-third (1/3) of the aggregate number of directors (or as close as practicable to one-third depending on the aggregate number of Directors) may be chosen each year.

4.2.5 The Board of Directors shall be divided between the number of directors who are Lay Directors (as hereafter provided) and the number of directors who are Professional Directors (as hereafter provided) so as to assure as closely as is practicable that seventy-five percent (75%) of the total number of directors are Lay Directors and twenty-five percent (25%) of the total number of directors are Professional Directors. The Ex-Officio Director shall be counted in arriving at the number of directors who are Lay Directors or the number of directors who are Professional Directors, as the case may be.

4.2.6 To be eligible to serve as a Professional Director, an individual must be a health service doctor (as defined in 40 Pa.C.S.A. § 6302(a)) (each such person, a "Health Service Doctor") and a party to one or more professional provider contracts with the Corporation.

4.2.7 At least a majority of the directors shall be persons whom the Board of Directors has determined are "independent directors" within the meaning of such term as defined in the listing requirements of the New York Stock Exchange or such other requirements as the Board of Directors may approve. Notwithstanding the previous sentence, considering the unique relationship of the Corporation with providers of health care, a person's status as a Health Service Doctor in and of itself shall not cause such person to be considered to be lacking independence. No director, other than the Ex Officio Director, shall be an officer or employee of the Corporation or any entity controlled by the Corporation.

4.2.8 Any person who is, or ever has been, subject to an order of a court or the Securities and Exchange Commission prohibiting such person from acting as an officer or director of a public company shall not be eligible to serve as a director.

4.2.9 No person who is seventy-five (75) years of age or older may be nominated or re-nominated for election or re-election as a director. Any director who reaches the age of seventy-five (75) shall no longer be qualified to serve as a director after the next annual meeting of the Corporate Member.

4.3 Election and Term.

4.3.1 The Ex-Officio Director shall serve as a director by virtue of the office held. Except as provided in Section 4.4, the remaining directors shall be elected by the Corporate Member.

4.3.2 All directors, except the Ex-Officio Director, shall serve for terms of three (3) years or until their successors are elected and have qualified. The Ex-Officio Director shall serve as a director for so long as such person serves as the Chief Executive Officer of the Corporation.

4.3.3 The Board of Directors shall elect from among the directors an individual to serve as Chairperson of the Board. The Chairperson shall not be an officer or employee of the Corporation. The Chairperson shall preside at all meetings of the Board of Directors and of the Executive Committee and shall perform all duties incident to the office of Chairperson of the Board and such other duties as may be prescribed by the Board of Directors.

4.3.4 The Board of Directors may elect from among the directors a Vice Chairperson of the Board. The Vice Chairperson shall not be an officer or employee of the Corporation. The Vice Chairperson shall perform the duties of the office of Chairperson of the Board in the absence of the Chairperson of the Board and such other duties as may be prescribed by the Board of Directors.

4.4 Vacancies. Any vacancy in the Board of Directors caused by the death, resignation or removal of a director or a director ceasing to qualify to serve as a director prior to the expiration of that director's term and occurring in the interim between annual meetings of the Corporate Member may be filled by an individual elected by the Board of Directors, subject to the approval of the Corporate Member, or by the Corporate Member. The director so elected shall serve the remaining unexpired term of the director so replaced or until his or her earlier death, resignation or removal or ceasing to qualify to serve as a director.

4.5 Meetings.

4.5.1 Annual Meetings. The annual organizational meeting of the Board of Directors for, among other purposes, the election of officers shall be held during the month of April or May of each year or such other date as the Board of Directors may determine, at such time and place as shall be determined by the Board of Directors, without further notice than the resolution setting such date, time and place.

4.5.2 Regular Meetings. Regular meetings of the Board of Directors shall be held not less than four (4) times a year, each at such date, time and place as shall be determined by the Board of Directors, without further notice than the resolution setting such date, time and place.

4.5.3 Special Meetings. Special meetings of the Board of Directors may be called at any time by the Chairperson of the Board, the Chief Executive Officer, one-third (1/3rd) of the members of the Board of Directors, or the Chief Executive Officer of the Corporate Member, the date, time and place of each such meeting to be designated in the notice calling the

meeting. Notice of any special meeting of the Board of Directors shall be given at least forty-eight (48) hours prior thereto and shall state the general nature of the business to be transacted.

4.5.4 Adjournment. When a meeting of the Board of Directors is adjourned, it shall not be necessary to give any notice of the adjourned meeting or the business to be transacted at the adjourned meeting other than by announcement at the meeting at which such adjournment is taken.

4.5.5 Quorum and Voting. Directors constituting a majority of the directors in office shall constitute a quorum for the transaction of business at any meeting of the Board of Directors. Each director shall be entitled to one vote on any matter submitted to a vote of the Board of Directors, and action by the Board of Directors on any matter shall require the affirmative vote of a majority of the directors in office unless a greater proportion of affirmative votes is required by applicable law, the Articles of Incorporation or these Bylaws.

4.5.6 Use of Conference Telephone. Except as the Board of Directors otherwise may determine, one or more persons may participate in a meeting of the Board of Directors or of any committee thereof by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear and be heard by each other. Participation in a meeting in such manner shall constitute presence in person at the meeting.

4.5.7 Action by Unanimous Written Consent. Any action which may be taken at a meeting of the Board of Directors may be taken without a meeting if a consent or consents in writing setting forth the action so taken shall be signed by all of the directors in office and filed with the Secretary.

4.6 Resignation/Removal.

4.6.1 Resignation. Any director may resign his or her office at any time, such resignation to be made in writing and to take effect immediately or at such subsequent time stated in such writing. Any director who ceases to meet the eligibility requirements contained in applicable law or in these Bylaws to serve as a director forthwith shall resign his or her office, such resignation to be made in writing and to take effect immediately.

4.6.2 Removal. Any director may be removed, with or without cause, either (a) by the affirmative vote of at least two-thirds (2/3rd) of the directors in office taken at any regular or special meeting, provided that each director has been given at least ten (10) days written notice that such action is to be considered at such meeting or (b) by action of the Corporate Member.

4.6.3 Mandatory Offer of Resignation for Retirement or Change in Employment Circumstances. Any director who retires from active employment or whose employment circumstances change materially from those in effect at the time of his or her election or re-election as a director shall submit promptly to the chairperson of the Corporate Governance and Nominating Committee an offer of resignation from the Board of Directors. Such resignation shall not be effective unless and until accepted by the Board of Directors. The chairperson of the Corporate Governance and Nominating Committee shall cause such offer of resignation to be considered by the Corporate Governance and Nominating Committee and a recommendation to

be made to the Board of Directors as soon as practicable concerning the advisability of accepting such resignation.

4.6.4 Effect of Repeated Absences from Meetings. If a director shall be absent from four consecutive meetings of the Board of Directors, including regular meetings and special meetings duly called, the Board of Directors may, in its discretion, declare the office of such director vacated, and a successor shall be elected as provided in these Bylaws.

4.7 Conflict of Interest.

4.7.1 Related Party Transactions. No contract or transaction between the Corporation and one or more of its directors, officers or employees, or between the Corporation and any other corporation, partnership, association or other organization in which one or more of the Corporation's directors, officers or employees are directors, officers or employees or have a financial interest, shall be void or voidable solely for such reason, or solely because such director, officer or employee is present at or participates in the meeting of the Board of Directors which authorizes such contract or transaction, or solely because any such person's vote is counted for such purpose, if the material facts as to the relationship or interest and as to the contract or transaction are disclosed or are known to the Board of Directors and the Board of Directors in good faith authorizes the contract or transaction by the affirmative vote of a majority of the disinterested directors even though the disinterested directors are less than a quorum.

4.7.2 Determination of Quorum. Interested directors may be counted in determining the presence of a quorum at a meeting of the Board of Directors which authorizes a contract or transaction specified in Section 4.7.1.

4.7.3 No Improper Influence. In no event shall a director vote on or otherwise use his or her position as a director to influence any matter on which he or she has a conflict of interest, including, without limitation, on any matter involving payment made or to be made to him or her, directly or indirectly, for the provision of health care services; provided, however, that any director may vote on matters that affect providers of health care services in general.

4.8 Limitation of Liability. A director shall not be personally liable, as such, for monetary damages for any action taken, or any failure to take any action, unless (a) the director has breached or failed to perform the duties of the director's office as set forth in the Nonprofit Corporation Law; and (b) the breach or failure to perform constitutes self-dealing, willful misconduct or recklessness. The preceding provisions of this Section 4.8 shall not apply to (x) the responsibility or liability of a director pursuant to any criminal statute; or (y) the liability of a director for the payment of taxes pursuant to federal, state or local law. The provisions of this Section 4.8 shall be deemed to be a contract with each director who serves as such at any time while this Section 4.8 is in effect, and each such director shall be deemed to be so serving in reliance on the provisions of this Section 4.8. Any repeal or modification of this Section 4.8 shall be prospective only and shall not affect, to the detriment of any director, any limitation on the personal liability of a director existing at the time of such repeal or modification.

4.9 Compensation. The Board of Directors may determine the compensation of directors for their services as directors, committees of the Board of Directors or otherwise, and also may determine the compensation of persons who are not directors who serve on any committees established by the Board of Directors.

ARTICLE V

Regional Advisory Boards

5.1 Establishment. The Corporation shall have a Regional Advisory Board for each of the Corporation's primary service areas as determined by the Board of Directors. Each such Regional Advisory Board shall consist of not fewer than ten (10) or more than twenty (20) persons, who shall be appointed by the Board of Directors. In making appointments to the Regional Advisory Boards, the Board of Directors shall consider the interests of customers, health care professionals, suppliers, creditors and the communities served by the Corporation.

5.2 Purpose and Functions. The purpose and functions of the Regional Advisory Boards shall be determined by the Board of Directors. The Regional Advisory Boards initially shall have the following purposes and functions:

5.2.1 To advise the Corporation on regional advertising, marketing, product development and community initiatives;

5.2.2 To advise the Corporation on matters of public policy and, if requested by the Board of Directors, to advocate the Corporation's position in the community; and

5.2.3 To advise the Corporation on such other matters as may be requested by the Board of Directors.

5.3 Limitations on Authority. The Regional Advisory Boards shall have no authority to direct the activities of the Corporation or to bind the Corporation in any respect and shall at all times be subject to the powers and prerogatives of the Board of Directors. Nothing in these Bylaws is intended to create in any individual or group of individuals serving on a Regional Advisory Board any rights or duties of a member, director, member of an other body, officer or otherwise pursuant to the Nonprofit Corporation Law.

5.4 Meetings. Meetings of each Regional Advisory Board shall be held at such date, time and place as shall be determined by such Regional Advisory Board, and each Regional Advisory Board may adopt procedures with respect to the conduct of its meetings as such Regional Advisory Board deems to be appropriate and desirable, provided such procedures are not inconsistent with applicable law, the Articles of Incorporation or these Bylaws.

5.5 Compensation. Members of the Regional Advisory Boards shall be entitled to be reimbursed for their reasonable expenses incurred in connection with attendance at meetings of the Regional Advisory Boards and such other compensation for their services as may be determined by the Board of Directors.

ARTICLE VI

Officers

6.1 Principal Officers; Election. The principal officers of the Corporation shall be a Chief Executive Officer, a Chief Financial Officer, a Treasurer and a Secretary, each of whom

shall be elected by the Board of Directors, and such other officers as the Board of Directors may elect, which may include one or more Presidents, one or more Executive, Senior or Corporate Vice Presidents, and one or more Assistant Treasurers or Assistant Secretaries. Each such officer shall hold office for a term of one year (or such other term as the Board shall determine for any office from time to time) and until his or her successor has been selected and qualified or until his or her earlier death, resignation or removal. Any number of offices may be held by the same person.

6.1.1 Other Officers. The Chief Executive Officer may appoint President(s), Vice Presidents (including Executive, Senior and Corporate Vice Presidents), Assistant Treasurers or Assistant Secretaries who have not been elected by the Board of Directors and such other officers or agents of the Corporation as he or she determines to be appropriate, who shall hold their offices subject to the discretion of the Chief Executive Officer.

6.1.2 Chief Executive Officer. The Chief Executive Officer shall be responsible for the general and active management of the business and affairs of the Corporation and shall exercise general supervision and authority over all of its agents and employees and shall perform all duties incident to the office of Chief Executive Officer and such other duties as may be assigned by the Board of Directors. The Chief Executive Officer shall supervise the implementation of all policies, orders and resolutions of the Board of Directors and shall execute all contracts and agreements authorized by the Board of Directors, except that he or she may delegate to other officers of the Corporation the power to execute contracts in the ordinary course of business or as otherwise may be authorized by the Board of Directors.

6.1.3 President(s). The President(s) shall be responsible for the direct administration, supervision and control of such activities in the management of the Corporation as may be assigned by the Chief Executive Officer or the Board of Directors.

6.1.4 Chief Financial Officer. The Chief Financial Officer shall be responsible for financial accounting and reporting for the Corporation and such other duties as may be assigned by the Chief Executive Officer or the Board of Directors.

6.1.5 Vice Presidents. Each Vice President shall perform such duties as may be assigned by the Chief Executive Officer or the Board of Directors.

6.1.6 Treasurer. The Treasurer shall, in accordance with the policies of the Board of Directors and under the direction of the Chief Executive Officer or the Chief Financial Officer, have general charge and custody of and be responsible for all funds and securities of the Corporation, and shall make such reports in such form and manner as the Chief Executive Officer, the Chief Financial Officer or the Board of Directors may direct. The Treasurer shall receive and give receipts for monies due and payable to the Corporation and deposit such monies in the name of the Corporation in such banks, trust companies or other depositories as may be selected in accordance with the provisions of these Bylaws. The Treasurer shall keep account of such receipts and deposits and approve expenditures of the Corporation and shall perform all duties incident to the office of Treasurer and such other duties as may be assigned by the Chief Executive Officer, the Chief Financial Officer or the Board of Directors.

6.1.7 Secretary. The Secretary shall keep the minutes of the meetings of the Board of Directors and its committees in one or more books provided for that purpose, shall

notify members of the Board of Directors of their election, shall see that all notices are duly given in accordance with the provisions of these Bylaws, shall be custodian of the corporate records and of the seal of the Corporation, and shall see that the seal of the Corporation is affixed, when necessary, to all instruments and documents the execution of which has been authorized by the Board of Directors or a committee thereof, shall keep a record of the address of each director, and shall perform all duties incident to the office of Secretary and such other duties as may be assigned by the Chief Executive Officer or the Board of Directors. In the absence of the Secretary or in the event of his or her inability to act, the Chairperson of the Board shall appoint an individual to discharge the duties of the Secretary.

6.1.8 Assistant Secretaries and Assistant Treasurers. The Assistant Secretaries and Assistant Treasurers shall perform such duties as may be assigned by the Secretary or the Treasurer, respectively, or by the Chief Executive Officer or the Chief Financial Officer, as appropriate, or the Board of Directors.

6.2 Removal of Officers. Any officer of the Corporation may be removed, with or without cause, by the Board of Directors. Any officer appointed by the Chief Executive Officer may be removed, with or without cause, by the Chief Executive Officer.

6.3. Bonds. The Board of Directors may require any officer to give bond and security in such sum and with such surety or sureties as the Board of Directors may determine.

ARTICLE VII

Committees

7.1 Standing Board Committees. The Board of Directors shall have an Executive Committee, a Corporate Governance and Nominating Committee, an Audit Committee, an Investment Committee, an Affirmative Action and Diversity Committee and a Personnel and Compensation Committee, and the Board of Directors may establish such other standing committees as it deems to be necessary or desirable (the "Standing Board Committees"). All Standing Board Committees shall be comprised solely of directors and shall have charters governing their powers and duties, which charters shall be approved by the Board of Directors. The Board of Directors shall appoint the members and a chairperson and a vice chairperson of each Standing Board Committee.

7.2 Term. Except as otherwise provided in these Bylaws, each member of a Standing Board Committee shall continue as such until the next annual organizational meeting of the Board of Directors or until a successor has been appointed as provided herein, unless such person resigns, is removed or otherwise ceases to serve on such Standing Board Committee for any reason.

7.3 Special Committees and Program Committees. The Board of Directors may establish one or more special committees of directors ("Special Committees") to advise the Board of Directors and to perform such other functions as the Board of Directors determines. The Board of Directors may establish one or more committees, such as a Medical Affairs Committee and a Quality and Safety Committee, which may include directors and persons who are not directors, to assist it with program aspects of the Corporation's operations ("Program Committees"). Subject to the provisions of these Bylaws, the Board of Directors may delegate

such authority to a Special Committee or a Program Committee as it deems to be appropriate and desirable and as is not prohibited by applicable law. The Board of Directors shall establish the manner of selecting members, chairpersons and vice chairpersons, if any, and the terms of office of the members of each Special Committee and Program Committee.

7.4 Quorum. Except as otherwise provided in these Bylaws or the charter of a committee approved by the Board of Directors, one-third (1/3rd) of the members comprising any committee appointed by the Board of Directors pursuant to these Bylaws shall constitute a quorum for the transaction of business, and the acts of a majority of committee members present at a meeting at which a quorum is present shall constitute the acts of the committee, unless a greater proportion is required by applicable law, the Articles of Incorporation or these Bylaws.

7.5 Action by Unanimous Written Consent. Except as otherwise provided in these Bylaws or a charter of a committee approved by the Board of Directors, any action which may be taken at a meeting of any committee appointed by the Board of Directors pursuant to these Bylaws may be taken without a meeting if a consent or consents in writing setting forth the action so taken shall be signed by all of the members of such committee and filed with the Secretary.

7.6 Removal. Any member of a Standing Board Committee, Special Committee or Program Committee may be removed at any time, with or without cause, by the Board of Directors at any regular or special meeting.

7.7 Vacancies. Any vacancy in any Standing Board Committee or Special Committee caused by the death, resignation or removal of a director prior to the expiration of that director's term shall be filled by another director appointed by the Board of Directors. The director so appointed shall serve the remaining unexpired term of the director so replaced.

7.8 Executive Committee.

7.8.1 The Executive Committee shall consist of at least seven (7) but not more than twelve (12) directors as the Board of Directors shall determine. The Chairperson of the Board, the Vice Chairperson of the Board and the Chief Executive Officer shall be members of the Executive Committee, and the Chairperson of the Board shall serve as the chairperson of the Executive Committee. In the absence of the Chairperson of the Board, the Vice Chairperson of the Board, if any, shall serve as the chairperson of the Executive Committee and, in the absence of the Vice Chairperson, the Chief Executive Officer shall act as such chairperson.

7.8.2 The Executive Committee shall have and may exercise the power and authority of the Board of Directors when the Board of Directors is not in session, except such power and authority as by law, the Articles of Incorporation or these Bylaws may be required to be exercised by the Board of Directors or Corporate Member, or as the Board of Directors or Corporate Member may expressly reserve for itself or delegate to another committee.

7.8.3 Regular meetings of the Executive Committee may be held at such date, time and place as determined by the Board of Directors or the Executive Committee, without further notice than the resolution setting such date, time and place. Special meetings of the Executive Committee may be called at any time by the Chairperson of the Board, the Chief Executive Officer or any two members of the Executive Committee, the date, time and place of

such meeting to be designated in the notice calling the meeting. Notice of any special meeting of the Executive Committee shall be given at least forty-eight (48) hours prior thereto and shall state the general nature of the business to be transacted.

7.8.4 A majority of the members of the Executive Committee shall constitute a quorum for the transaction of business, and the acts of a majority of the members of the Executive Committee shall be the acts of the Executive Committee.

7.8.5 The Executive Committee shall keep regular minutes of its proceedings and report the same to the Board of Directors at its next regular meeting or when otherwise required.

7.9 Corporate Governance and Nominating Committee.

7.9.1 The Corporate Governance and Nominating Committee shall consist of at least eight (8) directors, comprised as closely as is practicable of seventy-five percent (75%) Lay Directors and twenty-five percent (25%) Professional Directors. None of the members of the Corporate Governance and Nominating Committee shall be officers or employees of the Corporation or of any entity controlled by the Corporation.

7.9.2 In addition to any responsibilities delegated to it by the Board of Directors, the Corporate Governance and Nominating Committee shall be responsible for:

(a) Recommending the candidates to be nominated by the Board of Directors for election as directors at each annual meeting of the Corporate Member;

(b) Recommending the candidates to be nominated by the Board of Directors for election as directors to fill any vacancies occurring on the Board of Directors; and

(c) Recommending the candidates for election or reelection as Chairperson of the Board and Vice Chairperson of the Board.

7.9.3 At least fifteen (15) days before each annual, regular or special meeting of the Board of Directors, the Corporate Governance and Nominating Committee shall recommend the requisite number of individuals who satisfy the qualifications established in these Bylaws for election as directors of the Corporation.

7.10 Audit Committee.

7.10.1 The Audit Committee shall consist of at least five (5) directors. None of the members of the Audit Committee shall be officers or employees of the Corporation or of any entity controlled by the Corporation.

7.10.2 In addition to any responsibilities delegated to it by the Board of Directors, the Audit Committee shall be responsible for:

(a) Recommending to the Board of Directors the selection of independent certified public accountants for the Corporation, subject to approval by the Corporate Member; and

(b) Reviewing the Corporation's financial condition and the scope and results of the independent audit and any internal audit of the Corporation.

7.11 Personnel and Compensation Committee.

7.11.1 The Personnel and Compensation Committee shall consist of at least five (5) directors. None of the members of the Personnel and Compensation Committee shall be officers or employees of the Corporation or of any entity controlled by the Corporation.

7.11.2 In addition to any responsibilities delegated to it by the Board of Directors, the Personnel and Compensation Committee shall be responsible for:

(a) Evaluating the performance of the principal officers of the Corporation; and

(b) Recommending to the Board of Directors the selection and compensation of the principal officers of the Corporation.

7.12 Controlled Entities. The Board of Directors may designate the Corporate Governance and Nominating Committee, the Personnel and Compensation Committee and/or the Audit Committee to serve as such committee(s) for one or more insurers or other entities controlled by the Corporation.

ARTICLE VIII

Medical Review Committee

8.1 General.

8.1.1 All matters, disputes or controversies relating to the professional health services (as defined in 40 Pa.C.S.A. § 6302(a)) rendered by Health Service Doctors to subscribers who have coverage under contracts issued by the Corporation, and any questions involving the professional ethics of such persons, shall be considered and determined exclusively by the committee established pursuant to this Article VIII in accordance with the requirements of 40 Pa.C.S.A. § 6324(c) (the "Medical Review Committee") to provide a fair and impartial forum for resolution of all matters, disputes and controversies relating to professional health services and all questions involving professional ethics.

8.1.2 The Medical Review Committee also shall provide a fair and impartial forum to consider and determine any other matters, disputes or controversies which may be submitted to it as set forth in these Bylaws or as may be provided in any written agreement between the Corporation or any one or more entities controlled by the Corporation and any Health Service Doctor or other provider of health care services (all such persons collectively, "Providers").

8.1.3 The Medical Review Committee shall operate independently of the Corporation, and the Board of Directors shall have no authority over the decisions of the Medical Review Committee. Except as otherwise provided in Section 8.7 or in any agreement with a

Provider, all decisions of the Medical Review Committee shall be final and binding upon all parties to any matter, dispute or controversy submitted to it.

8.1.4 The Corporation shall, at its expense, provide reasonable resources to the Medical Review Committee to discharge its duties under these Bylaws.

8.2 Medical Review Committee Selection Committee.

8.2.1 The members of the Medical Review Committee, who must satisfy the requirements set forth in Section 8.3, shall be appointed and may be removed as provided in this Article VIII by the Medical Review Committee Selection Committee (the "Selection Committee").

8.2.2 The Selection Committee shall consist of at least five (5) persons, a majority of whom shall be Health Service Doctors, and the balance of whom shall be subscribers who are not Health Service Doctors and who have coverage under contracts issued by the Corporation or an entity controlled by the Corporation. All Health Service Doctors who are members of the Selection Committee shall be parties to one or more professional provider contracts with the Corporation.

8.2.3 No member of the Selection Committee may be a director, officer or employee of the Corporation or a member of a Regional Advisory Board, nor may any such person have served on the Medical Review Committee during any part of the two (2) year period immediately prior to his or her appointment to the Selection Committee.

8.2.4 The members of the Selection Committee shall be appointed by the Chairperson of the Board, and each shall hold office for a term of two (2) years.

8.3 Appointment of Medical Review Committee Members; Term; Removal. The Medical Review Committee shall consist of at least eight (8) persons who meet the criteria set forth in this Section. Any person may submit to the Selection Committee names of prospective Medical Review Committee members; provided, however, that the Selection Committee shall not be bound to appoint any person whose name is so submitted. The Selection Committee shall make appointments to the Medical Review Committee using the following criteria:

8.3.1 A majority of the members of the Medical Review Committee shall be Health Service Doctors, and the balance shall be subscribers who are not Health Service Doctors and who have coverage under contracts issued by the Corporation or an entity controlled by the Corporation. At least seventy-five percent (75%) of the Health Service Doctors who are members of the Medical Review Committee shall be medical doctors or doctors of osteopathy.

8.3.2 All Health Service Doctors who are members of the Medical Review Committee shall be parties to one or more professional provider contracts with the Corporation.

8.3.3 No member of the Medical Review Committee shall be a director, officer or employee of the Corporation or a member of a Regional Advisory Board.

8.3.4 At least two-thirds (2/3) of the members of the Medical Review Committee shall have no relationship with the Corporation or any entity controlled by the Corporation, other than as Health Service Doctors who submit claims in the ordinary course of business or as subscribers.

8.3.5 No member of the Medical Review Committee shall have any conflict of interest that would prevent him or her from rendering a fair and impartial decision in matters, disputes or controversies between the Corporation, or, if applicable, any entity controlled by the Corporation, and a Provider; provided, however, that a member may be recused from individual matters, disputes or controversies in the event of any specific conflict of interest with respect thereto.

8.3.6 No Health Service Doctor who is a member of the Medical Review Committee shall have any history of (a) material adverse utilization or claims coding determinations by the Medical Review Committee, or (b) material repayments to the Corporation or any entity controlled by the Corporation resulting from utilization or claims coding reviews.

8.3.7 The Health Service Doctors who are members of the Medical Review Committee shall be broadly representative of the various specialties whose professional health services generally are covered under contracts issued by the Corporation.

8.3.8 Members of the Medical Review Committee must be willing to commit to regular attendance at committee meetings and to devoting adequate time to committee business to permit them to fully understand the committee's work and to give full and fair consideration to all matters coming before the committee.

8.3.9 Each member of the Medical Review Committee shall be appointed for a term of two (2) years and may be removed during his or her term only for cause as determined by the Selection Committee, including, but not limited to, failure to regularly attend committee meetings or to devote adequate attention to committee work.

8.3.10 The Selection Committee shall consider the need for continuity and orderly rotation of members when making appointments or reappointments to the Medical Review Committee.

8.4 Officers of the Medical Review Committee. The Medical Review Committee shall have three officers: a chairperson, a vice chairperson and a secretary, selected as follows:

8.4.1 The Selection Committee shall appoint a chairperson of the Medical Review Committee. The chairperson shall be a member of the Medical Review Committee and shall preside at all meetings of the Medical Review Committee, but shall not vote in any matter being considered by the Medical Review Committee except when necessary to break a tie.

8.4.2 The Selection Committee shall appoint a vice chairperson of the Medical Review Committee. The vice chairperson shall be a member of the Medical Review Committee and preside at meetings of the Medical Review Committee in the chairperson's absence and, when serving in such capacity, shall vote only when necessary to break a tie. The vice chairperson shall also perform such other duties as the chairperson may assign.

8.4.3 The Corporation shall provide one of its employees to serve as secretary for the Medical Review Committee. The secretary's role shall be solely that of administrator, and not that of a member of the Medical Review Committee. The secretary shall keep the minutes of the Medical Review Committee meetings and perform the duties enumerated in Section 8.6 and such other duties as the committee may assign.

8.5 Submission of Matters to the Medical Review Committee. All matters, disputes or controversies relating to professional health services and questions involving professional ethics referred to in Section 8.1 or otherwise required to be considered and determined by the Medical Review Committee shall be submitted in writing to the secretary of the Medical Review Committee. Either the Corporation or a Provider may submit a matter, dispute or controversy relating to professional health services or a question involving professional ethics for consideration and determination.

8.6 Medical Review Committee Proceedings.

8.6.1 The Medical Review Committee shall maintain written procedural guidelines to assure that each Provider receives full, fair and impartial consideration of any matter, dispute, controversy or question presented to the Medical Review Committee.

8.6.2 Only the Health Service Doctors who are members of the Medical Review Committee may vote on any matter brought before the committee.

8.6.3 One-third (1/3rd) of the voting members of the Medical Review Committee shall constitute a quorum for the transaction of business, and the acts of a majority of voting members of the committee present at a meeting at which a quorum is present shall constitute the acts of the committee.

8.6.4 In considering any matter, dispute or controversy relating to professional health services or any question involving professional ethics brought before it, the Medical Review Committee shall have authority to take any one or more of the following actions (subject to any binding contractual prohibitions or restrictions agreed to in writing by the Corporation or, if applicable, any entity controlled by the Corporation):

(a) Make a referral to any appropriate committee, board or division of any applicable state or local professional society;

(b) Make a referral to an appropriate law enforcement officer or agency of any applicable federal, state or local government if the Medical Review Committee has probable cause to believe that a Provider secured payment for services performed on the basis of material false information submitted with the intention of defrauding the recipient(s);

(c) Make a referral to the applicable state professional licensure board of a Provider;

(d) Render a determination that the Corporation or, if applicable, one or more entities controlled by the Corporation is or is not entitled, in whole or in part, to a refund of fees paid to a Provider;

(e) Render a determination that authorizes the Corporation or one or more entities controlled by the Corporation to collect any refund by withholding future payments due to a Provider; or

(f) Render any such other determination or take any such other action as may be necessary or appropriate.

8.6.5 If a particular matter, dispute or controversy relating to professional health services or a particular question involving professional ethics includes any actual or alleged action or failure to act which would justify denying a Health Service Doctor registration with the Corporation pursuant to 40 Pa.C.S.A. § 6324(a), or the suspension or termination of such registration, the Corporation may request that a hearing be held by the Medical Review Committee in accordance with Section 8.7 to consider such registration status. Such action or failure to act may include by way of example and not limitation:

(a) Violation of the Health Service Doctor's professional provider contract with the Corporation or any regulations of the Corporation for participating providers; or

(b) Violation of any statute with which the Corporation or the Provider is required to comply.

8.7 Proceedings Involving Status of Registered Health Service Doctor.

8.7.1 The procedures set forth in this Section 8.7 apply in all cases where the Corporation has requested pursuant to Section 8.6.5 that a hearing of the Medical Review Committee be held to determine the status of an individual as a registered Health Service Doctor. In any such case, the Corporation shall prepare an appropriate complaint setting forth the allegations against the individual.

8.7.2 The chairperson of the Medical Review Committee promptly shall fix a time, date and place for such hearing of the Medical Review Committee. The applicable Health Service Doctor shall be given at least thirty (30) days written notice by the secretary of the Medical Review Committee of the date, time and place of such hearing and shall be furnished with a copy of the complaint.

8.7.3 The Health Service Doctor shall be allowed to file a written answer to the complaint, provided such answer is filed with the secretary of the Medical Review Committee at least ten (10) days prior to the hearing. At the hearing, such witnesses may be heard and such evidence may be received as is deemed by the Medical Review Committee to be relevant and of reasonable probative value; provided, however, that formal rules of evidence or procedure need not be followed. The Health Service Doctor shall be afforded a reasonable opportunity to be heard before the Medical Review Committee, either in person or by counsel, and to produce evidence and witnesses at such hearing. All testimony shall be recorded and a complete record shall be kept of the hearing.

8.7.4 Promptly following the hearing, the Medical Review Committee shall take whatever action it deems appropriate, based on the evidence and testimony produced at the hearing. If such action involves either the denial of registration as a Health Service Doctor with the Corporation or the suspension or termination of such registration, the matter shall be referred promptly to the Secretary of the Commonwealth of Pennsylvania Department of Health for approval or for such other action as said Secretary of Health may deem appropriate.

8.8 Other Appeals.

8.8.1 The Medical Review Committee also shall serve as the final and binding appeal body for any Provider whose registration as a preferred or similar provider pursuant to any other professional provider contract of the Corporation or, if applicable, one or more entities controlled by the Corporation is rejected, suspended or terminated by the Corporation or such other entity.

8.8.2 Any such Provider may appeal such decision by a written submission to the secretary of the Medical Review Committee. The appealing Provider shall be entitled to appear before the Medical Review Committee and to present evidence or argument, but the hearing will not be recorded and the committee's decision will not be referred to the Secretary of the Commonwealth of Pennsylvania Department of Health for approval.

8.8.3 In connection with any such appeal, the Medical Review Committee may consider any:

(a) Violation of the Provider's agreement(s) with the Corporation or any entity controlled by the Corporation to render health care services or supplies to subscribers;

(b) Violation of any statute with which the Corporation or the Provider is required to comply;

(c) Violation of any of the regulations or requirements referenced in the Provider's agreement(s) with the Corporation or any entity controlled by the Corporation with which the Provider is required to comply; or

(d) Refusal to adhere to the billing, payment or service benefit provisions of any contract issued by the Corporation or any entity controlled by the Corporation which utilizes the applicable professional provider network in which the Provider has agreed to participate.

8.9 Compensation. Members of the Medical Review Committee and the Selection Committee shall be entitled to be reimbursed for their reasonable expenses incurred in connection with attendance at meetings of the Medical Review Committee or the Selection Committee, as the case may be, and such other compensation for their services as may be determined by the Board of Directors.

ARTICLE IX

Indemnification of Directors, Officers and Others

9.1 Right to Indemnification – General. Any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative (whether brought by or in the name of the Corporation or otherwise), by reason of the fact that he or she is or was a representative of the Corporation, or is or was serving at the request of the Corporation as a representative of another corporation, partnership, joint venture, trust or other enterprise, shall be indemnified by the Corporation to the fullest extent now or hereafter permitted by applicable law in connection with such action, suit or proceeding) arising out of such person's service to the Corporation or to such

other corporation, partnership, joint venture, trust or other enterprise at the Corporation's request. The term "representative," as used in this Article IX, shall mean any director, officer or employee, including any employee who is a medical doctor, lawyer or other licensed professional, any member of a Regional Advisory Board, or any committee created by or pursuant to these Bylaws, and any other person who may be determined by the Board of Directors to be a representative entitled to the benefits of this Article IX.

9.2 Right to Indemnification - Third Party Actions. Without limiting the generality of Section 9.1, any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative (other than an action by or in the right of the Corporation), by reason of the fact that he or she is or was a representative of the Corporation, or is or was serving at the request of the Corporation as a representative of another corporation, partnership, joint venture, trust or other enterprise, shall be indemnified by the Corporation against expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by him or her in connection with such action, suit or proceeding if he or she acted in good faith and in a manner he or she reasonably believed to be in, or not opposed to, the best interests of the Corporation, and, with respect to any criminal action or proceeding, had no reasonable cause to believe his or her conduct was unlawful. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not of itself create a presumption that the person did not act in good faith and in a manner which he or she reasonably believed to be in, or not opposed to, the best interests of the Corporation, and, with respect to any criminal action or proceeding, had reasonable cause to believe that his or her conduct was unlawful.

9.3 Right to Indemnification - Derivative Actions. Without limiting the generality of Section 9.1, any person who was or is a party, or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding by or in the right of the Corporation to procure a judgment in its favor by reason of the fact that he or she is or was a representative of the Corporation, or is or was serving at the request of the Corporation as a representative of another corporation, partnership, joint venture, trust or other enterprise, shall be indemnified by the Corporation against expenses (including attorneys' fees) actually and reasonably incurred by him or her in connection with the defense or settlement of such action, suit or proceeding if he or she acted in good faith and in a manner he or she reasonably believed to be in, or not opposed to, the best interests of the Corporation; except, however, that indemnification shall not be made under this Section 9.3 in respect of any claim, issue or matter as to which such person has been adjudged to be liable to the Corporation unless and only to the extent that the Court of Common Pleas of the county in which the registered office of the Corporation is located or the court in which such action, suit or proceeding was brought determines upon application that, despite the adjudication of liability but in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for such expenses that the Court of Common Pleas or such other court shall deem proper.

9.4 Advance of Expenses. Expenses (including attorneys' fees) incurred by any representative of the Corporation in defending any action, suit or proceeding referred to in this Article IX shall be paid by the Corporation in advance of the final disposition of such action, suit or proceeding upon receipt of an undertaking by or on behalf of the representative to repay such amount if it is ultimately determined that he or she is not entitled to be indemnified by the Corporation as authorized in this Article IX or otherwise.

9.5 Procedure for Effecting Indemnification. Unless ordered by a court, any indemnification under Section 9.1, Section 9.2 or Section 9.3 shall be made by the Corporation only as authorized in the specific case upon a determination that indemnification of the representative is proper in the circumstances because he or she has met the applicable standard of conduct set forth in such subsections. Such determination shall be made:

9.5.1 By the Board of Directors by a majority of a quorum consisting of directors who were not parties to such action, suit or proceeding; or

9.5.2 If such a quorum is not obtainable, or if obtainable and a majority vote of a quorum of disinterested directors so directs, by independent legal counsel in a written opinion.

9.6 Indemnification not Exclusive. The indemnification and advancement of expenses provided by or granted pursuant to this Article IX shall not be deemed exclusive of any other rights to which a person seeking indemnification or advancement of expenses may be entitled under any other provision of these Bylaws, agreement, vote of disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office shall continue as to a person who has ceased to be a representative of the Corporation and shall inure to the benefit of the heirs and personal representatives of such person.

9.7 When Indemnification Not Made. Indemnification pursuant to this Article IX shall not be made in any case where the act or failure to act giving rise to the claim for indemnification is determined by a court to have constituted willful misconduct or recklessness.

9.8 Grounds for Indemnification. Indemnification pursuant to this Article IX, under any other provision of these Bylaws, agreement, vote of directors or otherwise may be granted for any action taken or any failure to take any action and may be made whether or not the Corporation would have the power to indemnify the person under any provision of law except as otherwise provided in this Article IX and whether or not the indemnified liability arises or arose from any threatened, pending or completed action by or in the right of the Corporation. The provisions of this Article IX shall be applicable to all actions, suits or proceedings within the scope of Section 9.1, Section 9.2 or Section 9.3, whether commenced before or after the adoption hereof, whether arising from acts or omissions occurring before or after the adoption hereof.

9.9 Power to Purchase Insurance. The Corporation may purchase and maintain insurance on behalf of any person who is or was a representative of the Corporation or is or was serving at the request of the Corporation as a representative of another corporation, partnership, joint venture, trust or other enterprise against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have the power to indemnify him or her against such liability under the provisions of this Article IX.

9.10 Creation of a Fund to Secure or Insure Indemnification. The Corporation may create a fund of any nature, which may, but need not be, under the control of a trustee, or otherwise secure or insure in any manner its indemnification obligations, whether arising under or pursuant to this Article IX or otherwise.

9.11 Status of Rights of Indemnitees. The rights to indemnification and advancement of expenses provided by or granted pursuant to this Article IX shall (i) be deemed to create contractual rights in favor of each person who serves as a representative of the Corporation at any time while such Article is in effect (and each such person shall be deemed to be so serving in reliance on the provisions of such Article), and (ii) continue as to a person who has ceased to be a representative of the Corporation.

9.12 Applicability to Predecessor Companies. For purposes of this Article IX, references to the "Corporation" includes all constituent corporations or other entities which shall have become a part of the Corporation by consolidation or merger or other similar transaction and their respective current and former affiliates, and references to "representatives" shall include members of any such corporation, entity or affiliate, so that any person who was a member, director, officer, employee, agent or other representative of such a corporation, entity or affiliate or served as a member, director, officer, employee, agent or other representative of another corporation, partnership, joint venture, trust or other enterprise at the request of any such corporation, entity or affiliate shall stand in the same position under the provisions of this Article IX with respect to the Corporation as he or she would if he or she had served the Corporation in the same capacity. Without limitation of the foregoing, each member, director, officer and employee of each predecessor to the Corporation shall have the same contract rights as are afforded to directors, officers and employees of the Corporation pursuant to Section 9.11.

ARTICLE X

Contracts, Loans, Checks and Deposits

10.1 Contracts. The Board of Directors may authorize any officer or officers or agent or agents to enter into any contract or execute or deliver any agreement or instrument in the name of and on behalf of the Corporation, and such authority may be general or confined to specific instances.

10.2 Loans. The Board of Directors may authorize the borrowing by the Corporation of such sum or sums of money as the Board of Directors may deem advisable, and to mortgage or pledge any or all of the real or personal property and any or all of the other available assets of the Corporation in order to secure the payment of the principal amount of any such borrowing and the interest thereon and any and all such other amounts as may become due on account thereof.

10.3 Checks. All checks, drafts or other orders for the payment of money, notes or other evidence of indebtedness shall be issued in the name of the Corporation and shall be signed by such officer or officers or agent or agents of the Corporation and in such manner as from time to time shall be determined by the Board of Directors.

10.4 Deposits. All funds of the Corporation shall be deposited to the credit of the Corporation in such banks, trust companies or other depositories as the Board of Directors may approve.

ARTICLE XI

Notice and Conduct of Meetings

11.1 Written Notice. Except as otherwise provided in these Bylaws, whenever written notice is required to be given by any person under the provisions of any statute or these Bylaws, it may be given by sending a copy thereof through the mail or overnight delivery or by hand delivery, in each case with charges prepaid, or by facsimile confirmed by one of the foregoing methods, to the individual's address appearing on the books of the Corporation or supplied by the individual to the Corporation for the purpose of notice.

11.2 Written Waiver of Notice. Whenever any written notice is required as set forth in these Bylaws, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

11.3 Waiver of Notice by Attendance. Attendance of a person in person at any meeting shall constitute a waiver of notice of such meeting except when a person attends the meeting for the express purpose of objecting to the transaction of any business because the meeting has not been lawfully called or convened.

11.4 Procedure. All meetings of the Board of Directors, the committees thereof and the Regional Advisory Boards shall be conducted in an orderly manner with a view to affording full and fair discussion of the matters properly before such meetings.

ARTICLE XII

Miscellaneous

12.1 No Contract Rights. Except as specifically set forth in Sections 4.8, 9.3 and 9.4, no provision of these Bylaws shall vest any property or contract right in any person.

12.2 Corporate Seal. The Board of Directors shall prescribe the form of a suitable corporate seal, which shall contain the full name of the Corporation and the year and state of incorporation.

12.3 Fiscal Year. The fiscal year of the Corporation shall end on such day as shall be fixed by the Board of Directors, subject to approval by the Corporate Member.

ARTICLE XIII

Amendments

13.1 Amendments. These Bylaws may be altered, amended or repealed, or new Bylaws may be adopted, **(a) by proposal** by the Board of Directors at any meeting of the Board of Directors, subject to approval by the Corporate Member, by the vote of not less than seventy-five percent (75%) of the directors present, but not less than a majority of the directors in office, at any such meeting, provided that notice of any proposed amendment or a summary thereof

shall have been given to each director not less than ten (10) days prior to the date of the meeting, or (b) except as set forth in Section 3.3.2(e), by the Corporate Member.

EXHIBIT E

Below is a summary of the process that GT utilized to prepare projections related to WPAHS, and the related assumptions.

GT's projections are based on WPAHS's (sometimes herein, the System) and Highmark's collective development of an integrated delivery network to reduce the trend in the increase in the cost of healthcare in Southwestern Pennsylvania and reflect:

- The continuation of Highmark's provider contracts with certain UPMC hospitals and UPMC physicians through December 31, 2014;
- Highmark's ongoing affiliation efforts with doctors in Southwestern Pennsylvania;
- The reopening of West Penn Hospital's Emergency Department and other services;
- Productivity improvement and collaboration in the physician organizations; and
- Other initiatives and external factors.

Projections of Patient Volume and Related Revenue

Future patient volumes and revenue were projected based on historical patient volume and revenue and the estimated impact of the initiatives and external factors, including:

- i. **Physician Alignment** – Highmark has undertaken a multi-year plan to develop affiliations with a wide range of physicians across various specialties. This strategic alignment is expected to supplement the System's physician organization and bring expanded service offerings that drive financial growth at WPAHS.

Patient volumes were estimated based on an assessment of the likelihood of recruiting specific doctors identified in the recruiting pipeline and recruiting plan. An analysis of publicly available data was used to estimate the relevant financial metrics related to

recruited doctors. This analysis was extended to encompass additional expected future recruitment and hiring.

- ii. **Physician Organization (PO)** – The turnaround strategies for WPAHS have identified the WPAHS PO as a focus area. There are efforts underway to recruit additional physicians and improve the productivity of the existing physicians, both of which should increase the volume within WPAHS. Improved management of the PO and investments in additional personnel and systems to improve internal communications and facility utilization are expected to improve collaboration and increase productivity.

Historical data and industry benchmarks were used to estimate the potential increase in patient volumes from these efforts.

- iii. **West Penn Reopening** – The Emergency Department of West Penn Hospital was reopened in February 2012 and other services will return to West Penn Hospital within the next year. The estimated incremental patient volumes from the reopening of the Emergency Department and other services were projected based on historical information.
- iv. **Increased Competition** – The projected negative effects of actions by competitors on patient volume also were considered and estimated.
- v. **Highmark Product Changes** – Anticipated volume changes associated with the introduction of new insurance products were incorporated into the projections. As was noted above, the projections assume that UPMC will not renew its contracts with Highmark and access to certain UPMC facilities will be terminated effective December 31, 2014. Additional volume was incorporated into the projections due to these UPMC facilities being out of Highmark’s network at that time.

- vi. **Other Initiatives and Environmental Factors** – Other factors which are expected to have an effect on volumes also were identified and analyzed. These include changing demographics in the relevant market and the effectiveness of the IDN in changing care patterns, both of which are projected to have a negative effect on the volume at WPAHS.

Outpatient volumes were projected using the historical relationships of outpatient registrations to inpatient discharges for each hospital.

In order to estimate the effect on revenue of projected patient volumes, publicly available data and data provided by WPAHS were reviewed for certain key components of revenue. These key components greatly influence how projected patient volume is converted into revenue. Among the key components were:

- i. **Payor Mix** – Reimbursement rates for services performed vary based on whether the payor is Medicare, Medicaid, commercial insurance providers, Medicare managed care providers, Medicaid managed care providers or the patient. This payor mix is affected by many factors including demographics, regulation and hospital or System initiatives. The historical payor mix was reviewed, as were estimated changes to the mix based on certain known or expected changes, including the Accountable Care Act as currently enacted.
- ii. **Reimbursement Rates** – For each class of payor, historical and anticipated rate changes were used to project reimbursement rates for the projection period (note that changes in government reimbursement, such as for Medicare and Medicaid, could differ materially from the assumed changes).
- iii. **Case Mix Index (CMI)** – CMI is a commonly used industry metric which is used to assess the severity, acuity or complexity of patient volume at a hospital. The higher the CMI, the greater the reimbursement rates and related revenue received for providing care. Historical CMI data for each hospital was analyzed to estimate the effect of anticipated volume changes on CMI. Generally, CMI is projected to increase over time, as less acute

patients are managed outside of the hospital setting, resulting in a higher average acuity within the hospital.

Projected net patient service revenue was estimated by applying the expected payor mix, reimbursement rates and CMI to the projected inpatient and outpatient volume levels.

Other revenues related to certain governmental programs including DSH payments and potential incentives for meaningful use of electronic health records were also included in the revenue projections.

Projected Costs

An analysis was performed on the main drivers and components of costs and potential cost savings. Among the key components analyzed were:

- i. **Salaries, wages and fringe benefits** – The historical salaries and benefits for each hospital or other business unit were analyzed to estimate the cost to provide care and related support services for the projected patient volumes.
- ii. **Supplies/Drug Cost** – WPAHS and Highmark have worked together to institute a new purchasing program for supplies and drugs. It is anticipated that this new purchasing program, along with an increased management focus on costs, will result in near-term cost savings which will be magnified further as volume increases. The potential savings from these efforts are reflected in the projections.
- iii. **Case Mix Index** – As described previously, changes to CMI based on the volume initiatives were estimated. The estimated CMI was used as a component to derive the cost to deliver care.

- iv. **Average Length of Stay** – One of the primary metrics used to derive the cost of inpatient care is the average length of stay for patients who are admitted to hospitals in the System. The impact of the previously described patient volume initiatives on average length of stay was estimated and incorporated in the projections. Average length of stay is generally expected to increase slightly over the projection period.
- v. **Fixed and Variable Costs** – The fixed and variable components of the System’s cost structure for each of the main cost drivers, such as salaries and supplies for each hospital and business unit, including support services, were estimated. Fixed costs were increased for expected inflation during the projection period. Variable costs were projected based on incremental patient volumes and increased for expected inflation.
- vi. **Depreciation and Amortization of Fixed Assets** – The System plans to make significant capital investments in infrastructure and technology. This investment is expected to increase capacity and improve efficiency, communication and collaboration throughout the System. Projected capital expenditures include both specifically-identified investments and, in later years, estimates of expenditures. Depreciation and amortization are based on historical information, projected capital expenditures and estimated future asset lives.
- vii. **Interest Expense** – Interest expense was projected based on WPAHS’s historical and projected debt levels, including existing and planned future loans from Highmark as appropriate.

Summary Conclusion

WPAHS is projected to continue to experience operating losses in fiscal year 2013. The System is projected to produce net income and have positive operating cash flow by fiscal year 2015, but may still require a line of credit or other sources of cash flow to meet months with peak cash needs associated with debt service payments.

EXHIBIT F

UPE
 Combined Balance Sheets
 Internal Unaudited Projections
 (In Millions)

	2012	2013	2014	2015	2016
Cash and Investments	\$ 7,030.7	\$ 6,810.7	\$ 6,946.5	\$ 7,374.8	\$ 7,785.1
Accounts Receivable	2,350.7	2,505.5	2,558.6	2,390.6	2,675.9
Property and Equipment, net	1,084.3	1,447.0	1,662.9	1,585.3	1,548.9
Goodwill and Other Intangibles	1,001.5	1,015.9	1,031.1	1,020.1	1,014.6
Other Assets	939.3	1,011.5	1,050.8	1,078.0	1,084.8
TOTAL ASSETS	\$ 12,406.5	\$ 12,790.6	\$ 13,249.9	\$ 13,448.8	\$ 14,109.3
Claims Outstanding	2,403.0	2,571.7	2,635.3	2,479.8	2,735.7
Unearned Revenue	345.3	358.2	378.2	375.6	396.2
Other Payables and Accrued Expenses	2,182.4	2,235.4	2,261.0	2,320.0	2,343.2
Benefit Plan Liabilities	343.2	359.3	340.9	343.4	336.8
Debt	1,874.1	1,828.4	1,902.7	1,808.9	1,753.5
TOTAL LIABILITIES	7,148.0	7,353.0	7,518.1	7,327.7	7,565.4
TOTAL RESERVES	5,258.5	5,437.6	5,731.8	6,121.1	6,543.9
TOTAL LIABILITIES AND RESERVES	\$ 12,406.5	\$ 12,790.6	\$ 13,249.9	\$ 13,448.8	\$ 14,109.3

UPE
 Combined Income Statements
 Internal Unaudited Projections
 (In Millions)

	2012	2013	2014	2015	2016
Total Revenue	\$ 5,610.7	\$ 17,566.0	\$ 18,962.8	\$ 19,141.6	\$ 20,232.1
Total Expenses	5,635.5	17,402.3	18,445.8	18,501.7	19,519.0
Income (Loss) Before Income Taxes	(24.8)	163.7	517.0	639.9	713.1
Income Tax Provision (Benefit)	3.2	114.3	233.4	262.3	289.0
Net Income (Loss)	\$ (28.0)	\$ 49.4	\$ 283.6	\$ 377.6	\$ 424.1

Statements do not include fair value accounting in conjunction with the affiliation with WPAHS and JRMCC.