Company Name
Request for Proposal
Group Health Plan

RFP Released: **DATE**
Responses Due: **DATE AND TIME**

Table of Contents

A. Introduction

COMPANY NAME is releasing a Request for Proposal for health insurance,

pharmacy benefit management and disease management services. Proposing companies need only complete the sections of this RFP relevant to the service(s) they wish propose to COMPANY NAME. Health insurance is to be quoted on a fully insured *and* self insured basis.

This proposal, with any negotiated changes, will be incorporated, and become part of the contract between COMPANY NAME and the selected health insurance administrator.

B. Background of Company

C. Mechanics of the Response

The Health Plan response to this RFP should use the following guidelines:

a. Before the body of the RFP, please include a page with the name of the Health Plan, the primary contact's name, title, phone number, e-mail address, and mailing address.

b. Responses to questions must be in the order they appear in the RFP. Each question must be restated before the response, and all attachments must be labeled.

c. Attachments will be used to verify questionnaire responses. All attachments should be tabbed, numbered (e.g. Attachment A) and have relevant information highlighted. Attachments should be inserted at the end of the document.

d. All RFP responses must be provided in three ring binders with all attachments separated by marked tabs. Do not put attachments under separate cover.

e. Volume of response, per se, will not be rewarded. Short, to-the-point responses are highly preferred.

f. Proposals should be net of commission.

g. Submit two hardcopies and two CDs containing the Plan's response, prepared in Microsoft Word or Excel, and all non-data Exhibit requests labeled as **[Plan name] RFP 2008.**

   Send hard copy RFP response and CDs to:

   Name and address

D. Evaluation

This RFP constitutes the pricing component of COMPANY NAME's total evaluation process for health insurance, pharmacy benefit management and disease management services. Because the COMPANY NAME believes in Value-Based Purchasing principles, other health plan information will be evaluated in addition to the pricing questions contained in this RFP. COMPANY is a member of the HealthCare 21 Business Coalition (HC21) and, as such, will utilize health plan information from eValue8 and supplemental questions to analyze the quality and operational components of health plans.

E. Timeline

RFP Release:	DATE
Q & A Conference Call:	DATE AND TIME
Proposal Due Date:	DATE AND TIME
Evaluation/Finalist Presentations:	Week of DATE
Negotiation/Vendor Selection Date By:	MONTH, YEAR
Enrollment:	MONTH, YEAR
Effective Date:	DATE

Questions

Address questions to: Name, address and contact information

A. PRICING

1. Fully Insured Pricing

Provide pricing for a POS plan based on the benefits described in Appendix B:

Individual Coverage _____
Family Coverage _____

2. Self Insured Pricing

Please provide the ASO fees on a per employee per month (PEPM) basis net of commissions. *Detail all fees*. Use the following tiers:

- Employee
- Family

TPA Medical Administration_____

TPA Pharmacy Administration_____

Network _____

Disease Management _____

EAP _____

Other _____

- Employee data is provided in Appendix A
- Current benefit plan design is provided in Appendix B
- Claims data is found in Appendices C through E

Please list stop loss pricing for the following terms and **specific** thresholds with each answer:

Term	Threshold: $50,000	Threshold: $75,000	Threshold: $100,000
12/12			
15/12			
12/15			

List each stop loss carrier you are using in this quote and their A M Best rating.

PERFORMANCE STANDARDS 2008

1. Indicate if the health plan will (yes), will not (no) agree to each of the following standards.

	Performance Category	Performance Standard	How Measured	Y/N
1	ID Cards	100% of ID cards mailed a minimum of five days prior to the effective date provided clean eligibility data is received 21 days prior to the effective date.	Health plan management reports detailing the production and mailing of ID cards	
2	Claims Processing	99% accuracy of total dollars paid and total dollar paid in error, whether the error is over or under payment.	Self-reported	
3		95% accuracy rate for all claims paid that have any financial or procedural error.	Self-reported	
4		Meet turnaround of claims processing time- 85% with 10 working days or 14 calendar days.	Self-reported	
5	Automatic Claim Audit	Resolve or explain issues raised by a claims cost analysis to the employers' satisfaction within 60 days.	Issues Resolved	
6	Data Access	Provide all the member data according to the specifications set forth in the "Data Availability" section of this RFI supplement to HC21 or its data warehouse vendor for: 1) all self funded clients, and 2) fully insured clients with 150 or more employees.	Data transfers as specified in the "Data Availability" section of this RFI supplement.	
	Data Access	Full Cooperation in periodic data validation (reconciliation).	On a per request basis; by providing high level "targets" and target methodology if requested.	
7	Claims Reports	Provide a summary report of claims to the employer at 6 months and 12 months.	Claims reports sent in adherence to the standard	
8	Disease Management	Provide detailed individual level records when requested (HIPAA Compliant)	Data Provided	
9	Disease Management	Transition all active disease management cases to a new plan within 60 days of effective date. If you are the new plan, enroll active cases from a previous plan within 60 days of the effective date.	Transition Completed	
10	Disease Management	Provide disease management utilization reports at 6 months, 9 months, and 12 months for all disease management programs.	Utilization reports sent in adherence to the standard.	
11	Case Management	Provide detailed individual level records when requested (HIPAA Compliant)	Data Provided	
12	Case Management	Transition all active case management cases to a new plan within 60 days of effective date. If you are the new plan, enroll active cases from a previous plan within 60 days of effective date.	Transition Completed	
13	Customer Service	Meet satisfactory phone response time – 90% in 45 seconds between menu selection and human voice.	Automated phone logs	
14		Meet satisfactory abandon call rate less than 5%.	Automated phone logs	

15		85% First call to resolution in 45 days or less.	Self-reported	
16		70% problem resolution during the initial call.	Self-reported	
17		Does the Health Plan include in its contract with hospitals language to the effect that payment for NQF Never Events occurring in the hospital will not be required from the Plan or Plan Sponsors or members?	Sample Contract Language	
18	eValue8	Complete the National Business Coalition on Health's (NBCH) health plan RFI tool called eValue8 for each year this contract is in force.	eValue8 Completed	
19	Health Risk Assessment	Provide detailed individual level records when requested (HIPPA compliant)	Data Provided	

2. Please state the Plan's financial guarantee for these performance standards.

3. If requested, is the Plan willing to cooperate with an audit of self-reported data?

APPENDIX A. EMPLOYEE DEMOGRAPHICS

Employees select either employee only (EE) or family (F) coverage. Dependents are included and are specified as spouse or child.

Active employees: (category/coverage/gender/dob/zip code/coverage dates)

Retirees: (category/coverage/gender/dob/zip code/coverage dates)

APPENDIX B. CURRENT BENEFIT DESIGN

COMPANY NAME

UnitedHealthcare
Choice Plus *Plan 079 Modified*

Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination[SM] services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are

covered.

Childhood immunizations are

covered. Mammograms are

covered.

Vision and hearing screenings are covered.

TNXGM07904

Choice Plus *Benefits Summary*

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law. Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. *Prior Notification is required for certain services.	**Annual Deductible:** $1,000 per Covered Person per calendar year, not to exceed $3,000 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $3,000 per Covered Person, per calendar year, not to exceed $6,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** No Maximum Policy Benefit.	**Annual Deductible:** $2,000 per Covered Person per calendar year, not to exceed $6,000 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $8,000 per Covered Person, per calendar year, not to exceed $16,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** $1,000,000 per Covered Person.
1. Ambulance Services - Emergency only	Ground Transportation: 20% of Eligible Expenses Air Transportation: 20% of Eligible Expenses	Same as Network Benefit
2. Dental Services - Accident only	*20% of Eligible Expenses *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to $3,500 per calendar year.	No Charge	*40% of Eligible Expenses *Prior notification is required when the cost is more than $1,000.
4. Emergency Health Services	$200 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	$25 per visit	40% of Eligible Expenses Eye Examinations for refractive errors are not covered.
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	20% of Eligible Expenses	*40% of Eligible Expenses
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	20% of Eligible Expenses	*40% of Eligible Expenses
8. Hospital - Inpatient Stay	20% of Eligible Expenses	*40% of Eligible Expenses
9. Injections Received in a Physician's Office	No Charge	40% per injection
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit.	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	20% of Eligible Expenses	40% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment	40% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	20% of Eligible Expenses	40% of Eligible Expenses
Outpatient Therapeutic Treatments	20% of Eligible Expenses	40% of Eligible Expenses
12. Physician's Office Services	Preventive Medical Care - $25 per visit, except that the Copayment for a Specialist Physician Office visit is $40 per visit.	No Benefits for preventive care.
	Sickness or Injury - $25 per visit, except that the Copayment for a Specialist Physician Office visit is $40 per visit.	40% of Eligible Expenses
13. Professional Fees for Surgical and Medical Services	20% of Eligible Expenses	40% of Eligible Expenses

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to $2,500 per calendar year.	20% of Eligible Expenses	40% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services - Outpatient Therapy Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy (including subluxations and manipulations); 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	$40 per visit	40% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	20% of Eligible Expenses	*40% of Eligible Expenses
18. Transplantation Services	*20% of Eligible Expenses	*40% of Eligible Expenses Benefits are limited to $30,000 per transplant.
19. Urgent Care Center Services	$100 per visit	40% of Eligible Expenses

Additional Benefits

Dental Services - Inpatient/Outpatient	20% of Eligible Expenses	*40% of Eligible Expenses
Diabetes Services	20% of Eligible Expenses	40% of Eligible Expenses
Mental Health Services - Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 40 visits per calendar year.	$40 per individual visit; $40 per group visit	40% of Eligible Expenses
Mental Health Services - Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 25 days per calendar year.	20% of Eligible Expenses	40% of Eligible Expenses
Phenylketonuria Treatment	Same as 8, 11, 12 and 13	*Same as 8, 11, 12 and 13
Substance Abuse Services - Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 20 visits per calendar year.	$15 per individual visit; $15 per group visit	40% of Eligible Expenses
Substance Abuse Services - Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 25 days per calendar year.	$50 per Inpatient Stay	40% of Eligible Expenses
Temporomandibular Joint Disorders	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the COC under the headings *Dental Services - Accident Only* and *Dental Services - Inpatient/Outpatient*, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies except as described in Section 1 of the COC under the heading *Diabetes Services*. Examples include: elastic stockings, ace bandages, gauze and dressings, ostomy supplies and syringes. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the COC.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk, except for the treatment of phenylketonuria.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising prior to the date your coverage under the Policy ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury, cancer or as described in Section 1 of the COC under the heading *Temporomandibular Joint Disorders* ("TMJ"). Orthognathic surgery and jaw alignment.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Certificate of Coverage, the Certificate of Coverage prevails. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.

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APPENDIX C. CLAIMS: JANUARY 2007 THROUGH DECEMBER 2007

PVC- Paid – All Service Months (Composite)

Bill/Book Year/Month	Restated Billed Subscribers	Actual Restated Billed Members	Restated Billed Premium	Restated Billed Premium PSPM	Restated Billed Premium PMPM	Capitation Payments	Managed Pharmacy Payments	HMO In-Network Claim Payments	Other Claim Payments	Total Payments	Total Payments PSPM	Total Payments PMPM	Claim to Premium Ratio

PVC- Paid – All Service Months (Regular Employees, Excluding COBRA)

Bill/Book Year/Month	Restated Billed Subscribers	Actual Restated Billed Members	Restated Billed Premium	Restated Billed Premium PSPM	Restated Billed Premium PMPM	Capitation Payments	Managed Pharmacy Payments	HMO In-Network Claim Payments	Other Claim Payments	Total Payments	Total Payments PSPM	Total Payments PMPM	Claim to Premium Ratio

PVC- Paid – All Service Months (COBRA Enrollees)

Bill/Book Year/Month	Restated Billed Subscribers	Actual Restated Billed Members	Restated Billed Premium	Restated Billed Premium PSPM	Restated Billed Premium PMPM	Capitation Payments	Managed Pharmacy Payments	HMO In-Network Claim Payments	Other Claim Payments	Total Payments	Total Payments PSPM	Total Payments PMPM	Claim to Premium Ratio

PVC- Paid – All Service Months (Retirees)

Bill/Book Year/Month	Restated Billed Subscribers	Actual Restated Billed Members	Restated Billed Premium	Restated Billed Premium PSPM	Restated Billed Premium PMPM	Capitation Payments	Managed Pharmacy Payments	HMO In-Network Claim Payments	Other Claim Payments	Total Payments	Total Payments PSPM	Total Payments PMPM	Claim to Premium Ratio

Claim Expenses by Size of Payment (Composite)

Payment Category	Number of Claimants	% Claimants	Payments	% Payments
$.01-$49				
$50-$99				
$100-$249				
$250-$499				
$500-$999				
$1,000-$2,499				
$2,500-$4,999				
$5,000-$9,999				
$10,000-$14,999				
$15,000-$19,999				
$20,000-$24,999				
$30,000-$39,999				
$50,000-$74,999				
$350,000-$399,999				
Total				

Claim Expenses by Size of Payment (Regular Employees, Excluding COBRA)

Payment Category	Number of Claimants	% Claimants	Payments	% Payments
<$.01				
$.01-$49				
$50-$99				
$100-$249				
$250-$499				
$500-$999				
$1,000-$2,499				
$2,500-$4,999				
$5,000-$9,999				
$10,000-$14,999				
$15,000-$19,999				
$20,000-$24,999				
$30,000-$39,999				
$50,000-$74,999				
Total				

Claim Expenses by Size of Payment (COBRA Enrollees)

Payment Category	Number of Claimants	% Claimants	Payments	% Payments
$250-$499				
$500-$999				
$1,000-$2,499				
$2,500-$4,999				
$5,000-$9,999				
$20,000-$24,999				
$350,000-$399,999				
Total				

Claim Expenses by Size of Payment (Retirees)

Payment Category	Number of Claimants	% Claimants	Payments	% Payments
$250-$499				
$500-$999				
$1,000-$2,499				
$2,500-$4,999				
$5,000-$9,999				
Total				

APPENDIX D. CLAIMS: JULY 2006 THROUGH DECEMBER 2006

All groups (active employees, COBRA and retirees)

Payment Category	Number of Claimants	% Claimants	Payments	% Payments
$.01-$49				
$50-$99				
$100-$249				
$250-$499				
$500-$999				
$1,000-$2,499				
$2,500-$4,999				
$5,000-$9,999				
$10,000-$14,999				
$30,000-$39,999				
Total				

Active only

Customer Segment Number	Subgroup1	Subgroup2	Payment Category	Number of Claimants	% Claimants	Payments	% Payments
000709940	A	0001	$.01-$49				
000709940	A	0001	$50-$99				
000709940	A	0001	$100-$249				
000709940	A	0001	$250-$499				
000709940	A	0001	$500-$999				
000709940	A	0001	$1,000-$2,499				
000709940	A	0001	$2,500-$4,999				
000709940	A	0001	$5,000-$9,999				
000709940	A	0001	$10,000-$14,999				
000709940	A	0001	Total				

COBRA only

Customer Segment Number	Subgroup1	Subgroup2	Payment Category	Number of Claimants	% Claimants	Payments	% Payments
000709940	A	0002	$50-$99				
000709940	A	0002	$500-$999				
000709940	A	0002	$1,000-$2,499				
000709940	A	0002	$2,500-$4,999				
000709940	A	0002	$30,000-$39,999				
000709940	A	0002	Total				

Retirees only

Customer Segment Number	Subgroup1	Subgroup2	Payment Category	Number of Claimants	% Claimants	Payments	% Payments
000709940	A	0003	$100-$249				
000709940	A	0003	$500-$999				
000709940	A	0003	$1,000-$2,499				
000709940	A	0003	Total				

APPENDIX E. CLAIMS: HISTORY JULY 2005 – JUNE 2006

Month	Members	Medical Claims	Pharmacy Claims	Capitation	Opt-Out	Total Claims	PMPM