NETWORK QUESTIONNAIRE

Our approach to pricing Stop Loss over provider networks depends on the level of services provided and the savings realized in the network. In order for us to accurately evaluate your network, we ask you to carefully complete the following questions and supply us with the information requested below.

1. Network Name:_____________________________________________________________
   Full Address:__________________________________________________________________
   Contact Name:_________________________________________________________________
   E-Mail Address: _____________________________
   Phone: (____) _____ - _________       Ext: __________      Fax: (____) _____ - _________

2. In the past two years, has your network been involved in any mergers and/or acquisitions?
   (___) Yes (___) No.  If yes, please explain ________________________________________
   ___________________________________________________________________________

3. Please confirm which of the following features you offer:
   HMO ________ Yes    _________ No  U/R ________ Yes _________ No
   PPO ________ Yes    _________ No  LCM ________ Yes _________ No
   POS ________ Yes    _________ No
   EPO ________ Yes    _________ No

4. Network Service Area:__________________________________________________________________
   ______________________________________________________________________________

5. Enrollment data. Current Year: ______________  Prior Year: ________________

6. What percentage of all eligible individuals utilizes network facilities? ________________
7. Are access fees on a PMPM or a % of savings basis? ________________________________
   If both, what percent of business is on a % of savings basis? ________%
   What is the % of savings charged? ________%

If your network does in-house repricing, please provide the information requested in numbers 8
and 9 below. If you do not reprice in-house, please skip to numbers 10 and 11 below.

8. Please provide us with two claimant by claimant listings of all in-network claims where
   billed charges are over $30,000, before and after repricing (billed and repriced), for the latest
   12 month period, identifying the network hospital for each claimant, length of stay, hospital
   state, zip code and primary diagnosis code. One listing should include all claims by
   claimant, and the other should include hospital only claims by claimant. All data should
   exclude secondary payor and ineligible claims. Here is an example of what we are looking
   for:

   Listing 1:
<table>
<thead>
<tr>
<th>Claimant</th>
<th>Total Billed</th>
<th>Total Allowed</th>
<th>State</th>
<th>Employee Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td># 1.</td>
<td>$139,999</td>
<td>$85,550</td>
<td>CT</td>
<td>06010</td>
</tr>
<tr>
<td># 2.</td>
<td>$65,000</td>
<td>$48,999</td>
<td>FL</td>
<td>32740</td>
</tr>
</tbody>
</table>

   Listing 2:
<table>
<thead>
<tr>
<th>Claimant</th>
<th>Hospital Billed</th>
<th>Hospital Allowed</th>
<th>Hospital</th>
<th>LOS</th>
<th>Hospital State</th>
<th>Hospital Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td># 1.</td>
<td>$100,000</td>
<td>$70,000</td>
<td>ABC</td>
<td>15 Days</td>
<td>CT</td>
<td>06010</td>
</tr>
<tr>
<td># 2.</td>
<td>$50,000</td>
<td>$40,000</td>
<td>XYZ</td>
<td>7 Days</td>
<td>FL</td>
<td>32740</td>
</tr>
</tbody>
</table>

   If your provider contracts differ for your EPO product and your PPO product, please provide
   this information separately.

   Please provide all claim information on diskette in Comma Delimited ASCII, Excel
   Spreadsheet, or ACCESS Database format.

9. Also, for the same 12 month period, please provide total (all claims down to First dollar) in-
   network billed claims, and total allowed claims, by 3 digit employee zip codes. Below is an
   example of what we are looking for.

   Listing 3:
<table>
<thead>
<tr>
<th>State</th>
<th>Zip Code</th>
<th># Claimants</th>
<th>Total Billed</th>
<th>Total Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>060</td>
<td>43,454</td>
<td>$70,184,200</td>
<td>$45,617,780</td>
</tr>
<tr>
<td>CT</td>
<td>064</td>
<td>15,656</td>
<td>$25,484,330</td>
<td>$19,113,248</td>
</tr>
<tr>
<td>FL</td>
<td>327</td>
<td>4,748</td>
<td>$ 7,522,400</td>
<td>$ 6,017,920</td>
</tr>
</tbody>
</table>
If you are unable to provide the data requested in numbers 8 and 9 above, please provide data requested in numbers 10 and 11 below.

10. Please provide us with a list of all contracted hospitals including hospital name, city, state, zip code, tax identification number, and the terms of the contract, including any outlier (stop loss) provisions. If your contracts differ by product, please provide us with contract information for each product.

11. Please provide the average savings by each of the following categories by Service Areas.
   - Inpatient
   - Outpatient
   - Physician

For Example:

<table>
<thead>
<tr>
<th>MSA</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Physician</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicago</td>
<td>45%</td>
<td>40%</td>
<td>50%</td>
<td>48%</td>
</tr>
</tbody>
</table>

12. List the expenses which are usually capitated in your network, if any.

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

_______________________________________________________          __________________
Signature/Title                                                                 Date