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? _____

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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:

Claimant	Total Billed	Total Allowed	State	Employee Zip
# 1.	$139,999	$85,550	CT	06010
# 2.	$65,000	$48,999	FL	32740

Listing 2:

Claimant	Hospital Billed	Hospital Allowed	Hospital	LOS	Hospital State	Hospital Zip
# 1.	$100,000	$70,000	ABC	15 Days	CT	06010
# 2.	$50,000	$40,000	XYZ	7 Days	FL	32740

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:

State	Zip Code	# Claimants	Total Billed	Total Allowed
CT	060	43,454	$70,184,200	$45,617,780
CT	064	15,656	$25,484,330	$19,113,248
FL	327	4,748	$ 7,522,400	$ 6,017,920

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:

MSA	Inpatient	Outpatient	Physician	Total
Chicago	45%	40%	50%	48%

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

_____

_____

_____

_____

_____ _____

Signature/Title Date

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