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? ________________
**NETWORK QUESTIONNAIRE**

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 in Comma Delimited ASCII, MS Excel Spreadsheet, or MS 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