<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation Payment</td>
<td>2</td>
</tr>
<tr>
<td>Definition</td>
<td>2</td>
</tr>
<tr>
<td>Calculation of Capitation Payment</td>
<td>2</td>
</tr>
<tr>
<td>The Capitation Payment Summary Key</td>
<td>3</td>
</tr>
<tr>
<td>Sample HMO Capitation Payment Summary</td>
<td>4</td>
</tr>
<tr>
<td>Comparison of Capitation Payment Summary with the Eligibility List Summary</td>
<td>5</td>
</tr>
<tr>
<td>Utilization Management Fund</td>
<td>7</td>
</tr>
<tr>
<td>Example Calculation of the Interim and Final Utilization Management Fund</td>
<td>8</td>
</tr>
<tr>
<td>Calculation of Target Units</td>
<td>10</td>
</tr>
<tr>
<td>Calculation of the Actual Units Utilized</td>
<td>10</td>
</tr>
<tr>
<td>Calculation of Utilization Management Fund Amount Due to the IPA</td>
<td>13</td>
</tr>
<tr>
<td>Office-Based Surgery (Appendix B) - Exception Request to the Utilization Management Fund Form</td>
<td>14</td>
</tr>
<tr>
<td>Payment of Utilization Management Fund</td>
<td>15</td>
</tr>
<tr>
<td>IPA Challenges to the Utilization Management Fund</td>
<td>16</td>
</tr>
<tr>
<td>Code Key for the Utilization Management Fund Detail Report</td>
<td>17</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>19</td>
</tr>
<tr>
<td>Non-Capitated Services (Catastrophic) Claims</td>
<td>19</td>
</tr>
<tr>
<td>Quality Improvement Fund</td>
<td>20</td>
</tr>
<tr>
<td>1. Semi-Annual Payments</td>
<td>20</td>
</tr>
<tr>
<td>2. Special HEDIS Payments</td>
<td>21</td>
</tr>
<tr>
<td>3. Annual Payments</td>
<td>21</td>
</tr>
<tr>
<td>Prescription Drug Fund</td>
<td>26</td>
</tr>
<tr>
<td>Co-Payments</td>
<td>27</td>
</tr>
</tbody>
</table>
Capitation Payment

Definition

Capitation payment is the amount paid to the IPA based on the number of members each month, regardless of whether or not services are provided to the Member during the month. Capitation rates for each type of Member contract may be found in the IPA's current Medical Service Agreement.

There is a separate Capitation Payment made for Women’s Principal Health Care Provider (WPHCP) services. The following descriptions apply to both the WPHCP and the regular Capitation Payments.

The Capitation Payment which is made to the IPA by the 10th of each month is actually a "Net" Capitation Payment. The specific steps for calculating the Net Capitation Payment are detailed below.

Calculation of Capitation Payment

The Net Capitation Payment made to the IPA is calculated in two steps: "current" and "retroactive" capitation. "Current" capitation is calculated by multiplying the number of members enrolled by the capitation rates in effect for the age- sex category. This figure is then adjusted (plus or minus) by the "retroactive" capitation calculation. "Retroactive" capitation is calculated by adding or subtracting the capitation rates for the Members added or deleted from the IPA Eligibility List for periods prior to the current month.

Both the "current" and "retroactive" calculations are listed in the HMO Capitation Payment Summary mailed to the IPA monthly. If the IPA has any questions about the calculation of its monthly capitation check, this Summary should be consulted first.
The Capitation Payment Summary Key

Use the following key to understand the HMO Capitation Payment Summary on page 4.

a. Month - Month for which capitation is being paid.

b. IPA Number and Name - Identification of the IPA to whom capitation is being paid.

c. Current and Retroactive Capitation - Dollar amount of current and retroactive calculated capitation.

d. Manual Adjustments - Dollar amount (positive or negative) of manual adjustments to the month's capitation. The adjustments will be explained by the following:

<table>
<thead>
<tr>
<th>Process Date</th>
<th>Date that manual adjustment occurred.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Number</td>
<td>Identification of member for whom manual adjustment is being made.</td>
</tr>
<tr>
<td>Subscriber Number</td>
<td>Identification of member for whom manual adjustment is being made.</td>
</tr>
<tr>
<td>Comment</td>
<td>Brief explanation of the reason for the adjustment.</td>
</tr>
<tr>
<td>Adj Type</td>
<td>Type of Adjustment</td>
</tr>
<tr>
<td>M</td>
<td>Manual</td>
</tr>
<tr>
<td>N</td>
<td>No adjustment needed (no financial impact)</td>
</tr>
<tr>
<td>SRC</td>
<td>Source of manual adjustment</td>
</tr>
<tr>
<td>C</td>
<td>Computer calculated</td>
</tr>
<tr>
<td>G</td>
<td>Employer Group</td>
</tr>
<tr>
<td>H</td>
<td>Health Services Programs (the HMO)</td>
</tr>
<tr>
<td>I</td>
<td>Incentive (UM or other Fund Advance)</td>
</tr>
<tr>
<td>L</td>
<td>Loan Payment (Monthly deduction for repayment)</td>
</tr>
<tr>
<td>M</td>
<td>Marketing</td>
</tr>
<tr>
<td>S</td>
<td>Special adjustment (not in above categories)</td>
</tr>
</tbody>
</table>
## Sample HMO Capitation Payment Summary

### BlueCross BlueShield of Illinois

**CAPITATION PAYMENT SUMMARY**
**FOR THE MONTH OF**
**JANUARY, 2002**

<table>
<thead>
<tr>
<th>MEDICAL GROUP NUMBER:</th>
<th>MEDICAL GROUP NAME:</th>
<th>CURRENT AND RETRACTIVE CAPITATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$ 564,498.13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NET MANUAL ADJUSTMENTS</th>
<th>TOTAL CAPITATION</th>
<th>CHECK NUMBER:</th>
<th>DATE: 01/02/02</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 618,639.86</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MANUAL ADJUSTMENTS

<table>
<thead>
<tr>
<th>PROCESS DATE</th>
<th>GROUP</th>
<th>SUBSCRIBER</th>
<th>COMMENT</th>
<th>ADJ</th>
<th>SRC</th>
<th>ADJUSTMENT AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/28/01</td>
<td>JAN 2002 MONTHLY INSTALLMENT</td>
<td>M  I</td>
<td>54,141.73</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LEGEND:**
- SRC = SOURCE TYPE
- C = COMPUTER CALCULATED
- G = EMPLOYER GROUP
- H = HEALTH SERVICE PROGRAM
- I = INCENTIVE
- L = LOAN PAYMENT
- M = MARKETING
- P = POINT OF SERVICE
- R = PDC CLAIM
- S = SPECIAL
- ADJ = ADJUSTMENT TYPE
- M = MANUAL ADJUSTMENT
- N = NO ADJUSTMENT NEEDED
**Comparison of Capitation Payment Summary with the Eligibility List Summary**

The Eligibility List Summary is a computer count of all active members as of the date of the Eligibility Run. This Summary also identifies all active Medicare Primary members.

Also included in the above totals are "overage dependents". Certain employers carry coverage for dependents beyond the age of 23 years. For these "overage dependents" the HMO pays regular capitation for the age and sex of the member.

In order to reconcile the current month’s capitation, check the following:

a) Multiply the number of Members under each Benefit Plan by the capitation amount specified in the Medical Service Agreement.

b) Review the Change Page. Total all the retroactive capitation changes shown. A comparison can be made by calculating the number of retroactive member months using the Change Page effective date and by accumulating the plus or minus changes (adds and transfers-in are plus; cancellations and transfers-out are minus).

The following rules apply regarding retroactive changes:

1. When a member is cancelled retroactively the HMO will deduct the capitation paid to the IPA for all the cancelled months.

2. When a member is added retroactively (new add or re-add) the HMO will pay the capitation for all months to the IPA.

3. When a member is reinstated; the HMO will pay the IPA the capitation up for the affected months.

4. When a member transfers in from another IPA; the HMO will deduct from and pay to the corresponding IPAs capitation for all months.

5. When a member transfers out of your IPA, the HMO deducts the capitation for all months.

c) Add a) and b) together. This should equal the Total Capitation paid that is listed on the Capitation Payment Summary. Discrepancies should be brought to the attention of the HMO using the Request for Manual Capitation Adjustment Form.
REQUEST FOR MANUAL CAPITATION ADJUSTMENT

Note: ALL FIELDS with an asterisk (*) ARE MANDATORY AND MUST BE COMPLETED IN ORDER FOR YOUR FORM TO BE PROCESSED. If any of the fields are left blank, your form will not be processed and will be returned.

*Date: ________________  *Subscriber Name: ______________________
*MG Name: ______________________  *Member(s) Name: ________________
*MG Site Number: ________________  *Member(s) DOB: ________________
*Contact Name: ______________________  *Member Group #: ________________
*Contact Phone Number: ________________  *Member ID #: ________________
*Contact Fax Number: ________________  *Eligibility Period(s) in Question (for example, 7/1-8/1/2003): ________________
*Contact Email Address: ______________________

*Type of Issue: (Please attach the pertinent eligibility list pages)

☐ PCP Issue
☐ WPHCP Issue

☐ Newborn Capitation – Services rendered in birth month, cap not paid
What months should you have received capitation? ________________
Amount of Cap due: $ ________________

☐ Retroactive Capitation –
What months did you receive cap? ________________
What months should you have received cap? ________________
Amount of Cap due: $ ________________

☐ Current Capitation –
What months did you receive cap? ________________
What months should you have received cap? ________________
Amount of Cap due: $ ________________

☐ Other (please include what month member appeared on eligibility list, if you received cap and if cap is due): ________________

*Amount of Cap due: $ ________________

**Email this form to: MANUALCAP@BCBSIL.COM or Fax to: 312-819-1650**
(Note: Emailing the form will expedite processing)

Do not write below this line - For office Use only

Response:
☐ Capitation adjustment of $ ________________ will be made on the ________________ Capitation Payment Summary Report. This is ________________ months @ $______________ for a total of $______________.

☐ Eligibility system has been updated. The change will be reflected on the ________________ Eligibility List.

☐ No capitation is due - Capitation was already paid on ________________. (copy of page attached)

☐ Other: ______________________________

Preparer: ________________  Response Date: ________________

Page 1 of 1
Utilization Management Fund

In addition to Capitation Fees, each IPA can earn a Utilization Management Fund. This Fund is based on the difference between the number of units actually utilized in the IPA’s Anniversary Year, and the target number of units established for the IPA, as described in the Medical Service Agreement.

The Utilization Management Fund amount is divided into two separate payments - an Interim Payment and a Final Payment. See the following pages for an example calculation of the Interim and Final Utilization Management Fund.
Example Calculation of the Interim and Final Utilization Management Fund

1) Calculate enrollment for six-month period by category of member. (The Final UM Fund would use a twelve month period).

<table>
<thead>
<tr>
<th></th>
<th>Adult Male</th>
<th>Adult Female</th>
<th>Child Male</th>
<th>Child Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>June</td>
<td>124</td>
<td>119</td>
<td>56</td>
<td>62</td>
</tr>
<tr>
<td>July</td>
<td>133</td>
<td>120</td>
<td>58</td>
<td>65</td>
</tr>
<tr>
<td>August</td>
<td>140</td>
<td>138</td>
<td>58</td>
<td>66</td>
</tr>
<tr>
<td>September</td>
<td>150</td>
<td>148</td>
<td>59</td>
<td>67</td>
</tr>
<tr>
<td>October</td>
<td>155</td>
<td>127</td>
<td>60</td>
<td>70</td>
</tr>
<tr>
<td>November</td>
<td>122</td>
<td>134</td>
<td>60</td>
<td>75</td>
</tr>
<tr>
<td>Total Member Months</td>
<td>824</td>
<td>786</td>
<td>351</td>
<td>405</td>
</tr>
<tr>
<td>Total Member Years (Member Months ÷ 12)</td>
<td>68.67</td>
<td>65.5</td>
<td>29.25</td>
<td>33.75</td>
</tr>
</tbody>
</table>

For the purpose of this Fund, an Adult Male or Adult Female is considered any member 18 years of age or older, whether a Subscriber or dependent, who has selected the IPA as his/her Participating IPA. A Child is any member less than 18 years of age, either male or female.

2) Calculate target units per category using factors* stated in the Medical Service Agreement.

<table>
<thead>
<tr>
<th></th>
<th>Adult Male</th>
<th>Adult Female</th>
<th>Child Male</th>
<th>Child Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Member Years</td>
<td>68.67</td>
<td>65.5</td>
<td>29.25</td>
<td>33.75</td>
</tr>
<tr>
<td>multiplied by HMO Illinois factors</td>
<td>0.4517</td>
<td>0.5882</td>
<td>0.3081</td>
<td>0.2806</td>
</tr>
<tr>
<td>Total Target Units</td>
<td>31.02</td>
<td>38.53</td>
<td>9.01</td>
<td>9.47</td>
</tr>
</tbody>
</table>

To determine the number of Total Target Units for the IPA’s population, add the Total Target Units Per Category. \[31.02 + 38.53 + 9.01 + 9.47 = 88.03\]

* Check Medical Service Agreement for that time period for correct factors.
3) From claim records determine incurred units during six month period. (The Final UM Fund would use a twelve month period).

<table>
<thead>
<tr>
<th></th>
<th>Actual Days</th>
<th>Unit Value</th>
<th>Charged Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days(Class I, Contracting Facility)</td>
<td>25</td>
<td>1.0</td>
<td>25</td>
</tr>
<tr>
<td>Extended Care Facility days (Contracting)</td>
<td>12</td>
<td>0.50</td>
<td>6</td>
</tr>
<tr>
<td>Home Health Care Visits (Contracting Facility)</td>
<td>10</td>
<td>0.33</td>
<td>3.30</td>
</tr>
<tr>
<td>Hospital Based Ambulatory Surgery Cases(Class I Contracting Facility)</td>
<td>5</td>
<td>1.00</td>
<td>5</td>
</tr>
<tr>
<td>Free Standing Ambulatory Surgery Cases</td>
<td>1</td>
<td>1.00</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40.30</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4) To determine the number of units assumed but unutilized; subtract the results from step 3 (total charged units) above from step 2 (total target units) above.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Units</td>
<td>88.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Units Charged</td>
<td>47.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Units saved</td>
<td>30.42</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5) Multiply results of 4) by the amount cited in the Medical Service Agreement for each assumed but unutilized unit.**

** a. Interim Calculation of Utilization Management Fund:**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of units assumed but not utilized</td>
<td>47.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiplied by amount for each unit (as cited in MSA)</td>
<td>$675.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Utilization Management Fund earned</td>
<td>$32,217.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interim Amount (Earned amount ÷ 2)</td>
<td>$16,108.88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>less monthly advance or other payments, (if applicable)</td>
<td>$6,403.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interim Utilization Management Fund earned and paid to the IPA</td>
<td>$9,705.59</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This amount, if positive, as in this example, will be paid to the IPA. If the interim amount is negative, no payment will be made for the Interim Calculation.

** b. Final Calculation of Utilization Management Fund:**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of units assumed but not utilized</td>
<td>71.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiplied by amount for each unit (as cited in MSA)</td>
<td>$675.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Utilization Management Fund earned</td>
<td>$47,925.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>less Interim Amount paid</td>
<td>$9,705.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>less monthly advance or other payments, (if applicable)</td>
<td>$582.12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final Utilization Management Fund earned and paid to the IPA</td>
<td>$37,637.29</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** Check Medical Service Agreement for that time period for correct amount per unit.
Calculation of Target Units

a. The target number of units for each IPA is calculated based on enrollment figures. The IPA’s target units for each type of Member can be found in the Medical Service Agreement. The enrollment figures for the first six months of the Anniversary Year are used for the Interim Payment. The enrollment figures for all twelve months of the Anniversary Year are used for the Final Payment.

b. The number of members in each category is totaled for the month. A six or twelve month figure is then calculated - depending on if the Interim or Final UM Fund Calculation is being done. These totals are also known as “member months”.

c. The six or twelve-month total is then divided by 12 to arrive at an annualized member count. This figure is also known as “member years”.

d. The annualized member count in each category is then multiplied by the target factor stated in the Medical Service Agreement. All categories are added together to arrive at the total number of target units for the IPA. This total is the number of units expected to be utilized by the IPA’s HMO members during the period covered by the calculation.

Calculation of the Actual Units Utilized

a. Hospital: consists of all group-approved inpatient units, charged as Class I (1.00 Unit), Class II (1.5 Unit), Class III (2.00) or Class IV (3.00) in a contracting hospital. If inpatient days are incurred in a non-contracting hospital without prior approval from the HMO, each day will be charged as four (4.0) units.

   If a Member is admitted as an inpatient due to an Emergency Medical Condition to a hospital within a 30-mile radius of the IPA; each day will be charged to the Utilization Management Fund. If the hospital is out of area (more than 30 miles from the IPA) no units will be charged.

b. Extended Care Facility Days: Each day of confinement in a contracting facility will count as one-half (0.5) unit. Each day of confinement in a non-contracting facility will count as one and one-half (1.5) units, if prior approval for use of the non-contracting provider was not obtained from the HMO.
Calculation of the Actual Units Utilized (cont.)

c. Home Health Care Visits: Each home visit will count as one-third (0.33) unit if a contracted facility is used. If prior approval was not obtained from the HMO for group-approved services provided by a non-contracting facility, the IPA shall be responsible for payment of all claims submitted by such non-contracting entity.

d. Hospice Care: The number of units charged will be according to the type of facility in which the care is rendered.

e. Day/Night Psychiatric Care: Each day of confinement will count as one quarter (0.25) unit in a contracting facility.

f. Outpatient Surgery: Utilization of Hospital-based ambulatory surgery or free-standing ambulatory surgery centers will be charged from Class I (1 unit) to Class III (3.00 units) depending on the facility used. If a non-contracted provider is used, four (4) units will be charged.

Certain medical procedures performed in an outpatient or free-standing facility, which could have been performed in a physician’s office, will be charged an additional 0.50 unit, in addition to the regular unit charge.

Appendix B (of the Medical Service Agreement) contains a list of CPT codes for procedures which are expected to be performed in the provider office setting. When a claim contains surgical codes which are all from this list, and the procedure(s) were performed in a surgicenter, hospital outpatient department, or GI lab, rather than a provider office, an additional 0.5 units will be charged to the UM Fund in the annual UM Fund reconciliation. (This is in addition to the units normally charged for any surgical procedure in an outpatient facility.)

An Exception Request process is available, however, to waive this charge for a given claim, when mitigating clinical circumstances exist.

Automatic Exceptions (no form needed)

BCBSIL will review claim data and make certain automatic exceptions. The following exceptions are automatic, and do not require a written exception request from the IPA:

- Inpatient services
- Emergency Room services
- 23-hour Observation services
- Service in question is performed in conjunction with a non-office surgical procedure (not on Appendix B), on the same claim
Calculation of the Actual Units Utilized (cont.)

All Other Exceptions - faxed form required – (Note: form is located at end of this section)

If the only surgical CPT codes on the claim are on the Appendix B list, and none of the above circumstances apply, the IPA must fax a completed Exception Request form to be granted an exception. The IPA must attach a copy of the physician’s claim and any supporting information. A copy of the facility claim, if available, should be included. This exception request is a retrospective process, after the date of service but at least 90-days prior to the final UM Fund calculation.

Please complete the identifying information at the top of the form.

Several types of situation (children under age 14, use of laser for skin lesions, fluoroscopy used) do not require a narrative explanation. In the case of one of these, check the appropriate box, sign the form and fax it as directed.

All other situations will need a written explanation of the reason the service could not be performed in an office setting, including the type of anesthesia that was used.

Please be aware of the following examples of explanations which will not generally be accepted:

- “The surgeon felt it was necessary.” [For what reason?]
- “The office is not equipped to perform the procedure.” [The Appendix B list of CPT codes was based on the fact that the majority of surgeons perform them in the office setting.]
- “A procedure in this location is at high risk for bleeding or infection.” [If there is something unique about the location (i.e., a deep lesion in the axilla), please specify.]

Once a decision has been made, the HMO will fax a copy of the completed form back to the IPA at the number specified on the form.

The IPA may not challenge the 0.50 chargeback if there is no approved UM Fund Exception on file.

g. Hospital Observation: Group approved all hours will count as one half (0.50) unit

Additional information regarding units charged for special circumstances can be found in the Medical Service Agreement.
Calculation of the Actual Units Utilized (cont.)

Calculation of Utilization Management Fund Amount Due to the IPA

a. The actual units are then subtracted from the target units.

b. The difference, if positive, is then multiplied by the amount cited in the Medical Service Agreement for each assumed but unutilized unit.
Office-Based Surgery (Appendix B) - Exception Request to the Utilization Management Fund Form

A written notice from IPA to waive a Utilization Management Fund assessment for a particular surgical procedure on the Appendix B list. This is a retrospective process to address UM fund charges – Do not delay care. Please fax completed form to: Augie DeLisa RN (312-228-9060). Attach physician claim form and any supporting information.

IPA Name: _____________________________ IPA #: _____________________________

IPA Contact Name: _____________________________ Fax: _____________________________

E-mail: _____________________________ Phone: _____________________________

Subscriber Group & ID: _____________________________

Subscriber’s Name: _____________________________

Patient’s Name: _____________________________ Date of birth: _____________________________

Date(s) of Service: _____________________________

Place of Service: _____________________________

☐ Surgicenter ☐ Other

☐ Hosp Outpatient

CPT Code(s): _____________________________

Exception Requests that do not require written explanation or claim form. (Check any that apply and sign below):

☐ Child under age 14 ☐ Fluoroscopy used in procedure

☐ Laser destruction of skin lesion

All other Exception Requests DO need a written explanation. (Please explain in the space below and/or on attachment):

Specify anesthesia: ☐ Local ☐ Regional ☐ Other _____________________________

☐ General ☐ Conscious sedation

Please explain why this procedure had to be performed in a non-office setting.

Also, if anesthesia other than local was needed, please explain why this was the case.

Signature of Requestor: _____________________________ Date of Request: _____________________________

For BCBSIL use only:

BCBSIL decision: _____________________________ Reason: _____________________________

BCBSIL signature: _____________________________ Date: _____________________________

OFFICE-BASED SURGERY (APPENDIX B)

EXCEPTION REQUEST TO THE UTILIZATION MANAGEMENT FUND
Payment of Utilization Management Fund

a. Monthly Advance

On or before the 10th day of each month, the HMO will make an advance payment to the IPA at the rate of 3% of the IPA's previous year's Utilization Management Fund Amount. This is an optional provision. Discussion should occur with your Provider Network Consultant. A written request needs to be submitted to the HMO; an Amendment to the Medical Service Agreement will need to be executed to begin/continue this advance payment.

b. Interim Payment

The interim payment is due to the IPA 190 days following the end of the sixth month of the Anniversary Year. This will be one-half of the Utilization Management Fund amounts earned in that period, minus any advance payments paid to the IPA.

c. Final Payment

The final payment will be paid to the IPA 190 days following the end of the Anniversary Year. If the amount due is positive, the HMO will pay the IPA the earned amount minus any interim payment and advance payments. If the amount due is negative, any unearned and previously paid interim or advance payments must be paid to the HMO by the IPA within 30 days of the HMO informing the IPA of the amount due.

Example:

At the time the interim payment is due, the HMO calculates a Utilization Management Fund earned amount of $10,000 for the IPA. The HMO pays the IPA $5,000 (one-half the calculated amount). No advance monthly payments were paid because no Utilization Management Fund amount was earned the previous year.

At the time of the final payment, the HMO calculates an earned amount of $15,000 for the IPA. Since an interim payment of $5,000 has already been paid, the HMO will pay the IPA the difference between the final payment amount and the interim payment, or $10,000.

d. Upon Termination

In cases where the Medical Service Agreement is terminated, one-half of the Utilization Management Fund will be paid 175 days following the date of termination. This is called the Preliminary Final UM Fund Calculation. A second calculation (called the Final Final) will be made 395 days after the date of termination. The reason for the second calculation is to include any units which were not processed and paid during the initial calculation. Any amount owed to the IPA will be paid 30 days following this Final Final Calculation. If an overpayment has been made to the IPA, the IPA will pay the HMO within 30 days of notification of the amount overpaid.
IPA Challenges to the Utilization Management Fund

a. Monthly Paid Claims Report

To assist the IPA in tracking the actual days that will be charged against the Utilization Management Fund, the HMO provides a monthly report of paid claims. This report lists all claims paid during the month regardless of incurred (admission) date.

This report will show the member's name, date of service, provider, amounts charged and paid, and the units that may be charged to the Utilization Management Fund. It will be sent one month following the close of the month being reported. The IPA should check this list carefully to assure that all claims listed are correct and should be charged to the Utilization Management Fund. Any discrepancies found on these reports should be noted by the IPA.

The IPA cannot challenge any claim listed on the monthly Paid Claims report. A challenge can only be done on the Interim and Final Claim Summary Report that will accompany the Interim and Final Calculation of the Utilization Management Fund.

b. Interim and Final Claim Summary Report

This report documents all incurred and paid claims for the IPA's Anniversary Year. An example page and a Code key for reading this report can be found in this section of the manual. If an IPA finds a discrepancy in one of these reports, a challenge can be made to the HMO.

Refer to the HMO Policy and Procedure Section of this manual for information on how to submit a challenge to the HMO.
**Code Key for the Utilization Management Fund Detail Report**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI</td>
<td>Initial of Subscriber's first name</td>
</tr>
<tr>
<td>SSN</td>
<td>Social Security Number of Subscriber</td>
</tr>
<tr>
<td>PR</td>
<td>Indicates relationship of patient to Subscriber</td>
</tr>
<tr>
<td></td>
<td>EM - Employee SP - Spouse</td>
</tr>
<tr>
<td></td>
<td>MC - Male child FC - Female child</td>
</tr>
<tr>
<td>PROVIDER</td>
<td>Identification number for health care provider</td>
</tr>
<tr>
<td>GROUP</td>
<td>Employer Group Number</td>
</tr>
<tr>
<td>SERVICE DATE</td>
<td>Date service incurred</td>
</tr>
<tr>
<td>COR</td>
<td>Condition of Reimbursement (identifies why claim was paid)</td>
</tr>
</tbody>
</table>

(GA means Group Approved; NGA means Non-Group Approved)

- COR 1: Inpatient GA Medical
- COR 2: Inpatient NGA (Excluding Accident)
- COR 3: Outpatient Group Approved Surgery
- COR 4: Extended Care Facility (GA or NGA)
- COR 5: Home Health Care (GA or NGA)
- COR 6: Catastrophic (GA or NGA)
- COR 7: Inpatient GA Mental Health/Chemical Dependency
- COR A: Inpatient GA Surgery
- COR D: Inpatient NGA Mental Health/Chemical Dependency
- COR E: Accident
- COR L: Pre-Admission Testing
- COR M: GA Obstetric
- COR O: Other (DME, Professional Charges, Default Category)
- COR P: Day/Night Psych or Chemical Dependency
**Code Key for the Utilization Management Fund Detail Report (cont.)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLAG</td>
<td>Identifies unusual claims payment</td>
</tr>
<tr>
<td>FLAG B</td>
<td>Newborn Baby’s claim</td>
</tr>
<tr>
<td>FLAG C</td>
<td>Chemical Dependency</td>
</tr>
<tr>
<td>FLAG E</td>
<td>Life Threatening Emergency</td>
</tr>
<tr>
<td>FLAG L</td>
<td>GA &quot;scopy” procedures (outpatient surgery with revenue codes 314,321 or 750</td>
</tr>
<tr>
<td>FLAG Q</td>
<td>GA outpatient claims with service procedure code = OBC and claim procedure code not 999</td>
</tr>
<tr>
<td>FLAG R</td>
<td>GA Observation room charges with service procedure codes = 760,762,769 or OBC with claim procedure code 999</td>
</tr>
<tr>
<td>FLAG S</td>
<td>GA outpatient, maternity or emergency surgery claims, including service procedure codes = 360,370,490,OR, or 481</td>
</tr>
<tr>
<td>FLAG T</td>
<td>Outpatient services</td>
</tr>
</tbody>
</table>

**TOTAL DAYS**
Number of days actually paid

**FACTORED NET DAYS CHARGED**
Number of days charged to incentive

**AMOUNT CHARGED**
Amount charged on claim

**AMOUNT PAID**
Amount of claims paid

**AMOUNT NOT PAID**
Amount of claims not paid
Reinsurance

Refer to the Claims Processing Section for information on reinsurance.

Non-Capitated Services (Catastrophic) Claims

Refer to the Claims Processing Section for information on non-capitated services (catastrophic) claims.
Quality Improvement Fund

The total additional compensation that can be earned under the Quality Improvement Fund is Sixteen and one-half percent (16.5%) of Capitation Fees plus the Special HEDIS Payments, as follows:

1. Semi-Annual Payments

The HMO shall pay the IPA a percentage of the Capitation Fees paid, as described below, for compliance with the stated requirements, as determined by the HMO and subject to execution of this Agreement:

Two percent (2.0%) of Capitation Fees will be paid for compliance with all of the following:

a) An HMO Administered Complaint ratio below 1.0 per 1,000 Members per year.

b) Maintenance and monthly submission, within 10 days after the end of the month, of the following documents that must meet HMO requirements and be submitted in a format acceptable to the HMO:

   1) Denial logs; for IPAs that do not have any denials to report they must submit a copy of their inquiry policy describing their process and provide a one month log on an annual basis;
   2) Denial files within 10 calendar days of request once sample files are chosen;
   3) Referral log upon request;

c) Submission of a complete roster of contracted providers and the current written service agreement which the IPA is required to have executed with all providers of professional and ancillary services, as referenced in Section I.C.1.h. including the Hospital based specialists listed in Section I.C.1.a.2.m) Anesthesia, ER, Pathology, Radiology, and Neonatology, if applicable.

d) Submission of the IPA financial statements per the requirements referenced in Section I.C.9.d.

e) Participation in at least 50% of all regularly scheduled Managed Care Roundtable meetings by the IPA Medical Director or an IPA Physician.

f) Submission of complete (as verified by HMO analysis) claim and encounter data per the requirements referenced in Section I.C.9.b.

   The HMO shall calculate compliance rates for semi-annual payments at the end of two periods: January 1, 2008, through June 30, 2008; and July 1, 2008, through December 31, 2008. The HMO shall pay the IPA within 90 days of the end of each period. Compliance shall be defined as meeting the above criteria each quarter, or as otherwise required.

g) Upon termination of this Agreement, the HMO may retain an amount equivalent to outstanding bills of the IPA.
Quality Improvement Fund (cont.)

2. Special HEDIS Payments

Additional compensation for submission of data supplied in 2008 for reporting 2007 HEDIS results will be paid for compliance with the following, as determined by the HMO and subject to execution of this Agreement:

Payment will be made in accordance with the criteria sent with the HEDIS Data Request Forms. In 2008, the Special HEDIS Payment will be made only for unique members for whom the MG/IPA supplies data in response to a specific written HEDIS data request form sent to the MG/IPA. HEDIS data must be submitted by the due date, which will be no sooner than 21 days after the date of the request, and must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator.

a) $1,100 will be paid to the IPA for submission of documentation of care that fulfills criteria for inclusion in the HEDIS numerator was provided to a sampled Member.

b) $1,100 will be paid to the IPA for submission of documentation that fulfills criteria to exclude a Member from the HEDIS sample.

c) $75 will be paid to the IPA for submission of requested information about the sampled Member that does not fulfill criteria for inclusion in the HEDIS numerator. Documentation must appear to be complete and accurate.

d) The Special HEDIS Payments will be made within 90 days after June 30, 2008.

3. Annual Payments

The HMO shall pay the IPA a percentage of Capitation Fees paid, as described below, for compliance with the stated requirements, as determined by the HMO and subject to execution of this Agreement:

a) The HMO shall pay the IPA:

1) One and a half percent (1.5%) of Capitation Fees for acceptable performance of utilization review activities and on-going adherence to a written Utilization Management Plan, as demonstrated through the annual HMO on-site Utilization Management audit, as described in the 2008 HMOs of BCBSIL Utilization Management Plan. For purposes of this provision, an acceptable level of performance will be a compliance rating of at least 90%.

2) One-half percent (0.5%) of Capitation Fees for submission of a revised Utilization Management Plan by February 15, 2008 and with final approval of the Plan as meeting HMO requirements set forth in the Utilization Management Plan of the HMOs of BCBSIL by April 30, 2007. Behavioral Health UM Plan (if delegated) must be submitted with the revised UM Plan and be reviewed and approved by the delegating IPA prior to submission.

3) One-half percent (0.5%) of Capitation Fees if overall IPA Member satisfaction rating is > 83% AND member satisfaction with the referral process for specialists is > 83% based on the 2008 MG/IPA Member Satisfaction survey.

4) One-half percent (0.5%) of Capitation Fees if the cumulative audit score for quarterly denial file audits is at least 90%. Denials that must be included on the denial/appeal log are: medical necessity (including out of network or re-directed referrals) and benefit determinations resulting in a denial. The audit will be based on denial files selected by HMO. If denial files are not available for review, due to failure to submit a denial log or due to there being no denials, compliance cannot be determined and the IPA will not be eligible for this one-half percent (0.5%) of the QI Fund.

b) The HMO shall pay the IPA a possible total of eleven (11.00%) of Capitation Fees for participation in QI activities, with payment based upon performance as specified below:
### Quality Improvement Fund (cont.)

<table>
<thead>
<tr>
<th>QI Activity</th>
<th>% of Capitation available</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Influenza Vaccination QI Fund Project</strong></td>
<td></td>
</tr>
<tr>
<td>Participation in the HMO influenza vaccination project, with submission of documentation for measurement of the 2006-07 IPA influenza vaccination rate (for Members who are 65 years of age or older or who have diabetes, CAD or asthma) by the specified date. Payment will be made in accordance with the criteria sent with the project mailing. Influenza vaccination data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. Payment will be made as follows:</td>
<td>Up to 0.75%</td>
</tr>
<tr>
<td>• IPA Influenza vaccination rate &gt; 60%: 0.75% capitation</td>
<td></td>
</tr>
<tr>
<td>• IPA Influenza vaccination rate &gt; 50% but &lt; 60%: 0.50% of capitation.</td>
<td></td>
</tr>
<tr>
<td>• IPA Influenza vaccination rate &gt; 40% but &lt; 50%: 0.25% of capitation.</td>
<td></td>
</tr>
<tr>
<td><strong>Cervical Cancer Screening QI Fund Project</strong></td>
<td></td>
</tr>
<tr>
<td>A payment of 0.75% of Capitation Fees will be made to IPAs for cervical cancer screening outreach efforts. To earn the payment, IPAs must provide documentation that between 1/1/2008 and 9/30/2008:</td>
<td>Up to 0.75%</td>
</tr>
<tr>
<td>• a list was obtained from the HMO reporting vendor’s website of members who, based upon claim and encounter data, are due for cervical cancer screening, and</td>
<td></td>
</tr>
<tr>
<td>• for outreach purposes, the IPA provided PCPs and WPHCPs with a list of their members due for cervical cancer screening, and</td>
<td></td>
</tr>
<tr>
<td>• there has been physician outreach to encourage cervical cancer screening for identified members with no claim or encounter data for current cervical cancer screening. (Members for whom there is other evidence of screening, such as medical record or registry documentation, may be excluded from outreach.)</td>
<td></td>
</tr>
<tr>
<td><strong>Asthma QI Fund Project</strong></td>
<td></td>
</tr>
<tr>
<td>Payment for the Asthma QI Fund Project requires submission of written asthma action plans that have been provided and reviewed with identified members between 12/1/2007 and 11/30/2008 AND submission of documentation of assessment of asthma control between 12/1/2007 and 11/30/2008. Payment will be made in accordance with the criteria sent with the project mailing. Data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator.</td>
<td>Up to 1.00%</td>
</tr>
<tr>
<td>• If written asthma action plans and evidence of assessment of asthma control are provided for &gt; 75% of identified Members, 1.00% of Capitation Fees will be paid.</td>
<td></td>
</tr>
<tr>
<td>• If written asthma action plans and evidence of assessment of asthma control are provided for &gt; 65% but &lt; 75% of identified Members, 0.75% of Capitation Fees will be paid.</td>
<td></td>
</tr>
<tr>
<td>• If written asthma action plans and evidence of assessment of asthma control are provided for &gt; 55% but &lt; 65% of identified Members, 0.50% of Capitation Fees will be paid.</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes QI Fund Project</strong></td>
<td></td>
</tr>
<tr>
<td>Payment for the Diabetes QI Fund Project requires submission of documentation from a diabetic flowsheet (or electronic system) that tracks, at a minimum, HbA1c, eye exam, LDL cholesterol, blood pressure and screening for nephropathy, and is organized to both trend results over time and remind the practitioner when a service is due. Payment will be made in accordance with the criteria sent with the project mailing. Diabetes data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator.</td>
<td>Up to 1.75%</td>
</tr>
<tr>
<td>• HbA1c Control</td>
<td></td>
</tr>
<tr>
<td>• 0.25% of Capitation fees will be paid if the diabetic flowsheet confirms that an HbA1c performed in 2008 was &lt; 9.0% for at least 75% of the identified Members.</td>
<td></td>
</tr>
<tr>
<td>• Eye Exam</td>
<td></td>
</tr>
<tr>
<td>• 0.25% of Capitation Fees will be paid if diabetic flowsheet documentation of a dilated retinal eye exam by an eye care professional in 2008 is provided for &gt; 60% of identified Members. If the flowsheet includes the date but does not document the results of the exam, supporting documentation of the results must be submitted. LDL-C</td>
<td></td>
</tr>
</tbody>
</table>
Quality Improvement Fund (cont.)

- 0.25% of Capitation Fees will be paid if diabetic flowsheet documentation of LDL-C confirms that the result of a test performed in 2008 was <100 mg/dl for ≥45% of identified Members.

**Medical Attention for Nephropathy**
- 0.25% of Capitation fees will be paid if the diabetic flowsheet confirms that at least 80% of the identified Members received medical attention for nephropathy in 2008, documented by a microalbuminuria test, a macroalbuminuria test with positive results, a visit to a nephrologist, or ACE Inhibitor/ARB treatment.

**Blood Pressure Control**
- 0.25% of Capitation fees will be paid if the diabetic flowsheet confirms that a blood pressure reading in 2008 was <140/90 for at least 60% of diabetics.

**Overall Diabetes Preventive Care**
An additional 0.25% of Capitation fees will be paid if the submitted documentation confirms that at least 20% of identified diabetics met ALL of the following criteria:
- An HbA1c test in 2008 was <9.0%.
- An LDL in 2008 was <100 mg/dl.
- The Member received medical attention for nephropathy in 2008.
- The Member had a dilated retinal eye exam by an eye care professional in 2008.

Screening for Depression: Payment will be made for documentation that Members included in the Diabetes QI Fund Project were screened for Depression in accordance with the Screening for Depression guideline:
- 0.25% of capitation fees will be paid if documentation (on the flowsheet or from another portion of the medical record) that the member has been screened for depression in accordance with the BCBSIL Screening for Depression Guideline is provided for at least 60% of identified members. (Note: Members with documentation of a diagnosis of depression since January 1, 2006 will be excluded.)

**Follow-Up After Hospitalization for Mental Illness QI Fund Project**
Payment for the HMO Follow-Up After Hospitalization for Mental Illness project requires submission of documentation for measurement of the October 1, 2007 - September 30, 2008 IPA Follow-Up After Hospitalization for Mental Illness rate by the specified dates. Payment will be made in accordance with the criteria sent with the project mailing. Mental Health Follow-Up data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. Payment will be made as follows:
- IPA Follow-Up After Hospitalization for Mental Illness 7 day rate ≥70%: 0.50% of capitation.
- IPA Follow-Up After Hospitalization for Mental Illness 7 day rate >60% but <70%: 0.25% of capitation.

**Childhood Immunization QI Fund Project**
Payment for the HMO childhood immunization project requires submission by the specified dates of documentation for measurement of the 2008 IPA Childhood Immunization Combination 3 rate (for Members who turn 2 years of age between January 1, 2008 and December 31, 2008). Payment will be made in accordance with the criteria sent with the project mailing. Childhood immunization data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. Payment will be made as follows:
- IPA childhood immunization Combination 3 rate ≥70%: 0.75% of capitation.
- IPA childhood immunization Combination 3 rate >65% but <70%: 0.50% of capitation.
- IPA childhood immunization Combination 3 rate >60% but <65%: 0.25% of capitation.

An additional 0.25% of Capitation Fees will be paid if documentation is provided that during at least three of the quarters in 2008:
- a list was obtained from the HMO reporting vendor’s website of members who, based upon claim and encounter data, are in need of immunization(s), and for outreach purposes, the IPA provided PCPs with a list of their members in need of immunization(s).
Management of Members with Cardiovascular Conditions QI Fund Project

Payment for the HMO Management of Members with Cardiovascular Conditions Project requires submission of documentation regarding control of cardiovascular risk factors. This Population-based project will include members with ischemic vascular disease as well as those with a hospitalization for acute MI, CABG or PTCA.

Payment will be made in accordance with the criteria sent with the project mailing. Data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator.

The following risk factors will be evaluated for identified members:

LDL-C Control:
- If documentation of an LDL-C performed between 10/1/07 and 9/30/08 confirms that the result was <100 mg/dl for ≥55% of identified Members, 0.25% of Capitation Fees will be paid.

Blood Pressure Control:
- If documentation confirms that a blood pressure measurement between 10/1/07 and 9/30/08 was <140/90 for >60% of identified Members, 0.25% of Capitation Fees will be paid.

Advice to Quit Smoking:
- If documentation is provided that >75% of identified members who are smokers have been advised to quit smoking between 10/1/07 and 9/30/08, 0.25% of Capitation will be paid. (Members whose smoking status has not been assessed are assumed to be smokers.)

Breast Cancer Screening QI Fund Project

Payment for the HMO breast cancer screening project requires submission of documentation for measurement of the 2006-07 IPA breast cancer screening rate for the population of female members age 42-69 by the specified date. Payment will be made in accordance with the criteria sent with the project mailing. Breast cancer screening data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. This is a population-based project, utilizing only administrative data. Payment will be made as follows:

- IPA Mammography rate >70%: 0.75% of Capitation Fees.
- IPA Mammography rate >60% but <70%: 0.50% of Capitation Fees.
- IPA Mammography rate >50% but <60%: 0.25% of Capitation Fees.

An additional payment of 0.25% of Capitation Fees will be paid to IPAs for breast cancer screening outreach efforts. To earn the payment, IPAs must provide documentation that between 1/1/2008 and 6/30/2008:
- a list was obtained from the HMO reporting vendor’s website of members who, based on claim and encounter data, are due for breast cancer screening and for outreach purposes, the IPA provided PCPs and WPHCPs with a list of their members due for breast cancer screening.

Colorectal Cancer Screening QI Fund Project

Payment for the HMO colorectal cancer screening project requires submission of documentation for measurement of the IPA 2007 colorectal cancer screening rate for a random sample of members age 51-80 by the specified date. Payment will be made in accordance with the criteria sent with the project mailing. Colorectal cancer screening data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. Payment will be made as follows:

- IPA Colorectal cancer screening rate ≥50%: 0.50% of Capitation Fees.
- IPA Colorectal cancer screening rate >40% but <50%: 0.25% of Capitation Fees.

IPAs must have a 2007 colorectal cancer screening rate of >50% to earn a Blue Star.

An additional payment of 0.75% of Capitation Fees will be paid to IPAs for colorectal cancer screening outreach efforts. To earn the payment, IPAs must provide documentation that between 1/1/2008 and 9/30/2008:
- a list was obtained from the HMO reporting vendor’s website of members for who, based upon claim and encounter are due for colorectal cancer screening, and
Quality Improvement Fund (cont.)

- for outreach purposes, the IPA provided PCPs and WPHCPs with a list of their members due for colorectal cancer screening, and
- there has been physician outreach to encourage colorectal cancer screening for identified members with no claim or encounter data for current colorectal cancer screening. (Members for whom there is other evidence of screening, such as medical record or registry documentation, may be excluded from outreach.)

### Controlling High Blood Pressure

Payment for the HMO controlling high blood pressure project requires submission of documentation by the specified date for measurement of the IPA blood pressure control rate for members age 18-85. The blood pressure is defined as being in control if a pressure reading between 7/1/07 and 6/30/08 was <140/90. IPAs that have not submitted complete encounter data for 2007 to McKesson by April 10, 2008 will not be eligible for this payment. (This project includes Members identified from outpatient encounters and excludes Members in the 2008 diabetes or cardiovascular conditions QI Fund projects.)

Payment will be made in accordance with the criteria sent with the project mailing. Controlling high blood pressure data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. Payment will be made as follows:

- IPA Blood Pressure Control rate >68%: 0.75% of Capitation Fees.
- IPA Blood Pressure Control rate >60% but <68%: 0.50% of Capitation Fees.
- IPA Blood Pressure Control rate >50% but <60%: 0.25% of Capitation Fees.

### Wellness and Prevention Project

Payment for the HMO Wellness and Prevention project requires submission of documentation by the specified date for a random sample of IPA Members age 2-64 for whom encounter data confirmed a PCP visit in 2007. Data to be collected includes medical record documentation of BMI, assessment of and/or recommendations regarding physical activity and, for Members age >18, smoking status and, for smokers, advice to quit smoking. The IPA must submit complete 2007 encounter data by April 10, 2008 to be eligible for participation in this project.

Payment will be made in accordance with the criteria sent with the project mailing. Wellness and prevention project data submissions must be accompanied by an attestation of accuracy and completeness signed by the IPA Medical Director or Administrator. For 2008, payment will be based upon submission of data, NOT on results. Payment will be made as follows:

- Submission of a Data Request Form and supporting documentation for at least 90% of IPA sample: 0.50% of Capitation Fees.

### Patient Safety Physician Education Project

Payment for the Patient Safety Physician Education project requires submission of documentation necessary to confirm IPA Physician completion of the American Board of Medical Specialties Patient Safety Improvement Program on or before 11/30/2008.

- IPA Physician completion rate >80%: 1.0% of Capitation
- IPA Physician completion rate >60% but <80%: 0.75% of Capitation
- IPA Physician completion rate >40% but <60%: 0.50% of Capitation
- IPA Physician completion rate >25% but <40%: 0.25% of Capitation

### Site Survey Compliance

c) The HMO shall pay the IPA for quality site survey compliance scores of 90% for both physical site reviews and medical record content review, as determined by the HMO, which includes: accessibility, facility inspection, preventive care review, medical record quality of care and medical record entry for a possible total of one-half percent (0.5%) of Capitation Fees.

Site visit compliance rates for the year ending December 31, 2008 will be based on the medical record review of all PCPs within the IPA for whom a review was completed in 2007. Subsequent reviews will occur biennially from the date of the last review.
Prescription Drug Fund

The Prescription Drug Fund is determined annually and subject to the execution of the Medical Service Agreement. It is based on the relative performance of the IPA in judiciously managing the use of the prescription drug benefit.

The HMO will report prescription drug usage and Formulary usage to the IPA quarterly. This report will be physician specific for the top 25 prescribers for the IPA.

Appropriate management of prescription drug costs will be measured based on the generic drug utilization of the IPA by all providers. The HMO will pay the IPA an additional ten percent (10.0%) of Capitation Fees if generic drugs account for sixty-five percent (65.00%) or more of total prescriptions for Members enrolled with the IPA. The HMO will pay the IPA eight percent (8.0%) of Capitation Fees if generic drugs account for sixty-one to sixty-four point nine nine percent (61.00-64.99%) of the total prescriptions for Members enrolled with the IPA. The HMO will pay the IPA six percent (6.0%) of Capitation Fees if generic drugs account for fifty-eight to sixty point nine-nine percent (58.00-60.99%) of the total prescriptions for Members enrolled with the IPA. The HMO will pay the IPA four percent (4.0 %) of Capitation Fees if generic drugs account for fifty-four to fifty-seven point nine-nine percent (54.00-57.99%) of the total prescriptions for Members enrolled with the IPA and two percent (2.0%) of Capitation Fees if generic drugs account for fifty one to fifty three point nine-nine percent (51.00% - 53.99%) of the total prescriptions for Members enrolled with the IPA.
Co-Payments

1. Benefits for all covered services rendered by a physician on an outpatient basis (except for Maternity Services) can be subject to a co-payment per visit. These amounts vary by Benefit plan. Refer to the most current Benefit Matrix located at www.bcbsil.com for this information.

   Effective January 1, 2007, an outpatient office based service rendered by an Advanced Practice Nurse (includes Certified Nurse Midwife, Certified Nurse Practitioner, Certified Registered Nurse Anesthetist and Certified Clinical Nurse Specialist) or a Physician Assistant can also be subject to a co-payment per visit.

   Services rendered by any other health professional are not subject to the co-payment. Examples of these services would include (but are not limited to) lab draws or medication injections provided by a nurse or technician. The only exception to this is when the member has an outpatient rehabilitative co-payment (see related note below).

2. When Medicare is primary with the HMO being secondary: The IPA, at their discretion, may charge the member an office visit co-payment when applicable, (for those members whose policies include an office visit co-payment).

3. When a member (with a co-pay) also has co-coverage as a dependent through a spouse’s HMO insurance (who has a lesser or no co-pay); the lesser co-pay should be collected. Eligibility should be verified for both benefit plans.

4. For visits for the purpose of pharmacological management for mental health medications, the PCP/Specialist office visit copay (dependent upon who is providing the service) should be collected. The outpatient mental health co-pay would not be applicable. Refer to Scope of Benefits Section for further information.

5. Some Benefit Plans have a two or three tier co-payment structure. The first is for a Primary Care Physician (PCP) office visit. PCPs include Family Practice, General Practice, Internal Medicine, Pediatrics and Obstetrics-Gynecology. The second tier is for a Specialist Physician office visit. The third tier is for a wellness office visit. A wellness visit is defined by the use of the Preventive Medicine Services codes (99381-99249) that are used to report routine evaluation and management of adults and children in the absence of patient complaints or counseling and/or risk factor reduction intervention services to healthy individuals.

6. Psychiatric care rendered under the supervision of a physician by a psychiatric social worker or other mental health professional is subject to a co-pay. Due to the Serious Mental Illness Legislation; effective with the employer group renewal after January 1, 2007: A specialist co-pay will apply for all serious mental illness claims. The mental health co-pay, as indicated on the benefit matrix, will apply for all non-serious mental health services. A rehab co-pay (if applicable) will apply for speech therapy for treatment of pervasive developmental disorder claims.

7. There are some benefit plans that include an outpatient rehabilitative therapy co-payment. In determining the co-payment the following should be considered: A single date of service by the same provider will be counted as one treatment/visit for the collection of a co-payment. In other words, if a member is sent for PT but at the visit the member is also provided ST, there is only one visit, regardless of the fact that more than one modality of treatment was provided.

8. Routine eye exam co-payments: If a member has a three tier co-payment structure – a wellness co-payment should be collected. If a member has a two tier co-payment structure, a PCP co-payment should be collected.