Exhibit II.F

"Mental Health & Substance Abuse Program for the Empire Plan, Excelsior Plan, and Student Employee Health Plan RFP"
Reports Due Dates

Report Name	Brief Description	Frequency	Due Date(s)
Contract Management Reports			
Utilization	Quarterly summary of utilization trends for I/P, ALOC, and O/P services, as well as compliance with performance standards.	Quarterly	60 days from the end of the quarter
Performance Guarantees	Quarterly summary of compliance with performance standards.	Quarterly	60 days from the end of the quarter
Annual Report	Annual summary of utilization, performance, and future direction of the program	Annual	March 15th
Financial Management Reports			
Annual Financial Statement	Financial Settlement for the Plan Year just ended	Annually	March 15th
Annual Premium Renewal	Proposal for Forthcoming Plan Year Premium Rates and Retention charges	Annually	September 1st
Quarterly Statement of Experience	Plan Year financial experience through the quarter just ended plus projected financial experience for the entire Plan Year (also includes projected rate development for the forthcoming Plan Year and Qtrly Trend Statistics)	Quarterly	15th day after end of quarter
Monthly Paid Claims by Month of Incurral	Paid claims by core, enhancements, and benefit program	Monthly	15th day after end of month
Quarterly Paid Claims by Type of Service	Paid Claims ($ amt and # of svcs) during the quarter just ended by Type of Sevice; broken out by BP, EE/DEP, Year of Incurral, In/Out Network, Core/Enhancements	Quarterly	15th day after end of quarter
PA Mediprime Claims	Paid Claims ($ amt and # of svcs) per PA during the quarter just ended; broken out by Coverage Type, Year of Incurral, In/Out Network, EE/DEP, Medicare/No Medicare, Core/Enhancements	Quarterly	15th day after end of quarter
Claim Production Report	Summary of claims processed for the month just ended (also aging of claims): paid, declined, deductible not satisfied, other and # outstanding	Monthly	15th day after end of month
Coordination of Benefits Report	Medicare and Other COB Savings for the month just ended (and all prior current calendar year months)	Monthly	15th day after end of month
Copayment Savings Report	Outpatient Participating Provider Paid Claim Dollars per Month and Related Per Month Co-Payment Dollars	Monthly	15th day after end of month
In-Network Triangle Report	Total Paid In-Network claims per month of incurral; separate triangles for Empire, Excelsior and SEHP.	Monthly	15th day after end of month
Out-Network Triangle Report	Total Paid Out-of-Network claims per month of incurral; separate triangles for Empire, Excelsior and SEHP.	Monthly	15th day after end of month
Claims Paid by Agency	Enrollee and Dependent Paid Claims per agency for the Plan Year just ended	Annually	January 31st
Audit Reports			
Claim Data	Individual claim transactions	Monthly	

Empire Plan Mental Health & Substance Abuse

Financial Reports Specifications and Due Dates

REQUIRED DATA FIELDS FOR MHSA MIS REPORTS

	Report		Description	Field Name
(a)	IA. Monthly Paid Claims by Month of Incurral	1	Month Paid	MONTH PAID
		2	Year Paid	YEAR PAID
		3	Month Incurred	MONTH INC
		4	Year Incurred	YEAR INC
		5	Benefit Program Code	PROGRAM/BPI
		6	Benefit Type (Core, NY Enhancement or PA Enhancement)	BENEFIT TYPE
		7	Network (In-Network or Non-Network)	NETWORK
		8	Medicare Primary (Yes or No)	MEDICARE
		9	# of Services: Enrollees	EE SERVICES
		10	$ Amount Paid: Enrollees	EE PAID
		11	# of Services: Dependents	DEP SERVICES
		12	$ Amount Paid: Dependents	DEP PAID
		13	# of Services: Total	TOTAL SERVICES
		14	$ Amount Paid: Total	TOTAL PAID
(b)	IIA. Quarterly Paid Claims by Type of Service	1	Quarter and Year Paid	QTR PAID
		2	Year Incurred	YEAR INC
		3	Benefit Program Code	PROGRAM/BPI
		4	Benefit Type (Core, NY Enhancement or PA Enhancement)	BENEFIT TYPE
		5	Network (In-Network or Non-Network)	NETWORK
		6	Type of Service & Type for GAUC	TOS
		7	# of Services: Enrollees	EE SERVICES
		8	$ Amount Covered: Enrollees	EE COVERED
		9	$ Amount Paid: Enrollees	EE PAID
		10	# of Services: Dependents	DEP SERVICES
		11	$ Amount Covered: Dependents	DEP COVERED
		12	$ Amount Paid: Dependents	DEP PAID
		13	# of Services: Total	TOTAL SERVICES
		14	$ Amount Covered: Total	TOTAL COVERED
		15	$ Amount Paid: Total	TOTAL PAID
(c)	IB. PA Claims (Medicare/Non Medicare)	1	Quarter and Year Paid	QTR PAID
		2	Year Incurred	YEAR INC
		3	Benefit Type (Core, NY Enhancement or PA Enhancement)	BENEFIT TYPE
		4	Network (In-Network or Non-Network)	NETWORK
		5	Agency Code	AGNCYCD
		6	Coverage (Individual or Family)	COV
		7	Medicare Primary (Yes or No)	MEDICARE
		8	# of Services: Enrollees	EE SERVICES
		9	$ Amount Paid: Enrollees	EE PAID
		10	# of Services: Dependents	DEP SERVICES
		11	$ Amount Paid: Dependents	DEP PAID
		12	# of Services: Total	TOTAL SERVICES
		13	$ Amount Paid: Total	TOTAL PAID
(d)	IVG. Annual Claims & Credits Paid by Agency	1	Year Paid	YEARPD
		2	Year Incurred	YEARINC
		3	Network (In-Network or Non-Network)	NETWORK
		4	Agency Code	AGNCYCD
		5	Enrollee or Dependent Claim	EEDEP
		6	Enrollee Type (Active, Retiree or Other)	EE Type
		7	Number of Claims	CLAIMS
		8	Amount Paid	AMTPD
		9	Name of MHSA Progam Carrier	CARRIER