Exhibit II.F

Empire Plan Prescription Drug Program

SCHEDULE OF PRESCRIPTION DRUG REPORTS

	Report Name	Frequency	Due Date	Type
	MIS REPORTS (ACCESS Format):			
1	Monthly Paid Claims by Month of Incurral	Monthly	30th day after end of month	electronic file
2	Monthly Paid Claims by by Pharmacy and Rx Type	Monthly	30th day after end of month	electronic file
3	Participating Agency (PA) Claims (Medicare/Non Medicare)	Quarterly	30th day after end of quarter	electronic file
4	Claims & Credits Paid by Agency	Annual	Jan. 30th	electronic file

FORMAT: Compatible with Access 2007

TABLE NAME: 1A YYYY

DESCRIPTION: Monthly Summary of Paid Claims by Month of Incurral

Field	Field Name	Format	Description
1	MONTH PAID	Text – 2	Month Paid (MM)
2	YEAR PAID	Text – 4	Year Paid (YYYY)
3	MONTH INC	Text – 2	Month Incurred (MM)
4	YEAR INC	Text – 4	Year Incurred (YYYY)
5	CARRIER	Text – 1	Carrier: 1 = Commercial 2 = EGWP 3 = Wrap 4 = EGWP Foreign Claims 5 = EGWP COB – Dual Empire Cov Only 6 = Total
6	BP	Text – 3	Benefit Program Code
7	PHARMACY TYPE	Text – 1	Pharmacy Type (see table below)
8	EE CLAIMS	N	# of Claims: Enrollees
9	EE PAID	N	$ Amount Paid: Enrollees
10	DEP CLAIMS	N	# of Claims: Dependents
11	DEP PAID	N	$ Amount Paid: Dependents
12	TOTAL CLAIMS	N	# of Claims: Total
13	TOTAL PAID	N	$ Amount Paid: Total
14	REPORT PERIOD	Text – 6	Report Period (MMYYYY)

Pharmacy Type	Category	Description
A	DIRECT	Enrollee Submit/Other
B	PHARMACY	NY Chain Pharmacy
C	PHARMACY	NY Independent Pharmacy
D	PHARMACY	Non NY Retail
E	PHARMACY	Specialty Pharmacy
F	MAIL ORDER	Mail Order

FORMAT: Compatible with Access 2007

TABLE NAME: 2A YYYY

DESCRIPTION: Monthly Summary of Paid Claims by Pharmacy and Drug Type

Field	Field Name	Format	Description
1	MONTH PAID	Text – 2	Year Paid (MM)
2	YEAR PAID	Text – 4	Month Paid (YYYY)
3	CARRIER	Text – 1	Carrier: 1 = Commercial 2 = EGWP 3 = Wrap 4 = EGWP Foreign Claims 5 = EGWP COB – Dual Empire Cov Only 6 = Total
4	TRANS TYPE	Text – 1	Transaction Type (P = Payment, R = Reversal)
5	PHARMACY TYPE	Text – 1	Pharmacy Type (see table below)
6	RX TYPE	Text – 1	Drug type (see table below)
7	TOTAL CLAIMS	N	# of Claims Paid: Total
8	QUANTITY DAYS	N	# of the days supply
9	AWP	N	Average Wholesale Price (AWP) of Rx Dispensed
10	ING COST	N	Allowed Ingredient Cost (after discount)
11	DISP FEES	N	Dispensing Fees
12	LEVEL OF EFFORT	N	Level of Effort
13	TAXES	N	Sales Taxes
14	ANC CHRG	N	$ Ancillary Charge Amount
15	COPAY	N	$ Employee Co-pay Amount
16	AMT PAID	N	$ Amount Paid (by the Plan)
17	REPORT PERIOD	Text – 6	Report Period (MMYYY)

Pharmacy Type	Category	Description
A	DIRECT	Enrollee Submit/Other
B	PHARMACY	NY Chain Pharmacy
C	PHARMACY	NY Independent Pharmacy
D	PHARMACY	Non NY Retail
E	PHARMACY	Specialty Pharmacy
F	MAIL ORDER	Mail Order

Drug Type (RX TYPE)	Desciption
A	Generics Drugs
B	Preferred Brand Drugs
C	Non-Preferred Brand Drugs
D	Compound Drugs
X	Specialty Drugs

FORMAT: Compatible with Access 2007

TABLE NAME: PA MEDICARE YYYY

DESCRIPTION: Quarterly Summary of Participating Agency (PA) Claims Paid by Medicare Eligible Status.

Field	Field Name	Format	Description
1	QTR PAID	Text – 1	Quarter Paid (Q): A = 1st quarter B = 2nd quarter C = 3rd quarter D= 4th quarter
2	YEAR PAID	Text - 4	Year Paid (YYYY)
3	YEAR INC	Text – 2	Year Incurred (YY)
4	CARRIER	Text – 1	Carrier: 1 = Commercial 2 = EGWP 3 = Wrap 4 = EGWP Foreign Claims 5 = EGWP COB – Dual Empire Coverages Only 6 = Total
5	AGENCY CODE	Text – 5	5 Digit Agency Code (Customer ID #)
6	COV	Text – 3	Type of Coverage: Individual Coverage = IND Family Coverage = FAM
7	PHARMACY TYPE	Text – 1	Pharmacy Type (see table below)
8	EE CLAIMS	N	# of Claims: Enrollee
9	EE PAID	N	$ Amount Paid: Enrollee
10	DEP CLAIMS	N	# of Claims: Dependent
11	DEP PAID	N	$ Claims: Dependent
12	TOTAL CLAIMS	N	# of Claims: Total
13	TOTAL PAID	N	$ Amount Paid: Total

Pharmacy Type	**Category**	**Description**
A	DIRECT	Enrollee Submit/Other
B	PHARMACY	NY Chain Pharmacy
C	PHARMACY	NY Independent Pharmacy
D	PHARMACY	Non NY Retail
E	PHARMACY	Specialty Pharmacy
F	MAIL ORDER	Mail Order

FORMAT: Compatible with Access 2007

TABLE NAME: YYYY IVG

DESCRIPTION: Annual Paid Claims by Agency Code

Field	Field Name	Format	Description
1	YEAR PAID	Text – 4	Year Paid (YYYY)
2	AGENCY CODE	Text –5	5 Digit Agency Code (Customer ID#)
3	YEAR INC	Text – 4	Year Incurred (YYYY)
4	MM_PP	Text - 1	Left blank (NOT APPLICABLE)
5	EEDEP	Text – 11	1-Enrollee = Enrollee 2-Dependent = Dependent Child / Spouse / Domestic Partner
6	AGENCY TYPE	Text – 1	As identified by the Benefit Program (BP) Code: P = Participating Agency (P**) N = NYS Agencies and Participating Employers (BP = A**, M**, C**, R**, G**, L**, D** or E**)
7	CLAIMS	N	# of Claims
8	AMT PAID	N	Amount Paid
9	CARRIER	Text – 10	CONSTANT: D-DRUGS