

Proposed Year 2001 Amendments to the Standard Contract for Community Rated Carriers

1. Redate Section 1.7, STATISTICS AND SPECIAL STUDIES, as JAN 2001 and revise paragraph (c) to delete the reference to Appendix C, as follows:

SECTION 1.7 STATISTICS AND SPECIAL STUDIES (JAN 1999 **2001**)

(c) The Carrier shall furnish the routine reports in the required number of copies to the addresses specified in Appendix C, *Contract Administration Data* as instructed by OPM.

2. Redate Section 1.8, NOTICE, as JAN 2001 and revise the clause to delete the reference to Appendix C, as follows:

SECTION 1.8 NOTICE (JAN 1991**2001**)

~~Where the contract requires that notice be given to the other party, such notice shall be given in writing to the address specified in Appendix C, *Contract Administration Data*. Where the contract requires the Carrier/contractor to notify the government, the Carrier shall send written notice to its Contracting Officer, unless otherwise specified.~~

3. Redate Section 1.9, FEHB QUALITY ASSURANCE, as JAN 2001 and reorganize and update the clause to reflect OPM's increased focus on health care quality and reducing medical errors, as follows:

SECTION 1.9 FEHB QUALITY ASSURANCE (JAN 1999 **2001**)

(a) The Carrier shall develop and apply a quality assurance program specifying procedures for assuring

~~contract quality. At a minimum the program must include procedures to address:~~

~~—(1) Accuracy of Payments.~~

~~—(i) Processing Accuracy—the number of FEHB claims processed accurately divided by the total number of FEHB claims processed for the given time period, expressed as a percentage.~~

~~—REQUIRED STANDARD: An average of 95 percent of FEHB claims must be processed accurately.~~

~~—(ii) COB Processing—the Carrier must demonstrate that a statistically valid sampling technique is routinely used to identify FEHB claims prior to or after processing that require(d) coordination of benefits (COB) with a third party payer. As an alternative, the Carrier may provide evidence that it pursues all claims for COB.~~

~~—(2) Timeliness of Payments to Members or Providers~~

~~—(i) Average Processing Time (All FEHB Claims)—the average number of working days from the date an FEHB claim is received to the date it is adjudicated (paid, denied or a request for further information is sent out), for the given time period, expressed as a cumulative percentage.~~

~~—REQUIRED STANDARD:~~

~~—(A) An average of 60 percent of FEHB claims received over the given time period are adjudicated within 20 working days (28 calendar days).~~

~~—(B) An average of 80 percent of FEHB claims received over the given time period are adjudicated within 30 working days (42 calendar days).~~

~~—(C) An average of 95 percent of FEHB claims received over the given time period are adjudicated within 60 working days (84 calendar days).~~

~~—(3) Quality of Services and Responsiveness to Members~~

~~—(i) Member Inquiries — the number of working days taken to respond to an FEHB member's written inquiry, expressed as a cumulative percentage for the given time period.~~

~~—REQUIRED STANDARD:~~

~~—(A) An average of 60 percent of FEHB member written inquiries are responded to within 10 working days (14 calendar days).~~

~~—(B) An average of 90 percent of FEHB member written inquiries are responded to within 30 working days (42 calendar days).~~

~~—(ii) Telephone Access — the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.~~

~~—(A) Telephone Waiting Time — the number of seconds elapsed before a member's telephone call is connected to a Carrier representative.~~

~~—REQUIRED STANDARD: On average, no more than 1.5 minutes elapse before a member's telephone call is connected to a Carrier representative.~~

~~—(B) Telephone Blockage Rate — the percentage of time that callers receive a busy signal when calling the Carrier.~~

~~—REQUIRED STANDARD: On average, callers receive a busy signal no more than 10 percent of the time.~~

~~—(C) Telephone Abandonment Rate — the number of calls attempted but not completed (presumably because callers tired of waiting to be connected to a Carrier representative) divided by the total number of calls attempted (both completed and not completed), expressed as a percentage.~~

~~—REQUIRED STANDARD: On average, no more than 8 percent of calls are abandoned.~~

~~—(4) Responsiveness to FEHB Member Requests for Reconsideration:~~

~~—REQUIRED STANDARD: For 100 percent of written FEHB disputed claim requests received for the given time period, within 30 days after receipt by the Carrier, the Carrier must affirm the denial in writing to the FEHB member, pay the claim, provide the service, or request additional information reasonably necessary to make a determination.~~

~~—(5) Quality Assurance Plan — the Carrier must demonstrate that a statistically valid sampling technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance and abuse prevention standards.~~

~~—(6) Physician Credentialing — the Carrier must demonstrate that it requires the following credential checks of all of its physicians, both during the initial hiring process and during periodic re-credentialing. As an alternative, the Carrier may demonstrate that the following credential checks are performed by a secondary source, such as a hospital.~~

~~—(A) Verification of medical school graduation records.~~

~~—(B) Routine check with local and/or state medical societies and/or boards.~~

~~—(C) Routine check of the Department of Health and Human Services (DHHS) list of debarred providers.~~

~~—(D) Routine check of the National Practitioner Data Bank.~~

~~—(7) Appointments — All Health Maintenance Organization carriers must meet the following standards for the given time period. Except that, if this information is not routinely collected, report results from periodic surveys.~~

~~—REQUIRED STANDARD:~~

~~—(i) Urgent appointments are available, on average, within 24 hours of an authorized request for one.~~

~~—(ii) Routine appointments are available, on average, within 1 month of an authorized request for one.~~

~~—(iii) Average office waiting times on average, members who arrive on time for a scheduled appointment wait no more than 30 minutes before they are seen by the provider of the medical service.~~

~~—(NOTE: For the purpose of this standard (7), a simplified classification system is used in which all appointments are classified as either emergency, urgent or routine. Emergency appointments must be seen immediately to prevent health deterioration. Urgent appointments are those for the sudden, acute onset of symptoms that must be seen within 1 (one) day to prevent health deterioration. All other appointments are considered routine.)~~

~~—(8) Assessing Quality of Health Care. The Carrier shall collect data on the measures endorsed by the Foundation for Accountability (FACCT), as requested by the OPM for services rendered through the Carrier's Preferred Provider Organization and/or Point of Service networks. Further, the Carrier shall provide statistical reports in accordance with FACCT guidelines when requested by OPM. The Carrier may be asked to collect data on one or more measures in a specified 2. geographic locality. In addition, the Carrier shall report on measures developed by the National Committee for Quality Assurance as directed by OPM.~~

~~—(b) The Carrier shall conduct a program to assess its vulnerability to fraud and abuse and shall operate a system designed to detect and eliminate fraud and abuse internally by Carrier employees and subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members.~~

~~—(c) The Carrier shall keep complete records of its quality assurance~~

~~procedures and fraud program and the results of their implementation and make them available to the Government as determined by OPM. If the Carrier cannot separate FEHB claims from all other claims, the Carrier may report compliance based on all claims and indicate this on the report.~~

~~—(d) The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order.~~

~~—(e) Assessing Member Services. In addition to any other means of surveying Plan members that the Carrier may develop, the carrier shall participate in either a National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) consumer survey or an FEHB-specific consumer survey, to provide feedback to enrollees on enrollee experience with the various FEHB plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.7.~~

(a) Health Care Quality.

(1) Effectiveness of Care Measures.

The Carrier shall measure and/or collect data on the quality of the health care services it renders to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Health Plan Employer Data and Information Set (HEDIS) or ORYX™, or similar measures developed by accreditation agencies such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of

Healthcare Organizations (JCAHO), or the American Accreditation Healthcare Commission/URAC. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data shall be the Carrier's responsibility.

(2) **Reducing Medical Errors.** The Carrier shall implement a patient safety improvement program. At a minimum, the Carrier shall --

(i) Report to OPM on its current patient safety initiatives;

(ii) Report to OPM on how it will strengthen its patient safety program for the future;

(iii) Assist OPM in providing its members with consumer information and education regarding patient safety; and

(iv) Work with its providers, independent accreditation agencies, and others to implement patient safety improvement programs.

(3) **Physician Credentialing.** The Carrier is encouraged to use an independent accrediting organization for physician credentialing. If the Carrier's physicians meet the credentialing requirements of the credentialing organization, it has met and exceeds the minimum requirements listed below. Otherwise, the Carrier must demonstrate that it requires the following credential checks of all of its physicians, both during the initial hiring process and during periodic re-credentialing. As an alternative, the Carrier may demonstrate that the following credential checks are performed by a secondary source, such as a hospital.

- Verification of medical school graduation records.
- Routine check with local and/or state medical societies and/or boards.

- Routine check of the Department of Health and Human Services (DHHS) list of debarred providers.
- Routine check of the National Practitioner Data Bank.

(4) In order to allow sufficient implementation time, the Contracting Officer will notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a)(1) and (a)(2).

(b) Access and Measures of Service.

(1) In addition to any other means of surveying Plan members that the Carrier may develop, the Carrier shall participate in the HEDIS Consumer Assessments of Health Plans Surveys (CAHPS) to provide feedback to enrollees on enrollee experience with the various FEHBP plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.7.

(2) The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality. At a minimum the program shall include procedures to address:

(i) Accuracy of Payments.

(A) Processing Accuracy - the number of FEHB claims processed accurately and the total number of FEHB claims processed for the given time period.

REQUIRED STANDARD: An average of 95 percent of FEHB claims must be processed accurately.

(B) COB Processing - the Carrier must demonstrate that a statistically valid sampling technique is routinely used to identify FEHB claims prior to or after processing that require(d) coordination of benefits (COB) with a third party payer. As an alternative,

the Carrier may provide evidence that it pursues all claims for COB.

(ii) Timeliness of Payments to Members or Providers:

(A) Average Processing Time (All FEHB Claims) - the average number of working days from the date the Carrier receives an FEHB claim to the date it adjudicates it (paid, denied or a request for further information is sent out), for the given time period, expressed as a cumulative percentage.

REQUIRED STANDARD:

- The Carrier adjudicates an average of 60 percent of FEHB claims received over the given time period within 20 working days (28 calendar days).
- The Carrier adjudicates an average of 80 percent of FEHB claims received over the given time period within 30 working days (42 calendar days).
- The Carrier adjudicates an average of 95 percent of FEHB claims received over the given time period within 60 working days (84 calendar days).

(iii) Quality of Service and Responsiveness to Members:

(A) Processing ID cards on change of plan or option - the number of calendar days from the date the Carrier receives the enrollment from the agency or retirement system to the date it issues the ID card.

REQUIRED STANDARD:

The Carrier issues the ID card within fifteen calendar days after receiving the enrollment from the agency or retirement system.

(B) Member Inquiries - the number of working days taken to respond to an FEHB member's written inquiry, expressed as a cumulative percentage, for the given time period.

REQUIRED STANDARD:

- The Carrier responds to an average of 60 percent of FEHB

member written inquiries within 10 working days (14 calendar days).

- The Carrier responds to an average of 90 percent of FEHB member written inquiries within 30 working days (42 calendar days).

(C) Telephone Access - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. *Except that*, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(a) Telephone Waiting Time - the average number of seconds elapsing before the Carrier connects a member's telephone call to its service representative.

REQUIRED STANDARD: On average, no more than 1.5 minutes elapse before the Carrier connects a member's telephone call to its service representative.

(b) Telephone Blockage Rate - the percentage of time that callers receive a busy signal when calling the Carrier.

REQUIRED STANDARD: On average, callers receive a busy signal no more than 10 percent of the time.

(c) Telephone Abandonment Rate - the number of calls attempted but not completed (presumably because callers tired of waiting to be connected to a Carrier representative) divided by the total number of calls attempted (both completed and not completed), expressed as a percentage.

REQUIRED STANDARD: On average, the Carrier abandons no more than 8 percent of calls.

(iv) Responsiveness to FEHB Member Requests for Reconsideration:

REQUIRED STANDARD: For 100 percent of written FEHB disputed claim requests received for the given time period, within 30 days after receipt by the Carrier, the Carrier shall affirm the denial in writing to the FEHB member, pay the claim, provide the service, or request additional information reasonably necessary to make a determination.

(v) **Quality Assurance Plan.** The Carrier must demonstrate that a statistically valid sampling technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance/fraud and abuse prevention standards.

(c) **Detection of Fraud and Abuse.**

The Carrier shall conduct a program to assess its vulnerability to fraud and abuse and shall operate a system designed to detect and eliminate fraud and abuse internally by Carrier employees and subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members.

(d) **Appointments.**

All Health Maintenance Organization carriers must meet the following standards for the given time period. *Except that*, if this information is not routinely collected, report results from periodic surveys.

REQUIRED STANDARD:

(1) Urgent appointments are available, on average, within 24 hours of an authorized request for one.

(2) Routine appointments are available, on average, within 1 month of an authorized request for one.

(3) Average office waiting times - on average, members who arrive on time for a scheduled appointment wait no more than 30 minutes before they are seen by the provider of the medical service.

(NOTE: For the purpose of this standard (d), a simplified

classification system is used in which all appointments are classified as either emergency, urgent or routine. Emergency appointments must be seen immediately to prevent health deterioration. Urgent appointments are those for the sudden, acute onset of symptoms that must be seen within 1 (one) day to prevent health deterioration. All other appointments are considered routine.)

(e) **Reporting Compliance.**

The Carrier shall keep complete records of its quality assurance procedures and fraud program and the results of their implementation and make them available to the Government as determined by OPM. If the Carrier cannot separate FEHB claims from all other claims, the Carrier may report compliance based on all claims and indicate this on the report.

(f) **Correction of Deficiencies.**

The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order.

4. Redate Section 1.24, TRANSITIONAL CARE, as JAN 2001 and add a new paragraph (c) addressing transitional care for members receiving mental health and substance abuse services, as follows:

**SECTION 1.24
TRANSITIONAL CARE (JAN 2000
2001)**

(a) "Transitional care" is specialized care provided for up to 90 days or through the postpartum period to an enrollee who is undergoing treatment for a chronic or disabling condition or who is in the second or third trimester of pregnancy when his or her carrier

terminates (1) all or part of its FEHBP contract, or (2) the enrollee's specialty provider contract for reasons other than cause. The 90-day period begins the earlier of the date the enrollee receives the notice required under Section 1.23, Notice to Enrollees on Termination of FEHBP or Provider Contract, or the date the carrier's or the provider's contract ends.

(b) Beginning January 1, 2000, the Carrier shall ensure the following:

(1) *If it terminates a part of its FEHB contract or a specialty provider contract other than for cause, it allows enrollees who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy to continue treatment under the specialty provider for up to 90 days, or through their postpartum period, under the same terms and conditions that existed at the beginning of the transitional care period; and*

(2) *If it enrolls a new member who involuntarily changed carriers because the enrollee's former carrier was no longer available in the FEHB Program, it provides transitional care for the enrollee if he or she is undergoing treatment for a chronic or disabling condition or is in the second or third trimester of pregnancy for up to 90 days, or through the postpartum period, under the same terms and conditions the enrollee had under the prior carrier.*

(c) If the Carrier terminates a mental health and substance abuse specialty provider other than for cause, or changes the plan's benefit structure for 2001 so that the member's out of pocket costs for mental health and substance abuse services only are greater than they were in year 2000, it must allow continued coverage with the specialty provider for up to ninety days under the same terms and conditions that existed at the beginning of the transitional care period. This transitional period will

begin with the Carrier's notice to the member of the change in coverage and ends 90 days after the notice.

~~(e)~~ **(d)** In addition, the Carrier shall (1) pay for or provide the transitional care required under this clause at no additional cost to enrollees;

(2) require the specialty provider to promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the patient; and,

(3) require the specialty provider to give all necessary information to the Carrier for quality assurance purposes.

5. Redate Section 2.6, COORDINATION OF BENEFITS, as JAN 2001 and update the reference to the NAIC Coordination of Benefits model regulation in paragraphs (c) and (f), as follows:

SECTION 2.6
COORDINATION OF BENEFITS
(JAN 1996**2001**)

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC ~~Model Guidelines for Coordination of Benefits (COB)~~ **Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits**, as specified by OPM.

(f) Changes in the order of precedence established by the NAIC ~~Model Guidelines~~ **Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits**, implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term.

6 Redate Section 2.11, CLAIMS PROCESSING, as JAN 2001, replace the term "physicians" with "providers" and update the clause as follows:

SECTION 2.11
CLAIMS PROCESSING (JAN 1998
2001)

A standardized claims filing process shall be used by all FEHB carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) ~~By the year 2000,~~ The majority of provider claims should be submitted electronically;

(2) All ~~physicians~~ **providers** shall be notified that ~~future~~ claims shall be submitted electronically or on the Health Care Financing Administration 1500 form:

(3) The Carrier shall not use any unique ~~physician~~ **provider** claim form(s) for such FEHB member claims:

(4) The Carrier should reject all such claims submitted on forms other than the HCFA 1500 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

7. Redate Section 3.1, PAYMENTS, as JAN 2000 and add paragraph (f) to conform to a FEHBAR amendment published in the Federal Register on June 8, 2000, as follows:

SECTION 3.1
PAYMENTS--COMMUNITY RATED
CONTRACTS (JAN 1999
2000)
(FEHBAR 1652.232-70)

(f) Exception for the 3-Year DoD Demonstration Project (10 U.S.C. 1108).

The Carrier may, at its discretion, request funds from the Employees Health Benefits Fund to mitigate excessive costs in relation to premiums. If the Carrier requests funds from the Employees Health Benefits Fund to mitigate risk, it will

be required to perform annual reconciliations for the duration of the demonstration project. OPM will reimburse the Carrier's costs significantly in excess of the premiums first from the Carrier's demonstration project Contingency Reserve and then from the Employees Health Benefits Fund Administrative Reserve. After the final accounting, OPM will place any surplus demonstration project premiums in the regular Contingency Reserves of all carriers continuing in the FEHB Program for the contract year following the year in which the demonstration project ends. Credit will be in proportion to the amount of subscription charges paid and accrued to each carrier's plan for the last year of the demonstration project.

(End of clause)

8. Revise paragraph (c), Section 3.2, ACCOUNTING AND PRICE ADJUSTMENT, to conform to the FEHBAR amendment published in the Federal Register on June 8, 2000, as follows:

SECTION 3.2
ACCOUNTING AND PRICE
ADJUSTMENT (JAN 2000) (FEHBAR
1652.216-70)

~~(c) Exception for the 3-Year DoD Demonstration Project (10 U.S.C. 1108)~~

~~(1) Similarly sized subscriber group (SSSG) rating methodologies shall not be used to determine the reasonableness of the Carrier's demonstration project premium rates. The Carrier's rates shall not be adjusted for equivalency with SSSG rating methodologies. The Carrier shall benchmark premiums against adjusted community rates if available, Medigap offerings, or other similar products.~~

(End of clause)

(c) Exception for the 3-Year DoD Demonstration Project (10 U.S.C. 1108).

(1) Similarly sized subscriber group (SSSG) rating methodologies shall not be used to determine the reasonableness of the Carrier's demonstration project premium rates. The Carrier's rates shall not be adjusted for equivalency with SSSG rating methodologies. The Carrier shall benchmark premiums against adjusted community rates if available, Medigap offerings, or other similar products.

(2) The Carrier shall account separately for health benefits charges paid using demonstration project funds and regular FEHB funds. Direct administrative costs attributable solely to the demonstration project shall be fully chargeable to the demonstration project. Indirect administrative costs associated with the demonstration project will be allocated to the demonstration project based on the percentage obtained by dividing the dollar amount of claims processed under the demonstration project by the dollar amount of total claims processed for FEHB Program activity.

(End of clause)

9. Update Section 3.3, RATE REDUCTION FOR DEFECTIVE PRICING OR DEFECTIVE COST OR PRICING DATA, by adding a new paragraph (d) to conform to the FEHBAR amendment published in the Federal Register on June 8, 2000, as follows:

**SECTION 3.3
RATE REDUCTION FOR DEFECTIVE PRICING OR DEFECTIVE COST OR PRICING DATA (JAN 2000) (FEHBAR 1652.215-70)**

(d) Exception for the 3-Year DoD Demonstration Project (10 U.S.C. 1108).

(1) Similarly sized subscriber group (SSSG) rating methodologies shall not be used to determine the reasonableness of the Carrier's demonstration project premium rates. The Carrier's rates shall not be adjusted for equivalency with SSSG rating methodologies. The Carrier shall benchmark premiums against adjusted community rates if available, Medigap offerings, or other similar products.

(2) The Carrier shall account separately for health benefits charges paid using demonstration project funds and regular FEHB funds. Direct administrative costs attributable solely to the demonstration project shall be fully chargeable to the demonstration project. Indirect administrative costs associated with the demonstration project will be allocated to the demonstration project based on the percentage obtained by dividing the dollar amount of claims processed under the demonstration project by the dollar amount of total claims processed for FEHB Program activity.

(End of clause)

10. Add a new Section 3.8 entitled TAXPAYER IDENTIFICATION NUMBER, to conform to FEHBAR clause 1652.204-73, published in the Federal Register on June 8, 2000, as follows:

**SECTION 3.8
TAXPAYER IDENTIFICATION NUMBER (JAN 2000)(FEHBAR 1652.204-73)**

(a) Definitions.

"Common parent," as used in this provision, means that corporate entity that owns or controls an affiliated group of corporations that files its Federal income tax returns on a consolidated basis, and of which the Carrier is a member.

“Taxpayer Identification Number (TIN),” as used in this provision, means the number required by the Internal Revenue Service (IRS) to be used by the Carrier in reporting income tax and other returns.

(b) The Carrier must submit the information required in paragraphs (d) through (f) of this clause to comply with debt collection requirements of 31 U.S.C. 7701(c) and 3325(d), reporting requirements of 26 U.S.C. 6041, 6041A, and 6050M, and implementing regulations issued by the IRS. The Carrier is subject to the payment reporting requirements described in Federal Acquisition Regulation (FAR) 4.904. The Carrier’s failure or refusal to furnish the information will result in payment being withheld until the TIN number is provided.

(c) The Government may use the TIN to collect and report on any delinquent amounts arising out of the Carrier’s relationship with the Government (31 U.S.C. 7701(c)(3)). The TIN provided hereunder may be matched with IRS records to verify its accuracy.

(d) *Taxpayer Identification Number (TIN).*

TIN: _____

- (e) Type of organization.
 - Sole proprietorship;
 - Partnership;
 - Corporate entity (not tax-exempt);
 - Corporate entity (tax-exempt);
 - Other

_____.

(f) Common parent.
Carrier is not owned or controlled by a common parent as defined in paragraph (a) of this clause.

Name and TIN of common parent:

Name _____
TIN _____

(End of Clause)

11. Appendix C, CONTRACT ADMINISTRATION DATA, is removed and reserved.

~~APPENDIX C
CONTRACT ADMINISTRATION DATA~~

APPENDIX C
[RESERVED]

12. Rename Appendix E as RULES FOR COORDINATION OF BENEFITS as follows:

~~APPENDIX E
ORDER OF BENEFIT DETERMINATION
RULES~~
RULES FOR COORDINATION OF
BENEFITS