SCHEDULE OF COVERED EXPENSES
Health Maintenance Organizations
Ref: Sections 601.42 (1g) (d) and 609.91, Wis. Stat.

State of Wisconsin
Office of the Commissioner of Insurance
P. O. Box 7873
Madison, WI 53707-7873

INSTRUCTIONS: List all covered expenses by provider. Covered expenses are those expenditures and outstanding liabilities of the HMO for health care cost for which an enrollee is not liable under s. 609.91, Wis. Stat. Section I of this form is used to report expenses to providers subject to Mandatory Holdharmless. These are expenses subject to s. 609.91 (1) (a), or (am), Wis. Stat. Section II of this form (reverse) is used to report covered expenses to a provider which are not subject to the Mandatory Holdharmless but for which the provider may "opt-out" of the holdharmless. These generally are expenses to IPAs or hospitals or to selected providers for physician services. Such providers should not be included, however, if the provider has filed an "opt-out" form with the Commissioner. Section II should also include expenses to any other provider which has filed an "opt-in" form with the Commissioner. List the top five providers in each category and the remaining providers included in aggregate. It is not necessary to submit a detailed list with the form; however, such a list must be made available upon request. Section III, Line A, should be the total of all covered expenses listed on this form. Expenses are to be reported on a cumulative basis; i.e., second quarter filings should include both first and second quarter expenses. Covered expenses for incurred but not reported expenses should be estimated based on historical data and the best information available to the HMO. Total medical expenses should be the sum of the medical and hospital expenses on the statement of revenue and expenses of the current financial statement, less incentive pool adjustments.

HMO Name	As of Date

SECTION I—MANDATORY HOLDHARMLESS PROVIDERS

A. Hospitals

Name	Amount	Name	Amount
	$		$
	$		$
	$		$
	$	All Other Section IA. Providers	$
		Total Section IA.	$

B. IPAs

Name	Amount	Name	Amount
	$		$
	$		$
	$		$
	$	All Other Section IB. Providers	$
		Total Section IB.	$

C. Selected Providers

Name	Amount	Name	Amount
	$		$
	$		$
	$	All Other Section IC. Providers	$
		Total Section IC.	$
		Grand Total Section I	$

SECTION II—OTHER PROVIDERS

A. Hospitals

Name	Amount	Name	Amount
	$		$
	$		$
	$		$
	$	All Other Section IIA. Providers	$
		Total Section IIA.	$

B. IPAs

Name	Amount	Name	Amount
	$		$
	$		$
	$		$
	$	All Other Section IIB. Providers	$
		Total Section IIB.	$

C. Selected Providers

Name	Amount	Name	Amount
	$		$
	$		$
	$		$
	$	All Other Section IIC. Providers	$
		Total Section IIC.	$

D. Other "Opted-In" Providers

Name	Amount	Name	Amount
	$		$
	$		$
	$	All Other Section IID. Providers	$
		Total Section IID.	$
		Total Section II.	$

SECTION III

A. Total Covered Expenditures (Total of Section I and II) ..... $

B. Estimated Covered IBNR ..... $

C. Total Covered Expenses (Sum of Lines A and B) ..... $

D. Total Medical and Hospital Expenses (Annual or Quarterly Statement Page 4, Column 2, Line 15) ..... $

E. Percentage (C/D) x 100 ..... %