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DETERMINING ELIGIBILITY

The Department of Medical Assistance Services (DMAS) administers Virginia's medical assistance programs: Medicaid and CHIP (called FAMIS in Virginia). Per state regulations, eligibility determinations for the medical assistance programs are made by the local departments of social services (LDSS) and by the Cover Virginia Central Processing Unit (CPU).

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at <https://coverva.dmas.virginia.gov/>. DMAS will not pay providers for services, supplies, or equipment until the applicant's eligibility has been determined. (See "Assistance to Patients Possibly Eligible for Benefits.") An applicant can also be determined in some Medicaid programs for retroactive coverage for up to three months before the month in which the application was filed. Except during periods of 12-month Continuous Eligibility (CE) for children and pregnant women, a member's eligibility must be reviewed when a change in the member's circumstances occurs. All members are subject to an annual renewal (redetermination) of eligibility.

Groups Covered by Medical Assistance

Individuals who apply for Medicaid are evaluated under the covered group or groups they meet. Each covered group has a prescribed income limit, and some covered groups also have an asset or resource limit. The FAMIS programs—FAMIS for Children, FAMIS MOMS and FAMIS Prenatal Coverage for pregnant women—offer coverage similar to Medicaid but have higher income limits.

Individuals may be eligible for full medical assistance coverage, including the payment of Medicare premiums for Medicaid members with Medicare, if they fall into one of the following covered groups and meet the nonfinancial and financial requirements for the group:

- Auxiliary Grants (AG) recipients
- Aged, blind or disabled (ABD) recipients of Supplemental Security Income (SSI) and certain former SSI recipients with "protected" status
- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older, blind, or disabled and/or who are eligible for or enrolled in Medicare.
- Low-Income Families with Children (parents with a dependent child under age 18 years in the home)

- Pregnant women, and postpartum women through the end of the 12 month postpartum period (Medicaid and FAMIS MOMS)
- Pregnant women otherwise ineligible due to immigration status, through the FAMIS Prenatal Coverage program. FAMIS Prenatal Coverage members are eligible for the duration of the pregnancy and through the end of the calendar month in which the 60th postpartum day falls.
- Newborns up to age one year born to individuals enrolled in Medicaid at the time of birth or retroactively within 3 months of the birth. Newborns up to age one year born to individuals enrolled in FAMIS or FAMIS MOMS at the time of the birth.
- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.
- Children under age 19 years (Children's Medicaid, FAMIS)
- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare. These individuals are referred to as Modified Adjusted Gross Income (MAGI) Adults.
- Individuals under age 21 in institutional care.
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)—women and men who were certified through the Breast and Cervical Cancer Early Detection Program.
- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care.

The following individuals may be eligible for limited Medicaid coverage if they meet the nonfinancial and financial requirements for their covered group:

- Qualified Medicare Beneficiaries (QMBs) with income less than or equal to 100% of the FPL. This group is eligible for Medicaid coverage of **Medicare premiums, deductibles, and coinsurance only**.
- Special Low-Income Medicare Beneficiaries (SLMB) with income over 100% and less than or equal to 120% of the FPL. This group is eligible for Medicaid coverage of **Medicare Part B premiums only**.

- Qualified Individuals (QI) with income over 120% but less than or equal to 135% of the FPL. This group is eligible for Medicaid coverage of the **Medicare Part B premiums only**.
- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of **Medicare Part A premiums only**.
- Plan First – any individual with income up to 200% of FPL. This group is eligible for limited Medicaid coverage of family planning services only and not covered for full Medicaid benefits. Members who do not wish to be enrolled in Plan First should contact the local DSS to be disenrolled.

Medically Needy Covered Groups and Spenddown

Through a process known as “spenddown,” Medicaid provides a limited period of full coverage for certain groups of “Medically Needy” individuals who meet all of the Medicaid eligibility requirements but have excess income for full benefit Medicaid. Individuals to which spenddown may apply include:

- ABD individuals
- Pregnant women and their newborn children
- Children under age 18
- Individuals under age 21 in institutional care, under supervision of the Department of Juvenile Justice, foster care, or subsidized adoptions
- Individuals in long-term care institutions and those receiving services under a home and community-based care waiver or who have elected hospice care.

To be eligible for Medicaid, the individual must have incurred allowable medical expenses that at least equal the spenddown liability. If the individual’s allowable medical expenses equal the spenddown liability amount before the end of a budget period (six-month period for non-institutionalized individuals or a one month period for institutionalized individuals), the applicant may receive a limited period of Medicaid coverage which will stop at the end of the budget period. The spenddown liability is the difference between the individual’s income and the Medically Needy income limit for the individual’s locality, multiplied by the number of months in the individual’s spenddown period. Eligibility must be re-determined in order to establish eligibility in subsequent budget periods.

An individual placed on a spenddown does **not** have full Medicaid coverage until the spenddown is met, however they may be eligible for limited Medicaid coverage or Plan First during the spenddown period. Medicaid cannot pay medical expenses incurred prior to the date the spenddown is met.

Emergency Medicaid Services for Noncitizens

To be eligible for full Medicaid or FAMIS benefits, an individual must be a resident of Virginia and a U.S. citizen or a noncitizen qualified for full benefits. Included in this definition are lawfully residing immigrants who are pregnant or within the first 12 months postpartum, and lawfully residing immigrant children under the age of 19. In addition, the FAMIS Prenatal Coverage program offers prenatal coverage, through 60 days postpartum, for uninsured pregnant women up to 200% FPL who do not meet immigration status criteria but are otherwise eligible for Medicaid or FAMIS MOMS.

Individuals who do not qualify for full Medicaid benefits due to their Immigration status may be eligible for Medicaid coverage of emergency services if they meet all other nonfinancial and financial eligibility requirements for full Medicaid coverage.

Individuals can contact (and providers can refer individuals to) the LDSS or Cover Virginia to determine if they can receive emergency Medicaid services.

For more information, please see the Emergency Medicaid Services Supplement that is attached to the Physician-Practitioner, Hospital, and Transportation Manuals.

Medicaid Eligibility for Institutionalized Individuals

An institutionalized individual is defined as one who is receiving long-term services and supports (LTSS) as an inpatient in a medical institution or nursing facility or in the home or community setting. Home and community-based services (HCBS) include waiver services such as personal care, adult day health care, respite care, and the Program for All Inclusive Care for the Elderly (PACE).

To be approved for Medicaid-covered LTSS, the individual must be institutionalized in a nursing or other medical facility or have been assessed and authorized for HCBS, and be eligible for Medicaid in a full-benefit covered group.

If an individual is not eligible for Medicaid in any other full-benefit covered group, the individual's eligibility in one of the special income covered groups is determined. The policy for these groups allows a different method of determining income and resource eligibility, a higher income limit of 300% of the SSI payment for one person.

A married institutionalized individual's spouse at home is referred to as the community spouse. The community spouse is able to retain a specified amount of resources in order to continue to meet maintenance needs in the community. Some of the institutionalized spouse's monthly income may also be allocated to the community spouse if certain criteria are met. At the time of application for Medicaid, the LDSS completes a resource assessment, producing a compilation of a couple's combined countable resources at the time one spouse became institutionalized and a calculation of a spousal share (the amount of shared resources that can be

allocated to the community spouse). An institutionalized spouse with a community spouse may also request a resource assessment without submitting a Medicaid application to assist with financial planning.

Most individuals receiving LTSS have an obligation toward the cost of their care, known as the patient pay. MAGI adults do not have a patient pay responsibility.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS) PLAN

FAMIS Children

FAMIS is Virginia's Title XXI Children's Health Insurance Program (CHIP) and is a comprehensive health insurance program for children from birth through age 18 who are not covered under other creditable health insurance and whose income is over the Medicaid income limit but no more than 200% of the FPL.

When children are initially enrolled in FAMIS they will have brief coverage in fee-for-service (FFS), with a Medicaid look-alike benefit package, before transitioning to a managed care organization (MCO). Once in managed care, FAMIS children are eligible for benefits similar to those covered for children under the State Plan for Medical Assistance, with some exceptions.

FAMIS MOMS

The FAMIS MOMS program covers uninsured pregnant women whose income is over the Medicaid income limit but no more than 200% of the FPL. This coverage extends through 12 months postpartum. FAMIS MOMS provides the same benefits to pregnant women as Medicaid, including dental services.

FAMIS Prenatal Coverage

Effective July 1, 2021, prenatal coverage is available through the FAMIS Prenatal Coverage program for uninsured pregnant women who meet all other eligibility criteria for Medicaid and FAMIS MOMS but do not meet immigration status rules. FAMIS Prenatal Coverage is available through the end of the calendar month in which the 60th postpartum day falls.

12-MONTHS CONTINUOUS ELIGIBILITY FOR CHILDREN

It is mandatory for states to provide 12 months of continuous eligibility for children under age 19 in Medicaid and CHIP (FAMIS), with limited exceptions. Continuous eligibility (CE) means the child remains enrolled for a protected 12-month period, during which their coverage cannot be reduced or terminated regardless of changes in circumstance. Changes in circumstance that will no longer impact eligibility until the end of the child's CE period include, but are not limited to, an increase in

household income, loss of Supplemental Security Income (SSI), or a FAMIS-enrolled child obtaining other qualifying health coverage.

Exceptions to the CE requirement are listed below:

- The child turns age 19. Coverage under a children's eligibility group will end at the end of the month in which the individual turns 19. The individual will be evaluated for ongoing coverage as an adult and enrolled if eligible.
- The child moves out of Virginia. Coverage ends at the end of the month in which the child ceases to be a Virginia resident.
- The child or their representative requests termination of the child's coverage.
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child/child's representative.
- Death of the enrolled child.

Medicaid-enrolled children may not be moved into FAMIS during the 12-month continuous eligibility period as this is a reduction of coverage. FAMIS-enrolled children may be moved into Medicaid during a CE period but must be given a new 12-month CE period when the change occurs.

MEMBER ELIGIBILITY CARD

A white plastic eligibility card with the Cardinal Care logo on front is issued to members enrolled in either Medicaid, FAMIS, or Plan First coverage to present to participating providers. **The provider is obligated to determine that the person to whom care or service is being rendered is the same individual listed on the eligibility card.** The provider has the responsibility to request such identification as he or she deems necessary. Presentation of a plastic ID card is not proof of coverage nor guarantee of payment. A sample of an eligibility card is included under "Exhibits" at the end of this chapter.

Eligibility must be confirmed each time service is rendered. Verification can occur through a verification vendor, the voice response system or the web-based verification system. LDSS do not provide verification of eligibility to providers.

Some individuals have coverage under a Virginia Medicaid/FAMIS contracted managed care organization (MCO) and should not receive services outside their network without a referral and authorization from the MCO. These members will have an MCO card from their assigned MCO provider with the Cardinal Care logo in addition to the Medicaid/FAMIS Cardinal Care logo card. Both cards should be presented to the provider when requesting services or medications. The verification response will advise if the member has restrictions such as a contracted MCO

enrollment, or a primary payer.

The provider must determine if the service is within the dates of eligibility. These dates must be checked prior to rendering any service. Benefits are available only for services performed during the indicated period of eligibility; Medicaid/FAMIS will not pay for care or services rendered before the beginning date or after the end date of eligibility.

Name of Eligible Person

An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Check the name against another proof of identification if there is any question that the card does not belong to the member. Cards with “Do Not Use” or other non-names should not be accepted.

Member's Eligibility Number

The **member's** complete eligibility number is embossed on the front of the eligibility card. Eligibility numbers are distinct and permanent. When a member relocates or moves into another case, or has a break in eligibility, they keep the same number and the same card. This number serves as a “key” in verifying current eligibility status.

All 12 digits must be entered on Medicaid forms for billing purposes.

Bank Identifier

The six numbers on the plastic card represent the Bank Identifier Number (BIN), which is required for pharmacy benefit cards under the National Council of Prescription Drug Programs (NCPDP).

Date of Birth

The date of birth indicates the member's age and identifies eligibility for those services with age restrictions. The date of birth should be checked prior to rendering any services. The provider should verify the age of the member. If the provider has a question as to the age of the member, means of identification other than the Medicaid/FAMIS card should be examined.

Card

The sequential number of the member's card is given. If a card is lost or stolen and another is issued, the prior card will be de-activated.

VERIFICATION OF MEMBER ELIGIBILITY

It is the obligation of the provider of care to determine the identity of the person named on the eligibility card and the current eligibility status, to include program type or MCO enrollment. It is in the best interest of the provider to review the card each time services are rendered. Possession of a card does not mean the holder is currently eligible for benefits. **The member does not relinquish the card when coverage is cancelled.** Replacement cards must be requested.

Program/Benefit Package Information

Members' benefits vary depending upon the program in which they are enrolled. The eligibility verification will provide information on which program the member is participating in. Examples of these programs include Cardinal Care, Medicaid fee-for-service, FAMIS MCO, CCC Plus Waiver, FAMIS fee-for-service and Medicare premium payment.

Limited Benefit Programs for Which Members Receive Eligibility Cards

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to QMBs. There are two levels of coverage for QMBs, based on financial eligibility.

QMB Coverage Only—Members in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the member's copayment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY--QMB." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage—Members in this group are dually-eligible for full Medicaid coverage and Medicare. They are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These members are responsible for copays for pharmacy services, health department clinic visits, and vision services.

SLMBs and QIs do not receive member eligibility cards because they are not eligible for the payment of medical services rendered.

Plan First—Men and women enrolled in Plan First can receive limited Medicaid covered family planning services only, and they receive a Plan First identification card. This group's Medicaid verification provides the message, "limited benefits only." See the Plan First Manual for more information.

All Others—Members without ANY of these messages at time of verification will be

eligible for those covered services listed in Chapter I of this manual.

Special Indicator Code (formerly Copayment Code – Copayments are no longer charged for Medicaid and FAMIS eligible members)

The Special Indicator Code indicates eligibility for certain additional services. These codes are:

<u>Code</u>	<u>Message</u>
A	Under 21.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care
C	All Other Members

Insurance Information

The “Insurance Information” in the verification response indicates any type of insurance coverage the member has in addition to Medicaid. This information includes specific insurance companies, dates of coverage, policy numbers, and a code that specifies the particular type of coverage of the policy. These items are:

Carrier Code	A three-digit code indicating the name of the insurance carrier, e.g. 001 for Medicare (See Insurance Company Code List for these code numbers in “EXHIBITS” at the end of this chapter.) If the carrier code is 003 (not listed), call the member’s local eligibility worker for assistance in obtaining the name of the insurance carrier.
Begin Date	The first date on which this insurance policy was effective
Type Code	An alpha character describing the type of coverage provided by the policy, such as a "D" for dental coverage. (See the Type of Coverage Code List under “EXHIBITS” at the end of this chapter for a list of these codes.)
Policy Number/ Medicare Code	The specific policy or Medicare number for the insurance identified by the Carrier Code

Only insurance information for active policies during the period for which eligibility is requested is provided at verification. If the member reports insurance information different from what is on the card, refer the member to their LDSS eligibility worker to correct the data so bills will be processed correctly.

Under the assignment of benefits regulations, DMAS can act on behalf of the member (subscriber) and recover third-party payment from the primary carrier.

Workers' Compensation and other liability insurances (e.g., automobile liability insurance or home accident insurance) **are always considered as primary carriers** for cases where coverage is applicable to the injury being treated. Because the member's eligibility card cannot indicate this coverage, it is necessary that cause-of-injury information be obtained from the member.

Primary Care Providers (PCPs) for the Client Medical Management Program

A primary care designation or restriction is imposed by the Member Monitoring Unit of DMAS as a result of high utilization of services by the member causing unnecessary or duplicate services. Eligibility verification will list the names of designated primary care providers (physician and/or pharmacy). The designated providers must agree to the relationship prior to the designation appearing on the member's card. Unless it is an emergency, do not provide services without contacting the primary care provider first for authorization.

MANAGED CARE PROGRAMS

Most Medicaid members are enrolled in one of the Department's managed care programs (Cardinal Care and PACE). Each program has specific eligibility requirements and health plan assignment criteria for its members. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact and/or eligibility and assignment information for managed care plans can be found on the DMAS website for each program as follows:

- Cardinal Care:
<https://dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/>
- Program of All-Inclusive Care for the Elderly (PACE)
<https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care>

MEMBER WITHOUT AN ELIGIBILITY CARD

A member who seeks services should be considered responsible for all charges incurred unless eligibility is verified. The provider can verify eligibility without the card using two other identification keys, including name, Social Security Number, and date of birth. These can be used to access the MediCall automated System, the verification vendors, and the web verification system (ARS). See Chapter I for further information about verification methods. LDSS do not provide verification of eligibility to providers.

ASSISTANCE TO PATIENTS POSSIBLY ELIGIBLE FOR BENEFITS

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover Virginia Call Center at 1-855-242-8282 for an application for health care coverage. The LDSS or Cover Virginia will notify the patient of eligibility or ineligibility. Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility. The effective date of Medicaid eligibility may be retroactive up to three months prior to the month in which the application was filed, if the patient was eligible during the retroactive period. Once a patient is found eligible, providers may bill Medicaid for covered services, and upon receipt of payment from Medicaid, must reimburse the patient for the out-of-pocket expenses; Medicaid does not reimburse members for out-of-pocket expenses.

MEDICAID APPLICATIONS – AUTHORIZED REPRESENTATIVE POLICY

Medicaid eligibility requirements require an applicant or someone conducting business on their behalf to verify citizenship or immigration status, declare all income and assets, and make assignment of insurance and medical support benefits. In order to accurately determine eligibility, LDSS must ensure that an individual who files an application or someone conducting business on behalf of the applicant has full knowledge of the applicant's situation and can provide correct information.

A Medicaid applicant must sign the application form unless the application is filed and signed by the applicant's legal guardian or conservator, attorney-in-fact, or other person who is authorized to apply on the applicant's behalf. If the applicant is unable to sign their name but can make a mark, the mark must be designated "his/her mark" and witnessed by one person.

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless the child is legally emancipated from their parents. If a child is not legally emancipated, the parent or legal guardian, **or** an authorized representative designated by the parent or legal guardian, or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age may apply for Medicaid on behalf of their own child.

A legally competent individual age 18 or older may authorize anyone age 18 or older to file a Medicaid application on their behalf provided that the authorization is in writing, identifies the individual or organization authorized to conduct business on their behalf, and is signed by the individual giving the authorization.

When an individual has been determined by a court to be legally incompetent or legally incapacitated, the individual's legally appointed guardian or conservator is the individual's authorized representative and can apply for Medicaid on the

individual's behalf. If an individual does not have a legal guardian or authorized representative and is mentally unable to sign an application or designate a representative, the individual's spouse will be considered the authorized representative for Medicaid purposes. In situations where the individual is not married, is estranged from their spouse, or the spouse is unable to represent him or her, a relative of the individual who is willing to take responsibility for the individual's Medicaid business may be considered their authorized representative. Relatives who may be considered authorized representatives in this situation are, in the following order of preference: the individual's adult child; parent; adult sibling; adult niece or nephew; or adult aunt or uncle.

If it is determined that an individual cannot sign an application and does not have an attorney-in-fact or authorized representative, a Medicaid application may be filed by someone other than an authorized person provided the individual's inability to sign the Medicaid application is verified by a written statement from the individual's doctor. The statement must indicate that the individual is unable to sign and file a Medicaid application because of their diagnosis or condition. The LDSS will pend the application until it can be appropriately signed if it is determined that court action has been initiated to have a guardian or committee appointed for the individual or until an Adult Protective Services investigation concludes that guardianship proceedings will not be initiated. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.

An application may be filed on behalf of a deceased person by their guardian or conservator, attorney-in-fact, executor or administrator of their estate, surviving spouse, or a surviving family member, in the following order of preference: adult child, parent, adult sibling, adult niece or nephew, or adult aunt or uncle. The application must be filed within a three-month period subsequent to the month of the individual's death. Medicaid coverage can be effective no earlier than three months prior to the application month. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

NON-MEDICAID PATIENT RELATIONSHIP

Medicaid-eligible members who elect to be treated as private patients or who decline to verify their Medicaid eligibility with providers will be treated as private pay patients by the provider and by DMAS. Providers are required to furnish supporting documentation whenever patients fall into either of these categories.

NEWBORN INFANT ELIGIBILITY

All newborn days, including claims for “well babies,” must be submitted separately. “Well baby” days cannot be processed as part of the mother’s per diem, and no information related to the newborn must appear on the mother’s claim.

A newborn is automatically considered eligible for Medicaid or FAMIS through age 1 year if the newborn’s mother was eligible for full coverage Medicaid or enrolled in FAMIS or FAMIS MOMS at the time she gave birth. A medical assistance application must be filed for any child whose mother was not eligible for Medicaid or enrolled in FAMIS/FAMIS MOMS at the time of the child’s birth.

A streamlined way to report the birth of the newborn is through the Medicaid MES/FAS Web Provider Portal [www.virginiamedicaid.dmas.virginia.gov/http://vamedicaid.dmas.virginia.gov/](http://vamedicaid.dmas.virginia.gov/) under the link “E-213”. Any provider approved for access to the Portal may report the newborn’s birth. To review the newborn’s Member ID number, access the portal 30 days after submitting the E-213.

The newborn’s birth can also be reported by calling CoverVA (1-833-5CALLVA/ 833-522-5582) or by reporting to the local department of social services in the locality where the member resides.

The provider can verify newborn eligibility from the card using the Member name, Member ID number and DOB listed on the Cardinal Care card.

See Chapter I for more information on eligibility verification.

MEDICAID ELIGIBILITY FOR HOSPICE SERVICES

To be eligible to elect hospice as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as terminally ill. “Terminally ill” is defined as having a medical prognosis that life expectancy is six months or less. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked concurrently under both programs.

GUIDELINES ON INSTITUTIONAL STATUS

Federal regulations in 42 CFR 435.1009 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution, and
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are

receiving inpatient psychiatric services. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An Intermediate Care Facility for the Intellectually Disabled (ICF-ID) is not an IMD.

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole. An individual is considered incarcerated until permanent release, bail, probation or parole.

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid. The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds.

Incarcerated Individuals

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer, provided they meet all other Medicaid eligibility requirements.

Incarcerated individuals include:

- individuals under the authority of the Virginia Department of Corrections (DOC) or Virginia Department of Juvenile Justice (DJJ), and
- individuals held in regional and local jails, including those on work release.

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail or juvenile facility.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

Individuals released from jail under a court probation order due to a medical emergency are NOT inmates of a public institution because they are no longer incarcerated.

Once an individual is released from the correctional facility, they can be enrolled in full benefit Medicaid, provided they meet all Medicaid eligibility requirements.

Juveniles

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post- disposition situations, and types of facilities.

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- juvenile who is in a detention center due to criminal activity
- juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site:

<https://www.djj.virginia.gov/documents/ppi/Juvenile-Detention-Centers-and-Homes-Contacts.pdf><https://www.djj.virginia.gov/pages/residential/residential-services.htm>.

If they go to a non-secure group home, they can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center.

A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile who resides in an ineligible public residential facility is not eligible for full-benefit Medicaid. The child can be eligible for Medicaid coverage limited to inpatient hospitalization if they are admitted to a medical facility for inpatient services.

Who is Not an Inmate of a Public Institution

An individual is NOT an inmate of a public institution if:

- the individual is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- the individual is in a public institution for a temporary period pending other arrangements appropriate to his needs. Individuals in public institutions for a temporary period include:
 - individuals admitted under a TDO
 - individuals arrested then admitted to a medical facility
 - inmates out on bail
 - individuals on probation (including a juvenile on conditional probation or probation in a secure treatment center), parole, or conditional release
 - juveniles in a detention center due to care, protection or in their best interest.

APPEALS OF ADVERSE ACTIONS

An appeal is a request for a review of an adverse decision taken by DMAS, a DMAS contractor, or another agency on behalf of DMAS. There are two types of appeals – a provider appeal, which may be filed by a provider or their authorized representative, and a client appeal, which may be filed by an individual or an authorized representative on the individual’s behalf. The client appeals process is described below. The provider appeals process is described in Chapter II.

CLIENT APPEALS

Definitions

Administrative Dismissal – The dismissal of a client appeal on various grounds, such as lack of a signed authorized representative form, or the lack of a final adverse action from the Medicaid Managed Care Organization (“MCO”), other DMAS Contractor, or other agency acting on behalf of DMAS.

Adverse Action – means the denial or termination of enrollment or reduction in coverage, or the partial approval, denial, reduction, suspension, or termination of a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise their right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 C.F.R. § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1. For non-members, defined as a request for review of an adverse action by DMAS, a DMAS Contractor, or another agency acting on behalf of DMAS.
2. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members enrolled in an MCO, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or
3. For members receiving fee-for-service ("FFS") services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Internal Appeal – means a request to the MCO by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination. The internal appeal is the only level of appeal with the MCO and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before

the member may initiate a State fair hearing.

Representative (or Authorized Representative) - means an individual who has been authorized to represent someone who received an adverse action. The authorized representative can be anyone such as a family member, friend, neighbor, provider, etc. However, the authorization for someone to serve as a representative for an individual 18 years of age or older must be in writing and submitted to the DMAS Appeals Division to process the appeal. This includes authorization for a provider to represent a member when the services at issue have not been rendered. Written authorization can include a power of attorney, proof of guardianship, or other legal documents establishing the representation. DMAS also has an authorized representative form available on its website at: <https://www.dmas.virginia.gov/appeals>.

State Fair Hearing – means the Department’s *de novo* evidentiary hearing process for client appeals. Any adverse action by DMAS, a DMAS Contractor, or other agency acting on behalf of DMAS or internal appeal decision rendered by the MCO may be appealed by the member to the Department’s Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

There are three types of client appeals, each of which is described below. The first two types, MCO and FFS, involve individuals who are enrolled in Medicaid or a Medicaid program and receiving services either through an MCO or through fee-for-service. The third type, non-member, involves individuals who are seeking to become enrolled in Medicaid or a Medicaid program.

Member Appeals (MCO)

A member, an attorney, a provider authorized to represent a member, or another authorized representative on behalf of the member have the right to appeal adverse benefit determinations to the Department. However, the MCO’s internal appeal process must be exhausted, or deemed exhausted (due to the failure of the MCO to adhere to the notice and timing requirements), prior to a member filing an appeal with the DMAS Appeals Division.

Any member, member’s attorney, or member’s authorized representative wishing to appeal an adverse benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. For individuals with special needs or who do not understand English, the appeal rights must be provided in such a manner as to make it understandable by the individual.

A member may request continuation of services during the MCO’s internal appeal and DMAS’ State fair hearing. If an appeal is filed before the effective

date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at Virginia Administrative Code 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at <https://www.dmas.virginia.gov/appeals/>. From there, you can fill out a client appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at <https://www.dmas.virginia.gov/appeals/>. You can use that form or a letter to file the client appeal. The request can be submitted by:
 - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
 - Email to appeals@dmas.virginia.gov; or
 - Fax to (804) 452-5454
- By phone at (804) 371-8488 or in-person at the Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq.* and the Rules of Court.

Member Appeals (FFS)

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Adverse actions may be appealed by the Medicaid member or by an attorney, by a provider authorized to

represent the member, or other authorized representative on behalf of the member. Adverse actions include terminations of enrollment, or partial approvals, denials, reductions, suspensions, and terminations of service. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the adverse action is upheld by the hearing officer, the member may be required to repay DMAS or the DMAS Contractor for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The DMAS contractor will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, DMAS or the DMAS contractor may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals may be requested orally or in writing by the member, the member's attorney, or the member's authorized representative. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. Forms are available on the internet at <https://www.dmas.virginia.gov/appeals> or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through AIMS at <https://www.dmas.virginia.gov/appeals/>. From there you can fill out a client appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at <https://www.dmas.virginia.gov/appeals/>. You can use that form or a letter to file the client appeal. The request can be submitted by:
 - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
 - Email to appeals@dmas.virginia.gov; or
 - Fax to: (804) 452-5454
- By phone at (804) 371-8488 or in-person at the Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

The Department's state fair hearing decision may be appealed to the appropriate Circuit Court by the member in accordance with the Administrative Process

Act at Va. Code § 2.2-4025, *et. seq.* and the Rules of Court.

NON-MEMBER APPEALS

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS, its contractors, or another agency on behalf of DMAS, takes an action that affects the non-member. Adverse actions may be appealed by the non-member, an attorney, a provider authorized to represent the member, or other authorized representative on behalf of the member. Adverse actions include denials of enrollment in the Medicaid program or denial of services that would result in enrollment in a Medicaid program. Also, failure to act within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

Appeals may be requested orally or in writing by the member, the member's attorney, or the member's authorized representative. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. Forms are available on the internet at <https://www.dmas.virginia.gov/appeals> or by calling (804) 371-8488. A copy of the notice or letter about the action should be included with the appeal request. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through AIMS at <https://www.dmas.virginia.gov/appeals/>. From there you can fill out a client appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at <https://www.dmas.virginia.gov/appeals/>. You can use that form or a letter to file the client appeal. The request can be submitted by:
 - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
 - Email to appeals@dmas.virginia.gov; or
 - Fax to (804) 452-5454
- By phone at (804) 371-8488 or in-person at the Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq.* and the Rules of Court.


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EXHIBITS

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SAMPLE MCO MEDICAID CARDINAL CARE CARDS



Aetna Better Health[®] of Virginia


Name
Medicaid/Member ID # **DOB** **Sex**
Language
PCP
PCP Phone **Effective Date**

RxBIN: 610591 RxCN: ADV IbxGROUP: RX8837
 Pharmacist Use Only: 1-855-270-2365



AetnaBetterHealth.com/Virginia

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. WACARD-1



In case of an emergency go to the nearest emergency room or call 911.

Important numbers for members

Member Services	1-800-279-1878 (TTY 711)
Behavioral Health and Substance Use Hotline	1-800-279-1878
24 Hour Nurse Line	1-800-279-1878
Dental	1-888-962-3456
Transportation	1-800-734-0430



Important numbers for providers

Eligibility/Preauthorization:	1-800-279-1878
Radiology Preauthorization:	1-888-683-3211

Submit claims to
 Aetna Better Health of Virginia
 P.O. Box 582974
 El Paso, TX 79968-2974
 EDI Payer 128VA

Submit grievances and appeals to
 Aetna Better Health of Virginia
 P.O. Box 81158
 6801 Postal Road
 Cleveland, OH 44181

WACARD-2

JOHN Q SAMPLE

Member ID 123456789	PCP Name PCP Phone Medicaid ID
------------------------	--------------------------------------

Group Number	HKP00200	PCP/Specialist	\$0/\$0
BC/BS Plan	923	Outpatient	\$0
RxBIN:	020107	Inpatient	\$0
RxCN:	FM	Emergency	\$0
RxGRP:	WQWA	Rx	\$0/\$0

WAC1 102

anthem.com/vamedicaid

Member Services: 800-961-0628
Provider Services: 800-961-0628
 TTY: 711
 24/7 NurseLine: 888-961-0628
 Behavioral Health Crisis Line: 844-429-9628
 Authorization: 888-961-0628
 Dental*: 888-912-3456
 Transportation Services: 877-852-3588
 Pharmacy Member Services: 833-267-3128



*Department of Medical Assistance Services program

HealthKeepers, Inc.
 P.O. Box 21491
 Mail Drop VA2002-A600
 Richmond, VA 23279

HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Claims Filing Address: Post Office Box 27401
 Contractor ID: 0047993253
 Richmond, VA 23279

WAC1 102

Medicaid

Member name: XXXXXXXX
Preferred language: English
Medicaid ID #: 123456789
Subscriber ID #: 123456789
Effective date: xx/xx/xx

Pharmacy
RxBN: BIN number
RxCN: RXPEN
RxGRP: RXGroup

In case of emergency, go to the nearest emergency room or call 911

Member numbers
 Call (800) 424-4518 (TTY/TDD: 711) for information about your benefits which may include:

24/7 Pharmacy Help Line	Provider Services
Behavioral Health Crisis	Pre-Authorization
Care Coordination	Transportation
Member Services	

Dental: 888-912-3456
24/7 Nurse Advice Line (NAL): (1-800)

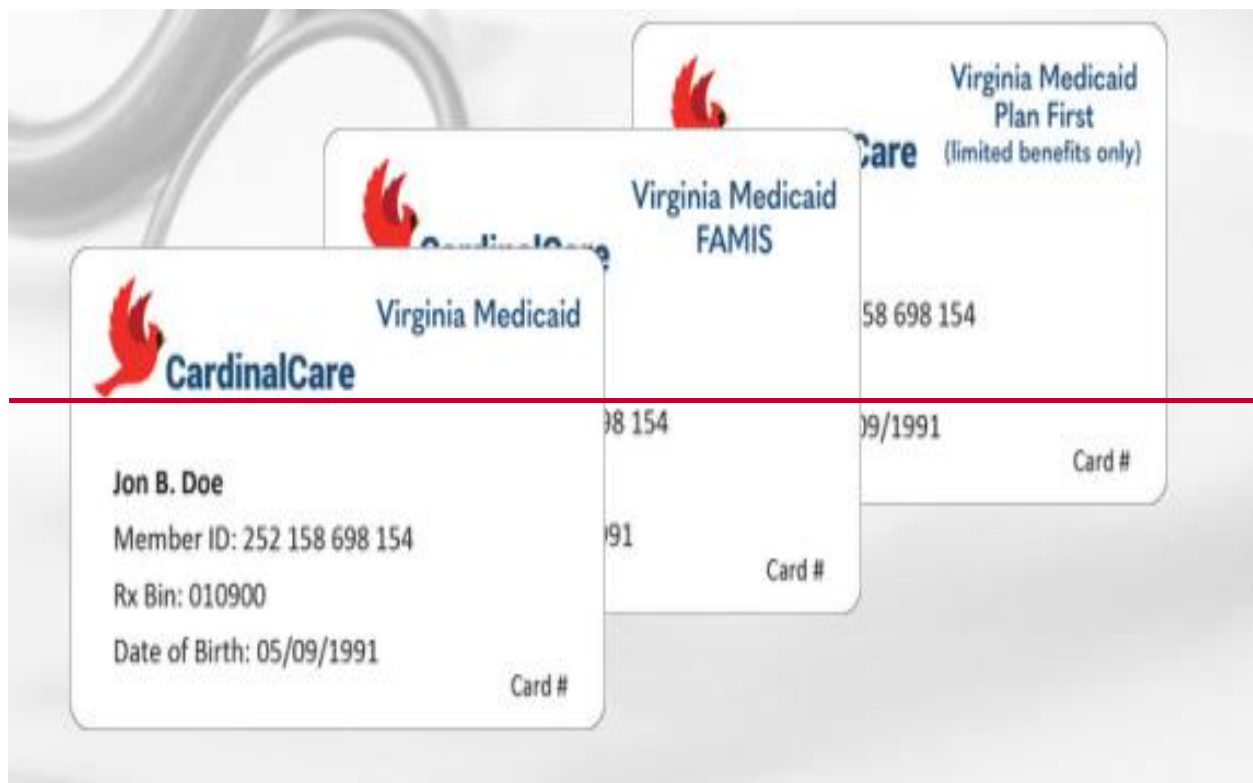
Providers/Hospitals:
 For your addresses, hours, eligibility, and general information, please call Member Services (see above).

Submit claims to:
Medicaid/Keystone: Molina Healthcare P.O. Box 72407, Long Beach, CA 90807
Pharmacy: Molina Healthcare 1050 Green Park Center, Suite 100, Raleigh, NC 27607

General mailing address:
 Molina Healthcare 3277 Oakdale Road, Richmond, VA 23221

MolinaHealthcare.com

SAMPLE MEDICAID/FAMIS/PLAN FIRST CARDINAL CARE CARDS



INSURANCE COMPANY CODES

CARRIER CODE	CARRIER NAME
00001	MEDICARE
00002	ABSENT PARENT
00003	NOT LISTED

00004 AMERICAN COMM MUT LIFE INS CO
 00005 ACADEMY LIFE INS CO
 00006 AETNA US HEALTHCARE
 00007 ALLSTATE INSURANCE CO
 00008 AMERICAN DEFENDER LIFE INS CO
 00009 AMERICAN FIDELITY ASSUR CO
 00010 AMERICAN HERITAGE LIFE INS CO
 00011 AMERICAN MUT LIABILITY INS CO
 00012 AMERICAN RESERVE LIFE INS CO
 00013 APPALACHIAN LIFE INS CO
 00014 WILSET ASOCIATES INS
 00015 WALMART ASSOC HLTH PLAN
 00016 AMERICAN INCOME LIFE INS CO
 00017 AMERICAN SENIOR CITIZENS
 00018 AMERICAN CANCER
 00019 AMERICAN INTEGRITY INS CO
 00020 BANKERS FIDELITY LIFE INS CO
 00021 BANKERS LIFE AND CASUA INS CO
 00022 BANKERS LIFE INS CO OF NE
 00023 BENEFICIAL NATIONAL
 00024 BLUE RIDGE INSURANCE CO
 00025 BUILDERS LIFE
 00026 AMERICAN FAMILY LIFE ASSUR CO
 00027 ATLANTIC LIFE INSURANCE CO
 00028 AMERICAN MOTORISTS INS CO
 00029 BENEFICAL MULTIPLE INS
 00030 TRIGON BC/BS OF VA
 00031 BLUE CROSS BLUE SHIELD SW VA
 00032 BC/BS OF THE NAT'L CAP'TL AREA
 00033 BLUE CROSS BLUE SHIELD MD
 00034 ANTHEM BC/BS OF CHATTANOOGA TN
 00035 BLUE CROSS BLUE SHIELD OF KY
 00036 OTHER BC BS
 00037 COMMONWEALTH LIFE INS CO OF KY
 00038 CONSTITUTION LIFE INS CO
 00039 COLUMBIA MUTUAL
 00040 CHAMPUS
 00041 CHAMPVA
 00042 CHARTER SECURITY
 00043 CHESAPEAKE LIFE INS CO
 00044 THE CITADEL LIFE INS CO
 00045 CITIZENS HOME
 00046 COASTAL STATES LIFE INS CO
 00047 COLONIAL LIFE ACCIDENT INS CO
 00048 COLONIAL PENN INSURANCE CO
 00049 COMBINED INS CO OF AMERICA
 00050 CIGNA
 00051 CONTINENTAL CASUALTY COMPANY
 00052 CENTRL ST HLTH LIF INS OMAHA
 00053 DEER
 00054 FOUNDERS LIFE ASSURANCE CO
 00055 KLAIS & COMPANY
 00056 BENEFIT ADMIN OF AMERICA INC
 00057 DURHAM LIFE INSURANCE CO
 00058 GROUP HEALTH ASSOCIATION INC

00059 GUARANTEE TRUST LIFE INS CO
00060 EASTERN INSURANCE COMPANY
00061 EMMCO INSURANCE COMPANY
00062 EMPLOYERS LIFE INS CO WAUSAU
00063 EQUITABLE LIFE ASSURANCE
00064 EQUITY NATIONAL LIFE INS CO
00065 DARDEN RESTAURANTS
00066 GROUP HEALTH ASSOCIATION INC
00067 GUARDIAN LIFE INS CO OF AMER
00068 HEALTH BENEFIT ADMINISTRATORS
00069 AETNA INS CO FORT WAYNE
00070 FEDERAL HOME LIFE INS CO
00071 NAT'L CLAIM ADMIN SERV (NCAS)
00072 FEDERATED LIFE INS CO
00073 FIDELITY BANKERS LIFE INS CO
00074 FIREMANS FUND INS CO
00075 METRO MACHINE CORP
00076 HUNT TAYLOR
00077 FIRST VIRGINIA LIFE INS CO
00078 THE FRANKLIN LIFE INS CO
00079 IDEAL MUTUAL
00080 ITT LIFE INSURANCE CO
00081 INA BENEFIT SER
00082 GEN FIDELITY
00083 GLOBE LIFE INSURANCE COMPANY
00084 GEOTWN COM HTH PLAN
00085 GOV EMP LIFE INS
00086 GULF LIFE INSURANCE CO
00087 BEVERLY ENTERPRISES
00088 INDEPENDENT LIFE ACCID INS CO
00089 THE LINCOLN NATL LIFE INS CO
00090 HARTFORD LIFE INSURANCE CO
00091 HERALD LIFE INSURANCE CO
00092 HOME BENEFICIAL LIFE INS CO
00093 HOME LIFE GROUP BENE SERV INC
00094 PEOPLE SECURITY INSURANCE CO
00095 LABORERS DIST COU VA HLTH WELF
00096 LIFE INVESTORS INS CO OF AMER
00097 MEDICO LIFE INSURANCE CO
00098 MONTGOMERY WARD LIFE INS CO
00099 INDEPENDENCE
00100 INTEGON LIFE INSURANCE CORP
00101 INTEGRITY NATL LIFE INS CO
00102 INTER STATE ASSURANCE COMPANY
00103 INVESTORS
00104 NATL ASSOC GOVER EMPLOY
00105 NATL SENIOR CITIZENS GROUP
00106 NATIONAL TRAVELERS LIFE CO
00107 JOHN HANCOCK MUTUAL LIF INS CO
00108 NATIONAL BENEFIT LIFE INS CO
00109 GREAT WEST LIFE ASSUR.CO-MD
00110 KENTUCKY CENTRAL LIFE INS CO
00111 KEY LIFE
00112 NATL ACCIDENT AND HLTH
00113 NATL LIFE AND ACCID INS CO

00114 NATIONAL CASUALTY CO
00115 LIBERTY LIFE INS CO
00116 LIBERTY NATIONAL LIFE INS CO
00117 LIFE AND CASUALTY INS CO TN
00118 LIFE INS CO OF GEORGIA
00119 LIFE INS CO OF NORTH AMERICA
00120 THE LIFE INSURANCE CO OF VA
00121 LINCOLN INCOME LIFE INS CO
00122 LONE STAR LIFE INSURANCE CO
00123 LUMBERMENS
00124 ORANGE STATE LIFE HLTH INS CO
00125 PEOPLES SECURITY LIFE INS CO
00126 PROTECTIVE LIFE INS CO
00127 THE PYRAMID LIFE INSURANCE CO
00128 MARYLAND LIFE
00129 MASSACHUSETTS GEN LIFE INS CO
00130 MASSACHUSETTS MUT LIFE INS CO
00131 MAYFLOWER NATIONAL LIFE INS CO
00132 MED INDEMNITY CO
00133 METROPOLITAN CASUALTY INS CO
00134 MIDLAND MUTUAL LIFE INS CO
00135 MID SOUTH INS CO
00136 MID STATES
00137 MIDWEST SECURITY INS CO
00138 MUTUAL OF OMAHA INS CO
00139 MUTUAL LIFE
00140 BENEFIT PLAN STRATEGIES
00141 NYHART (WYNN'S PRECISION)
00142 SOUTHEAST LIFE
00143 NATL AMER LIF INS CO OF PA
00144 BUSINESS ADMIN & CONSULTANTS
00145 NATIONAL HOME LIF ASSURANCE C
00146 INTERCARE BENEFIT SYSTEMS
00147 NATIONAL LIFE INSURANCE CO
00148 NATIONAL SAVINGS LIFE INS CO
00149 NATL UN FIRE INS PITTSBURG PA
00150 NATIONWIDE LIFE INSURANCE CO
00151 NEW YORK LIFE INSURANCE CO
00152 NORTH AMERICAN INS CO
00153 NORTHWESTERN NATL LIFE INS CO
00154 UFCW HLTH AND WELFARE FUND
00155 SOUTHWESTERN LIFE INS CO
00156 OCCIDENTAL
00157 OPTOMETRIC SERV CORP
00158 SENTRY LIFE INS CO
00159 STANDARD LIFE SEC INS CO OF NY
00160 PAUL REVERE LIFE INS CO THE
00161 PENN MUTUAL LIFE INS CO
00162 STONEBRIDGE INSURANCE COMPANY
00163 PENSION LIFE INS CO OF AMERICA
00164 PHYSICIANS LIFE IN CO
00165 JEFFERSON PILOT LIFE INS CO
00166 PIONEER LIFE INS CO OF IL
00167 PROVIDEN LIFE & ACCIDENT INS C
00168 PRUDENTIAL INS CO OF AMERICA

00169 CONFED-ADMIN-SERVICES-INC
00170 C & O RAILROAD
00171 SENIOR-AMER
00172 RELIANCE
00173 REPUBLIC-AMERICAN-LIFE-INS-CO
00174 NATIONAL-FINANCIAL
00175 ROYAL-GLOBE
00176 TRUST
00177 UNION-LABOR-LIFE-INS-CO
00178 UNION-BANKERS-INS-CO
00179 UNITED-EQUITABLE-INS-CO
00180 SAFECO
00181 SCHOLASTIC
00182 TRIGON-ADMINISTRATORS--VA
00183 SHENANDOAH-LIFE-INS-CO
00184 SOUTHERN-AID-LIFE-INS-CO-INC
00185 SOUTHLAND-LIFE-INS-CO
00186 SOUTHWEST-GENERAL
00187 STATE-FARM-FIRE-&-CASUALTY-CO
00188 SUN-LIFE-ASSURANCE-CO-OF-CANAD
00189 ITPE-NMU
00190 NETWORK-HEALTH-PLAN-CORP
00191 UNITED-CHAMBER-ASSUR-PLN
00192 TRANS-GENERAL-LIFE-INS-CO
00193 TRAVELERS
00194 TWENTIETH-CENTURY-LIFE-INS-CO
00195 AETNA-FMC-CORPORATION
00196 UNION-CENTRAL-LIFE-INS-CO-THE
00197 USAF-DEPT-OF-DEFENSE
00198 UNITED-FAMILY-LIFE-INS-CO
00199 USAA-LIFE-INS-CO
00200 UNION-SECURITY-LIFE-INS-CO
00201 UNITED-AMERICAN-INS-CO
00202 UNITED-FIRE-INSURANCE-COMPANY
00203 UNITED-MIN-WORK-OF-AMER-HLTH
00204 UNIVERSAL-LIFE-INS-CO
00205 CENTRAL-RESERVE-LIF-OF-N-AMER
00206 UNITED-INS-CO-OF-AMERICAL
00207 NATIONAL-FOUNDATION-LIFE-INS-C
00208 WESTERN-AND-SOUTHERN-LIFE-INS
00209 ZEBBA-TRUST
00210 ALUMINUM-WKRS
00211 AMALGAMATED-CLOTHING-&-TEXTILE
00212 AMAL-MEATCUTTERS
00213 AMERICAN-FED-OF-GOVT-EMP
00214 POSTAL-WKRS-UNION
00215 ASBESTOS-WKRS
00216 BAKERY-AND-CONFECTIONERY-BENE
00217 BRICKLAYERS-UNION
00218 BRHD-RAILWAY-CLERKS
00219 CARPENTERS-UNION
00220 COMM-WKRS-OF-AMER
00221 CONST-GEN-LAB-UNION
00222 INT-ASSO-MACHINSTS
00223 INT-BRHD-ELECT-WKRS

00224 INT UN OP ENGINEERS
00225 IRON WORKERS TRUST FUND
00226 MILLWRIGHTS UNION
00227 NATIONAL ASSOC OF LTR CARRIERS
00228 MAIL HANDLERS BENEFIT PLAN
00229 PLAST & CEMENT
00230 PLUMBERS & STEAMFITTERS
00231 SHEET METAL WORKERS' LOCAL 100
00232 TEAMSTERS JOINT COUNCIL NO 83
00233 FOOD & COMM WKRS
00234 UNITED PAPERWKRS
00235 UNITED STEELWKRS
00236 WAREHOUSE EMP
00237 BENEFIT PLAN SERVICES
00238 GREAT AMERICAN INS CO
00239 BANKERS MULTIPLE LINE INS CO
00240 VA DENTAL PLAN
00241 VA FARM BUR MUT
00242 VA MUT BENEFIT
00243 VA SURETY CO
00244 VOLUNTEER ST
00245 EMERSON ELEC BENE PLAN T
00246 EASTERN MED SUPPLY POLIC
00247 HARDEN & CO
00248 WAUSAU INSURANCE COMPANY
00249 WESTERN NAT LIFE INS CO
00250 WORLD INS CO
00251 HEALTH CARE ADINISTRATORS INC
00252 CROWN LIFE INS CO
00253 KEYSTONE INS CO
00254 YOUTHGUARD
00255 UNITED BENEFIT LIFE INS CO
00256 VA HLTH AND ACCIDENT ASSOC
00257 GUARANTEE RESERVE LIF INS CO
00258 NATIONAL LIBERTY LIFE
00259 GEORGE WASHINGTON LIFE INS CO
00260 PENNSYLVANIA LIFE INS CO
00261 OLD AMERICAN INS CO
00262 MONUMENTAL LIFE INS CO
00263 CENTRAL VA UFCW
00264 NEWPORT NEWS SHIPYARD
00265 PHYSICIAN MUTUAL INS CO
00266 REINSURED LEX GROUP INS
00267 EMPLOYEE BENEFIT CLAIMS
00268 VETERANS LIFE INS CO
00269 WASHINGTON AREA CORP CAR
00270 WAYNE ADMIN GROUP INS
00271 NEW ENGLAND GEN LIFE INS CO
00272 FIRST CONTINENTAL LIFE & ACCID
00273 MOUNTAIN TRAIL INSURANCE
00274 NAT'L HOME HEALTH
00275 WILLIS CORROON ADMIN SERV
00276 VA INDEPENDENT COAL CORP
00277 UNITED OF OMAHA LIFE INS CO
00278 NAT'L LEAGUE OF POSTMAST

00279 BENEFITS PLAN SERVICES INC
 00280 CONTRACT DRIVERS INS TRUST
 00281 TRANS AMER ACCIDENTAL LF
 00282 FOOD HEALTH CARE
 00283 RICHMOND BENEFICAL LIFE
 00284 UNION FIDELITY LIFE INS CO
 00285 SOUTHERN LUMBER MANF SPE
 00286 UNION PLAN ADMINSTRATIO
 00287 WOODMEN OF THE WORLD LIF INS
 00288 WASHINGTON NATIONAL INS CO
 00289 NORTH CAROLINA MUT LIF INS CO
 00290 SPERRY MARINE SYSTEM
 00291 DEPARTMENT OF LABOR
 00292 CIF SERVICE CENTER
 00293 VIRGINIA PLAN
 00294 THE MINISTERS & MISSIONARIES B
 00295 KISER INSURANCE CO
 00296 CENTRAL VA RETAIL CLERK
 00297 COSTAL PLAIN INS
 00298 N N INVESTORS LIFE INS
 00299 STUDENT ACCIDENT PROTECT
 00300 VA DENTAL SERVICE PLAN
 00301 WEAVER ASSOCIATES
 00302 HORSEMEN BEN & PROT ASSOC
 00303 PACIFIC MUTUAL LIFE INS CO
 00304 THE OHIO STATE LIFE INS CO
 00305 DELTA DENTAL PLAN OF VA
 00306 POSTMASTERS BENEFIT PLAN
 00307 EQUICOR
 00308 ESMARK
 00309 OPTIMA HEALTH PLAN
 00310 SMITHFIELD FOOD HEALTH PLAN
 00311 J P KENNEDY INS CO
 00312 HUMANA INSURANCE
 00313 ALLIANCE HLTH BENE PLAN
 00314 HRSA/ILA
 00315 ROLLINS INS CO
 00316 AARP
 00317 TIME INSURANCE COMPANY
 00318 COSTAL HEALTH CARE PLAN
 00319 HMO PLUS
 00320 HEALTH AMERICA
 00321 QUAKER CITY
 00322 MONUMENTAL GENERAL INS CO
 00323 UNION LIFE/HOSP INDEMNIT
 00324 UNION FEDERAL NATIONAL
 00325 COLONIAL BENEFIT ADMINISTRATOR
 00326 AETNA
 00327 NORTHEAST DELTA INSURANCE
 00328 H J WILLIAMS COMPANY INS
 00329 BENEFICIAL STANDARD LFE INS CO
 00330 FEDERAL LIFE INS CO
 00331 BAYLY MARTIN & FAY INS
 00332 HMO OF PENNSYLVANIA
 00333 BOILERMAKER NAT HLTH & WEL FND

00334 ENGINEERS UNION 106
 00335 U-S FIDELITY & GUARANTY
 00336 AVTEX FIBERS INC
 00337 STOUFERS CONCOURSE HOTEL
 00338 LOYAL AMERICAN LIFE INS CO
 00339 PRUDENTIAL AUTO DEALER
 00340 SECURITY TRST LFE INS CO OF GA
 00341 STATE MUTUAL INS CO OF AMERICA
 00342 NAT'L CAPITAL ADMIN SERVC
 00343 KISER GEORGETOWN INS
 00344 PRIVATE HEALTH CARE SYS
 00345 SECARE 65
 00346 TEACHERS PROTECTIVE MUT LFE IN
 00347 CCEB TRUST
 00348 SEA FARERS
 00349 CNS WHOLESALE GROCERY
 00350 WEYERHAEUSER GROUP INS
 00351 MAIL HANDLERS BENEFIT PLAN
 00352 CHOICE INS HEALTH PLAN
 00353 MWH MEDICORP MEDICAL PLN
 00354 GOVERNMENT EMPLOYEES HOSP ASSOC
 00355 VULCAN LIFE INS CO
 00356 JOHN ALDEN LIFE INS CO
 00357 PROVIDERS ALLCARE ADMINISTRATO
 00358 LIFE & HLTH INS CO OF AMERICA
 00359 CENTRAL LIFE ASSURANCE CO
 00360 IBEX BENEFITS
 00361 GREAT WESTERN
 00362 CONFEDERATION LIFE
 00363 BLUE CROSS/BLUE SHIELD OF MASS
 00364 AMERICAN REPUBLIC INS CO
 00365 HLTH CARE PLAN ADMIN
 00366 HORACE MANN INS CO
 00367 GENERAL AMERICAN INS CO
 00368 OXFORD LIFE INSURANCE CO
 00369 GENERAL AMERICAN INS CO
 00370 NORTH BROOK INSURANCE
 00371 HERITAGE NAT'L HLTH PLAN
 00372 GLOBAL INS MANAGEMENT
 00373 FLORIDA ROCK INDUSTRIES
 00374 VETERANS OF FOREIGN WARS
 00375 HUDSON GROUP ADMINIS
 00376 KAISER PERMANENTE
 00377 HARVEST LIFE INS CO
 00378 TENNESSEE COMPANY GROUP
 00379 TRANSPORT LIFE INSURANCE CO
 00380 CONTROL DATA SYSTEMS INC.
 00381 GREAT WEST LIFE ASSURANCE CO
 00382 HECHINGER
 00383 HOME BLDS ASSOC OF VA HLTH BNF
 00384 GREAT WEST LIFE ASSURANCE CO
 00385 CHESTERFIELD RESORCE INC
 00386 SECURITY TRST LFE INS OF GA
 00387 HILTON NEVADA CORP GRP HLTH BN
 00388 DAYSTORM LADD FURNITURE

00389 SENTARA HEALTH PLAN
00390 CAPITOL AMERICAN LIFE INS CO
00391 PRINCIPAL MUTUAL LIFE INS CO
00392 FIELDCREST MILLS
00393 HUDSON GROUP ADMINISTRATOR
00394 GOLDEN RULE LIFE INS CO
00395 CONSUMERS UNITED LIFE INS CO
00396 COMPREHENSIVE BENEFITS SERV CO
00397 DEAN COMPANY EMPLOYEE
00398 PLANNED ADMINISTRATOR INC.
00399 AWANA CLUBS INT'L GROUP INS
00400 DAN RIVER MILLS INC
00401 LINCOLN NATIONAL LIFE INS CO
00402 BOOKE AND COMPANY
00403 MEDICAL DOCTORS INDIV PRACTICE
00404 CORPORATE SYSTEMS ADMIN
00405 TRANSPORT LIFE INS COMPANY
00406 C AND A INSURANCE COMPANY
00407 FEDERAL EXPRESS CORP GRP HLTH
00408 ROSES INTERACTIVE MEDICAL SER
00409 CHARLES CO EMPLOYEE BENEFIT TR
00410 PROVIDERS ALLCARE ADM
00411 SETTLERS LIFE INS CO
00412 NORTHERN GROUP SERVICES INC
00413 AID ASSOCIATION FOR LUTHERANS
00414 OLD SURETY LIFE OF TEXAS
00415 PACIFIC FIDELITY LIFE INS CO
00416 LANE CO IN HLTH CARE PLAN
00417 REYNOLDS METALS INSURANCE
00418 C AND O EMPLOYEES HOSP ASSOC
00419 CAMPBELL TAGGART INC
00420 COBRA SERVICE
00421 BASSETT WALKER
00422 ATLANTA GROUP BENEFIT CENTER
00423 LONG - AIR DOX CO
00424 ALTA
00425 UNITED FURNITURE WORKERS INS
00426 ATLANTA LIFE INSURANCE CO
00427 GROUP HEALTH ADMINISTRATORS
00428 MEDICAL FACILITIES OF AMERICA
00429 CIGNA
00430 ADVANCED INSURANCE SERVICE
00431 ITT HARTFORD LIFE & ANNUITY
00432 HEALTH CLAIM SERVICES
00433 FRINGE BENEFIT REVIEW
00434 NGS AMERICAN
00435 JEFFERSON PILOT C/O AMPRO FISH
00436 CRUM & FOSTER INS COMPANIES
00437 T P A OF GEORGIA
00438 SECURITY LIFE INS CO OF AMER
00439 MCDONOUGH CAPERTON BENEFIT SER
00440 PCS HEALTH SYSTEM CLAIMS
00441 LAWRENCE MUSGROVE ASSOC
00442 WASHINGTON POST - SELF INSURER
00443 OPTIMUM CHOICE INC

00444 BLUE CROSS-BLUE SHIELD(EMPIRE)
 00445 GHI
 00446 BENEFIT PLAN ADMINISTRATORS
 00447 B/C--B/S OF ILLINOIS
 00448 JOHN DEERE LIFE INS COMPANY
 00449 NRECA NAT'L ROYAL ELECTRIC COR
 00450 H. L. DUKE & COMPANY
 00451 AMERICAN NATIONAL INS CO
 00452 THE MUTUAL GROUP
 00453 ACORDIA LOCAL GOV'MNT BENEFITS
 00454 AM FOREIGN SERV PROT ASSOC
 00455 E-B SERVICES INC
 00456 SELF FUNDED PLANS INC
 00457 PHYSICIANS ASSOC
 00458 FLEETWOOD INDUSTRIES
 00459 PAID PRESCRIPTION PROGRAM
 00460 SOUTHERN HEALTH INSURANCE
 00461 HEALTH PLUS
 00462 B/C--B/S OF NORTH CAROLINA
 00463 CAPITAL CARE BC BS
 00464 NATIONAL HEALTH INS CO
 00465 E-D S ELECTRONIC DATA SYSTEM
 00466 INSUREX BENEFITS
 00467 BENEFIT CONSULTANT SERVICES
 00468 MAMSOVA
 00469 AETNA LIFE INS CO NC
 00470 TOWER LIFE INSURANCE CO
 00471 SERV BEN PLAN RETAIL PHARM PRO
 00472 UNITED STATES LIFE INS CO
 00473 NATIONAL BENEFIT PLANS
 00474 CHESAPEAKE BAY FISHING CO
 00475 JOHN HANCOCK INS CO
 00476 GROUP HEALTH COOPERATIVE
 00477 AMALGATED LIFE INS CO
 00478 SAVERS LIFE INS CO
 00479 METLIFE (METROPOLITAN)
 00480 CIGNA HEALTHCARE
 00481 ROSES INC
 00482 BLUE CROSS/BLUE SHIELD-MI
 00483 BLUE CROSS-BLUE SHIELD-OF WV
 00484 BMA BUSINESS MEN'S ASSURANCE
 00485 HEALTH STRATEGIES
 00486 CORPORATE BENEFITS SERVICE INC
 00487 HEALTHKEEPERS
 00488 BLUE CROSS-BLUE SHIELD-OF AL
 00489 BC/BS OF PA (INDEPENDENCE)
 00491 AETNA LIFE INS CO INDIANA
 00492 KANAWHA INSURANCE CO
 00493 AMERICAN MEDICAL SECURITY
 00494 AMER POSTAL WORKERS UNION PLAN
 00495 TRAVELERS
 00496 PRIORITY HLTH CARE-HLTHKEEPERS
 00497 NATL ASSOC OF HOME BUILDERS
 00498 EMPLOYERS HEALTH INS CO
 00499 BORDEN INC

00500 PAN AMERICAN LIFE INS CO
 00501 THE GUARDIAN
 00502 NOBLE LOUNDES AND JOHNSON
 00503 CONTINENTAL GENERAL INS CO
 00504 SOUTHERN BENEFIT SERVICE
 00505 AMER BANKERS LIFE ASSUR OF FL
 00506 NATIONWIDE LIFE INS CO
 00507 GUARANTEE MUTUAL LIFE INS CO
 00508 PIECE GOOD SHOPS INC SELF INSU
 00509 WASHINGTON WHOLESALERS INS CO
 00510 STATE FUND WORKERS COMPENS INS
 00511 ADMINISTRATIVE CONSULTANTS
 00512 BLUE CROSS BLUE SHIELD OF FL
 00513 GROUP BENEFITS SERVICES
 00514 PHOENIX MUTUAL LIFE INS
 00515 DUKE AND CO EMPLOYEE BEN MANAG
 00516 THE PRINCIPAL FINANCIAL GROUP
 00517 PLUMBERS PIPEFITTERS MED FUND
 00518 EMPLOYEE BENEFIT MANAGEMENT CO
 00519 CENTRAL BENE NATL LIFE INS CO
 00520 FORTIS BENEFITS INS CO
 00521 BLUE CROSS BLUE SHIELD OF MO
 00522 ALICARE INC
 00523 RURAL ELECTRIC GRP INS ADMINIS
 00524 METROPOLITAN LIFE INS CO
 00525 BLUE CROSS BLUE SHIELD OF TX
 00526 CLAIMSWARE INC
 00527 HEALTH RISK MANAGEMENT
 00528 THE MEGA LIFE & HEALTH INS CO
 00529 BC/BS OF MAINE
 00530 TPA OF FORT WORTH
 00531 ACORDIA NATIONAL
 00532 BC/BS OF CENTRAL NEW YORK
 00533 DIVERSIFIED GROUP ADMIN. INC.
 00534 AFF TEAMS HLTH/WEL MD-LOCAL311
 00535 PIEDMONT ADMINISTRATORS
 00536 FIRST HEALTH - UTAH
 00537 GLOBE LIFE & ACCIDENT INS. CO.
 00538 COMMUNITY MUTUAL INS CO
 00539 BLUE CROSS-BLUE SHIELD-HIGHMRK
 00540 CIGNA
 00541 THE GUARDIAN
 00542 ALLIANCE ASSURANCE CO
 00543 TRAVELERS-NEW YORK
 00544 UNITED MEDICAL RESOURCES INC
 00545 HEALTH SOURCE INS GROUP
 00546 AMERICAN CONT LIFE INS CO
 00547 TRAVELERS-DENTAL-NEW YORK
 00548 HMO OF VIRGINIA
 00549 A CONSULTING SERVICES
 00550 AETNA HEALTH PLAN-OHIO
 00551 FCE BENEFIT ADMINISTRATORS
 00552 FIRST HLTH ADVANTAGE-PROVIDIAN
 00553 PRO CLAIM ADMIN INC (PROCLAIM)
 00554 CORESOURCE INC (NC)

00555 METRAHEALTH
00556 CORESOURCE INC
00557 DUKE BENEFITS SERVICES
00558 PHARMACY NETWORK NAT CORP
00559 BANKERS UNITED LIFE ASSURANCE
00560 SOUTHERN HEALTH SERVICES
00561 GRGE WASHINGTON UNIV HLTH PLAN
00562 METRO LIFE INS CO (DE)
00563 BA MULLICAN LUMBER/MANUF CO
00564 HOME LIFE GP BEN & SERV INC
00565 CONTINENTAL ASSURANCE CO
00566 AETNA LIFE INS CO - TX
00567 BC/BS OF WI
00568 NAT TELE COOP ASSOC/GRP HLTH
00569 AMPRO FISHERIES COMPANY
00570 EXPRESS SCRIPTS
00571 HARRINGTON BENEFIT SERVICES
00572 PARTNERS NAT HLTH PLANS NC
00573 GROUP INSURANCES SERVICES
00574 ASSOCIATED BENEFITS CORP OF TN
00575 FOUNTAINHEAD ADMIN INC
00576 SINGER FURNITURE - ROANOKE
00577 HUMANA HEALTH PLAN
00578 BLUE CROSS AND BLUE SHIELD TN
00579 CHUBB LIFEAMERICA INS. CO
00580 SPECTRUM ADMINISTRATORS
00581 GENERAL HEALTH BENEFITS
00582 BLUE CROSS AND BLUE SHIELD NJ
00583 HEALTHTRUST
00584 BLUE CROSS AND BLUE SHIELD MS
00585 AMINITRON
00586 TRAVELERS PLAN ADMIN OF TENN
00587 GALLAGHER BASSETT
00588 ALEXANDRIA HOSPITAL PLAN
00589 PROVIDENT LIF AND ACCID
00590 HEALTHSOURCE PROVIDENT-MEDICAL
00591 NASI WELFARE FUND
00592 WILLSE & ASSOCIATES INC
00593 CLAIM MANAGEMENT SERVICE
00594 PENN WESTERN BENEFITS INC
00595 PHILADELPHIA AMERICAN LIFE INS
00596 JONBIL INC
00597 ELECTRO-MECHANICAL CORP
00598 COLUMBIA FOREST PRODUCTS
00599 FEDERAL BLACK LUNG ASSOC
00600 JEFFERSON PILOT LIFE INS CO TN
00601 GENERAL ELECTRIC MED BENEFITS
00602 E.B.C. MID-AMERICAL
00603 HELATH NETWORK AMERICA
00604 MENNONITE MUTUAL AID
00605 THE TRAVELERS-MANAGED CARE SYS
00606 LIFE INSURANCE CO OF N AMER
00607 MEDICAL CLAIMS MANAGEMENT CORP
00608 METRA HLTH/RAILROAD ACCOUNTS
00609 MAMSI

00610 CAREMARK PRESCRIPTION SERV DIV
00611 MID-ATLANTIC MED SERV
00612 NEW YORK LIFE/HEALTH PLUS
00613 WEIMAN UPHOLSTERY
00614 ACORDIA NATIONAL-BC/BS OF KY
00615 POWELL MOUNTAIN COAL CO INC
00616 NOBEL GROUP BENEFITS
00617 BLUE CROSS/BLUE SHIELD OF NJ
00618 U-S HEALTHCARE
00619 MCKEE FOODS GROUP BENEFITS
00620 STATE FARM INSURANCE
00621 BLUE CROSS/BLUE SHIELD OF IOWA
00622 BASSETT FURNITURE
00623 BRESCO INC
00624 BLUE CROSS/BLUE SHIELD OF SC
00625 NEW RIVER INDUSTRIES INC
00626 BLUE CROSS/BLUE SHIELD KANSAS
00627 COST MANAGEMENT TECHNOLOGIES
00628 BLAIR MILL ADMINISTRATORS
00629 CENTRA HEALTH BENEFITS
00630 MAN-U SER CONTRACT TRUST FUND
00631 WILLIAM TALLEY SIGN CO
00632 B.P.S. INC
00633 CELTIC LIFE INS CO
00634 LADD MEDICAL CLAIMS DEPT
00635 SELF INSURED SERV CO
00636 SHOOSMITH BROTHERS INC HLTH PLN
00637 MANCHESTER GROUP HEALTH PLAN
00638 DOANE PRODUCTS CO GROUP BENE
00639 EDUCATORS MUTUAL LIFE
00640 CENTRAL CAROLINA WAREHOUSE GRP
00641 MANGE-MEDICAL CLAIMSWARE
00642 ELECTRICAL WELFARE TRUST FUND
00643 PRUDENTIAL INSURANCE COMPANY
00644 MET LIFE DENTAL
00645 GREAT WEST LIFE & ANNUITY INS
00646 BASSETT EMPLOYEE BENEFITS
00647 ANTHEM LIFE
00648 CIGNA HEALTHCARE OF VA
00649 JOHN HANCOCK
00650 JOHN DEERE HLTH CARE
00651 HILSTON VALLEY MED CTR
00652 THE GUARDIAN
00653 SOTHERN HEALTH TPA
00654 NETWORK INSURANCE INC
00655 ROCCO BENEFITS
00656 MANPOWER
00657 LAB DIST CO HL & WEL TRST FD#2
00658 MASS MUTUAL UNICARE
00659 JONES HILL & MERCER EMPL BENE
00660 BLUE CROSS AND BLUE SHIELD
00661 AETNA LIFE INS CO-PENNSYLVANIA
00662 CARILION HEALTH PLANS
00663 AETNA LIFE INS CO-FLORIDA
00664 CIGNA-DELEWARE

00665 STARMARK
00666 MEDICARE PART B-RAILROAD
00667 AETNA HEALTH PLAN-OKLAHOMA
00668 FIRST HEALTH-MARYLAND
00669 GREAT WEST LIFE ASSUR CO PITTSB
00670 CONTINENTAL LIFE AND ACCIDENT
00671 TYSON FOODS INC
00672 STRATEGIC RESOURCE COMPANY
00673 WASHINGTON GAS & LIGHT CO
00674 AETNA LIFE INS CO-MASS
00675 DENTAL HLTH ADMIN & CONSLT SR
00676 FAISON INSURANCE ASSOCIATES
00677 TEACHER'S STATE EMPLOYEES'
00678 HEALTH PLANS INC
00679 FEDERATED MUTUAL INS.
00680 ACORDIA BENEFITS OF THE SOUTH
00681 ADMINITRON INC.
00682 ACORDIA BENEFITS
00683 HEATAC INC.
00684 VIRGINIA SPRINKLERS
00685 MANAGED PRESCRIPTION SERVICES
00686 PULASKI FURNITURE CORPORATION
00687 PIEDMONT COMMUNITY HEALTH PLAN
00688 CONSUMER DENTAL CARE
00689 ALTA HEALTH STRATEGIES INC
00690 METRAHEALTH
00691 AETNA LIFE INS CO-TYLER TX
00692 EMPLOYESS PLAN INC
00693 FEDERAL EMP BENE-TRIGON-BCBS
00694 DONOVAN BENEFIT SYSTEMS INC
00695 EXPRESS SCRIPTS INC
00696 NATIONAL PRESCRIPTION ADM-NPA
00697 KIRK VAN ORSDEL INC
00698 BLUE CROSS & BLUE SHIELD OHIO
00699 GOODYEAR GROUP INS.
00700 INDIANAPOLIS NEWSPAPERS INC
00701 VIRGINIA HEALTH NETWORK
00702 EPOCH GROUP
00703 UNITED HEALTHCARE CORPORATION
00704 THE NEW ENGLAND CARE HLTH PLAN
00705 COLUMBIA HOSP CORP OF AMERICA
00706 PROVANTAGE
00707 MEDIPLUS
00708 FIRST ALLMERICA FINAN LIFE
00709 BC/BS OF CT
00710 CENTRAL UNITED INSURANCE CO
00711 AETNA LIFE INS CO-CALIF
00712 DONNKENNY APPAREL INC.
00713 ALLMERICA FINANCIAL
00714 SRX PHARMACY SPECIALISTS
00715 HEALTHSOURCE PROVIDENT
00716 BC/BS OF PA (CAPITAL)
00717 L & H ADMINISTRATORS
00718 GRAPHIC COMM & NAT'L H & W FND
00719 RELIASTAR(PRESTO PROD-#187119)

00720 METROPOLITAN LIFE INS CO-ILL
 00721 QUALCHOICE OF NORTH CAROLINA
 00722 AETNA HEALTH PLAN-MID-ATLANTIC
 00723 WISCONSIN PHYS SERV/INSUR-TEG
 00724 GATEWAY HEALTH ALLIANCE
 00725 CORPORATE HEALTH ADMINISTRATOR
 00726 AETNA LIFE INS CO--MICHIGAN
 00727 PRUDENTIAL INS CO (ALBANY)
 00728 TRIGON ADMINISTRATORS--NC
 00729 AETNA LIFE INS CO--READING
 00730 BC/BS OF PUERTO RICO
 00731 AETNA LIFE INS CO--FRESNO CA
 00732 STANDARD INSURANCE COMPANY
 00733 YOUNG LIFE BENEFIT PLAN
 00734 BLUE CROSS/BLUE SHIELD-CALIF
 00735 BC/BS OF ARKANSAS
 00736 AETNA INS CO.- KENTUCKY
 00737 AETNA HEALTH PLAN--ILLINOIS
 00738 BLUE CROSS/BLUE SHIELD
 00739 ANTHEM BLUE CROSS/BLUE SHIELD
 00740 PRUDENTIAL HEALTHCARE GROUP
 00741 POSITIVE CARE ADMINISTRATORS
 00742 TYSON FOODS INC-TEMPERANCEVILL
 00743 EMPLOYEE BENEFIT SERVICES INC
 00744 ALLIED ADMINISTRATORS
 00745 PRINCIPAL HLTH CARE OF MID-ATL
 00746 CENTRA
 00747 THE DARBY CHOICE PROGRAM
 00748 PRUDENTIAL HEALTHCARE
 00749 PENINSULA HEALTHCARE
 00750 INTERACTIVE MEDICAL SYSTEMS
 00751 VALUE BEHAVIORAL HEALTH
 00752 HEWITT COLEMAN AND ASSOCIATES
 00753 USA HEALTH NETWORK
 00754 ONE HEALTH PLAN
 00755 MEDIPLAN
 00756 CNA INSURANCE CO
 00757 SOUTHAMPTON MEM HOSP-VICARE AD
 00758 AETNA LIFE INS CO-DELAWARE
 00759 HEALTH PLAN SERVICES INC.
 00760 UNITED HLTHCARE ADMINISTRATORS
 00761 NYL CARE
 00762 MCELROY METAL MILL INC
 00763 ALLIANCE
 00764 UNITED HEALTH CARE
 00765 OPTIMUM CHOICE
 00766 UNICARE GROUP CLAIMS
 00767 CHA HEALTH
 00768 UNITED HEALTHCARE
 00769 LITTLE CAESAR FRANCHISE BEN PL
 00770 STARBRIDGE/STAR HUMAN RES GRP
 00771 BC/BS OF ROCHESTER AREA
 00772 EMPHESIS
 00773 KENTUCKY UTILITIES COMPANY
 00774 THE GUARDIAN (WASHINGTON)

00775 LINE CONSTRUCTION BENEFIT FUND
00776 NEW YORK LIFE
00777 UNICARE
00778 BC/BS OF MINNESOTA
00779 CRAWFORD & COMPANY
00780 BLUE CROSS BLUE SHIELD OF LA
00781 PROVIDENT LIFE & ACC-S.CAROLINA
00781 PROVIDENT LIFE & ACC-S.CAROLINA
00782 BUNKER HILL FOODS INC
00783 CIGNA - NEW MEXICO
00784 BENEFIT CONCEPTS INSURANCE
00785 HUMANA EMPLOYERS HEALTH
00786 BC/BS OF UTICA (NEW YORK)
00787 THE CENTENNIAL LIFE INS. CO.
00788 PREFERRED HEALTH PLAN INC.
00789 BENEFIX/OLAN MILLS GR MED PLAN
00790 JEFFERSON PILOT (BLUE RDG ADM)
00791 CUNA MUTUAL INS CO-CREDIT UNIO
00792 AMERITAS DENTAL CARE DIVISION
00793 PITTMAN AND ASSOCIATES
00794 COMMONWEALTH HEALTH ALLIANCE
00795 BENEFIT ASSISTANCE CORP
00796 COASTAL LUMBER HEALTH CARE
00797 ARAMARK
00798 VICARE
00799 PRIMARY HEALTH SERVICES
00800 ABC-ASSOC BLDRS & CONTRACTORS
00801 KEMPER NATIONAL INS COMPANY
00802 WORKMANS OIL INC.(ACS GROUP)
00803 WYNN'S
00804 THE TPA
00805 COMMUNITY HEALTH
00806 AMERICAN HEALTH SERVICES
00807 MVP SELECT CARE INC
00808 BC/BS OF DELAWARE
00809 GREAT WEST LIFE ASSUR CO.-OHIO
00810 PRIMARY PHYSICIAN CARE
00811 SOUTHEASTERN PIPE TRADES
00812 ADMINISTRATIVE SERVICES INC
00813 CARDAY ASSOCIATES
00814 PHOENIX GROUP SERVICES
00815 LAND-O-SUN DAIRIES INC.
00816 TUCKER ADMINISTRATOR
00817 SELF FUNDING ADMINISTRATORS
00818 MAKSIN MANAGEMENT CO.
00819 UNITED HEALTHCARE
00820 NATIONAL ELEVATOR INDUSTRY HLT
00821 INTER-RAIL TRANS. INC.
00822 MANUS INC.
00823 PILGRIM HEALTH CARE
00824 GEORGETOWN HEALTH PLAN
00825 AETNA LIFE INS CO-HARTFORD CT
00826 DAVIS-GARVIN AGENCY
00827 DIVERSIFIED PHARM. SERVICES
00828 ADVANCED PARADIGM INC.

00829 ALLIANCE PPO
00830 PEOPLES BENEFIT LIFE INSURANCE
00831 PARTNERS OF NORTH CAROLINA INC
00832 VICARE
00833 HEALTH ALLIANCE PLAN
00834 FINDLAY INDUSTRIES
00835 ECKARD HEALTH SERVICES
00836 ADVANCE DATA SOLUTIONS
00837 PHARMACY ADVANTAGE SYSTEMS
00838 MEDCO/PAID PRESCRIPTION
00839 VISION ONE
00840 ALL RISK ADMINISTRATORS INC.
00841 ADMINISTRATIVE SERV OF N.AMER
00842 AUTOMATED GRP ADMIN. INC.
00843 BENEFIT PLAN ADMINISTRATORS
00844 COOPERATIVE BENEFIT ADMIN
00845 CIGNA HEALTHCARE
00846 EXPRESS SCRIPTS INC.
00847 CIGNA HEALTH PLANS
00848 CIGNA HEALTHCARE
00849 AETNA US HEALTHCARE
00850 CIGNA HEALTHCARE
00851 RX PRIME
00852 CIGNA HEALTHCARE
00853 MET LIFE DENTAL
00854 CIGNA HEALTHCARE
00855 CIGNA HEALTHCARE
00856 CIGNA HEALTHCARE
00857 HOOKER FURNITURE
00858 CIGNA HEALTHCARE
00859 CIGNA HEALTHCARE
00860 EMPLOYEE BENEFIT CLAIMS INC.
00861 FEDERATED MUTUAL INS. CO.
00862 FIELDCREST CANNON INC.
00863 CIGNA INDEMNITY DENTAL
00864 GREAT WEST
00865 GREAT WEST
00866 GREAT WEST
00867 GROUP RESOURCES INC.
00868 JEFFERSON PILOT LIFE INS.
00869 KAISER PERMANENTE
00870 JOHN ALDEN LIFE INS. CO.
00871 KANAWHA HEALTHCARE SOLUTIONS
00872 BENESCRIP
00873 MID-WEST NATIONAL LIFE INS CO
00874 FIRST HEALTH
00875 MAMSI
00876 DIVERSIFIED PHARMACEUTICAL SVC
00877 JOHN P. PEARL & ASSOC.
00878 OPTIMUM CHOICE
00879 PACIFIC MUTUAL
00880 PIEDMONT COMMUNITY HEALTH PLAN
00881 PRINCIPAL FINANCIAL GROUP
00882 UNIVERSAL RX
00883 ULTRA LINK

00884 DELTA DENTAL OF ARKANSAS
00885 DELTA DENTAL OF PENNSYLVANIA
00886 UNICARE
00887 UNIFI INC./MEDCOST
00888 PHARMACARE
00889 VISION SERVICE PLAN
00890 DISNEY GROUP INC.
00891 AMERICAN GROUP ADMINISTRATOR
00892 CARITEN INSURANCE CO
00893 CIGNA HEALTHCARE
00894 SO.E.PIPETRADERS H & W FD/#491
00895 JOHN DEERE HEALTHCARE
00896 ANTHEM HEALTH & LIFE (AHL)
00897 AETNA PHARMACY MANAGEMENT
00898 SPECTERA
00899 PRUDENTIAL HEALTHCARE
00900 MEDIMPACT
00901 EAGLE MANAGE CARE
00902 EXPRESS SCRIPT VALUE RX
00903 UNICARE DENTAL
00904 PRUDENTIAL HEALTHCARE DENTAL
00905 PRINCIPAL FINANCIAL GROUP
00906 PRUDENTIAL INSURANCE
00907 PRUDENTIAL INSURANCE
00908 PROFESSIONAL CLAIMS MANAGEMENT
00909 FORTIS BENEFITS INS. CO.
00910 COMMUNITY HEALTHCARE
00911 UFCW
00912 GROUP DENTAL SERVICE
00913 ARGUS HEALTH SYSTEM
00914 ADMINISTRATED SOLUTIONS INC.
00915 SHEFFIELD OLSON & MCQUEEN INC.
00916 SCRIPT CARE
00917 PIEDMONT COMMUNITY HEALTH PLAN
00918 CIGNA HEALTHCARE
00919 PRINCIPAL FINANCIAL
00920 PRINCIPAL FINANCIAL
00921 PRINCIPAL FINANCIAL
00922 PRINCIPAL FINANCIAL
00923 PRINCIPAL FINANCIAL
00924 CIGNA HEALTHCARE
00925 CIGNA HEALTHCARE
00926 UNICARE
00927 UNITED HEALTHCARE OF MIDWEST
00928 GOLDEN RULE
00929 UNICARE
00930 UNICARE DENTAL
00931 ERISA DESIGNED SYSTEMS ADMIN
00932 NATIONAL TEXTILES
00933 ALLIANZ LIFE INSURANCE CO
00934 COMPANION LIFE
00935 MEDICHOICE
00936 SAI MEDICAL HEALTH
00937 KAISER PERMANENTE
00938 CORNING INC. HEALTH BENEFITS

00939 AON CONSULTING
00940 BLUE CROSS/BLUE SHIELD-S CAROL
00941 FIRST OPTION HEALTH PLAN
00942 AARP HC OPTIONS/UNITED HC CLAI
00943 INSURERS ADMINISTRATORS
00944 TUFTS BENEFIT ADMINISTRATORS
00945 RX NET
00946 DELMARVA UNITED F&C WKRS
00947 GROUP H PENSION ADMINISTRATOR
00948 RESERVE NATIONAL INS CO
00949 RURAL CARRIER BENEFIT
00950 FMH BENEFIT SERVICES INC.
00951 HRM CLAIM MANAGEMENT INC.
00952 THE BOARD OF PENSIONS
00953 CENTRA
00954 SIMA/SOUTHERN INSURANCE MGMT
00955 NEW ENGLAND FINANCIAL
00956 MEDICAL MUTUAL OF OHIO
00957 WELS VEBA HLTH PLAN GRP ASSOC
00958 MD HEALTH PLAN
00959 SERV-U PRESCRIPTION SERVICES
00960 SOUTH WEST INSURANCE
00961 METRA HEALTH ESSILOR OF AMERIC
00962 GALLAGHER BASSETT SERVICES INC
00963 DDP*DELTA
00964 JFP BENEFIT MANAGEMENT INC.
00965 VIRGINIA PREMIER HEALTH PLAN
00966 ANTHEM HEALTH & LIFE INS. CO.
00967 CHEVRON MEDICAL PLAN
00968 THE NYHART COMPANY INC.
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00970 FREEDOM LIFE INS CO OF AMERICA
00971 BOARD OF PENSIONS
00972 COMMUNITY CARE PLUS
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00975 USA ONE
00976 NEW ENGLAND FINANCIAL (MD)
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00983 PEOPLES BENEFIT & VETERANS LIF
00984 HEALTH MANAGEMENT CORPORATION
00985 DELTA DENTAL OF TENNESSEE
00986 JF MOLLOY & ASSOCIATES
00987 U.S. ABLE ADMINISTRATORS
00988 IBC
00989 SUN HEALTH INC.
00990 AMERIHEALTH ADMINISTRATORS
00991 THE LOOMIS COMPANY
00992 AETNA US HEALTHCARE-- MARYLAND
00993 LIFE INVESTORS

00994	CARENET
00995	AMERICAN BENEFITS MANAGEMENT
00996	TWENTY-FIRST CNTRY HLTH & BENF
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A06	UNITED HEALTH CARE
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A10	KANSAS CTY LIFE ADMIN SERVICES
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A12	HLTH & WELFARE BENEFIT SYSTEMS
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A14	SEABURY AND SMITH
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A20	LEGGETT & PLATT
A21	GROUP ADMINISTRATORS LTD
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A34	GREAT WEST
A35	AETNA US HEALTHCARE
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A38	CENTRAL STATES WELFARE FUND
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A41	AMERICAN GENERAL LIFE & ACCIDENT
A42	AAGI
A43	SCOTT AND WHITE HEALTH PLAN
A44	FEDERAL MOGUL
A45	CONCORDIA HEALTH PLAN
A46	IPS
A47	VIGILANT INSURANCE
A48	UNITED HEALTHCARE OF NEW YORK
A49	MAIL HANDLERS BENEFIT PLAN

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 A51 GLEN RAVEN MILLS INC.
 A52 CHARLOTTE HEALTH CARE SRV. CTR
 A53 CIGNA HEALTHCARE
 A54 CAMBRIDGE
 A55 RESTAT
 A56 MED TAC HEALTHCARE
 A57 CORESTAR/ELECTRA HEALTH NETWK
 A58 BENEFIT MANAGEMENT SERVICES
 A59 FOREIGN SERVICE BENEFIT PLAN
 A60 GREAT WEST LIFE
 A61 AETNA US HEALTHCARE
 A62 AETNA U.S. HEALTHCARE
 A63 MAMSI
 A64 MONUMENTAL LIFE INSURANCE
 A65 JOHN ALDEN LIFE INSURANCE CO.
 A66 GENERAL PRESCRIPTION
 A67 CHURCH MUTUAL INSURANCE
 A68 FOREIGN SERVICE BENEFIT PLAN
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 B07 NATIONAL MED. HLTH.CARD SYSTEM
 B08 AMALGAMATED INSURANCE FUND
 B09 MACHIGONNE BENEFIT ADMIN.
 B10 PEOPLES BENEFIT SERVICES INC.
 B11 OXFORD HEALTH PLAN
 B12 CORESOURCE
 B13 AMERICORPS PROGRAM
 B14 INSURANCE MANAGEMNT ADMIN(IMA)
 B15 ADVANCE PCS
 B16 CLAIMSPRO
 B17 HEALTH PLAN OF NEVADA INC.
 B18 CHESAPEAKE HEALTH
 B19 AETNA US HEALTHCARE
 B20 PANAMA CANAL AREA HLTH BENEFIT
 B21 PROCARE RX
 B22 BENEFITS SYSTEMS
 B23 NESTLE
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 B28 BENEFIT COORDINATORS INC.
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 B51 UNITED CONCORDIA
 B52 HCH ADMINISTRATION
 B53 ONE HEALTH PLAN
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 B55 HIGHMARK SERVICE COMPANY
 B56 THE CAPELLA GROUP
 B57 CONNECTICUT GEN/UNITED METHODIST
 B58 UNITED TEACHER ASSOC./MEDICARE
 B59 STANDARD LIFE & ACCID. INS. CO
 B60 CIGNA

B61 GENERAL PRESCRIPTION PROGRAM
 B62 WESTMORELAND COAL COMPANY
 B63 SOUTHERN HEALTH SERVICES INC.
 B64 PROVIDENCE HC RISK MANAGER
 B65 CIGNA HEALTHCARE
 B66 BLUE CROSS-BLUE SHIELD KEYCARE
 B67 BLUE CROSS-BLUE SHIELD FEDERAL
 B68 AARP-HEALTHCARE OPTIONS
 B69 GEICO GENERAL INSURANCE CO.
 B70 MINNESOTA COMM. HEALTH (MCHA)
 B72 HILLCO LTD
 B73 CIGNA HEALTHCARE
 B74 BLUE CROSS/BLUE SHEILD OF OK
 B75 VALLEY COMMUNITY HC NETWORK
 B76 RBMS LCC/RISK & BENEFIT MGMT
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 C06 UNICARE HEALTHCARE OF VIRGINIA
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 C09 PROVIDENCE HEALTH PLAN
 C10 PREFERRED ONE ADMIN. SERVICES
 C11 P-5 HEALTH SERVICES
 C12 HEALTHCOMP
 C13 USI ADMINISTRATORS
 C14 LBA HEALTH PLAN
 C15 EMPIRE BLUE CROSS/BLUE SHIELD
 C16 INTEQ/FOUNDATION ONE
 C17 STAR HUMAN RESOURCE GROUP

C18 EMPLOYEE BENEFIT MNGT. SERVICE
C19 PACIFIC LIFE & ANNUITY
C20 CONNECTICARE INC.
C21 THE ANTIOCH COMPANY
C22 HELLER ASSOCIATES
C23 MEDICA
C24 T. R. PAUL INC.
C25 WASHINGTON EMPLOYER'S TRUST
C26 CARDINAL HOME INC. BENEFITS
C27 ARLINGTON BENEFIT SERVICES
C28 FIDELITY INSURANCE
C29 LONG CLAIMS SERVICES
C30 S & S HEALTHCARE STRATEGIES
C31 FAMILY HERTIAGE LIFE INS. CO.
C32 UNITED MEDICAL RESOURCE INC.
C33 JSL ADMINISTRATORS INC.
C34 INSURANCE SERVICE OF LUBBOCK
C35 ALTERNATIVE INSURANCE RESOURCE
C36 FOUNDATION ONE
C37 CHESAPEAKE HEALTH/AON SELECT
C38 WELLPATH
C39 HOLDEN & COMPANY
C40 NAT. VISION ADM. OF WISCONSIN
C41 RWDSU BENEFITS
C42 EQUITABLE PLAN SERVICES
C43 LONDON HEALTH ADMINISTRATORS
C44 BLUE CROSS BLUE SHIELD OF NE
C45 TEAMSTERS LOCAL 639-EMPL. HEALTH
C46 PROFESSIONAL BENEFITS SERVICES
C47 NC STATE COMPREHENSIVE MAJOR
C48 SOUTHERN BEN. ADM. CAROLINA-VA
C49 BRIDGESTONE/FIRESTONE
C50 A.B.T LIFECARE CTRS. OF AMERICA
C51 HEALTH NEW ENGLAND
C52 SUPERIOR VISION SERVICES
C53 ASR GROUP
C54 BEECH STREET
C55 MAMSI
C56 AMERICAN HOME PATIENT
C57 LOCAL 1205 UNION
C58 ABA INC.
C59 INTER. UNION OF OPERATING ENG.
C60 ANTHEM BC/BS OF IDAHO
C62 LABORERS TRUST FUND
C63 JLT SERVICES
C64 PROTECTIVE CONSUMER DIRECT
C65 LUMENOS
C66 EQUITABLE LIFE AND CASUALTY
C67 ASSOCIATED PLAN ADMINISTRATORS



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Data Elements 3013 TPL Coverage Code

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GENERAL INFORMATION

A code that identifies the type of coverage an enrollee has with the third party. Allowed values in this report are 'A' = Part A, 'B' = Part B and 'RD' = Part D.

Subsystem: Financial

Business Name: N/A

Reference Name: C_CVRG_CVAL

Cobol Picture: X(02)

DB2 Data Type: CHAR(02)

Range: N/A

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BUSINESS RULES

Valid Code The data element must contain either a valid code (as defined by the domain / lookup table), or a blank.

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VALID VALUES

DESCRIPTION

A	Medicare Part A
B	Medicare Part B
C	Cancer
D	Dental
E	Not assigned
F	Home Health/Personal Care
G	Mental Health
H	Hospitalization

I	Indemnity/Accident
J	Dependent Pregnancy
K	Medicare Extended
L	Managed Care (HMO/PPO)
M	Major/Medical-Comprehensive
N	Intermediate Care Nursing Facility
O	Optical/Vision
P	Physician
Q	Chiropractor
R	Pharmacy
RD	Medicare Part D
S	Skilled Nursing
T	Transportation
U	Uninsured Absent Parent
V	Rehabilitation/Physical Medicine
W	Worker's Compensation
X	Preventive Care
Y	Medicare Part A-HMO (no longer used)
Z	Medicare Part B-HMO (no longer used)

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