The WellCare Group of Companies
EDI TRANSACTION SET

834 X12N HEALTH CARE BENEFIT ENROLLMENT AND MAINTENANCE ASCX12N (05010X220A1)

Companion Guide

Version 2.0

Outbound

834 Benefit Enrollment Reporting

TABLE OF CONTENTS

REVISION HISTORY

Date	Rev #	Author	Description
06/11/2010	1.0 Review	Lisa Bouabid	State Review
2011	1.0	Lisa Bouabid	Added MOOP AMT segment in 2100A loop Add REF '3H' value in 2000 loop
03/16/2012	2.0	Lisa Bouabid	Updated COB segment in 2320 loop Added COB Benefit Dates DTP segment in 2320 loop Added 'COB Address' N3 segment in 2330 loop Added 'COB City, Zip, St' N4 segment in 2330 loop Added 'Phone Number' PER04 segment in 2330 loop
10/17/2012	3.0	Lisa Bouabid	For KY lob's updated REF*17 segment in 2300 loop to determine MOOP. (MT# 920699) Updated AMT segment in 2100A loop to determine MOOP. For GMD updated REF*17 segment in 2300 loop to determine "COPAY". (MT# 920688)
11/16/2012	3.0	Lisa Bouabid	For KY and GA updated REF*ZZ segment in 2300 loop to indicate whether there copay has been waived.

DOCUMENT APPROVERS

Role	Name	Title	Approval	Date
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IT Owner	Nancy Dasch	Mgr, Application Development		

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INTRODUCTION

The WellCare Group of Companies ("the Plan") has determined the need to use the standard format for outbound Benefit Enrollment and Maintenance for Providers or Trading Partners (TPs). This X12N 834 Benefit Enrollment and Maintenance Companion Guide are intended for use by all of the Plan's Providers and TPs in conjunction with the ANSI ASC X12N National Implementation Guide. It has been written to assist those Receivers who will be implementing the standard X12N 834 EDI inbound transaction. This "Plan" Companion Guide clarifies the HIPAA-designated standard usage and must be used in conjunction with the following document:

The 834 Benefit Enrollment and Maintenance Implementation Guides (IG)

To purchase the IG, contact the Washington Publishing company at **www.wpc-edi.com/hipaa/** or call **1-800-972-4334**.

This Companion Guide contains data clarifications derived from specific business rules that apply to individual subcontractors and will be extracted and sent by the Plan.

GENERAL INFORMATION

The outbound enrollment batch file is transmitted from the Plan to the trading partner. The 834 Benefit Enrollment transactions will be sent monthly unless otherwise contracted, with the option of a daily Change file.

Additional Items of Note

Provider Information (Loop 2310)
In compliance with the NPI implementation and guidelines, the Plan will send Provider's applicable NPI number in loop 2310.NM109.

Delimiters

A delimiter is a character used to separate two (2) data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, the ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are then used as data element separators elsewhere in the transaction. The following characters are used as data delimiters for all transaction segments:

CHARACTER	PURPOSE
* Asterisk	Data Element Separator
: Colon	Sub-Element Separator
~ Tilde	Segment Terminator

Electronic Submission

The Plan will send 834 Enrollment files electronically using the ANSI ASC X12N 834 format.

File Transmission

834 Transaction files for production will be sent to Trading Partner specific site using secure File Transfer Protocol; see section FTP Process.

Submission Frequency

The files will be sent per negotiated agreements with the Plan's Trading Partners.

File Size Requirements

The following list outlines the file sizes by transaction type:

Transaction Type	Testing Purposes	Production Purposes
834 formats	50-100 member records per file	< 5000 member records per file

FTP PROCESS

Secure File Transfer Protocol

MOVEit® is the Plan's preferred file transfer method of transferring electronic transactions over the Internet. It has the FTP option or online Web interface.

Secure File Transfer Protocol (SFTP) is specifically designed to handle large files and sensitive data. The Plan utilizes Secure Sockets Layer (SSL) technology, the standard Internet security, and SFTP ensures unreadable data transmissions over the Internet without a proper digital certificate.

- Registered users are assigned a secure mailbox where all reports are posted. Upon enrollment, they will receive a login and password.

In order to send files to the Plan, submitters need to have an FTP client that supports AUTH SSL encryption.

The AUTH command allows the Plan to specify the authentication mechanism name to be used for securing the FTP session. Sample FTP client examples are:

- WS_FTP PRO® (The commercial version supports automation and scripting)
  - WS_FTP PRO® has instructions on how to connect to a WS_FTP Server using SSL.
- Core FTP Lite® (The free version supports manual transfers)
  - Core FTP Lite® has instructions on how to connect to a WS_FTP Server. Additionally, the Plan can provide setup assistance.

FILE TEST PROCESS

The Plan will send test files on a case-by-case basis. The Testing Coordinator will contact Vendor to coordinate a testing schedule.

Testing

1. The Plan will create test files in the ANSI ASC X12N 834 format.

    - Files will include all multiple member record; adds, changes, terms.
    - Batch files by 834 type and group by month.
    - Set Header Loops for Production:
        - Header ISA15 will be set to **''P'**
        - Header REF02 will be set to **'005010X220A1'** (834)
        - Header BGN08 value will be **"4"** = Verify (full audit)
        - Header BGN08 value will be **"2"** = Change file

2. Each batch file will be named according to the File Naming Standards listed below:

    - Node One equals Enroll834
    - Node Two equals Vendor name (e.g. JoeVendor)
    - Node Three equals Line of Business (i.e. WMR, GMR, OAB, etc.)
    - Node Four equals "AUDIT" or "CHANGE"
    - Node Five equals Date test file is created (CCYYMMDDHHMM)
    - **Example:** Enroll834_JoeVendor_WMR_AUDIT_200806041115.edi
      Enroll834_JoeVendor_WMR_Change_200909231012.edi

Production

For Production processing, the Plan will send a monthly full file 834 Benefit Enrollment to the specified FTP site negotiated with each receiver and if requested, also send an 834 daily Benefit Enrollment Change file.

Naming Standards: The Plan uses the file name to help track each batch file sent to the SFTP drop off site.

Name each batch file according to the File Naming Standards listed below:

- Node One equals Enroll834
- Node Two equals Vendor name (e.g. JoeVendor)
- Node Three equals Line of Business (i.e. WMR, GMR, OAB, etc.)
- Node Four equals "AUDIT" or "CHANGE"
- Node Five equals Date test file is created (CCYYMMDDHHMM)
- **Example:** Enroll834_JoeVendor_WMR_AUDIT_200806041115.edi
  Enroll834_JoeVendor_WMR_Change_200909231012.edi

THE PLAN VALIDATION PROCESS

When 834 Enrollment files are created by the Plan's enterprise system, that process calls the HIPAA validation process to ensure every file passes WEDI/SNIP levels. The Data Edit Program will:

- Validate using a HIPAA X12 validation tool.
- Edit the transactions for content against X12 Standards, eligibility history, Medicaid, and valid dates.
    - All dates are in the CCYYMMDD format.
    - All date/times are in the CCYYMMDDHHMM format.
    - Provider Ids are edited per line of business contract.

See the 834 IG for additional information about the response coding and Addendum C in this Guide.

FURTHER ENROLLMENT FIELD DESCRIPTION

Refer to the IG for the initial mapping information. The grid below further clarifies additional information the Plan will send.

Interchange Control Header:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
	ISA06	Interchange Sender ID	M	1		Set to **'WELLCARE'**
	ISA08	Interchange Receiver ID	M	1		Set to a Unique ID assigned by the Plan for the TP.
	ISA14	Acknowledgment Requested	M	1		Set to: **0** – Interchange Acknowledgment not necessary
	ISA16	Component Element Separator	M	1		Set to: **:** - Colon

Functional Group Header:

	GS02	Senders Code	M	1		Set to **"WELLCARE"**
	GS03	Receivers Code	M	1		Matches ISA08

Transaction Set Header:

329	**ST02**	Transaction set Control Number	M	1		ST02 will be unique and identical to SE02
1705	**ST03**	Implementation Convention Reference	O	1		Set to same value as GS08

Header:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
353	**BGN01**	Code identifying purpose of transaction set	R	1		Set to: **00** – Original
306	**BGN08**	Action Code	R	1		Set to: **4** – Audit (full file) **2** – Change file
	REF		S	1		This segment will only be sent in certain Medicaid Lines of business.
128	**REF01**	Master Policy Number id	R	1		Set to: **38**
127	**REF02**	Master Policy Number	R	1		
374	**DTP01**	Date/Time Qualifier	R	1		Set to: **303** – Maintenance Effective (date)
	QTY	Transaction Set Control Totals	S	1		New segment which have the total number of members being sent in the file.
673	**QTY01**	Quantity Qualifier	R	1		Set to: **TO**

380	**QTY02**	Quantity	R	1		Total number of INS segments within the file
LOOP ID 1000A – Sponsor Name					**1**	
98	**N101**	Sponsor Entity Identifier Code	R			Set to: **P5** – Plan Sponsor
93	**N102**	Sponsor Name	S			Set to "**WELLCARE OF …**", (based upon the Line of Business/vendor).
66	**N103**	Sponsor Identification Code Qualifier	R			Set to: **FI** – Federal Id
67	**N104**	Sponsor Identification	R			Federal Taxpayer's Id

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
LOOP ID 1000B – Payer Name					**1**	
98	**N101**	Payer Entity Identifier Code	R			Set to: **IN** – Insurer
93	**N102**	Payer Name	S			Set to "**WELLCARE**"
66	**N103**	Payer Identification Code Qualifier	R			Set to: **FI** – Federal Taxpayer's Id Number
67	**N104**	Payer Identification	R			Payer's Federal Taxpayer Id
LOOP ID 2000 – Member Level Detail					**>1**	
1073	**INS01**	Member Name	R	1		Set to **Y** – Yes
1069	**INS02**	Individual Relationship Code	R	1		Set to: 18 – Self
875	**INS03**	Maintenance Type Code	R	1		Set to: **030** – Audit or Compare (full roster) **001** – for Change file Changes **021** – Change file Adds **024** – Change file Terms
1216	**INS05**	Benefit Status Code	R	1		Set to **A** – Active
C052	**INS06**	Medicare Plan Code	S	1		***For Medicare only.*** Set to: **D** – Medicare Part – Unknown
584	**INS08**	Employment Status Code	R	1		Set to: **AC** – Active
128	**REF01**	Subscriber Reference Identification Qualifier	R	3		Set to: **0F** – Subscriber Number
127	**REF02**	Subscriber Reference Identification	R	3		Set to Subscriber ID Number (Medicaid – Medicare ID)
128	**REF01**	Member Policy Number	S			Set to: **1L** – Group or Policy

		Reference Identification Qualifier			Number
127	**REF02**	Reference Identification	S		Set to insured Group or Policy Number
128	**REF01**	Client Number Reference Identification Qualifier	S	5	***For Medicaid only.*** Set to: **23** – Client Number
127	**REF02**	Reference Identification	S	5	Set to the Recipient's Medicaid Number
128	**REF01**	Medicare Eligibility Reference Identification Qualifier	S	5	***For Medicare only.*** Set to: **F6** – Health Insurance Claim Number (Hic Number)
127	**REF02**	Reference Identification	S	5	Set to the member's HIC number or Medicaid #
128	**REF01**	Case number Reference Identification Qualifier	S	5	***For Medicaid only.*** Set to: **3H** – Case number
127	**REF02**	Reference Identification	S	5	Set to the member's Case number, this is identifier which ties families together

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
LOOP ID - 2100A – Member Name						***This loop will contain the member's primary address except for Medicare lines of business – for Medicare only, this is the secondary address. See 2100G loop for Medicare primary address.***
98	**NM101**	Entity Identifier Code	R	1		Set to: **IL** – Insured or Subscriber
1065	**NM102**	Entity Type Qualifier	R	1		Set to: **1** – Person
1035	**NM103**	Name Last or Organization Name	R	1		Subscriber Last Name
1036	**NM104**	Name First	R	1		Subscriber First Name
1037	**NM105**	Name Middle	R	1		Subscriber Middle Initial
1039	**NM107**	Name Suffix	R	1		Subscriber Suffix
366	**PER01**	Contact Function Code	S	1		Set to: **IP** – Insured Party
365	**PER03**	Communication Number Qualifier	S	1		Set to: **TE** –Telephone
364	**PER04**	Communication Number	S	1		Set to Member's Telephone Number
166	**N301**	Address Information	S	1		Set to Member's Primary Address Line 1
166	**N302**	Address Information	S	1		Set to Member's Primary Address Line 2
19	**N401**	City Name	S	1		Set to Member's Primary City
156	**N402**	State or Province Code	S	1		Set to Member's Primary State
116	**N403**	Postal Code	S	1		Set to Member's Postal Code
309	**N405**	Location Qualifier	S	1		Set to: **CY** – County/Parish
310	**N406**	Location Identifier	S	1		Set to Member's County
1250	**DMG01**	Date Time Period Format	S	1		Set to: **D8** – CCYYMMDD

		Qualifier			
1251	**DMG02**	Date Time Period	S	1	Set to Member's Birth Date
1068	**DMG03**	Gender Code	S	1	Set to one of the following: **F** – Female **M** – Male **U** – Unknown
C056	**DMG05**	Race or Ethnicity Code	S	1	Set to: **7** – Not Provided
522	**AMT01**	Amount Qualifier	S	1	This segment will be sent ONLY for Medicare lines of business or Kentucky Medicaid lines of business for members who have reached the Maximum Out of Pocket Amount. Value is set to: **B9** which identifies Co-pay amount
782	**AMT02**	Amount Monetary Amount	S	1	Set to the Maximum Out of Pocket value.
66	**LUI01**	Member Language Identification Code Qualifier	S	1	Set to: **LD** - NISO Z39.53 Language Codes
67	**LUI02**	Member Language Id. Code	S	1	Set to member language from code list

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
LOOP ID - 2100C–		**Postal Mailing Address**				**This segment only sent when requested by trading partner.**
98	**NM101**	Entity Identifier Code	S	1		Set to 31 – Insured or Subscriber Postal Mailing Address
1065	**NM102**	Entity Type Qualifier	S	1		Set to: **1** – Person
166	**N301**	Address Information	S	1		Set to Member's Mailing Address Line 1
166	**N302**	Address Information	S	1		Set to Member's Mailing Address Line 2
19	**N401**	City Name	S	1		Set to Member's Mailing City
156	**N402**	State or Province Code	S	1		Set to Member's Mailing State
116	**N403**	Postal Code	S	1		Set to Member's Mailing Postal Code

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
LOOP ID - 2100G – Responsible Person						***For Medicare only, this address should be used as the primary address. If not sent, then default to address in 2100A loop.***
98	**NM101**	Entity Identifier Code	S	1		Set to: **E1** – Person or Other Entity Legally Responsible for a Child (under age 18 or 21 depending on state) **QD** – Responsible Party
1065	**NM102**	Entity Type Qualifier	S	1		Set to: **1** – Person
1035	**NM103**	Name Last or Organization Name	S	1		Set to Responsible Party's Last Name
1036	**NM104**	Name First	S	1		Set to Responsible Party's First Name
1037	**NM105**	Name Middle	S	1		Set to Responsible Party's Middle Initial
1039	**NM107**	Name Suffix	S	1		Set to Responsible Party's Suffix
166	**N301**	Address Information	S	1		Set to Responsible Party's Address Line 1
166	**N302**	Address Information	S	1		Set to Responsible Party's Address Line 2
19	**N401**	City Name	S	1		Set to Responsible Party's City
156	**N402**	State or Province Code	S	1		Set to Responsible Party's State
116	**N403**	Postal Code	S	1		Set to Responsible Party's Postal Code
LOOP ID - 2300 – Health Coverage						
875	**HD01**	Maintenance Type Code	S	1		Set to: **030**- Audit/Compare **001** – for Change file Change **002** – for Change Void **021** – Change file Adds **024** – Change file Terms
1205	**HD03**	Insurance Line Code	S	1		Set to: **HMO** – Care Management Organ.
1204	**HD04**	Plan Coverage Description	S	1		Set to member's Plan Code.

1207	**HD05**	Coverage Level Code	S	1	Set to: **IND** – Individual
374	**DTP01**	Health Coverage Date/Time Qualifier	R	1	Set to: **348** – Benefit Begin **349** – Benefit End
1250	**DTP02**	Date Time Period Format Qualifier	R	1	Set to: **D8** – CCYYMMDD
1251	**DTP03**	Date Time Period	R	1	Set to one of the following: Benefit Begin Date Benefit End Date
128	**REF01**	Reference Identification Qualifier	S	1	Category 17 is used for the following cases: dual members – who have both Medicare and Medicaid coverage, behavioral health exclusion, indicator for those having met quarterly MOOP. Set to: **17**
127	**REF02**	Payment Methodology Indicator	S	1	Note: For Kentucky lines of business, if the value in this field is “KQ” then it means the member has met maximum out of pocket for the quarter (MOOP). If value in this field is “BH” then member is excluded from Behavioral Health benefits. All other values see external documents listed below for details regarding this value: Step Actions for Access Claims Payment Methodology Step Actions for Access and Select Dual Capitation Claims Payment Methodology Contact Provider Representative with any

					specific questions.
128	**REF01**	Reference Identification Qualifier	S	1	Mutually Defined indicator set to: ZZ is used to qualify the Co-pay indicator. Set to: **ZZ**
127	**REF02**	Copay Indicator	S	1	Note: For Kentucky and Georgia lines of business, if the value in this field is "NC" then it means NO co-pay is applicable for the member.
LOOP ID - 2310 – Provider Information					
554	**LX01**	Assigned Number	S	1	Set to **001** and increment by 1 for each repetition of the 2310 Loop.
98	**NM101**	Entity Identifier Code	R	1	Set to: **P3** – Primary Care Provider
1065	**NM102**	Entity Type Qualifier	R	1	Set to one of the following **1** – Person **2** – Entity

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
LOOP ID - 2310 – Provider Information						
66	**NM108**	Identification Code Qualifier	R	1		Set to: **XX** – National Provider ID or SV – where NPI is not found
67	**NM109**	Identification Code	R	1		Set to National Provider ID (NPI)

320	**NM110**	Entity Relationship Code	R	1		Set to: **25** – Established Patient
166	**N301**	Provider Address Information	S	1		Set to Provider's address
366	**PER01**	Contact code	S	1		Set to: **IC** – Information Contact
365	**PER03**	Communication Qualifier	S	1		Set to: **TE** – Telephone number
364	**PER04**	Provider Communication number	S	1		Set to: Provider's Telephone number
LOOP ID - 2320 – Coordination of Benefits					<= 5	
1138	**COB01**	Payer Responsibility Sequence Number Code	S	1		Set to: **P** – Primary **S** – Secondary **T** – Tertiary
1143	**COB02**	Policy Number	S	1		Set to: Member's policy number
1143	**COB03**	Coordination of Benefits Code	S	1		Set to: **1** – Coordination of Benefits
128	**REF01**	Reference Identification Qualifier	S	1		Set to one of the following: **6P –** Group Number
127	**REF02**	Reference Identification	S	1		Set to Member's Employer's group ID
374	**DTP01**	COB Benefits date	S	1		Set to one of the following: **344 –** COB benefits begin **345** – COB benefits end
1250	**DTP02**	Date Time Period Format Qualifier	S	1		Set to one of the following: **D8 –** Date Expressed in Format CCYYMMDD
1251	**DTP03**	Date Time Period	S	1		Set to Coordination of Benefits Date: Effective and Term date
LOOP ID - 2330 – Coordination of Benefits Related Entity						
98	**NM101**	Entity Identifier Code	R	1		Set to: **IN** – Insurer
1065	**NM102**	Entity Type Qualifier	R	1		Set to: **2** – Non-Person Entity
1035	**NM103**	Name Last or Organization Name	S	1		Set to: Full Name
166	**N301**	COB Entity related Address	R	1		Set to:

166	**N302**	COB Entity related Address	S	1	Carrier Address Line 1 Set to: Address Line 2
19	**N401**	City	S	1	Set to: Carrier City Name
156	**N402**	State	S	1	Set to: Carrier State
116	**N403**	Zip code	S	1	Set to: Carrier Zip code
366	**PER01**	Administrative Comm. Contact	R	1	Set to: **CN** – General Contact
365	**PER03**	Communication Number Qualifier	R	1	Set to: **TE** – Telephone
364	**PER04**	Communication Number	R	1	Set to: Carrier Phone Number

ATTACHMENT A

Glossary

Term	Definition
HIPAA	In 1996, Congress passed into federal law the Health Insurance Portability and Accountability Act (HIPAA) in order to improve the efficiency and effectiveness of the entire health care system. The provisions of HIPAA, which apply to health plans, health care providers, and health care clearinghouses, cover many areas of concern including: preventing fraud and abuse, preventing pre-existing condition exclusions in health care coverage, protecting patients' rights through privacy and security guidelines, and mandating the use of a national standard for EDI transactions and code sets.
SSL **(Secure Sockets Layer)**	SSL is a commonly used protocol for managing the security of a message transmission through the Internet. SSL uses a program layer located between the HTTP and TCP layers. The" sockets" part of the term refers to the sockets method of passing data back and forth between a client and a server program in a network or between program layers in the same computer. SSL uses the public-and-private key encryption system from RSA, which also includes the use of a digital certificate.
Secure FTP (SFTP)	Secure FTP, as the name suggests, involves a number of optional security enhancements such as encrypting the payload or including message digests to validate the integrity of the transported files to name two examples. Secure FTP uses Port 21 and other Ports, including SSL.
AUTH SSL	AUTH SSL is the explicit means of implementing secure communications as defined in RFC 2228. AUTH SSL provides a secure means of transmitting files when used in conjunction with an FTP server and client that both support AUTH SSL.
Required Segment	A required segment is a segment mandated by HIPAA as mandatory for exchange between trading partners.
Situational Segment	A situational segment is a segment mandated by HIPAA as optional for exchange between trading partners.
Required Data Element	A mandatory data element is one that must be transmitted between trading partners with valid data.
Situational Data Element	A situational data element may be transmitted if data is available. If another data element in the same segment exists and follows the current element, the character used for missing data should be entered.
N/U (Not Used)	An N/U (Not Used) data element included in the shaded areas if the Implementation Guide is NOT USED according to the standard and no attempt should be made to include these in transmissions.
ATTENDING PROVIDER	The primary individual provider who attended to the client/member during an in-patient hospital stay. Must be identified in 837I, Loop 2310A, REF02 Segment, by their assigned Medicaid/Medicare ID number assigned by State to the individual provider while the client

Term	Definition
	was an inpatient.
BILLING PROVIDER	The Billing Provider entity may be a health care provider, a billing service, or some other representative of the provider.
IMPLEMENTATION GUIDE (IG)	Instructions for developing the standard ANSI ASC X12N Health Care transaction sets. The Implementation Guides are available from the Washington Publishing Company.
PAY-TO-PROVIDER	This entity may be a medical group, clinic, hospital, other institution, or the individual provider who rendered the service.
REFERRING PROVIDER	Identifies the individual provider who referred the client or prescribed Ancillary services/items such as Lab, Radiology and Durable Medical Equipment (DME). Report this provider in Loop 2310A, REF02 Segment using the Medicaid/Medicare ID number assigned by State to the referring provider.
RENDERING PROVIDER	The primary individual provider who attended to the client/member. They must be identified in 83P, Loop 2310B, REF02 Segment, use the Medicaid/Medicare ID number assigned by State to the individual provider while the client was in active status.
TRADING PARTNERS (TPs)	Includes all of the following; payers, switch vendors, software vendors, providers, billing agents, clearinghouses
DATE FORMAT	All dates are eight (8) character dates in the format CCYYMMDD. The only date data element that varies from the above standard is the Interchange Date data element located in the ISA segment. The Interchange Data date element is a six (6) character date in the YYMMDD format.
DELIMITERS	A delimiter is a character used to separate two (2) data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction. The following characters are used as data delimiters for all transaction segments:

CHARACTER	PURPOSE
* Asterisk	Data Element Separator
: COLON	Sub-Element Separator
~ Tilde	Segment Terminator

ATTACHMENT B

File Example

834 Outbound Benefit Enrollment and Maintenance file – single transaction

Loop	Transaction Segment
ST	ST*834*0001~
BGN	BGN*00*1*20080531001*20080531*023220****4~
DTP	DTP*303*D8*20070111~
QTY	QTY*TO*1~
1000A	N1*P5*WELLCARE OF XXXXXX*FI*58-1234567~
1000B	N1*IN*WELLCARE*ZZ*121234567~
2000	INS*Y*18*030**A***AC~
2000	REF*0F*111014065934~ Client/Subscriber number
2000	REF*IL*XXX000001~ Group or Policy Number
2000	REF*23*11111111111~ Medicaid Number/All states
2000	REF*F6*111014065934~ HIC Number /Florida or Medicare
2100A	NM1*IL*1*NELLON*INDIA*D~
2100A	PER*IP**TE*8005947324~
2100A	N3*1101 ELM STREET~
2100A	N4*LAGRANGE*OH*302400000**CY*ERIE~
2100A	DMG*D8*19970723*F**7~
2100A	LUI*LD*ENG~
2100G	NM1*QD*1*NELLON*SHERIKA*D~
2100G	N3*1101 ELM STREET~
2100G	N4*LAGRANGE*OH*302400000**CY*ERIE~
2300	HD*030**HMO*OABMAA*IND~
2300	DTP*348*D8*20070401~
2310	LX*1~
2310	NM1*P3*1******XX*8287646150*25~
2310	N3*1 MAIN STREET~
2310	N4*ASHTABULA*OH*44044~
2310	PER*IC**TE*8132895200~
2320	COB*P**1~
2320	REF*6P*AZ12345~
2320	DTP*344*D8*19960401~
2330	NM1*IN*2*ABC INSURANCE CO~
2330	N3*50 ORCHARD STREET~
2330	N4*KANSAS CITY*MO*64108~
2330	PER*CN**TE*8015554321~
SE	**SE*000000029*0001~**

ATTACHMENT C

999 Interpretations

999 Acknowledgment result types:

A – Accepted
R – Rejected
E – Accepted with errors

Accepted 999

999 Acknowledgment sample data:

ST*999*0001*005010X231A1~
AK1*BE*6454*005010X220A1~
AK2*834*0001~
IK5*A~
AK9*A*1*1*1~
SE*6*0001~

Rejected 999

ST*999*0001*005010X231A1~
AK1*BE*6454*005010X220A1~
AK2*834*0001*005010X220A1~
IK3*N4*120**8~
IK4*1*19*4*P~
IK5*R~
AK9*R*1*1*1~
SE*8*0001~

THE WELLCARE GROUP OF COMPANIES (The Plan)

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

WellCare Health Insurance of Illinois, Inc.

WellCare Health Insurance of New York, Inc.

WellCare of Texas, Inc.

WellCare Health Plans of New Jersey, Inc.

WellCare of Florida, Inc.

HealthEase of Florida, Inc.

WellCare of Louisiana, Inc.

WellCare of New York, Inc.

WellCare of Connecticut, Inc.

WellCare of Georgia, Inc.

Harmony Health Plan of Illinois, Inc.

WellCare of Ohio, Inc.