STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS (OGB)

NOTICE OF INTENT TO CONTRACT (NIC)
FOR
ADMINISTRATIVE SERVICES ONLY (ASO)
FOR

PREFERRED PROVIDER ORGANIZATION PLAN (PPO)

ISSUED

January 15, 2010

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SECTION I

GENERAL INFORMATION AND INSTRUCTIONS OF PROPOSAL FORMAT

A. Introduction/Purpose

The State of Louisiana, Division of Administration (hereinafter called "DOA"), Office of Group Benefits (hereinafter called "OGB"), requests proposals from any qualified Organization (hereinafter called "Proposer") to provide Administrative Services Only (ASO) for the following Office of Group Benefits (OGB) Plan of Benefits:

Preferred Provider Organization Plan (PPO)

This Plan of Benefits is currently administered by the following entity:

Office of Group Benefits – State of Louisiana

Note: DOA reserves the right to reject any and all Proposals. DOA also reserves the right to withdraw this NIC at any time.

Proposal must be on a statewide basis (DOA will not accept proposals for individual or grouped regions).

B. General Information

The State of Louisiana through OGB is required by statute to provide health and accident benefits and life insurance to state employees, retirees and their dependents. Plan member eligibility includes employees of state agencies, institutions of higher education, local school boards that elect to participate and certain political subdivisions. Eligibility does not include local government entities, parishes, or municipalities.

Exhibit 1 – OGB Plan of Benefits
Exhibit 2 – OGB PPO Plan Summary of Benefits Chart
Exhibit 3 – Enrollment Information by Plan
Exhibit 4 – Enrollment Form
Exhibit 5 – Statewide Regions by City and Zip Codes
Exhibit 6 – OGB Official 2009-10 Premium Rates
Exhibit 7 – Contract/Business Associate Agreement/Data Reporting/Requirements
Exhibit 8 – 2010-2011 Benefit Modifications
Exhibit 9 – Hospital List

The contract will be with the OGB, and the OGB is seeking a Proposer/Contractor that can work with the agency to accomplish key objectives which are to provide high quality cost effective health care to members, to control escalating health care costs, to achieve greater

uniformity of coverage, and to minimize administrative efforts.

All Proposals must be prepared in accordance with the provisions of this Notice of Intent to Contract (NIC). Proposer must agree to meet the Proposer Requirements as delineated in the Proposer Requirements section of the NIC.

C. OGB Information Technology

Desktop: Dell 450 Workstations running Windows XP
LAN: 10/100/1000 Ethernet using Cisco switches
Servers: Windows servers, AIX UNIX servers, and LINUX servers
WAN: Frame Relay using Cisco routers, switches, and firewalls. In addition, Fujitsu scanners, and various laser printers are used

OGB computer applications include: Impact (claims adjudication, customer services, provider contracting and eligibility processes), Discoverer (Oracle report writer), MS Office, MS Exchange, FileNet (Oracle based imaging and document management system). OGB uses Oracle databases as its standard.

OGB uses ONESIGN – Biologin and e-Trust, a single-sign-on and centralized security system.

D. Term of Contract

The effective date of the contract will be July 1, 2010, with an Annual Enrollment to take place during April 2010. The contract will be for one year with an option to renew for a maximum of two additional one-year terms, exercisable by OGB.

Year One	July 1, 2010 – June 30, 2011
Year Two	July 1, 2011 – June 30, 2012
Year Three	July 1, 2012 – June 30, 2013

E. Standard Contract Provisions

See Exhibit 7 for the State of Louisiana, Office of Group Benefits Contract/Business Associate Agreement. Any deviation sought by a Proposer from these contract terms should be specifically and completely set forth.. The provisions of the NIC and winning proposal will be incorporated by reference into the contract. Any additional clauses or provisions, required by Federal or State law or regulation in effect at the time execution of the contract, will be included.

F. State Contribution to Cost

See Exhibit 6 for OGB Official 2009 -10 Insurance Premium Rates.

The contribution of the State to the cost of health coverage is subject to change through legislative action during the initial term and subsequent renewals of the contract.

OGB will establish the premium rates to be disclosed to and paid by plan members and the State of Louisiana. Proposers may not make their proposal contingent upon OGB premium rates established by OGB.

G. Instructions on Proposal Format

Proposers should respond thoroughly, clearly and concisely to all of the questions set forth in the Notice of Intent to Contract (NIC). Answers should specifically address current capabilities separately from anticipated capabilities, but in no case shall a proposer project or list anticipated providers not currently under contract.

1. Submit an original (clearly marked "original") and eight (8) copies of a completed, numbered proposal placing each in a three-ring binder.

2. Use tabs to divide each section and each attachment. The tabs should extend beyond the right margin of the paper so that they can be read from the side and are not buried within the document.

3. Order of presentation:

   Cover Letter & Executive Summary

   Your Executive Summary should not exceed three (3) pages. Please highlight in your Executive Summary what sets you apart from your competitors and state the reason(s) you believe you are qualified to partner with OGB.

   Section V – Proposer Requirements/Attachments/Checklist
   - Tab 1 – Audited Financial Statements
   - Tab 2 – Membership Satisfaction Survey
   - Tab 3 – Management Reports
   - Tab 4 – List of Network Providers
   - Tab 5 – Proposal Checklist – Completed

   Section VI – Tab 6 - Proposer Information

   Section VII – Tab 7 - Mandatory Signature Page

   Section VIII - Cost Quotation Proposal Form – Submit an original and eight (8) numbered copies, **in a separate, (do not include in three ring binder) sealed envelope clearly marked, "ASO NIC – PPO Cost Proposal"** on the outside of such envelope. See Section VIII of NIC. Proposal must be received on or before 4:00 pm CST on the date listed in the Schedule of Events.

4. Answer questions directly. Where you can not provide an answer, indicate not applicable or no response.

5. Do not answer a question by referring to the answer of a previous question; restate the answer or recopy the answer under the new question. If however, the question asks you to provide a copy of something; you may indicate where this copy can be found by an attachment/exhibit number, letter or heading. You are to state the question, then answer the question. Do not number answers without providing the question.

H. Ownership, Public Release and Costs of Proposals

1. All proposals submitted in response to this NIC become the property of DOA and will not be returned to the Proposers.

2. Costs of preparation, development and submission of the response to this NIC are entirely the responsibility of the Proposer and will not be reimbursed in any manner.

3. Proprietary, Privileged, Confidential Information in Proposals: After award of the Contract, all proposals will be considered public record and will be available for public inspection during regular working hours.

   As a general rule, after award of the Contract, all proposals are considered public record and are available for public inspection and copying pursuant to the Louisiana Public Records Law, La.R.S. 44.1 et.seq. DOA recognizes that proposals submitted in response to the NIC may contain trade secrets and/or privileged commercial or financial information that the Proposer does not want used or disclosed for any purpose other than evaluation of the proposal. The use and disclosure of such data may be restricted, provided the Proposer marks the cover sheet of the proposal with following legend, specifying the pages of the proposal which are to be restricted in accordance with the conditions of the legend:

   "Data contained in Pages _____ of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, DOA shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the right of DOA to use or disclose data obtained from any other source, including the Proposer, without restrictions.

   Further, to protect such data, each response containing such data shall be specifically identified and marked "CONFIDENTIAL".

   You are advised to use such designation only when appropriate and necessary. A blanket designation of an entire proposal as confidential is NOT appropriate. Your fee proposal may not be designated as confidential.

It should be noted, however, that data bearing the aforementioned legend may be subject to release under the provision of the Louisiana Public Records Law. DOA assumes no liability for disclosure or use of unmarked data and may use or disclose such data for any purpose. Any resultant contract will become a matter of public record.

DOA reserves the right to make any proposal, including proprietary information contained therein, available to its primary consultant, personnel of the Office of the Governor, Office of Contractual Review, or other state agencies or organizations for the purpose of assisting DOA in its evaluation of the proposal. DOA will require such individuals to protect the confidentiality of any specifically identified proprietary information or privileged business information obtained as a result of their participation.

In addition, you are to provide a redacted version of your proposal omitting those responses (or portions thereof) and attachments that you determine are within the scope of the exception to the Louisiana Public Records Law. In a separate document, please provide the justification for each omission.

The Louisiana Division of Administration (DOA) will make the edited proposal available for inspection and/or copying upon the request of any individual pursuant to the Louisiana Public Records Law without notice to you.

SECTION II

SCHEDULE OF EVENTS

A. Time Line

NIC Issued - Public Notice by Advertising in the Official Journal of the State/Posted OGB Website/Posted to LAPAC	January 15, 2010
NIC Mailed or Available to Prospective Proposers Posted to OGB Website; Posted to LAPAC	January 15, 2010
Deadline to Notify DOA of Interest to Submit a Proposal **(MANDATORY)**	January 27, 2010
Deadline to Receive Written Questions	January 27, 2010
Response to Written Questions	February 5, 2010
Electronic Data Sent to Interested Proposers	February 5, 2010
Proposer Conference- Attendance in Person **(MANDATORY)**	February 12, 2010
Proposals Due to DOA	February 22, 2010
Finalist's Interviews/Site Visits (If Necessary)	TBD
Probable Selection and Notification of Award	TBD
Contract Effective Date	July 1, 2010

NOTE: The DOA reserves the right to deviate from this schedule.

B. Mandatory – Notification to DOA of Interest to Submit a Proposal

All interested Proposers shall notify DOA of its interest in submitting a proposal on or before the date listed in the Schedule of Events. Notification should be sent to:

Barbara Goodson
Deputy Commissioner
Louisiana Division of Administration

Delivery:
1201 N. Third Street, Ste. 7-210
Baton Rouge, LA 70802

Mail:
Post Office Box 94095
Baton Rouge, LA 70804

C. Written Questions

Written questions regarding the NIC are to be submitted to and received on or before 4:00 p.m., Central Standard Time (CST) on the date listed in the Schedule of Events. Written questions should be sent to:

Barbara Goodson
Deputy Commissioner
Louisiana Division of Administration

Delivery:
1201 N. Third Street
Baton Rouge, LA 70802

Mail:
Post Office Box 94095
Baton Rouge, LA 70804

D. Mandatory - Proposers Conference

The Proposer's Conference will be held at 2:00 p.m. Central Standard Time (CST) on the date listed in the Schedule of Events at

Claiborne Building
1201 N. Third Street, Room 2-143
Baton Rouge, LA. 70802

A representative of your organization must participate in person at the Mandatory Proposers Conference on the date listed in the Schedule of Events. DOA and OGB staff will be available to discuss the proposal specifications with you, answer any questions you may have in regards to submitted questions and distribute Exhibits.

Proposals will only be accepted from Proposers that have met this mandatory requirement. Attendance by a subcontractor is welcome, but will not be an acceptable substitute for a representative of the primary proposing firm/organization.

E. Proposal Due Date

In order to be considered for award, the original proposal, together with all required copies, must be received by the Louisiana Division of Administration not later than 4:00pm CST on the date listed in the Schedule of Events. It is the vendor's responsibility to ensure the proposals have been received by the Louisiana Division of Administration by 4:00pm CST. Proposals should be delivered to:

Barbara Goodson
Deputy Commissioner
Louisiana Division of Administration

Delivery:
1201 N. Third Street, Ste. 7-210
Baton Rouge, LA 70802

Mail:
Post Office Box 94095
Baton Rouge, LA 70804

Proposals may not be submitted via fax or email.

SECTION III

SCOPE OF SERVICES

A. Core Services

Through this NIC, OGB seeks to contract with a third party administrator or insurer to offer an "Administrative Services Only (ASO)" Plan on a statewide basis at a minimum to service: Preferred Provider Organization

Services would commence July 1, 2010 after the April annual enrollment.

Services should include the following:

1. Inpatient Hospital Services (including hospital based ancillary services);
2. Outpatient Hospital Services (including hospital based ancillary services);
3. Ambulatory Surgical Services (including ASC based ancillary services);
4. Physician Services (including Chiropractic services);
5. Utilization Management and Medical Management;
6. Customer Service and Support.

The Contractor must be capable of providing all services and benefits set forth in the Plan of Benefits, except for retail and mail order pharmaceutical and mental health.

B. Eligibility

OGB determines eligibility of plan participants and forwards data to successful administrator.

A Contractor must agree to maintain identical eligibility requirements and continued coverage provisions as the OGB, as may be amended from time to time and no other exceptions or variations will be allowed.

See OGB Contract, Exhibit 7 for OGB Eligibility Information and Requirements.

C. Plan of Benefits

See Exhibit 1 for OGB's Plan of Benefits.

For purposes of proposal evaluation, any Proposer that chooses to offer a plan that includes enhanced benefits beyond the benefits specified in the "Plan of Benefits" may be considered to be non-responsive.

D. Use of Non-Contracted Providers

If the Contractor cannot deliver all the benefits and services required by this NIC through contracted providers, the Contractor shall arrange and pay for such services to be rendered by non-contracted providers. When the Contractor or one of its contracted providers arrange for non-contracted services covered under the master benefit plan, the plan member's financial liability is limited to the amount the member would have had to pay, if any, had the service been rendered by a contract provider. OGB responsibility will be limited to reimbursement as if the Provider were in network, based upon a methodology to be developed and detailed in the contract. The cost of the service beyond the plan member's usual financial liability and OGB's responsibility shall be the Contractor's obligation. Balance billing is prohibited. A violation of this requirement shall result in a fine of $1,000 per documented occurrence.

As used herein, the term "contracted provider" shall mean a "Network Provider" or a "Participating Provider," that is, a physician, hospital or other healthcare provider that participates in the network established and maintained by the Contractor, having entered into an agreement with the Contractor to provide healthcare services to plan participants for a negotiated reimbursement rate. A healthcare provider that does not participate in the Contractor's established network but enters into a limited "case rate" agreement shall be considered a non-contracted provider for purposes of this provision.

E. Required Membership Materials

The Contractor shall provide the following materials to each new enrollee within ten days of receipt of confirmation from OGB as to the validity of the enrollment application.

1. A member handbook, which includes information on all covered services, including but not limited to benefits, limitations, exclusions, co-payments, policies and procedures for utilizing clinical and administrative services, conditions under which an individual's membership may be terminated, procedures for registering complaints or filing grievances against the Contractor or any providers participating in a contractual agreement with the Contractor.

2. An on-line directory of providers, which includes all physicians, hospitals, and specialty facilities.

3. An interlink to Contractor's Website which includes Provider Directory, etc.

Violation of any of these requirements shall result in a fine of $1,000 per day beyond ten days, until 100% compliance is achieved.

F. Plan Member Communication Material, Advertisements and Marketing Material

The Contractor shall submit copies of all plan members communications materials and promotional materials to OGB. All such materials shall be approved in writing by OGB prior

to their use in promoting the health plan to eligible enrollees.

The cost of preparation and distribution of any and all plan member communications materials or promotional materials must be included in the administrative fee quoted herein.

G. Grievance Procedure

The Contractor shall maintain appeal, grievance and review procedures in compliance with Louisiana law and provide same to OGB upon request.

H. Contractor Administrative Contact

The Contractor must designate one individual and at least one back-up staff member who will be responsible for coordinating all relevant administrative issues with OGB. This individual must represent and coordinate all of a Contractor's operations with regard to OGB. OGB must be notified immediately in writing of any change(s) that may occur in the person designated as the Contractor's administrative contact.

I. Annual Enrollment Procedures

The Contractor must agree to the following Annual Enrollment procedures:

1. Annual Enrollment shall be the period announced by OGB to allow employees to join a Plan, members to change coverage, or to add eligible dependents without regard to age, sex, or health condition. It is anticipated that the Annual Enrollment period for an effective date of July 1, 2010 will be conducted in April, 2010.

2. The OGB shall furnish the Contractor with a list of agency personnel offices and their addresses to facilitate agency contact prior to Annual Enrollment. The OGB shall also furnish, upon request and payment, plan member name and address labels.

3. The OGB will schedule all enrollment meetings and will advise Contractor of the enrollment meeting logistics. Past meetings have numbered between three hundred and four hundred during the annual enrollment periods.

4. The Contractor shall provide sufficient knowledgeable personnel to attend scheduled information and enrollment meetings during the initial and any other Annual Enrollment meetings. The Contractor may be fined $1,000 for each enrollment meeting not attended. The penalty shall only apply to enrollment meetings held within the service area for which the Contractor is authorized to offer coverage.

5. The Contractor shall provide a summary description of its Plan in easy-to-understand language to plan members during the Annual Enrollment meeting. This health plan summary is intended to provide some basic and general information about the special benefits of membership in the Plan, including plan limitations and exclusions, to enable eligible plan members to make an informed decision when selecting among

available health plan options. Information must also be provided to OGB on a timely basis for use by OGB in the creation of plan comparison documents.

6. All paper eligibility documents shall be processed at the OGB office, including data entry into the billing and eligibility system. Eligibility data may also be received electronically from participating agencies. Electronic eligibility data will be transferred from OGB to the Contractor daily.

7. The Contractor must secure any information it may need which is not provided by the OGB.

8. The Contractor must maintain all records by agency billing codes as established by the OGB.

J. Reporting Requirements

The Contractor shall submit standardized data to OGB to be used for the purpose of evaluating plan member demographics, financial experience and other aspects of the Contactor's performance.

See OGB Contract Exhibit 7 for specific information regarding data information and description and layout of the required reports, including a penalty provision for failure to provide reports on a timely basis. Contractor shall strictly adhere to the prescribed format and content requirements established by OGB.

K. Cost Quotations Requirements

1. Commissions or finders fees are <u>not payable</u> under this contract.

2. The cost to develop, print and disseminate materials to communicate with employees, retirees and providers as necessary to effectively implement and manage the Plan must be included in your Cost Quotation. This communication material shall be subject to OGB advance approval. Cost associated with the above will not be separately reimbursed.

3. All services described in this NIC, including all necessary reports and any start-up costs must be included in your proposed cost proposals. Furthermore, your cost proposal must take into account your expenses associated with attendance at all required meetings in Baton Rouge with Board or its Committees and with the OGB management, staff and its Actuarial Services Contractor. You may assume up to 8 meetings per year. No pass-through of costs will be permitted.

4. The Contractor must be aware that the administrative fee quoted must include cost of services to be provided by Contractor to process run out of health claims at the termination of the contract.

SECTION IV

PROPOSAL EVALUATIONS

A. Proposal Evaluation

Proposals and claims will be evaluated by a selection team with claims cost estimates reviewed by a designated actuary. Each proposal will be evaluated to insure all requirements and criteria set forth in the NIC have been met. Failure to meet all of the Proposer Requirements will result in rejection of the proposal.

After initial review and evaluation, the selection team may invite those Proposers whose proposals are deemed reasonably susceptible of being selected for award for interviews and discussions, or the Committee may make site visits to the Proposers' offices and conduct interviews and discussions on site. The interviews and/or site visits will allow the Committee to substantiate and clarify representations contained in the Proposers written proposals, evaluate the capabilities of each Proposer and discuss each Proposers' understanding of the DOA and OGB's needs. The results of the interviews and/or site visits, if held, will be incorporated into the final scoring for the top scored proposals.

Following interviews and discussions, scoring will be finalized in accordance with the evaluation criteria below. The proposal receiving the highest total score will be recommended for contract award.

Note that the DOA at anytime throughout this process may decide to reject any and all proposals and administration would remain with OGB.

B. Evaluation Criteria

After determining that a proposal satisfies the Proposer Requirements stated in the NIC, an assessment of the relative benefits and deficiencies of each proposal, including information obtained from references, interviews and discussions and/or site visits, if held, shall be made using the following criteria:

1. Cost of Coverage	**50% Scoring**	**500 Points**
2. Qualitative/Network Assessment	**50% Scoring**	**500 Points**
	Total Points	**1,000 Points**

1. Cost of Coverage (500 Points)

Points will be based on expected claims cost **(actuarially determined)** and administrative services fee averaged over a maximum three year period.

2. Qualitative/Network Assessment (500 Points)

Emphasis will be placed on the following:

1. Plan members access to primary care physicians accepting new patients
2. Plan members access to specialists
3. Network Facility coverage
4. Claims Administration and Claims Aging
5. Provider Relations
6. Member Services, including Call Center and Regional Access
7. Adherence to the Data Reports and Data Warehouse Submissions
8. Internal Review of Quality of Healthcare, including Case Management and other reviews
9. Member Satisfaction
10. Audits of large dollar claims
11. Plan Member disruption when transferring from one plan selection to a like selection administered by a new vendor
12. Plan members access to contracted hospital-based doctors, included but not limited to pathology, radiology, ER, anesthesiology, radiology.
13. Access to all hospitals listed in Exhibit 9.

C. Cost Evaluation

The **maximum points** a finalist may receive is **1,000 points,** of which cost will account for 500 points. The maximum score for the cost of coverage (500 points) will be awarded to the lowest cost as explained above (Cost of Coverage).

Points for the other proposals/quotes shall be awarded using the following formula:

$$\frac{X}{N} \times 500 \text{ points} = Z$$

Where:
X = Lowest computed cost for any proposal
N= Actual computed cost awarded to the proposal
Z= Awarded Points

Points awarded within each category will be rounded to the nearest whole point. Any fractional points of 0.5 or greater will be rounded up; fractional points less than 0.5 will be rounded down.

The cost scores will be added to the qualitative (non-cost) scores, resulting in a total score.

SECTION V

PROPOSERS REQUIREMENTS/ATTACHMENTS/CHECKLIST

A. Proposers Requirements

To be eligible for consideration, a Proposer must provide documentation of the following:

1. You are a licensed Third Party Administrator (TPA) or Insurer pursuant to Title 22 of the Louisiana Revised Statutes or otherwise authorized by statute.

2. You are in good standing with the Louisiana Department of Insurance.

3. You have a minimum of three (3) years of operation experience in providing ASO health coverage to plan members within the State of Louisiana immediately prior to the date proposals are due and must have at least one group with at least 10,000 enrolled members.

4. The initial term of any Contract award pursuant to this NIC will be one twelve (12) month period commencing July 1, 2010 and ending June 20, 2011. By listing a provider you are guaranteeing a 97% retention rate of all physicians and 100% retention rate of all hospitals listed as a network provider throughout the initial term of the contract.

5. You must have a representative of your organization attend the Mandatory Proposer's Conference.

6. You must submit your firm's audited financial statements for your most recent (2) two fiscal years. If you are a Insurer or PPO you must submit your most recent Annual Statement filed with the Louisiana Department of Insurance.

7. You must be able to submit the required data/reporting information.

8. You must be able to provide an annual SAS-70 Type II Audit Report as required by the Louisiana Legislative Auditor.

9. You must have a current contract with the Center of Medicare and Medicaid Services (CMS) and be receiving electronic HIPAA 837 "crossover" Medicare claims electronically from them and you must be using this data to pay claims as the secondary payor.

10. You must currently be accepting HIPAA 837 electronic claims from clearinghouses.

11. You must currently have the system capability to deny claims for mental health and/or substance abuse electronically and forward said claims to the proper vendor and notify the providers of this action.

12. You must currently have the system capability to generate electronic funds transfers (EFTs) payments to providers while generating the appropriate HIPAA 835 electronic remittance advice (ERA) to providers, clearinghouses and their parties.

13. You must currently have the system capability to receive a HIPAA 837 electronic file from Medicaid and reimburse them any claims paid on behalf of PPO members.

14. You must provide a cost quotation for administering the LaCHIP Affordable Plan, including but not limited to establishing a provider network, processing and paying claims according to the required plan design, and administering eligibility. The process must be integrated with DHH which includes but not limited to production of quarterly financial reports and administrative reports, Dashboard reports, detail claim reports, creation of plan documents, processing retroactive enrollments and terminations, sending notices of appeals, paying for maternity claims for children and for claims with no copays or deductibles, and paying for claims for the administration of the vaccine as well as the cost of the injection.

15. You must accept the rates developed for the PPO by OGB as the rates for your program.

B. Required Attachments to Proposal

Proposer must provide the following attachments to their Proposal:

1. Audited Financial Statements for PPO - Tab 1 of Proposal

A copy of your audited financial statements for your most recent (2) two fiscal years that include your entire Louisiana operation.

You must provide a certificate of good standing from the Louisiana Department of Insurance along with a copy of your most recent Annual Statement filed with the department.

2. Membership Satisfaction Survey – Tab 2 of Proposal

A copy of the most recently completed member satisfaction survey, along with the corresponding survey instrument. If no such survey has been conducted, indicate by including a statement of such effect. Additionally, please provide a sample of the member satisfaction survey format/tool utilized for each Health Promotion and Education Program.

3. Management Reports – Tab 3 of Proposal

Please provide a sample of your current management reports that you submit to ASO clients.

4. **List of Network Providers – Tab 4 of Proposal**

List of all hospitals including but not limited to: acute care, tertiary care and pediatric facilities.

List of participating hospitals that do not include all ancillary services under contract. Additionally list along with the hospital the specific specialties not under contract.

List Primary Care Physicians accepting new patients: licensed medical doctors practicing in the areas of Family Practice, General Practice, Internal Medicine, Pediatrics and Obstetric/Gynecology.

Physicians practicing in the areas of: Allergy, Anesthesiology, Cardiology, Cardiovascular Surgery, Dermatology, Endocrinology, Gastroenterology, General Surgery, Hematology, Nephrology, Neurology, Neurosurgery, Oncology, Ophthalmology, Orthopedics, Otolaryngology, Pathology, Pulmonology, Radiology, and Urology.

Hospital based ancillary services including the professional and technical components of Radiology, Pathology, Anesthesiology, and Emergency Medicine.

NOTE: By listing a Provider you are guaranteeing a 97% retention rate of all physicians and 100% retention rate of all hospitals listed as network providers throughout the initial term of the contract.

The data requested must be provided electronically and must include a file layout.

C. **Proposer Checklist – Tab 5 of Proposal**

Answers may be handwritten on the Checklist form. Explanations can be attached or added onto the back of the Checklist if desired. This Checklist will be Tab 5 in your submitted Proposal.

Requirements - Questions	Yes	No
1. Are you a licensed Third Party Administrator (TPA) or insurer in Louisiana?		
2. Do you have at least three years of operational experience in providing the required services within the State of Louisiana?		
3. Are you currently providing PPO services to at least one group with at least 10,000 enrolled members in the State of Louisiana?		

Requirements - Questions	Yes	No
4. Do you agree to meet all of the General Contractual Requirements set forth in Exhibit 7 Contract/Business Associate Agreement?		
5. Do you agree to meet all of the requirements set forth in this NIC and the attached proposed contract?		
6. Will you designate one key person and at least one back-up staff member as the contacts to OGB for all daily operational questions related to your operations statewide?		
7. Did a representative from your organization attend the Mandatory Proposers Conference?		
8. Do you agree to administer the Plan of Benefits which meets the benefit plan requested in the NIC without exception?		
9. Do you acknowledge that any Sub-Contractor hired by you will be clearly identified in your proposal and that OGB will be notified in advance if you intend to subcontract any other services or change the way in which you contract with current subcontracted vendors during the course of the contract since Sub-Contractors are subject to prior approval?		
10. Do you agree to provide all of the required reports and data for the data warehouse requested in the NIC?		
11. Do you acknowledge that no commission or finder fees of any type will be payable by you with this contract?		
12. Have you included in your NIC response a complete copy of your audited financial statements for your most recent (2) two fiscal years that include your entire Louisiana operation?		
13. Have you included in your NIC response a complete copy of your last two annual Department of Insurance filings?		
14. Have you submitted a complete response to all questions set forth in the Narrative Section of this NIC (if required)?		
15. Have you included all of the required attachments		

Requirements - Questions	Yes	No
requested in the NIC?		
16. Can you provide a SAS-70 Type II Audit on a fiscal year basis as required by the State of Louisiana, Legislative Auditor?		
17. Do you agree to reprice the attached claims utilizing the discounts contained in your current PPO contracts with the identified providers?		
18 Do you agree to administer the LaCHIP Affordable Plan program?		
19. Do you have a current contract with CMS and are you receiving HIPAA 837 crossover Medicare claims from them to pay these claims as the secondary payer?		
20. Are you currently accepting HIPAA 837 electronic claims from clearinghouses?		
21. Does the claims processing system you currently use for PPO claims adjudication currently have the capability to recognize a claim for mental health or substance abuse (MHSA), deny these claims, then forward them to OGB's MHSA vendor and notify the provider of this action ?		
22. Is the claims processing system you currently use for PPO claims adjudication generating electronic funds transfers (EFTs) to providers while generating the appropriate HIPAA 835 electronic remittance advice (ERA) to providers, clearinghouses and third parties?		
23. Does your company receive a HIPAA 837 file from Medicaid for claims reconciliation purposes?		
24. Does your company currently interface with Disease Management vendors?		

SECTION VI

PROPOSER INFORMATION
Tab 6 of Proposal

A. PRIMARY PROPOSER

Please provide the following for your Organization:

- Name
- Address
- Principals
- Date Founded
- Contact Person Name and Title
- Telephone Number and Extension
- Fax Number
- E-Mail Address

B. PARENT COMPANY

SAME INFORMATION AS LISTED IN (A).

C. SUBSIDIARIES/AFFILIATES TO PERFORM SIGNIFICANT SERVICES

SAME INFORMATION AS LISTED IN (A) FOR EACH SUBSIDIARY AND AFFILIATE.

D. ASO Client References

Please provide three (3) references for your organization's three largest existing ASO clients. One of these must be for a client with at least 10,000 enrolled members.

Please provide the following for all three (3) references:

- Name
- Address
- Industry
- Contact Person and Title
- Telephone Number and Extension
- Fax Number
- Your Organization Account Executive Assigned to This Account
- How Long Has This Account Been With Your Organization
- Total # of Employees and Total # of Members
- Plan Design Currently in Place
- Services Provided For This Account

E. Please provide three (3) references that left your organization within the last three (3) years. Please state the reason(s) why.

Please provide the following for all three (3) references:

- Name
- Address
- Industry
- Contact Person and Title
- Telephone Number and Extension
- Fax Number
- Your Organization Account Executive Assigned to This Account
- Total # of Employees and Total # of Members
- Plan Design
- Services Provided For This Account
- Reason Services Terminated

SECTION VII

MANDATORY SIGNATURE PAGE

Tab 7 of Proposal

This proposal, together with all attachments and the fee proposal form, is submitted on behalf of:

Proposer:_____

I hereby certify that:

1. This proposal complies with all requirements of the NIC. In the event of any ambiguity or lack of clarity, the response is intended to be in compliance.

2. This proposal was not prepared or developed using assistance or information illegally or unethically obtained.

3. I am solely responsible for this proposal meeting the requirements of the NIC.

4. I am solely responsible for its compliance with all applicable laws and regulations to the preparation, submission and contents of this proposal.

5. All information contained in this proposal is true and accurate.

Date:_____ Printed Name:_____

Title:_____ Signature:_____

SECTION VIII

COST QUOTATION FORM

Cost Proposal Form is to be submitted in a separate envelope marked "ASO NIC – PPO Cost Proposal" on the outside of the envelope

1. Administration Fee

Proposer must provide a fixed monthly Administrative Fee for administering the OGB Plan of Benefits. A fee should be quoted for actives, non-Medicare retirees, and Medicare retirees. A Per Employee Per Month fee should be quoted for actives, and a Per Member Per Month Fee should be quoted for Retirees The Per Member Per Month Fee will be charged based on the number of retirees and spouses only. Split contract fees will be based on one Medicare and one non-Medicare member fee.

Plan	Plan Year	Fixed Monthly Administrative Fee Per Employee/Retiree		
		Actives	Non-Medicare	Medicare
PPO	7/1/10 – 6/30/11	$		
	7/1/11 – 6/30/12	$		
	7/1/12 – 6/30/13	$		

		Per Enrollee Per Month
LaCHIP Affordable Plan		
	7/1/10 – 6/30/11	$
	7/1/11 – 6/30/12	$
	7/1/12 – 6/30/13	$

NOTE: Contractor agrees that the Administrative fee includes services to be provided by Contractor to pay run out claims after termination of contract.

2. Estimated Incurred Monthly Claims Cost Effective 7/1/08 – 6/30/09

Each proposer will receive a CD containing claims actually incurred by OGB PPO members. The claims on this CD must be readjudicated by each proposer reflecting which of the identified

providers are in network and the discounts currently provided by your existing PPO contracted providers. These readjudicated claims should reflect actual allowed payments based on your contracts with providers and must be submitted electronically with your proposal.

NOTE: The original and eight (8) copies of the Cost Quotation Proposal Form are to be submitted in a separate envelope marked "ASO NIC – PPO Cost Proposal" on the outside of such envelope.

Proposer_____

BY (Print Name) _____ **Title**_____

Signature_____ **Date**_____

SECTION IX

EXHIBITS

EXHIBIT 1 Plan of Benefits

EXHIBIT 2 OGB PPO Summary of Benefits Chart

EXHIBIT 3 Enrollment Information By Plans

EXHIBIT 4 Enrollment Form

EXHIBIT 5 Statewide Regions by City and Zip Codes

EXHIBIT 6 OGB Official 2009-2010 Premium Rates

EXHIBIT 7 Contract/Business Associate Agreement/
Required Data Files (Attachments) & Reports

- Attachment A Financial Agreement
- Attachment B Performance Standards
- Attachment C Business Associate Agreement (BAA)
- Attachment D File Requirement & Layout
- Attachment E Required Reports

EXHIBIT 8 2010-2011 PROPOSED BENEFIT MODIFICATIONS

EXHIBIT 9 HOSPITAL LIST

EXHIBIT 1

OGB PPO PLAN OF BENEFITS

Plan of Benefits can be attained from The Office of Group Benefits website: www.groupbenefits.org.

- On the OGB Home Page, under "Quick Links," click Health Plans, then, under "Plan Documents", click PPO Plan.

- If you experience difficulty in this process please e-mail prahl@ogb.state.la.us.

EXHIBIT 2

OGB PPO SUMMARY OF BENEFITS CHART

Active Employees and Retirees without Medicare PPO Summary of Benefits

COVERED BENEFIT: IN-NETWORK	**PPO Plan *(statewide)*** ***Administered by OGB***
Lifetime Maximum Benefit (all eligible expenses)	$5 million per person
Plan Year Deductible	$500 active; $300 retired
Employees and dependents	Family unit maximum: 3 individual deductibles
Maximum Out-Pocket Expense In-Network	$1000 per person
Hospital Services (inpatient)	Member pays 10% of contracted rate [1, 2]
Surgeon, Anesthesia, Lab, X-rays & Injections	Member pays 10% of contracted rate[1]
Hospital Emergency Room (facility only)	$150 separate deductible; waived if admitted
	Member pays 10% of contracted rate[1]
Ambulatory Surgical Facilities	Member pays 10% of contracted rate[1]
Physician Visits	Member pays 10% of contracted rate[1]
Maternity (physician only)	Member pays 10% of contracted rate[1]
MRI/CAT Scan	Member pays 10% of contracted rate[1]
Sonograms	Member pays 10% of contracted rate[1]
Chemical/Radiation Therapy	Member pays 10% of contracted rate[1]
Pre-Admission Testing	Member pays 10% of contracted rate[1]
Dialysis	Member pays 10% of contracted rate[1]
Cardiac Rehabilitation Therapy	Member pays 10% of contracted rate[1, 8]
Physical and Occupational Therapy	Member pays 10% of contracted rate[1, 6]
Speech Therapy[2]	Member pays 10% of contracted rate[1, 7]
Oral Surgery (impacted tooth removal only)	Member pays 0% of fee schedule
Routine PAP Test	Member pays 10% of contracted rate[3]
Routine Mammogram	Member pays 10% of contracted rate[3]
Routine PSA Screening	Member pays 10% of contracted rate[3]
Durable Medical Equipment[2]	Member pays 10% of contracted rate[1]
Home Health Care[2]	Case management required
	Member pays 30% of negotiated rate[1]
	(Limited to 150 visits year per plan year)
Hospice Care	Case management required
	Member pays 20% of negotiated rate
Wellness Program	
Baby/Child (Routine exams, scheduled immunizations)	Member pays 10% of contracted rate[1]
Adult (Physical exam, lab, X-ray)	Member pays 0% of eligible expenses to $200 [3, 5]
Eye Exam (Annual)	Not covered
Prescription Drug Benefit In-Network	Member pays 50%; maximum $50 per 30-day fill; after $1200 per person per plan year, co-payment $15 brand, 0% generic *(Administered by Catalyst Rx)*
Mail Order Drug Program	Same as above
Mental Health/Substance Abuse - Inpatient[2] (Maximum 45 inpatient days per plan year)	Member pays 20% of contracted rate Separate $200 deductible (inpatient & outpatient) Inpatient deductible $50 per day; maximum 5 days *(Administered by OptumHealth)*
Mental Health/Substance Abuse - Outpatient[2] (Maximum 52 visits per plan year)	Member pays 20% of contacted rate *(Administered by OptumHealth)*
COVERED BENEFIT: OUT-OF-NETWORK	
Member resides in Louisiana	Member pays 30% of fee schedule [1, 4]
Member resides outside Louisiana	Member pays 10% of fee schedule [1, 4]

1 Subject to plan year deductible and co-insurance
2 Pre-authorization required
3 Age and/or time restrictions apply
4 Member pays difference between billed amount and fee schedule
5 Member pays any amount above $200 maximum
6 Limited to 50 visits per year
7 Limited to 26 visits per year
8 Within 6 months of qualifying event

Retirees with Medicare PPO Summary of Benefits

COVERED BENEFIT: IN-NETWORK	**OGB PPO Plan *(statewide)***
Lifetime Maximum Benefit	$5 million per person
Plan Year Deductible	$300 retired
Employees and dependents	Family Unit Maximum: 3 individual deductibles
Maximum Out-Pocket Expense In-Network	$2000 per person
Hospital Services - inpatient	Member pays 20% of MC co-ins/ded [1]
Surgery, Anesthesia, & X-rays	Member pays 20% of MC co-ins/ded [1]
Hospital Emergency Room (facility only)	$150 separate deductible/waived if admitted Member pays 20% of MC co-ins/ded [1]
Ambulatory Surgical Facilities	Member pays 20% of MC co-ins/ded [1]
Physician Visits	Member pays 20% of MC-co-ins/ded [1]
MRI/CAT Scan	Member pays 20% of MC co-ins/ded [1]
Sonograms	Member pays 20% of MC co-ins/ded [1]
Chemical/Radiation Therapy	Member pays 20% of MC co-ins/ded [1]
Dialysis	Member pays 20% of MC co-ins/ded [1]
Cardiac Rehabilitation Therapy	Member pays 20% of MC co-ins/ded [1, 3]
Physical and Occupational Therapy	Member pays 20% of MC co-ins/ded[1]
Speech Therapy	Member pays 20% of MC co-ins/ded[1]
Oral Surgery (impacted tooth removal only)	Member pays 0% of Fee Schedule
Routine PAP Test	Member pays 20% of MC co-ins/ded[1]
Routine Mammogram	Member pays 20% of MC co-ins/ded[1]
Routine PSA Screening	Member pays 20% of MC co-ins/ded[1]
Durable Medical Equipment	Member pays 20% of MC co-ins/ded[1]
Home Health Care	Non-covered benefit when MC is primary
Hospice Care	Non-covered benefit when MC is primary
Wellness Program	
Adult:	20% of Fee Schedule up to $200
Physical exam, lab, X-ray	Age and/or time restrictions apply
Prescription Drug Benefit	Member pays 50%; max $50 per 30-day fill; after $1200 per person per plan year, co-pay $15 brand, $0 generic Administered by Catalyst Rx
Mail Order Drug Program	same as above
Mental Health & Substance Abuse/Inpatient [2, 3]	Member pays 20% of contracted rate
Max 45 inpatient days/person/plan year	Separate $200 deductible (in & out patient) Inpatient $50 per day/max 5 days Administered by Optum Health
Mental Health & Substance Abuse/Outpatient [2, 3]	Member pays 20% of contracted rate
Max. 52 visits/year	Separate $200 deductible (in & out patient) Administered by Optum Health
COVERED BENEFIT: OUT-OF-NETWORK	
Hospital services - inpatient	$50 per day / max $250 per admission
All out-of-network providers	N/A

[1] Subject to plan year deductible and/or applicable co-insurance
[2] Pre-certification required
[3] Complete within 6 months
[4] Member pays difference between billed amount and fee schedule

EXHIBIT 3

ENROLLMENT INFORMATION BY PLAN

STS0010

Enrollees with Health Coverage by Region

Effective Date: 1/1/2010

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
FMOP-LEV1 NO/IN											
	5	8	1	16	2	12	4	11	3	62
Region	0.02%	0.17%	0.01%	0.13%	0.03%	0.03%	0.02%	0.10%	0.02%	0.04%
Plan	0.02%	12.90%	1.61%	25.81%	3.23%	19.35%	6.45%	17.74%	4.84%	100.00%
FMOP-LEV1 W/INS											
	11	12	16	17	12	13	14	18	7	120
Region	0.05%	0.26%	0.12%	0.14%	0.17%	0.03%	0.07%	0.16%	0.05%	0.08%
Plan	0.05%	10.00%	13.33%	14.17%	10.00%	10.83%	11.67%	15.00%	5.83%	100.00%
FMOP-LEV2 NO/IN											
	10	3	5	9	2	8	5	7	3	52
Region	0.04%	0.07%	0.04%	0.07%	0.03%	0.02%	0.02%	0.06%	0.02%	0.03%
Plan	0.04%	5.77%	9.62%	17.31%	3.85%	15.38%	9.62%	13.46%	5.77%	100.00%
FMOP-LEV2 W/INS											
	9	16	10	23	10	19	14	7	4	112
Region	0.04%	0.35%	0.07%	0.18%	0.14%	0.05%	0.07%	0.06%	0.03%	0.07%
Plan	0.04%	14.29%	8.93%	20.54%	8.93%	16.96%	12.50%	6.25%	3.57%	100.00%

STS0010

Enrollees with Health Coverage by Region

Effective Date: 1/1/2010

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
HUMANA FFS 65											
	45	17	19	12	29	5	25	35	8	5	200
Region	0.83%	0.08%	0.42%	0.09%	0.23%	0.07%	0.07%	0.17%	0.07%	0.03%	0.13%
Plan	22.50%	0.08%	9.50%	6.00%	14.50%	2.50%	12.50%	17.50%	4.00%	2.50%	100.00%
HUMANA HMO 65											
		261	4	184	1		342	11	55		858
Region		1.17%	0.09%	1.38%	0.01%		0.90%	0.05%	0.50%		0.57%
Plan		1.17%	0.47%	21.45%	0.12%		39.86%	1.28%	6.41%		100.00%
HUMANA(ST WIDE)											
	459	12,731	1,128	6,866	2,095	1,333	22,422	9,221	4,130	2,712	63,097
Region	8.44%	56.96%	24.64%	51.41%	16.65%	18.89%	58.98%	44.78%	37.21%	17.71%	41.96%
Plan	0.73%	56.96%	1.79%	10.88%	3.32%	2.11%	35.54%	14.61%	6.55%	4.30%	100.00%
LACHIP-COPAY											
	3	363	152	187	311	192	291	188	179	139	2,005
Region	0.06%	1.62%	3.32%	1.40%	2.47%	2.72%	0.77%	0.91%	1.61%	0.91%	1.33%
Plan	0.15%	1.62%	7.58%	9.33%	15.51%	9.58%	14.51%	9.38%	8.93%	6.93%	100.00%

Enrollees with Health Coverage by Region

Effective Date: 1/1/2010

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
LACHIP-NO COPAY											
		1	4		7	1	2	3	3	1	22
Region		0.00%	0.09%		0.06%	0.01%	0.01%	0.01%	0.03%	0.01%	0.01%
Plan		0.00%	18.18%		31.82%	4.55%	9.09%	13.64%	13.64%	4.55%	100.00%
LSU Health $10K											
	40	280	26	38	52	12	571	20	336	19	1,394
Region	0.74%	1.25%	0.57%	0.28%	0.41%	0.17%	1.50%	0.10%	3.03%	0.12%	0.93%
Plan	2.87%	1.25%	1.87%	2.73%	3.73%	0.86%	40.96%	1.43%	24.10%	1.36%	100.00%
LSU Health $5K											
	425	1,888	526	756	1,071	299	4,083	413	2,005	446	11,912
Region	7.82%	8.45%	11.49%	5.66%	8.51%	4.24%	10.74%	2.01%	18.06%	2.91%	7.92%
Plan	3.57%	8.45%	4.42%	6.35%	8.99%	2.51%	34.28%	3.47%	16.83%	3.74%	100.00%
MCOP-RANGE 1											
		23	8	5	23	8	13	13	12	7	112
Region		0.10%	0.17%	0.04%	0.18%	0.11%	0.03%	0.06%	0.11%	0.05%	0.07%
Plan		0.10%	7.14%	4.46%	20.54%	7.14%	11.61%	11.61%	10.71%	6.25%	100.00%

ST90010

Enrollees with Health Coverage by Region

Effective Date: 1/1/2010

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
MCOP-RANGE 2											
		7	1	4	7	1	2	3	3	2	30
Region		0.03%	0.02%	0.03%	0.06%	0.01%	0.01%	0.01%	0.03%	0.01%	0.02%
Plan		0.03%	3.33%	13.33%	23.33%	3.33%	6.67%	10.00%	10.00%	6.67%	100.00%
MED HOME HMO PL											
	3							78	2	1,864	1,947
Region	0.06%							0.38%	0.02%	12.17%	1.29%
Plan	0.15%							4.01%	0.10%	95.74%	100.00%
NOT FOUND											
		1	1		4	1	1		1	2	11
Region		0.00%	0.02%		0.03%	0.01%	0.00%		0.01%	0.01%	0.01%
Plan		0.00%	9.09%		36.36%	9.09%	9.09%		9.09%	18.18%	100.00%
OGB PPO											
	2,726	4,762	1,400	3,602	4,372	3,704	4,716	9,235	3,110	8,236	45,863
Region	50.15%	21.30%	30.59%	26.97%	34.75%	52.50%	12.40%	44.85%	28.02%	53.77%	30.50%
Plan	5.94%	21.30%	3.05%	7.85%	9.53%	8.08%	10.28%	20.14%	6.78%	17.96%	100.00%

Enrollees with Health Coverage by Region

Effective Date: 1/1/2010

	REGIONS										
	00	01	02	03	04	05	06	07	08	09	Totals
PEOPLE'S-MEDADV											
		35	1	29			80				145
Region		0.16%	0.02%	0.22%			0.21%				0.10%
Plan		0.16%	0.69%	20.00%			55.17%				100.00%
UNITED -MEDADV											
	10	4	7	1	24	2	20	14	2	8	92
Region	0.18%	0.02%	0.15%	0.01%	0.19%	0.03%	0.05%	0.07%	0.02%	0.05%	0.06%
Plan	10.87%	0.02%	7.61%	1.09%	26.09%	2.17%	21.74%	15.22%	2.17%	8.70%	100.00%
UNITED(ST WIDE)											
	1,720	1,870	1,218	1,563	4,273	1,346	5,256	862	1,075	1,532	20,715
Region	31.64%	8.37%	26.61%	11.70%	33.96%	19.08%	13.82%	4.19%	9.69%	10.00%	13.77%
Plan	8.30%	8.37%	5.88%	7.55%	20.63%	6.50%	25.37%	4.16%	5.19%	7.40%	100.00%
VANTAGE -MEDADV											
	5	74	43	77	248	125	143	457	135	327	1,634
Region	0.09%	0.33%	0.94%	0.58%	1.97%	1.77%	0.38%	2.22%	1.22%	2.13%	1.09%
Plan	0.31%	0.33%	2.63%	4.71%	15.18%	7.65%	8.75%	27.97%	8.26%	20.01%	100.00%

Enrollees with Health Coverage by Region

Effective Date: 1/1/2010

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
Grand Total	5,436	22,352	4,577	13,356	12,582	7,055	38,019	20,590	11,099	15,317	150,383

Region	Zip Codes	Name
00	N/A	Out of State
01	700-701	New Orleans
02	703	Houma/Thibodaux
03	704	Hammond
04	705	Lafayette
05	706	Lake Charles
06	707-708	Baton Rouge
07	713-714	Alexandria
08	710-711	Shreveport
09	712	Monroe

EXHIBIT 4

ENROLLMENT FORM

GB-01
06/09

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS
ENROLLMENT/CHANGE FORM

Agency Number	Agency Name	Date of Hire	Annual Salary	Employee Name changed to:

A. PURPOSE

☐ Waiver of Coverage ☐ Agency Transfer (Receiving Agency) ☐ New Enrollment ☐ Reinstate Coverage ☐ Re-enrollment - Previous Employment Rehired Retiree ☐ Yes ☐ No

☐ Annual Enrollment ☐ Add/Delete Dependent (s) _____ (Date) Reason for Addition/Deletion _____

☐ Surviving Spouse/Dependent ☐ Special Enrollment ☐ Late Applicant - Portability Law Applies? ☐ No ☐ Yes ☐ Retired _____ (Date)

☐ Employment Terminated _____ (Date) ☐ Deceased _____ (Date)

☐ **Cancel all coverage** (Health & Life) _____ (Reason for Cancellation) ☐ Other _____

B. PERSONAL INFORMATION - EMPLOYEE (Please print or type)

Name			Social Security Number		Date of Birth	
Address			City		State	Zip Code
Home Phone ( )	Work Phone ( )	Extension	Sex 1. ☐ Male 2. ☐ Female	Marital Status 1. ☐ Single 2. ☐ Married	Date of Marriage	Date of Divorce

C. HEALTH PLAN SELECTED:

D. LEVEL OF MEDICAL COVERAGE SELECTED

☐ No Coverage ☐ Employee Only ☐ Employee + Child/Children ☐ Employee + Spouse ☐ Family

Name (Last name, first, MI)	Relationship	Sex	Birth Date (mm/dd/ccyy)	Add/Delete	Social Security Number	Health	Dep. Life
Employee		☐ M ☐ F		☐ Add ☐ Delete			
Spouse		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes

Are you or family members listed above covered by any other group health insurance/HMO from another employer/organization/Medicaid? ☐ No ☐ Yes. If Yes provide the following:

Policy Holder's Name	Social Security No.	Birth Date	Policy Number	Group Number	Coverage Type	Effect. Date
Employer/Company	Insurance Company/HMO (Name/Address/Phone)			Persons covered under other policy		

E. COBRA

☐ Prior F/T Terminated ☐ Divorced Spouse ☐ Dependent

Name of original member _____ Social Security Number _____

F. MEDICARE

Employee	Spouse
☐ 1. No Coverage	☐ 1. No Coverage
☐ 2. Hospital (Part A)	☐ 2. Hospital (Part A)
☐ 3. Medical (Part B)	☐ 3. Medical (Part B)
☐ 4. Drugs (Part D)	☐ 4. Drugs (Part D)

A COPY OF MEDICARE CARD MUST BE ATTACHED

G. RETIREE 100

☐ Yes ☐ No ☐ Employee Only ☐ Dependent Only ☐ Employee & 1 Dependent

H. MENTAL HEALTH RIDER

☐ Yes ☐ No

I. LIFE INSURANCE (Check only one)

☐ No Coverage Employee/Dependent

BASIC

☐ Employee/No Dependent Coverage
☐ Employee/Dependent Coverage
Eligible Spouse $1,000 Eligible Child $500
☐ Employee/Dependent Coverage
Eligible Spouse $2,000 Eligible Child $1,000

Date of Last Salary Increase _____

BASIC PLUS SUPPLEMENTAL

☐ Employee/No Dependent
☐ Employee/Dependent Coverage
Eligible Spouse $2,000 Eligible Child $1,000
☐ Employee/Dependent Coverage
Eligible Spouse $4,000 Eligible Child $2,000

Annual Salary _____
Face Life _____

PAGE 1 OF 2
CONTINUE ON REVERSE SIDE

GB-01 06/09

SSN _____

Medical Release

I authorize health care providers of services to me and my dependents to release information (including information related to diagnosis or treatment of mental health and/or substance abuse problems, or acquired immune deficiency syndrome) to my Office of Group Benefits (OGB) health plan and all participating providers to the extent necessary to determine responsibility for payment of claims and for utilization review and quality assurance purposes. A copy of this authorization is as valid as the original.

I understand that the names of participating providers in my OGB health plan may change during the plan year. The health plan does not guarantee the continuing participation of the named health care providers.

Plan Members With Enrolled Children Please Note:

IF YOU ARE DIVORCED AND HAVE CHILDREN UNDER AGE 18 AND IF A COURT ORDER HAS BEEN ISSUED ASSIGNING FINANCIAL RESPONSIBILITY, YOUR HEALTH PLAN MUST BE PROVIDED WITH A COPY.

IF THE CHILD IS OVER AGE 21, PROOF OF FULL TIME STUDENT STATUS FROM AN ACCREDITED SCHOOL MUST BE PROVIDED TO YOUR HEALTH PLAN AT THE TIME OF INITIAL ENROLLMENT AND AT THE START OF EACH SEMESTER.

New Hires and Acknowledgements

I acknowledge that my application will be approved on a conditional basis.

I understand that unless the Portability Law applies, any illness, injury, disease, or condition for which any treatment was received within the six months prior to the date of application for coverage will have no benefits available for the 12 months following the effective date of application for coverage.

I understand that any disease, illness, accident, or injury will be classified as a pre-existing condition if, during the six-month period preceding the effective date of coverage, any treatment or services were received or drugs were prescribed for such disease, illness, accident, or injury.

The term **Treatment** shall mean all steps taken to effect the cure of a disease, illness, accident, or injury and shall include, but not be limited to, consultations, examinations, diagnosis, and any application of remedies.

I accept the conditional approval for coverage and agree that this declaration will become a part of my application for coverage.

J. WAIVER OF COVERAGE

_____ *I waive all coverage under the Office of Group Benefits Program/HMO and I understand if I enroll at a future date that the coverage will be subject to evidence of insurability for life insurance and a Pre-Existing Condition (PEC) for health insurance, and may be conditional.*

NOTE TO AGENCY REPRESENTATIVE: If employee waives right to all coverage, he/she must sign an enrollment document. A copy of this document is to be retained by the Agency as evidence the Employee was offered coverage within 30 days of eligibility and the employee declined. The original of this document is to be transmitted to Group Benefits.

_____ EMPLOYEE SIGNATURE _____ DATE

NOTICE: YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

I reviewed the descriptive literature about the Plans available to me. I apply for participation/change in the named health plan and agree to be bound by it's terms and conditions. I authorize deductions from my earnings or retirement check to pay for insurance for myself and dependents, if applicable. I CONSENT TO THE MEDICAL RELEASE AND OTHER ENROLLMENT INFORMATION AS EXPLAINED ABOVE. I certify that the information provided on this form is true and correct. I understand that if I provide material false information on this form, it may result in denial or recision of coverage retroactive to the initial day of coverage. A copy of my signature is as valid as the original.

X _____ _____
Employee Signature Date

_____ _____
Agency Rep. Date

OFFICE USE ONLY

Life Health Specialist Int. Date

EXHIBIT 5

STATEWIDE REGIONS BY CITY AND ZIP CODES

Regions by City and Zip Code

REGION 1
- Algiers
- Arabi
- Avondale
- Belle Chasse
- Boutte
- Buras
- Chalmette
- Davant
- Destrehan
- Edgard
- Gramercy
- Gretna
- Harahan
- Harvey
- Jefferson
- Kenner
- Laplace
- Luling
- Lutcher
- Marrero
- Metairie
- New Orleans
- Port Sulphur
- Reserve
- River Ridge
- St. Rose
- Terrytown
- Vacherie
- Westwego

REGION 2
- Cut Off
- Donaldsonville
- Galliano
- Golden Meadow
- Gray
- Houma
- Lockport
- Morgan City
- Napoleonville
- Paincourtville
- Pierre Part
- Plattenville
- Raceland
- Thibodaux

REGION 3
- Amite
- Bogalusa
- Covington
- Franklinton
- Greensburg
- Hammond
- Independence
- Kentwood
- Lacombe
- Madisonville
- Mandeville
- Ponchatoula
- Slidell

REGION 4
- Abbeville
- Basile
- Branch
- Breaux Bridge
- Carencro
- Church Point
- Crowley
- Erath
- Eunice
- Franklin
- Iota
- Kaplan
- Lafayette
- Mamou
- Maurice
- New Iberia
- Opelousas
- Port Barre
- Rayne
- Scott
- St. Martinville
- Sunset
- Turkey Creek
- Ville Platte

REGION 5
- Creole
- Dequincy
- DeRidder
- Elizabeth
- Elton
- Fenton
- Hackberry
- Iowa
- Jennings
- Kinder
- Lake Arthur
- Lake Charles
- Merryville
- Moss Bluff
- Oberlin
- Pitkin
- Sulphur
- Vinton
- Welsh
- Westlake

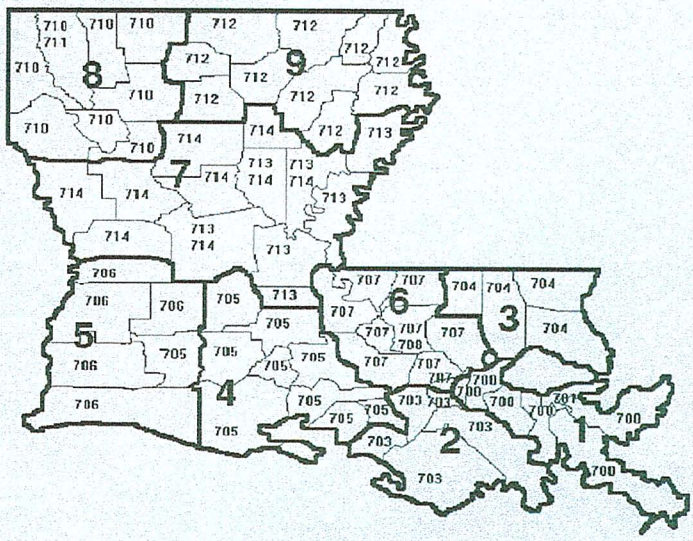
REGION 6
- Addis
- Baker
- Baton Rouge
- Brusly
- Clinton
- Denham Springs
- Gonzales
- Livingston
- Livonia
- Maringouin
- New Roads
- Plaquemine
- Port Allen
- Prairieville
- St. Francisville
- St. Gabriel
- Sunshine
- White Castle
- Zachary

REGION 7
- Alexandria
- Boyce
- Bunkie
- Colfax
- Columbia
- Ferriday
- Jena
- Jonesville
- Lecompte
- Leesville
- Mansura
- Many
- Marksville
- Melville
- Montogmery
- Natchitoches
- Newellton
- Oakdale
- Palmetto
- Pineville
- Sicily Island
- Simmesport
- St. Joseph
- Urania
- Vidalia
- Winnfield
- Zwolle

REGION 8
- Arcadia
- Benton
- Bossier City
- Coushatta
- Cullen
- Haughton
- Haynesville
- Homer
- Mansfield
- Minden
- Ringgold
- Sarepta
- Shreveport
- Springhill

REGION 9
- Bastrop
- Bernice
- Delhi
- Dodson
- Farmerville
- Jonesboro
- Lake Providence
- Mangham
- Mer Rouge
- Monroe
- Oak Grove
- Rayville
- Ruston
- Sterlington
- West Monroe
- Winnsboro

Region	Zip Codes
1	700 & 701
2	703
3	704
4	705
5	705* & 706
6	707 & 708
7	713 & 714
8	710 & 711
9	712



*Only zip codes beginning with 705 in Jeff Davis Parish are in Region 5.

EXHIBIT 6

OGB OFFICIAL 2009-10 PREMIUM RATES

OFFICE OF GROUP BENEFITS
OFFICIAL SCHEDULE OF RATES
EFFECTIVE SEPTEMBER 1, 2009

		STATEWIDE PPO RATES JULY 1, 2009			STATEWIDE EPO RATES JULY 1, 2009			STATEWIDE HMO RATES JULY 1, 2009			REGION 9 MEDICAL HOME HEALTH PLAN SEPTEMBER 1, 2009		
		STATE SHARE	EMP SHARE	TOTAL	STATE SHARE	EMP SHARE	TOTAL	STATE SHARE	EMP SHARE	TOTAL	STATE SHARE	EMP SHARE	TOTAL
ACTIVE													
	SINGLE	418.98	139.66	558.64	418.98	162.06	581.04	402.28	134.08	536.36	399.00	133.00	532.00
	WITH SPOUSE	732.94	453.62	1186.56	732.94	501.10	1234.04	703.66	435.46	1139.12	697.98	431.98	1129.96
	WITH CHILDREN	480.32	201.00	681.32	480.32	228.28	708.60	461.16	192.96	654.12	457.52	191.52	649.04
	FAMILY	765.36	486.04	1251.40	765.36	536.08	1301.44	734.78	466.58	1201.36	728.84	462.84	1191.68
RETIRED NO MEDICARE & RE-EMPLOYED RETIREE													
	SINGLE	899.62	139.66	1039.28	899.62	181.18	1080.80	863.64	134.08	997.72	856.52	133.00	989.52
	WITH SPOUSE	1381.58	453.62	1835.20	1381.58	526.98	1908.56	1326.26	435.46	1761.72	1315.62	431.98	1747.60
	WITH CHILDREN	956.64	201.00	1157.64	956.64	247.28	1203.92	918.44	192.96	1111.40	910.76	191.52	1102.28
	FAMILY	1369.74	456.58	1826.32	1369.74	529.62	1899.36	1314.96	438.32	1753.28	1304.34	434.78	1739.12
RETIRED WITH 1 MEDICARE													
	SINGLE	253.48	84.48	337.96	253.48	98.00	351.48	243.34	81.10	324.44	241.38	80.46	321.84
	WITH SPOUSE	936.54	312.18	1248.72	936.54	362.10	1298.64	899.02	299.66	1198.68	891.76	297.24	1189.00
	WITH CHILDREN	438.72	146.24	584.96	438.72	169.64	608.36	421.20	140.40	561.60	417.76	139.24	557.00
	FAMILY	1247.86	415.94	1663.80	1247.86	482.46	1730.32	1197.90	399.30	1597.20	1188.22	396.06	1584.28
RETIRED WITH 2 MEDICARE													
	WITH SPOUSE	455.62	151.86	607.48	455.62	176.10	631.72	437.38	145.78	583.16	433.70	144.58	578.28
	FAMILY	564.12	188.04	752.16	564.12	218.12	782.24	541.56	180.52	722.08	537.06	179.02	716.08
COBRA													
	SINGLE	0.00	569.82	569.82	0.00	592.66	592.66	0.00	547.06	547.06	0.00	542.64	542.64
	WITH SPOUSE	0.00	1210.30	1210.30	0.00	1258.70	1258.70	0.00	1161.88	1161.88	0.00	1152.84	1152.84
	WITH CHILDREN	0.00	694.96	694.96	0.00	722.78	722.78	0.00	667.16	667.16	0.00	661.80	661.80
	FAMILY	0.00	1276.44	1276.44	0.00	1327.42	1327.42	0.00	1225.38	1225.38	0.00	1215.60	1215.60
DISABILITY COBRA													
	SINGLE	0.00	839.96	839.96	0.00	871.54	871.54	0.00	804.52	804.52	0.00	800.12	800.12
	WITH SPOUSE	0.00	1779.84	1779.84	0.00	1851.04	1851.04	0.00	1708.66	1708.66	0.00	1694.96	1694.96
	WITH CHILDREN	0.00	1021.98	1021.98	0.00	1062.88	1062.88	0.00	981.14	981.14	0.00	973.04	973.04
	FAMILY	0.00	1877.10	1877.10	0.00	1952.14	1952.14	0.00	1802.02	1802.02	0.00	1787.52	1787.52

NOTE: 1) The breakdown between State Share and Employee Share may not be accurate for certain School Board employees due to local funding affecting contributions. Total premium columns are correct for all agencies.

2) All members that retire on or after July 1, 1997 must have Medicare-Parts A and B in order to qualify for the reduced premium rates.

Approved by:

Tammy P. Logue

8/28/2009

EXHIBIT 7

CONTRACT/BUSINESS ASSOCIATE AGREEMENT/ REQUIRED DATA/REPPORTING

STATE OF LOUISIANA

OFFICE OF GROUP BENEFITS (OGB)

ADMINISTRATIVE SERVICES ONLY (ASO)

CONTRACT

The STATE OF LOUISIANA, DIVISION OF ADMINISTRATION, OFFICE OF GROUP BENEFITS (hereinafter sometimes referred to as the OGB) located at 7389 Florida Blvd., Suite 400, Baton Rouge, LA 70806 and _____(Name and Address of Contractor)_____ (hereinafter sometimes referred to as "Contractor") do hereby enter into a Contract under the following terms and conditions:

1.0 DEFINITIONS

a. "Contract" shall mean this Contract between Contractor and OGB, including any and all documents and appendices attached hereto or incorporated by reference.

b. "Plan" shall mean the OGB self-funded (PPO) Plan of the group health and accident insurance Benefits plan adopted by OGB for the benefit of state employees, retirees and their dependents.

c. "Plan Participant" (Participant) shall mean a state employee or retiree who is entitled to Benefits under the Plan or any dependent of the employee or retiree who is entitled to Benefits under the Plan.

d. "OGB Plan Document" shall mean the applicable terms of the OGB's Program or Program of Benefits, including limitations and exclusions.

e. "Benefits" shall mean Medically Necessary and Appropriate health care services, supplies, equipment and facilities charges covered under, and in accordance with the OGB Plan Document.

f. "CMS" shall mean the Federal Center for Medicare and Medicaid Services (formerly the Health Care Financing Administration).

g. "Savings" shall mean the difference between the amount of Benefits that would be paid in the absence of a negotiated rate with a provider for a particular service or supply and the amount of the negotiated rate actually paid for that service.

h. "Confidential Plan Participant Information" shall mean information that contains personally identifiable health information about a Plan Participant.

i. "Managed Care Network" shall mean a network of " Participating Providers" that is, physicians hospitals, other healthcare providers that participate in a network established and maintained by the Contractor, having entered into agreements with the Contractor to provide healthcare services to plan participants for a negotiated reimbursement rate. A healthcare provider that does not participate in the Contractor's established network but enters into a limited "case rate" agreement shall be considered a non-Network or non-participating provider.

j. "Network Provider" shall mean a health care provider who participates in Contractor's Managed Care Network.

k. "Overpayments" shall mean payments that exceed the amount payable under the Plan (for example, because of a provider billing error, retroactive or inaccurate eligibility information, coordination of Benefits, Medicare disputes, or missing information), and other overcharges made by providers, including hospitals discovered during the course of a hospital bill audit.

l. "Self-Fund" or Self-Funded" shall mean that OGB has the sole responsibility to provide funds for all Plan Benefits. Contractor has no liability to provide these funds except for the following two conditions: (a) if Contractors pays a claim two (2) business days after OGB provided Contractor a data eligibility file with revisions/changes in eligibility that would have affected the payment of the claim; and (b) when Contractor pays an out of network Provider at a amount that exceeds the in network reimbursement rate.

m. "Urgent Care Claims" shall mean a claim that requires notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize the Plan Participant's life or health or the ability to regain maximum function, or in the opinion of a physician with knowledge of the Plan Participant's medical condition could cause severe pain.

n. "Bank" shall mean a bank chosen by the Contractor.

o. "Bank Account" shall mean the demand deposit bank account (DDA) maintained by Contractor for the payment of Plan Benefits, expenses and fees.

p. "Eligible Claims" shall mean a request for benefits payable in accordance with the terms of the plan that:

1. Is properly submitted in a standard format.
   a. CMS/HCFA 1500 and UB92 for nonelectronic claims, or
   b. ANSI ASC X 12N 837 v. 4010 format, or its successor adopted by the United States Department of the Health Insurance Portability and Accountability Act (42 USC 1302d et Seq. and 45 C.F.R. Parts 160 and 162).
2. Contains all required data elements.
3. Has no defect or impropriety, including any lack of required substantiating documentation or other particular circumstance requiring special treatment, that prevents timely payment from being made on the claim.

2.0 SCOPE OF SERVICES

a. The goal of the OGB is to fulfill its delegated responsibility to serve the State of Louisiana by meeting the needs of its past, present and future employees for an innovative approach to health, life, and related Benefits.

b. The objective of the OGB is to provide quality, cost-effective hospital and health care services to Plan Participants.

c. The Contractor will provide a PPO Physician and Hospital Provider Network to OGB Plan Participants as listed below:

Effective: _____.

Contractor will provide certain administrative services to OGB in connection with its Plan as follows:

1. Provide services pursuant to this contract in accordance with Benefits provided under the Plan and any changes thereto made during the term of this Contract.

2. Based upon OGB's determination and confirmation to Contractor of the validity of the enrollment application, enroll such Plan Participants to receive Plan Benefits in accordance with Plan provisions.

3. Prepare, subject to OGB's prior approval, the following Participant materials:

    a) A booklet during annual enrollment describing all covered services under the Plan, including but not limited to, Plan Benefits, limitations, exclusions, coinsurance, co-payments, policies and procedures for utilizing clinical and administrative services, conditions under which an individual's participation may be terminated, procedures for registering complaints or filing grievances against the Contractor or any providers participating in the Contractor's network.

    b) A electronic directory of providers, which includes all physicians, hospitals and specialists in the service area; and

4. Distribute Participant materials to newly enrolled Plan Participants within ten (10) days of confirmation from OGB of the validity of the Participant's enrollment application.

5. Prepare and print, subject to OGB's prior approval, a summary description of the Plan outlining basic and general information concerning the Plan and distribute the summary description to prospective enrollees at each annual enrollment meeting. Provide each prospective enrollee a summary description in each annual enrollment meeting.

6. Determine in accordance with the Plan the eligibility for payment of claims incurred

and submitted to it during the term of this Contract and make such investigation regarding said claims, as it deems necessary. In applying the Plan's provisions, Contractor will use claim procedures and standards that Contractor has developed for benefit claim determinations.

OGB authorizes Contractor the discretion and authority to use such procedures and standards. Contractor will refer potential subrogation claims and medical history to the Office of Group Benefits General Counsel.

7. Pay eligible claims pursuant to the terms of the Plan.

8. Furnish any necessary forms for submission of claims to Contractor.

9. Furnish to any claimant, notices of payment and explanation of Benefits and denials for claims.

10. Based on information available to Contractor, determine the primary, secondary and tertiary order of liability of the Plan and any other health Benefits program under which a Plan Participant may be eligible for Benefits and coordinate the payment of any Benefits in accordance with NAIC guidelines.

11. Provide initial review of Plan Participants' appeals and grievances and provide Contractor's Appeals and Grievances Policies and Procedures to OGB. OGB retains the right for final appeals to be heard.

12. Remit timely payments on or submit timely responses of non payment behalf of OGB to the Centers for Medicare and Medicaid Services (CMS) in response to HIPAA 837 transmissions or Demand Letters for the recovery of Medicare payments.

13. Facilitate management of the health care services afforded OGB's Plan Participants under the Plan, including but not limited to coordination services, transplant benefit management services, abuse and fraud management services, shared savings program services, facility reasonable charge determination and negotiation reduction services, all as described in further detail in this Contract.

14. Submit standardized data electronically (See Attachment D) to OGB to be used for the purpose of evaluating Plan Participant demographics, financial experience and other aspects of the Contractor's performance. The failure to submit such data in a timely manner shall subject the Contractor to the penalties set forth in Attachment A.

Claims Data: At the OGB's request, consistent with applicable law, Contractor shall provide to the OGB all claims data including Participant-specific claims information, ("Confidential Claims Information") which Contractor may obtain in the course of administering the Contract. Contractor may also release certain Participant-related claims data at Contractor's discretion to certain vendors or other third parties. The Contractor shall treat all Confidential Claims Information in accordance with the applicable federal and state laws and regulations, including but not limited to 42

C.F.R. Part 2 (confidentiality of alcohol and drug abuse patient records). Any use or disclosure of Confidential Claims Information or other information pursuant to this Section shall be subject to the terms and conditions of the HIPAA Business Associate Agreement attached hereto as Attachment C to the Contract.

15. Provide OGB with the required reports as set forth in Attachment E.

16. Attend informational and enrollment meetings as scheduled by OGB.

17. Eligibility and Enrollment Information/Requirement as listed below:

    OGB will transfer a daily eligibility data file to Contractor. Such file shall contain Employee Members, their eligible Dependents and shall include the following data match elements: (a) SSN/Contract Number; (b) birthdates; (c) name; (d) gender and (e) (as applicable) effective and termination dates. Contractor will be responsible for payment of claims under the following conditions: (a) if Contractor pays for a claim two (2) business days after OGB provided Contractor a data eligibility file with changes in eligibility that would have affected the payment of the claims; and (b) when Contractor pays an out of network Provider an amount that exceeds the in network reimbursement rate.

    Eligible Plan Participants: (a) Eligible Enrollee – Contractor shall enroll as Participants those persons who have been specified to Contractor by OGB as eligible persons for enrollment; (b) Eligible Dependent – must fall within eligibility requirements of OGB and be so designated as Eligible Dependent by OGB; and (c) Continuation of Coverage – the OGB shall retain full responsibility for notifying Participants of their rights to continuation coverage and administering the exercise of continuation rights as required by COBRA.

    The OGB shall provide notice to Contractor within five (5) business days of the effective date, as determined by OGB of: (a) coverage for all Participants and (b) termination of any Participant.

    OGB shall report eligibility activity in the format attached hereto as Attachment D-5. Each Eligibility transmission shall contain data pertinent to all Participants for which the Contractor has received updated eligibility information since the last transmission received by Contractor. Contractor will establish and maintain a single, uniform system to update eligibility records for Participants. This system shall accept eligibility data from OGB in accordance with its standard eligibility protocols through an online electronic transfer and perform eligibility file matches, and identify and correct discrepancies. Eligibility transmissions shall take place between 10:00 p.m. and 3:00 a.m. following each regularly scheduled OGB business days, barring unforeseen software or hardware complications. Contractor shall notify OGB by 12:00 p.m. of the day following an unsuccessful transmission so that OGB can reschedule the transmission. Each contract year Contractor shall submit a schedule to OGB outlining the days that Contractor will be unable to accept a transmission. In the event any discrepancies, Contractor shall notify OGB

thereof and its correction of such discrepancies. The transmitted data (data not requiring additional follow-up or investigation) shall be converted and applied to Contractor's claims system for purposes of claims payment within two (2) business days of receipt of a successful transmission. The two (2) business day deadline shall not apply during annual enrollment or file match periods, although Contractor shall convert and apply the transmitted data to its claims system as soon as possible.

Eligibility Suspension: Contractor shall convert and apply to its claims system all eligibility suspension codes sent to it by OGB as part of its nightly eligibility transmissions.

Retroactive Member Additions: Contractor shall convert and apply to a claims system retroactive additions of Participants under the following conditions: (a) OGB acknowledges that it shall assume liability for all Benefits determined by Contractor under the terms of this Contract with respect to claims incurred by the Participant subsequent to Participant's retroactive effective date; and (b) OGB shall be solely responsible for notifying the affected Participant(s) of the addition and its retroactive effect.

Retroactive Member Terminations: Contractor shall convert and apply to its claims system terminations of Participants under the following conditions: (a) OGB acknowledges that it shall remain liable for all claims paid or received by Contractor (1) prior to the date on which Contractor received notice of termination; and (2) during the two (2) business day period following the date on which Contractor received notice of termination. Contractor acknowledges that it will be liable for all claims paid by Contractor after the two (2) business day period following the date on which Contractor received notice of termination.

Prospective Member Terminations: A Participant's coverage will terminate when a Participant ceases to be an Eligible Person or and Eligible Dependent under the terms of the OGB Plan Document. OGB shall be responsible for notifying all Participants of the termination of coverage; however, coverage will be terminated regardless of whether OGB provides the notice. OGB shall be responsible for notifying Contractor regarding the termination and the effective date thereof. Provided that OGB properly notifies Contractor of a Participant termination, if Contractor processes a claim incurred after the termination effective date, then OGB shall not be financially liable for such claim.

Certificates of Creditable Coverage: Contractor will not produce or furnish certificates of creditable coverage which meet the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), on an automatic basis or on demand for former Participants.

Enrollment Reconciliation: OGB will provide a full and complete eligibility file to Contractor at the beginning of January, April, July and October of each Contract Year. Contractor shall, within ten (10) business days of receipt of this file, compare

and reconcile this full eligibility file to the eligibility file on its claims systems and send an exceptions report to OGB. Such full-file comparisons with respect to Enrollees and their Eligible Dependents shall include the following data match elements: (a) SSN/Contract number; (b) birth date; (c) name; and (d) (as applicable) effective and termination dates. Contractor shall not replace its eligibility file with this full file. OGB and Contractor will work in good faith to produce a fully accurate eligibility file no later than ten (10) business days following the submission of the exceptions report to OGB.

d. Contractor will identify and notify OGB of Participants that are potential candidates for Disease Management.

e. Contractor will provide a Internet Access Website that will provide information regarding benefits, claims, provider network, etc. that will be linked to OGB Website.

f. Contractor may agree to perform or otherwise provide special services to OGB by endorsement to this Contract or by letter agreement between the parties. The fee for any such special services shall be paid by OGB in addition to the monthly administrative services fee assessed in Article 4.0, in the amount and in the manner as provided in an amendment approved by Division of Administration, Director of Contractual Review.

g. See Attachment B for Performance Standards.

3.0 TERM OF CONTRACT

a. The term of this Contract shall commence, subject to paragraph 3.0(b) on July 1, 2010 and shall end on June 30, 2011. OGB has an option to renew the contract for a maximum of two additional one-year terms.

b. This Contract is not effective until approved by the Director of the Office of Contractual Review in accordance with La. R.S. 39:1502.

4.0 ADMINISTRATIVE FEES; PAYMENT TERMS

a. During the term of this Contract, OGB shall pay Contractor a monthly administrative services fee for services pursuant this Contract. The Administrative Fee Per Covered Employee/Retiree Per Month – See Attachment A.

b. If any amendment to the Plan of Benefits increases or decreases the OGB's claims experience, the Administrative Fee and/or other fees set forth in Attachment A may be adjusted accordingly by mutual written agreement of parties. If the parties fail to reach agreement on the financial terms, the parties agree to engage in good faith negotiations to amend the Contract which are consistent with the original economic objectives of the parties. Any such adjustment of the fees shall be effective on the date agreed on by the parties and after a contract amendment is approved by the Director of the Office of Contractual Review.

c. Contractor shall submit a monthly invoice to OGB for payment of the administrative fees within five (5) business days of the end of the month following the month during which services were provided pursuant to this Contract. The amount of Administrative fees which shall be paid will be based upon the number of Enrollees as determined by OGB's eligibility system, not the Contractor's system.

d. Failure of OGB to remit payment of the monthly administrative fee by the thirtieth (30^{th}) day of each month may result in the suspension of all administrative services performed by Contractor.

e. The maximum payable to Contractor for Administrative Services Fee and to be transferred for Claims Payment pursuant to this Contract shall not exceed _____To Be Determined) for any one year period unless the Director of the Office of Contractual Review approves a contract amendment.

f. Financial Arrangement/Reconciliation for Payment: See Attachment A.

5.0 SAVINGS AGREEMENT; COST CONTAINMENT PROGRAMS

a. OGB shall receive one hundred percent (100%) of Savings realized by Contractor under its cost containment programs which are attributable to claims under OGB's Plan, through billing of actual payments for claims made under these programs.

b. The cost for access to Contractor's cost containment programs shall be included in the Administrative Services Fee.

6.0 PROVIDER NETWORK SAVINGS

The OGB shall receive 100% savings in regards to Contractor's PPO provider contracts.

7.0 CLAIMS LIABILITY

a. OGB assumes full liability for funding all payments made for Plan claims (except for claims paid by Contractor after OGB provided Contractor a two (2) business days notification of a change in eligibility and when Contractor pays an out of network Provider an amount that exceeds the in network reimbursement rates), on or after the effective date of this Contract including payments remitted by Contractor to CMS in response to demand letters for the recovery of Medicare payments to Plan Participants except for any claim paid by Contractor after notification of an eligibility change. Contractor shall not be responsible under any circumstances for ensuring OGB's compliance with federal or state laws which may apply to the establishment and/or maintenance of these funds, or for advising OGB of any such federal or state laws.

b. If, for any reason, a provider fails to or is unable to render services it has agreed to provide through a Contract with Contractor, Contractor will honor a claim for services

equivalent to those agreed to by the defaulting provider while an individual continues to be a plan Participant. The claim shall be included in the billing of claims payment to OGB and shall be reimbursed by OGB as provided by this Article.

c. OGB shall hold Contractor harmless from any penalties or fines that may be assessed as a result of the suspension of the payment of claims as set forth in Paragraph b (2) above.

8.0 OGB PLAN RESPONSIBILITY

a. Except as specifically provided to the contrary, OGB retains final authority and responsibility for the Plan and its operation, including if applicable, compliance with any state and federal laws, and payment of claims filed under the Plan. Contractor is empowered to act on behalf of OGB only in an administrative capacity for the services specified herein, subject to the direction and authority of OGB. Any decision or action of Contractor regarding this Contract or the Plan which does not result from its grossly negligent, dishonest, fraudulent or criminal conduct and which is not overridden or otherwise modified by OGB in writing shall be deemed to be the exercise of OGB's discretionary power to make final decisions or conclusive action.

b. OGB shall be responsible for compliance with all state and federal laws except as specifically assumed by Contractor under this Contract.

c. OGB shall reimburse Contractor for any taxes, charges or fees which may be assessed against Contractor by any governmental entity for providing any service or Benefits to OGB as set forth under the Plan or this Contract, with the exception of income taxes owed by Contractor as specified in Article 16.0.

d. OGB will tell Contractor which state employees, retirees or their dependents and/or other persons are eligible Plan Participants. This information will be provided to Contractor in a daily eligibility data file.

e. OGB will notify Contractor in writing if OGB changes the Plan's Benefits or other relevant Plan provisions, including termination of the Plan, within a reasonable period time prior to the change becoming effective.

f. OGB shall be responsible for all subrogation activity arising from the activity from paying claims.

9.0 SINGLE PROGRAM, RIGHT TO ASSESS ALL PARTICIPANTS

The OGB seeks to make the Plan available to all eligible employees and retirees who wish to choose such means of acquiring health care services. However, eligible employees and retirees who enroll in the Plan are Participants of the OGB. In discharging its responsibility to administer the Plan and to assure that adequate health care coverage is available and affordable for all, the OGB may, from time to time, impose a cost allocation, premium surcharge, and/or risk assessment upon Plan Participants enrolled in

the Plan.

10.0 INSURANCE CERTIFICATE

a. Contractor shall procure and maintain for the duration of the Contract liability insurance, including coverage for but not limited to: claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by Contractor, its agents, representatives, employees or SubContractors; liability and insolvency protection, with a combined single limit liability of not less than Ten Million ($10,000,000.00) Dollars. The State of Louisiana, Office of OGB Benefits must be named as a loss payee.

b. Contractor shall on request furnish the OGB with certificate(s) of insurance effecting coverage required by this Contract. The certificate(s) for each insurance policy is to be signed by a person authorized by that insurer to bind coverage on its behalf. The OGB reserves the right to require complete, certified copies of all required insurance policies, at any time required by this contract.

11.0 LIABILITY FOR DAMAGES BY THE CONTRACTOR

a. The OGB shall not be held liable for claims for damages relating to any services rendered or arranged for by Contractor.

b. Contractor agrees to hold OGB harmless from all claims for damages relating to Contractor negligence, including any claims relating to failure of Contractor to provide services as specified in this Contract due to financial hardship or insolvency.

12.0 PERFORMANCE BOND

Contractor shall furnish a performance bond in the amount of $1,000,000 dollars.

13.0 INDEMNIFICATION

a. OGB and the State agrees to protect, defend, indemnify and hold harmless the CONTRACTOR, its subsidiaries and affiliates, there respective officers, directors, agents, servants and employees, including volunteers (each a CONTRACTOR Affiliated Indemnified Party), from and against any and all claims, demands, expense and liability arising out of injury or death to any person, or the damage, loss or destruction of any tangible property which may occur or in any way grow out of any act or omission of State, their agents, servants and employees, or any costs, expenses and/or attorney fees incurred as a result of any claim, demands, and/or cause of action **except** those claims, demands, and/or causes of action arising out of the act or omission of CONTRACTOR, its agents, representatives, and/or employees. OGB and the State agrees to investigate, handle, respond to, provide defense for and defend any such claims, demand, or suit at its sole expense and agrees to bear all other costs and expenses related thereto even if it (claim, etc.) is groundless, false or fraudulent, provided that (a) the CONTRACTOR

Affiliated Indemnified Party has given reasonable notice to OGB of the claim or cause of action, and (b) no CONTRACTOR Affiliated Indemnified Party has, by act or failure to act, compromised OGB's position with respect to the resolution or defense of the claim or cause of action.

b. CONTRACTOR and its subsidiaries and affiliates agree to protect, defend, indemnify and hold harmless the State, all State Departments, Agencies, Boards and Commissions, its officers, agents, servants and employees, including volunteers (each an OGB Affiliated Indemnified Party), from and against any and all claims, demands, expense and liability arising out of injury or death to any person, or the damage, or loss or destruction of any tangible property which may occur or in may way grow out of any act or omission of CONTRACTOR, its agents, servants and employees, or any and all costs, expenses and/or attorney fees incurred as a result of any claim, demands, and/or cause of action **except** those claims, demands, and/or causes of action arising out of the act or omission of the State, State Departments, Agencies, Boards and Commissions, its officers, agents, servants and employees. CONTRACTOR agrees to investigate, handle, respond to, provide defense for and defend any such claims, demand, or suit at its sole expense and agrees to bear all other costs and expenses related thereto even if it (claim, etc.) is groundless, false or fraudulent, provided that (a) the OGB Affiliated Indemnified Party has given reasonable notice to CONTRACTOR of the claim or cause of action, and (b) no OGB Affiliated Indemnified Party has, by act or failure to act, compromised CONTRACTOR position with respect to the resolution or defense of the claim or cause of action.

14.0 RESPONSIBILITIES AND OTHER RIGHTS; THIRD PARTY LIABILITY

a. Both parties will use their best effort to advise the other party of matters regarding potential legal actions involving the Plan or this Contract and shall promptly advise the other party of such legal actions instituted against either party which come to its attention.

b. Contractor shall make diligent but reasonable efforts to recover any erroneous payment of claims and any payment of claims for which an individual or entity other than the parties is primarily responsible. Contractor shall not be required to institute legal proceedings or to provide legal representation to OGB to force its rights of subrogation and/or reimbursement, or coordination of Benefits, but may secure such representation for OGB at OGB's expense in those instances where institution of legal proceedings is warranted, if authorized by OGB.

1. Each of the parties hereto shall use reasonable efforts to identify these claims and shall notify the other party of any such claims which come to its attention.

2. Contractor shall not be required to join as a party litigant in any such action, except as required by law, but shall cooperate fully in all such recovery efforts. However, Contractor, in its discretion and at its sole option, may join in any such action in which it has a justifiable interest.

3. Contractor shall monitor any legal proceedings for the recovery of said payments on behalf of OGB and shall advise and consult with OGB during the course of litigation.

4. OGB shall be responsible for all attorney fees, court costs and other expenses associated with such recovery efforts unless the need for such efforts resulted from the grossly negligent, dishonest, fraudulent or criminal conduct of Contractor.

15.0 PLAN ADMINISTRATION

OGB shall for all purposes be the "Administrator" and the "named fiduciary" of the Plan and shall assume fiduciary responsibilities for all operations of the Plan. Contractor shall act in a fiduciary capacity only with respect to the administrative duties delegated to it under this Contract. OGB expressly agrees that it shall not require Contractor to act in any manner or to provide any benefit or service which in its opinion is in violation of law, including the direction to pay extra-Contractual Benefits under the Plan.

16.0 TAXES

Contractor hereby agrees that the responsibility for payment of taxes from the administrative fees received under this Contract and/or legislative appropriation shall be Contractor's obligation and identified under Federal Tax Identification Number _____.

OGB shall reimburse Contractor for any taxes, charge of fees which may be assessed against Contractor by any governmental entity for providing any service or Benefits to OGB, as set forth under the Plan or this Contract, with the exception of income taxes owed by Contractor. In the event that the reimbursement of any Benefits of Plan Participants in connection with this Contract is subject to tax reporting requirements, OGB is responsible for complying with these requirements.

17.0 SYSTEM ACCESS SECURITY/PREMISES SECURITY

b. Access. Contractor grants OGB the nonexclusive, nontransferable right to access and use the functionalities contained within Contractor's systems ("Systems"), under the terms set forth in this section. OGB agrees that all rights, title and interest in the Systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the Systems will remain Contractor's. In order to obtain access to the systems, OGB shall obtain, and responsible for maintaining, at no expense to Contractor, the hardware, software and Internet browser requirements Contractor provides to OGB, including any amendments thereto. OGB shall be responsible for obtaining an Internet Service Provider or other access to the Internet. OGB shall not (a) access Systems or use, copy, reproduce, modify, or excerpt any of the Systems, for purposes other than as expressly permitted under this Contract; or (b) share, transfer or lease OGB's right to access and use Systems, to any other person or entity which is not a party to this Contract. OGB may designate any third party to access Systems on OGB's behalf, provided the third party

agrees to these terms and conditions of Systems access and assumes joint responsibility for such access.

c. Security Procedures. OGB shall use commercially reasonable physical and software based measures, and comply with Contractor's security procedures, as may be amended from time to time, to protect the System, its functionalities, and data accessed through Systems from any unauthorized access or damage (including damage caused by computer viruses). OGB shall notify Contractor immediately if any breach of the security procedures, such as unauthorized use, is suspected.

d. System Access Termination. Contractor reserves the right to terminate OGB's System access (a) on the date OGB fails to accept the hardware, software and browser requirements provided by Contractor, including any amendments thereto or (b) immediately on the date Contractor reasonably determines that OGB has breached, or allowed a breach of, any applicable provision of this Section. Upon termination of OGB's System access, OGB agrees to cease all use of Systems, and Contractor shall deactivate OGB's identification numbers and passwords and access to the System.

1. Both parties and their respective personnel will always comply with all security regulations in effect at each other's premises and externally for materials belonging to one another or to the project. Each party is responsible for reporting any breach of security to the other promptly.

18.0 CONFIDENTIALITY

The parties, their agents, staff Participants and employees agree to maintain as confidential all individually identifiable information regarding Louisiana Office of OGB Benefits Plan Participants, including but not limited to patient records, demographic information and claims history. All information obtained by Contractor from the OGB shall be maintained in accordance with state and federal law, specifically including but not limited to the Health Insurance Portability and Accountability Act of 1996, and any regulations promulgated thereunder (collectively, "HIPAA"). To that end, the parties have executed and hereby make a part of this Agreement a Protected Health Information (Business Associate) Addendum to be in full compliance with all relevant provisions of HIPAA, including but limited to all provisions relating to Business Associates.

Further, the parties agree that all financial, statistical, personal, technical and other data and information relating to either party's operations which are designated confidential by such party and made available to the other party in carrying out this Contract, shall be protected by the receiving party from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the OGB and/or Contractor. Neither party shall be required to keep confidential any data or information which is or becomes publicly available, is already rightfully in the party's possession, is independently developed by the party outside the scope of this Contract, or is rightfully obtained from third parties.

19.0 REPRODUCTION, PUBLICATION AND USE OF MATERIAL

Subject to the confidentiality obligations as set forth above, the OGB shall have authority to reproduce, publish, distribute, and otherwise use, in whole or in part, any reports, data, studies, or surveys prepared by Contractor for the OGB in connection with this Contract or in the performance hereof which are not designated as proprietary by Contractor.

20.0 ACKNOWLEDGEMENT OF PRIORITY POSITION

Contractor acknowledges that OGB is a primary responsibility of the organization, and that such acknowledgement places performance of its Contractual duties for the State of Louisiana, Office of OGB Benefits in a high priority position relative to other clients of of the organization.

21.0 MOST FAVORED CUSTOMER GUARANTEE

Contractor certifies and guarantees that the retention or other administrative charges to the OGB, as forth in this Contract, are comparable to or better than the equivalent fees or charges being offered by Contractor to any present or future customer or group of customers having a similar product design and of a comparable or lesser size. If Contractor shall, during the term of this Contract, enter into an administrative services only agreement with any other customer or group customers having a similar product design to administer a comparable plan for a similar or lesser number of Participants in Contractor's service area which provides for a lower retention or other administrative charges, this Contract shall be deemed thereupon amended to provide the same to the OGB, with a retroactive finance adjusted to the OGB dating back to the effective date of such lower retention or other administrative charge. An officer of the Contractor shall certify annually that, to the best of his or her knowledge, information, and belief, and predicated on his or her familiarity with the billing practices of Contractor, the fees being charged to the OGB by Contractor are in full and complete compliance, in all respects, with the provisions of this Section. Contractor shall provide such annual notice during the first quarter of each calendar year.

Contractor certifies and guarantees that its medical reimbursement fee schedule is, in all respects, at least as low as any other medical reimbursement fee schedule presently in effect, or which shall be in effect, at any time during the term of this Agreement. If, at any time during the term of this Agreement, Contractor offers a lower medical reimbursement fee schedule to any customer in the State of Louisiana it shall immediately notify the OGB to this effect in writing and all medical reimbursement fee schedules shall be immediately reduces to such lower amounts with a retroactive financial adjustment to the OGB dating back to the effective date of the lower medical reimbursement fee schedule.

22.0 PATENT, COPYRIGHT, AND TRADE SECRET INDEMNITY

Contractor warrants that all materials and/or products produced by Contractor hereunder

will not infringe upon or violate any patent, copyright, or trade secret right of any third party. In the event of any such claim by any third party against the OGB, the OGB shall promptly notify Contractor, and Contractor shall defend such claim, in the OGB's name, but at Contractor's expense, and shall indemnify the OGB against any loss, expense, or liability arising out of such claim, whether or not such claim is successful.

23.0 INDEPENDENT CONTRACTOR RELATIONSHIP

No provision of this Contract is intended to create nor shall it be deemed or construed to create any relationship between Contractor and the OGB other than that of independent entities Contracting with each other hereunder solely for the purpose of effecting the provisions of this Contract. The terms "Contractor" and "OGB" shall include all officers, directors, agents, employees or servants of each party.

24.0 PROJECT MANAGEMENT/MONITORING PLAN

a. If Contractor is required to provide contract management functions in the scope of services set forth in Article 2.0, Contractor shall provide, at a minimum, the following project management functions:

1. Routine Project Management: Contractor shall provide day-to-day project management using the best management practices for all tasks and activities necessary to complete the scope of services pursuant to this Contract.

2. Project Work Plan: Contractor shall develop and maintain a Project Work Plan which breaks down the work to be performed into manageable phases, activities and tasks as appropriate. The Project Work Plan will identify: activities/tasks to be performed, project personnel requirements, expected start and completion dates mutually agreed upon by both parties.

3. Project Reports: Contractor and OGB shall agree in writing upon reports that will be required to monitor the performance of services pursuant to the Contract.

4. Provide Issue Control: Contractor will develop and implement with the OGB approval, procedures and forms to monitor the identification and resolution of key project issues/problems.

b. Contractor agrees to provide the following Contract related resources:

1. Project Manager: Contractor shall provide a project manager to provide day-to-day management of project tasks and activities, coordination of Contractor support and administrative activities, and for supervision of Contractor employees. The project manager shall possess the technical and functional skills and knowledge to direct all aspects of the project.

2. Key Personnel: Contractor shall assign Personnel to perform the services pursuant

to this Contract that are qualified to perform the assigned duties, and Contractor will determine which personnel shall be assigned for any particular project and to replace and reassign such personnel doing such a project. Contractor assumes the responsibility for its personnel providing services hereunder and will make all deductions for social security and withholding taxes, contributions for employment compensation funds and shall maintain at Contractor's expense all necessary insurance for its employees, including but not limited to worker's compensation and liability insurance for each of them.

c. OGB agrees to provide the following Contract related resources:

1. Contract Supervisor: OGB shall appoint a Contract Supervisor for this Contract that will provide oversight of the activities conducted hereunder. The assigned Contract Supervisor shall be the principal point of contact on behalf of the OGB and will be the principal point of contact for Contractor concerning Contractor's performance under this Contract.

25.0 MANAGEMENT OF HEALTH CARE SERVICES

Contractor shall provide administrative services to OGB in connection with its Plan by facilitating management for the health care services afforded OGB's Plan Participants under the Plan, including but not limited to authorization services, discharge planning, and verification of provided services, care coordination services, transplant benefit management services, cancer resource services, abuse and fraud management services, shared savings program services, facility reasonable charge determination and negotiation reduction services, utilization management and quality assurance, as described in this article:

a. Care Coordination Services

1. Contractor shall provide care coordination services in accordance with the provisions contained in this section. The care coordination program focuses on offering education, accelerating access to care and providing surveillance and monitoring of chronic conditions. These services include the review of Plan Participants' diagnosis and proposed health care treatments with respect to whether or not the service is appropriate to treat the condition. The services are designed to facilitate Participant education, identify and prevent delays in treatments and provide intervention with respect to Plan Participants' health care needs that are likely to drive utilization and medical expenses of the Plan. Contractor will review health care services and supplies to determine whether they are covered services under the Plan. If Contractor determines that services or supplies are not covered under the Plan, then Contractor will provide the appeal services outlined above in this Section.

2. Contractor may provide, when appropriate for the individual Plan Participant, certain case management services, which are designed to provide a proactive and systematic process of coordination of health care services, including the evaluation of inpatient,

outpatient and ancillary services, Participant education, the review of the short term outpatient care needs and where appropriate, coordination and facilitation of discharge planning needs. These services address the unmet health care needs of Plan Participants who are not eligible for a disease management program under the Plan but are at significant risk for declining health status and high medical expense.

3. Contractor also provides an Alternative Benefit Program (ABP) of benefit coverage for health care services. This ABP program is designed by Contractor for the diagnosis and/or treatment of a particular Plan Participant's illness or injury with appropriate and cost effective health care services and supplies alternatives that would otherwise not be covered by the Plan. The Plan will pay for and cover as Plan Benefits the health care services and supplies contained in the ABP Program. OGB consents to Contractor's use and administration of the ABP Program and authorizes the Contractor the discretion and authority to develop and revise ABP's. Contractor will work with Plan Participants who satisfy the criteria for participation in case management services to develop a program of benefit coverage with appropriate and cost-effective health care services and supplies for the diagnosis and/or treatment of the Plan Participant's condition. If the Plan Participants and health care provider are not willing to participate in the process, Contractor will not provide these services.

b. Fraud & Abuse Management Services.

Contractor will provide services related to the detection and prevention of fraudulent and abusive claims. Contractor's Fraud and Abuse Management processes will be based upon proprietary and confidential procedures modes of analysis and investigations that Contractor develops. Contractor will use the procedures and standards in delivering Fraud and Abuse Management services to OGB and Contractor's other customers. These procedures and standards include, but are not limited to: whether or not to seek recovery, what steps to take if Contractor decides to seek recovery, and under what circumstances to compromise a claim settle for less than the full amount. The OGB authorizes Contractor the discretion and authority to use such procedures and standards, including the authority to undertake actions, including legal actions, which have the largest impact for the largest number of customers. The OGB recognizes that the use of these procedures and standards may not result in recovery or in full recovery for any particular cases. Contractor does not guarantee or warranty any particular level of prevention detection, or recovery. Contractor agrees to perform Fraud and Abuse Management services pursuant to the Industry standards of such services. Fees apply for fraud and abuse recoveries, and are equal to Contractor's recovery costs and will be deducted from the actual recoveries. If the Contract terminates, or if Contractor's claim recovery services terminate, Contractor can elect to continue fraud and abuse recoveries. The contingency fees will continue to apply.

26.0 COOPERATION WITH MENTAL HEALTH/SUBSTANCE ABUSE VENDOR

Contractor understands that the OGB has carved out the treatment of those diagnoses recognized by ICD9 as diagnosis codes for mental health and/or substance abuse

disorders. Contractor agrees to coordinate benefit coverage of Participants diagnosed with such mental health and/or substance abuse disorders with the OGB's Mental Health and Substance Abuse (MHSA) vendor.

Notwithstanding the provisions of the previous paragraph, Contractor will provide Benefits for services for the medical treatment and prescribing and monitoring of prescription drugs by non-mental health professionals for the following illnesses:

Attention Deficit Disorder (ADD)
Attention Deficit/Hyperactive Disorder (ADHD)
Tourette's Syndrome
Anorexia
Bulimia

In addition Contractor shall be responsible for providing Benefits for medical treatment for acute detoxification resulting from substance abuse (limited to seven (7) days per admission, four (4) admissions per lifetime). With the exception of the Benefits described in the section above, Contractor shall be responsible for providing Benefits for medical treatment for the first (and only the first) claim incurred by a Participant with a non-mental health and substance abuse professional which is coded with a psychiatric diagnosis.

27.0 DISEASE MANAGEMENT VENDOR

Contractor has been informed and understands that the OGB has implemented a state-wide Disease Management Program applicable to all Participants other than those for whom Medicare is primary in all of Contractor's Benefit Plans. Contractor agrees to cooperate in a commercially reasonable manner with the OGB's Disease Management Program vendor. This cooperation shall include, but not be limited to, the coordination of Contractor's Case Management obligations under this Contract with the operations of the OGB's Disease Management Program vendor.

28.0 PERFORMANCE MEASURES

The Contract Supervisor will be responsible for the Performance Evaluation Report in regards to the scope of services provided by Contractor pursuant to this Contract. The performance evaluation will be based on the following: personnel assigned to manage the contract; provider network; submission of required data/reporting; attendance at required meetings; and other measurements as determined by the Contract Supervisor.

See Attachment B for Performance Standards.

29.0 SUSPENSION OF ADMINISTRATIVE SERVICES AND/OR CLAIMS PAYMENTS

a. In the event that OGB fails to remit the monthly administrative fee and/or the weekly claim reimbursement billing as specified herein, Contractor shall advise OGB of the outstanding

administrative fees and/or claims reimbursement billings and the OGB shall resolve the matter.

b. If OGB is unable to resolve the matter in a manner satisfactory to Contractor, Contractor will undertake the following tasks to suspend administrative services and/or payment of claims:

1. Contractor's Customer Service department will direct all inquiries relating to the processing of OGB's claims to OGB for response.

2. Contractor's Provider Inquiry department will respond to all inquiries relating to the processing of OGB's claims, with information that Contractor has suspended administrative services and/or processing of claims for OGB and shall direct all further inquiries to OGB for response.

3. Contractor's claims processing systems shall suspend processing activities for OGB. Processing activities include, but are not limited to:

a) Data entry of hard copy claim filings from any source.
b) System input of electronically submitted claims.
c) Pre-certification of hospital admissions.
d) Case management approvals for treatment plans in progress.
e) Production of payment checks, Explanation of Benefits letters and associated mailings.
f) Processing of OGB's Participant eligibility information.
g) Production and/or distribution of informational reports.

c. The suspension of services and claims payments shall remain in effect until all outstanding fees and claims reimbursements are paid in full.

d. In the event of suspension of administrative services as discussed above, OGB shall be solely responsible for notifying its Plan Participants of the suspension of administrative services. However, in the event of suspension of claims payments and/or termination of this Contract, Contractor shall have the right to notify OGB's Plan Participants and applicable health care and/or allied service providers of the suspension or termination.

e. Contractor shall be liable for any penalties, fines or costs that may result from its negligent, dishonest, fraudulent or criminal conduct in the suspension of the administrative services or provision of information or documents required in Article 4.0 (d) above. OGB shall hold Contractor harmless from any penalties or fines that may be assessed as a result of the suspension of the administrative services set forth in Article 2.0 above that do not result from Contractor's negligent, dishonest, fraudulent or criminal conduct.

f. OGB shall hold Contractor harmless from any penalties or fines that may be assessed as a result of the suspension of the payment of claims.

30.0 TERMINATION FOR CAUSE

a. OGB may terminate this Contract for cause based upon the failure of Contractor to comply with the material terms and/or conditions of the Contract; provided that the OGB shall give the Contractor written notice specifying Contractor's failure. If within thirty (30) days after receipt of such notice, Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the OGB may, at its option, place Contractor in default and this Contract shall terminate on the date specified in such notice.

b. Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the OGB to comply with the terms and conditions of this Contract; provided that the Contractor shall give the OGB written notice specifying the OGB's failure. Furthermore, Contractor shall be entitled to suspend any and all services until such time as when OGB is not in default of its obligations under this Contract.

c. This Contract shall terminate automatically at the option of Contractor upon failure of OGB to pay any of the amounts due under this Contract. Contractor shall notify OGB immediately of the exercise of its option under this paragraph, in any manner which provides actual notice to OGB of said termination. All of the duties and obligations of Contractor shall cease on the date of notification.

31.0 TERMINATION FOR CONVENIENCE

OGB may terminate the Contract at any time without penalty by giving sixty (60) days written notice to the other. Upon any termination of this Contract the Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

32.0 CONTRACTOR'S DUTIES UPON TERMINATION

a. In the event of termination for any reason, Contractor agrees to perform the following tasks:

1. Administer the run out of claims. No additional Administrative Fee will be paid after termination of contract.
2. Provide OGB with a copy of the register that identifies the deductible and coinsurance accumulations by Plan Participant that correspond to the termination date.
3. Provide OGB with a hard copy of the register of its claims by provider that are unprocessed at the time of termination.
4. Provide OGB with all statistical reports for the current Plan year up to the date of termination.
5. Provide OGB with a hard copy register of any Coordination of Benefits or Third Party Liability recovery initiative that is in progress at the time of the termination.
6. Provide OGB with its Plan Participant eligibility file.

b. All claims, including demands from the Centers for Medicare and Medicaid Services for the recovery of Medicare payments, remaining unpaid in whole or in part on the date of termination shall be returned to OGB which shall be solely responsible for any processing and the payment of the claims.

33.0 REMEDIES FOR DEFAULT

a. Any claims or controversy arising out of this Contract shall be resolved in accordance with the provisions of La R.S. 39:1524 – 1526.

b. The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties hereunder, shall be construed pursuant to, and in accordance with, the laws of the State of Louisiana except where preempted by federal law. The venue of any action brought under this Contract shall be the Nineteenth (19th) Judicial District Court, State of Louisiana.

34.0 OWNERSHIP OF PRODUCT

All records, reports, documents and other material delivered or transmitted to Contractor by OGB shall remain the property of OGB, and shall be returned by Contractor to OGB, at Contractor's expense, at termination or expiration of this Contract. Contractor may retain one copy of such records, documents or materials for archival purposes and to defend its work product. All records, reports, documents, or other material related to this Contract and/or obtained or prepared by Contractor specifically and exclusively for the OGB in connection with the performance of the services Contracted for herein shall become the property of the OGB, and shall, upon request, be returned by Contractor to OGB, at Contractor's expense, at termination or expiration of this Contract.

35.0 ASSIGNMENT

Contractor shall not assign any interest in this Contract and shall not transfer any interest in same (whether by assignment or novation), without prior written consent of the OGB, provided however, that claims for money due or to become due to the Contractor from the OGB may be assigned to a bank, trust, or other financial institution without such prior written consent. Notice of any such assignment or transfer shall be furnished promptly to the OGB and to the Office of Contractual Review, Division of Administration.

36.0 RIGHT TO AUDIT

a. Contractor grants to the Office of the Legislative Auditor, Inspector General's Office, the Federal Government, and any other duly authorized agency of the State the right to inspect and review all books and records pertaining to services rendered under this Contract. Contractor shall comply with federal and/or state laws authorizing an audit of Contractor's operation as a whole, or of specific program activities. Any audit shall be conducted during ordinary business hours and upon reasonable advance written notice to

the Contractor. OGB's auditors shall abide by any state and federal laws regarding confidentiality of a Plan Participant's medical records and agrees to hold in confidence any information or data designated as proprietary by Contractor. This obligation of confidentiality shall survive termination of this Contract.

b. The place, time, type, duration and frequency of all audits must be reasonable and upon terms mutually agreed to by OGB and Contractor. With respect to Contractor's transaction processing services, the audit scope and methodology shall be consistent with generally acceptable auditing standards. If OGB has an outside auditor or consultant perform the audit, the entity must sign the Contractor's Third Party Disclosure Agreement or a similar Confidentiality Agreement before Contractor will give access to confidential Plan Participation information. OGB will pay any expenses that OGB incurs regarding the audit. OGB shall provide Contractor with a copy of any audit reports.

c. Upon request, Contractor shall prepare an annual accounting report consisting of a summary of Benefits provided during each twelve (12) consecutive month period for which this Contract remains in effect, which shall be forwarded to OGB within one hundred twenty (120) days after the end of said period.

d. Contractor shall provide a copy of a annual independent audit conducted on the processing of transactions, pursuant to Statement on Auditing Standards (SAS – 70-Type II Audit), as required by the State's Legislative Auditor. The audit should be received by OGB no later than five months after the Contractor's most recent fiscal year ends (example: if fiscal year ends June 30 than the audit report will be due by November 30. Contractor will be subject to a $1,000 per day penalty until receipt of the audit by OGB.

37.0 RECORD RETENTION

Contractor agrees to retain all books, records, and other documents relevant to this Contract and the funds expended hereunder for at least three years after last claims payment pursuant to services in the Contract, or as required by applicable Federal law, whichever is longer.

38.0 AMENDMENTS IN WRITING

Any alteration, variation, modification, or waiver of provisions of this Contract shall be valid only when it has been reduced to writing, duly signed. No amendment shall be valid until it has been executed by all parties and approved by the Director of the Office of Contractual Review, Division of Administration.

39.0 CAUSES BEYOND CONTROL

Neither party shall be responsible for delays in performance resulting from acts beyond the control of such party. Such acts shall include but not be limited to acts of God, strikes, riots, lockouts, acts of war, epidemics, governmental regulations superimposed after the fact, fire, communication line failures, power failure, earthquakes, or other disasters, or by

reason of judgment, ruling, or order of any court or agency of competent jurisdiction.

40.0 NON-DISCRIMINATION

Contractor agrees to abide by the requirements of the following as applicable: Title VI and VII of the Civil Rights Act of 1964, as amended by the Equal Opportunity Act of 1972, Federal Executive Order 11246, the Federal Rehabilitation Act of 1973, as amended, the Vietnam Era Veteran's Readjustment Assistance Act of 1974, Title IX of the Education Amendments of 1972, the Age Act of 1972, and Contractor agrees to abide by the requirements of the Americans with Disabilities Act of 1990. Contractor agrees not to discriminate in its employment practices, and will render services under this Contract without regard to race, color, religion, sex, national origin, veteran status, political affiliation, disabilities, or because of an individual's sexual orientation. Any act of discrimination committed by Contractor, or failure to comply with these obligations when applicable shall be grounds for termination of this Contract.

41.0 AVAILABILITY OF FUNDS

The continuation of this Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract. If the legislative fails to appropriate sufficient monies to provide for the continuation of the Contract, or if such appropriation is reduced by veto of the Governor or by any means provided in the appropriation act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reductions to provide insufficient monies for the continuation of the Contract, the Contract shall terminate on the date of the beginning of the first fiscal year for which funds have not been appropriated. Such termination shall be without penalty or expense to the OGB except for payments which have been accrued prior to the termination.

42.0 HEADINGS

Descriptive headings in this Contract are for convenience only and shall not affect the construction or meaning of Contractual language.

43.0 WORKER'S COMPENSATION

Contract is not in lieu of and does not affect any requirements of coverage under the Louisiana Worker's Compensation Act or any other federal or state mandated employer liability laws.

44.0 SUBCONTRACTORS

Upon approval of OGB Contractor can use its affiliates or other subcontractors to perform its services under this contract. However, Contractor will be responsible for those services to the same extent that Contractor would have been had Contractor performed those services without the use of an affiliate or Subcontractor.

45.0 ENTIRE AGREEMENT AND ORDER OF PRECEDENCE

a. This Contract (together with the NIC issued thereto by the OGB, the Proposal submitted by the Contractor in response to the OGB's NIC, and any exhibits specifically incorporated herein by reference) constitutes the entire agreement between the parties with respect to the subject matter.

b. This Contract shall, to the extent possible, be constructed to give effect to all provisions contained therein: however, where provisions are in conflict, first priority shall be given to the provisions of the Contract, excluding the NIC and the Proposal; second priority shall be given to the provisions of the NIC and amendments thereto; and third priority shall be given to the provisions of the Proposal.

Acknowledgement is made by both parties that any exceptions to any part of the NIC requirements shall be solely due to changes regarding the Contractor and the number of enrollees.

BY SIGNING BELOW, THE PARTIES AGREE TO ALL OF THE TERMS AND CONDITIONS SET FORTH ABOVE

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS (OGB)

SIGNATURE:_____

NAME: Tommy D. Teague

TITLE: Chief Executive Officer

(CONTRACTOR)

SIGNATURE:_____

NAME: _____

TITLE: _____

ATTACHMENT - A

FINANCIAL AGREEMENT

1. PAYMENT FACTORS:

Listed below identifies the applicable Administrative Fee charge Per Employee Per Month (PEPM) for each Contract Year during the Contract term.

Administrative Fees (Per Employee Per Month)

PPO

Plan Year 7/1/10 – 6/30/11	$_____	PEPM
Plan Year 7/1/11 – 6/30/12	$_____	PEPM
Plan Year 7/1/12 – 6/30/13	$_____	PEPM

LaCHIP Affordable Plan (Per Enrollee Per Month)

Plan Year 7/1/10 – 6/30/11	$_____	PEPM
Plan Year 7/1/11 – 6/30/12	$_____	PEPM
Plan Year 7/1/12 – 6/30/13	$_____	PEPM

Contractor agrees that the Administrative Fees includes services to be provided by Contractor to pay run out claims.

2. CLAIM PAYMENT PROCEDURES

Contractor will provide the OGB with an invoice, with an accompanying electronic check register file, on a daily basis showing all paid claims. The total of the claims paid on the invoice shall match the total of the claims paid on the file. Contractor shall use its best efforts to forward the invoice and file to the OGB no later than 2:00 p.m. on each day. The OGB shall pay the invoice (assuming the totals on the file and invoice match) within 48 hours after receiving the invoice(s) together with supporting details provided by Contractor, by wire transfer or other method acceptable to Contractor.

Separate invoices shall be prepared by Contractor with respect to claims for active and retiree participants.

Contractor agrees to pay its providers within 48 hours from receipt of payment from OGB.

OGB shall pay interest on all delinquent payments. The interest rate shall be the average of the Money Market Fund rates reported on the day of delinquency each in The Wall Street Journal.

3. FINAL SETTLEMENT

Within sixteen (16) months of the Contract termination date there shall be a final settlement between the OGB and Contractor. At the final settlement, Contractor shall report all claims which were incurred prior to the termination of the Contract, but which were paid during the twelve months immediately following termination. If the estimate of incurred claims calculated in the interim settlement is greater than the actual amount, the difference plus interest shall be refunded to the OGB. The interest rate shall be the average of the weekly Money Market Fund rates reported each Thursday in The Wall Street Journal. If the estimate of incurred claims calculated in the interim settlement is less than the actual amount, the OGB shall pay the difference to Contractor with ten (10) business days.

ATTACHMENT - B

PERFORMANCE STANDARDS

1. **Performance Standards**: This document sets forth certain levels of performance which Contractor agrees to achieve in providing designated services to the OGB under this Contract.

2. **Application:** The standards shall apply to the administration of the OGB's self-funded PPO Program under this Contract, including with respect to Contractor's administration of Benefits under the Program with respect to Participants who reside outside the Service Area.

3. **Measurement Periods:** The first period to be measured shall be July 1, 2010 through June 30, 2011. The second period to be measured shall be July 1, 2011 through June 30, 2012. The third period to be measured shall be July 1, 2012 through June 30, 2013.

4. **Performance Standard Definitions**: The following definitions shall apply:

Average Speed to Answer:

Definition: The abandon speed to answer standard measures the percent of telephone calls answered within forty-five (45) seconds by a Customer Services Representative.

Standard: No more than 5% of all incoming telephone calls shall be abandoned calls.

Inquiry Timeliness:

Definition: This measurement is based on entire population of inquiries and includes all requests for information, action, or a document from a Participant, Provider, or the OGB. Inquiry Timeliness measures the average number of calendar days it takes Contractor to respond to or resolve inquiries. The first day of processing (FDP) is the date the inquiry is received by the Contractor during regular business hours. The last day of processing (LDP) is the date when a complete response is given to the inquirer.

Standard: 90% of all inquiries shall be processed in seven (7) calendar days.

Financial Accuracy:

Definition: The financial accuracy standard measures the percentage of dollars that are paid correctly. Rejected claims, zero paid claims, claims paid correctly but to the wrong payee and adjustments are excluded.

Standard: 98% or more of all claim dollars paid shall be paid correctly.

Claims Accuracy:

Definition: This measurement represents the percentage of claims paid correctly and the sample size is based upon semi-annual projected populations. This standard reviews the components needed to process a claim properly. Some of the components reviewed include member eligibility, available benefits, system coding that impact payment levels, pricing, pre-authorization and referral data, and duplicate claims checks. Only original Provider and Participant submitted claims will be measured within its population. All adjustments are excluded.

Standard: 98% or more of all claims shall be processed accurately.

Eligibility Accuracy:

Definition: This measurement represents the percent of properly formatted membership files updated within two (2) business days of receipt. An enrollment file is received electronically on a daily basis. The first day of processing (FDP) is the date the electronic enrollment file is picked-up by the Contractor. The last pay of processing (LDP) is the date the requested change is completed to the Participants' in-house enrollment file.

Any requested changes in an enrollment file that do not automatically load into the Contractor's systems shall be excluded from any determination of whether membership files have been timely updated under this standard.

Standard: 98% within two (2) days of receipt.

Data Submission (Timeliness):

Definition: This measurement represents a daily flat fee penalty when data has not been submitted to OGB within five (5) days of the following month.

Standard: $10,000 Per Day Penalty.

5. **Performance Penalties:** If Contractor fails to achieve the Performance Standards set forth below as measured separately over the Measurement Periods, Contractor shall incur penalties not to exceed, in the aggregate, ten (10%) percent of the Administrative

Fees charged to the OGB as specified in the Contract. It is the intent of the parties that the ten (10%) percent cap on penalties shall apply jointly to all products. However the penalty for Data Submission Timeliness shall be based on a daily penalty of $10,000 Per Day.

6. **Payment Penalties:** The annual penalty, if any, shall be factored into the OGB's annual reconciliation and shall be deducted from any amount that the OGB may owe to Contractor, or added to any amount that Contractor may owe to the OGB.

7. **Performance Standards:** If Contractor fails to achieve the Performance Standards set forth below, then the OGB shall be entitled to the penalty as listed.

Access/Customer Services (PEBTF Specific)

Measurement	Performance Standard	Penalty
Average Speed of Answer	>45 Seconds	2.0%
	30-44 Seconds	1.0%
Abandon Call Rate	> 5% of Calls Abandoned	1.0%
Inquiry Timeliness	>90% of all inquiries answered within seven calendar days on average	1.0%
Financial Accuracy	<96%	2.0%
	96% - 97%	1.0%
Claims Accuracy	<96%	2.0%
	96% - 97%	1.0%
Eligibility Timeliness	<98% of membership files updated within 2 business days of receipt of enrollment file	1.0%
Total Percentage at Risk (as a % of the administrative expense portion of retention		10%
Data Reporting Timeliness	100% reporting within five (5) days after the following month.	$10,000 Per Day

ATTACHMENT C

BUSINESS ASSOCIATE AGREEMENT (BAA)

State of Louisiana, Division of Administration
Office of Group Benefits
Protected Health Information Addendum

I. Definitions

a) "Administrative Safeguards" shall mean administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's workforce in relation to the protection of that information., as more particularly set forth in 45 CFR § 164.308.
b) "Agreement" shall mean the agreement between Business Associate and OGB, dated _____, pursuant to which Business Associate is to provide certain services to OGB involving the use or disclosure of PHI, as defined below.
c) "Business Associate" shall mean _____.
d) "ePHI" shall have the same meaning as the term "electronic protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of OGB.
e) "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
f) "HIPAA Regulations" shall mean the Privacy Rule and the Security Rule.
g) "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
h) "OGB" shall mean the State of Louisiana, Division of Administration, Office of Group Benefits, which is a covered entity under the HIPAA Regulations, as defined herein.
i) "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of OGB.
j) "Physical Safeguards" shall mean physical measures, policies, and procedures to protect a covered entity's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion as more particularly set forth in 45 CFR § 164.310.
k) "Privacy Rule" shall mean the regulations promulgated pursuant to HIPAA regarding Privacy of Individually Identifiable Health Information at 45 CFR, Part 160 and Part 164, Subparts A and E.
l) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.
m) "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
n) "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR § 164.304.

o) "Security Rule" shall mean the regulations promulgated pursuant to HIPAA regarding Security Standards for Electronic Protected Health Information at 45 CFR, Part 160 and Part 164, Subparts A and C.
p) "Technical Safeguards" shall mean the technology and the policy and procedures for its use that protect electronic protected health information and control access to it, as more particularly set forth in 45 CFR § 164.312.
q) Any other terms used in this Addendum that are not defined herein but are defined in the HIPAA Regulations shall have the same meaning as given in the HIPAA Regulations.

II. Obligations and Activities of Business Associate

a) Business associate agrees to comply with OGB policies and procedures regarding the use and disclosure of PHI.
b) Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Addendum, or as Required by Law.
c) Business Associate agrees to limit all requests to OGB for PHI to the minimum information necessary for Business Associate to perform functions, activities, or services for or on behalf of OGB as specified in the Agreement.
d) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Addendum.
e) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum.
f) Business Associate agrees to report to OGB any use or disclosure of the PHI not provided for by this Addendum of which it becomes aware. Such report shall be made within two (2) business days of Business Associate learning of such use or disclosure.
g) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of, OGB agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such information. However, Business Associate shall not enter into any subcontractor or other agency relationship with any third party that involves use or disclosure of such PHI without the advance written consent of OGB.
h) Business Associate agrees to provide access, at the request of OGB, and in the time and manner designated by OGB, to PHI maintained by Business Associate in a Designated Record Set, to OGB or, as directed by OGB, to an Individual in order to meet the requirements under 45 CFR § 164.524.
i) Business Associate agrees to make any amendment(s) to PHI maintained by Business Associate in a Designated Record Set that OGB directs or agrees to pursuant to 45 CFR § 164.526 at the request of OGB or an Individual, and in the time and manner designated by OGB.
j) Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, OGB available to OGB, or at the request of OGB to the Secretary, in a time and manner designated by OGB or the Secretary, for purposes of the Secretary determining OGB's compliance with the Privacy Rule.

k) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for OGB to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
l) Business Associate agrees to provide to OGB or an Individual, in a time and manner designated by OGB, information collected in accordance with Section II.j of this Addendum, to permit OGB to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
m) At any time(s) requested by OGB, Business Associate agrees to return to OGB or destroy such PHI in its possession as directed by OGB.
n) Business Associate shall defend and indemnify OGB from and against any and all claims, costs, and/or damages arising from a breach by Business Associate of any of its obligations under this Addendum. Any limitation of liability provision set forth in the Agreement, including but not limited to any cap on direct damage liability and any disclaimer of liability for any consequential, indirect, punitive, or other specified types of damages, shall not apply to the defense and indemnification obligation contained in this Addendum.
o) Business Associates shall relinquish to OGB all control over responses to subpoenas Business Associate receives related to PHI.
p) Business Associate shall:
    1. Implement and document Administrative Safeguards, Physical Safeguards, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of OGB, specifically including, but not limited to, the following:
        i) Ensuring the confidentiality, integrity, and availability of all ePHI that it creates, receives, maintains, or transmits on behalf of OGB;
        ii) Protecting against any reasonably anticipated threats or hazards to the security or integrity of such information;
        iii) Protecting against any reasonably anticipated uses or disclosures of such information that are not permitted or required by this Addendum or Required by Law; and
        iv) Ensuring compliance with these requirements by its workforce;
    2. Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate safeguards to protect it;
    3. Report to OGB any Security Incident of which it becomes aware. If no Security Incidents are reported, Business Associate shall certify to OGB in writing within ten (10) days of each anniversary date of the Agreement that there have been no Security Incidents during the previous twelve months.
q) Business Associate shall not permit PHI to be disclosed to or used by any individual or entity outside of the territorial and jurisdictional limits of the fifty United States of America.

III. Permitted Uses and Disclosures by Business Associate

a) Except as otherwise limited in this Addendum, Business Associate may use or disclose PHI to perform functions, activities, or services for or on behalf of OGB as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by OGB or the minimum necessary policies and procedures of OGB.

b) Except as otherwise limited in this Addendum, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.
c) Except as otherwise limited in this Addendum, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that such disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that it will remain confidential and be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person promptly notifies the Business Associate of any known instances of breach of the confidentiality of the PHI
d) Except as otherwise limited in this Addendum, Business Associate may use PHI to provide Data Aggregation services to OGB as permitted by 45 CFR § 164.504(e)(2)(i)(B), provided that such services are contemplated by the Agreement.
e) Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1).

IV. Obligations and Activities of OGB

a) With the exception of Data Aggregation services as permitted by 45 CFR § 164.504(e)(2)(i)(B), OGB shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by OGB.
b) OGB shall notify Business Associate of any limitation(s) in OGB's Notice of Privacy Practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
c) OGB shall notify Business Associate of any changes in, or revocation of, permission by any Individual to use or disclose PHI, to the extent such changes may affect Business Associate's use or disclosure of PHI.
d) OGB shall notify Business Associate of any restriction to the use or disclosure of PHI that OGB has agreed to in accordance with 45 CFR § 164.522, to the extent such restriction may affect Business Associate's use or disclosure of PHI.

V. Term and Termination

a) Term. The Term of this Addendum shall commence on the effective date set forth below, and shall terminate when all of the PHI provided by OGB to Business Associate, or created or received by Business Associate on behalf of OGB, is destroyed or returned to OGB, or, if it is not feasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.
b) Termination of Agreement for Cause. In the event that OGB learns of a material breach of this Addendum by Business Associate, OGB shall, in its discretion:
    1. Provide a reasonable opportunity for Business Associate to cure the breach to OGB's satisfaction. If Business Associate does not cure the breach within the time specified by OGB, OGB may terminate the Agreement for cause; or
    2. Immediately terminate the Agreement if Business Associate has breached a material term of this Addendum and cure is not possible; or

3. If neither termination nor cure is feasible, OGB may report the violation to the Secretary.

c) Effect of Termination.
   1. Except as provided in paragraph (2) below, upon termination of the Agreement for any reason, Business Associate shall return or destroy all PHI received from OGB, or created or received by Business Associate on behalf of OGB. Business Associate shall retain no copies of the PHI. This provision shall also apply to PHI that is in the possession of subcontractors or agents of Business Associate.
   2. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to OGB written notification of the conditions that make return or destruction not feasible. Upon mutual agreement of the parties that return or destruction of PHI is not feasible, Business Associate shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction not feasible, for so long as Business Associate maintains such PHI.

VI. Miscellaneous

a) A reference in this Addendum to a section in the HIPAA Regulations means the section as in effect or as amended, and for which compliance is required.
b) The parties agree to amend this Addendum from time to time as necessary for OGB to comply with the requirements of the HIPAA Regulations and the Health Insurance Portability and Accountability Act, Public Law 104-191.
c) If applicable, the obligations of Business Associate under Section V.c.2 of this Addendum shall survive the termination of this Addendum.
d) Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits OGB to comply with the HIPAA Regulations. It is the intent of the parties that neither this Addendum, nor any provision in this Addendum, shall be construed against either party pursuant to the common law rule of construction against the drafter.
e) Except as expressly stated herein, the parties to this Addendum do not intend to create any rights in any third parties. Nothing in this Addendum shall confer upon any person other that the parties and their respective successors or assigns any rights, remedies, obligations, or liabilities whatsoever.
f) In the event of any conflict between the terms of the Agreement and the terms of this Addendum, the terms of this Addendum will control, with the exception that if the Agreement contains any provisions relating to the use or disclosure of PHI that are more protective of the confidentiality of PHI than the provisions of this Addendum, then the more protective provisions will control. The provisions of this Addendum are intended to establish the minimum limitations on Business Associate's use and disclosure of PHI.
g) The terms of this Addendum shall be construed in light of any applicable interpretation or guidance on HIPAA and/or the HIPAA Regulations issued from time to time by the Department of Health and Human Services or the Office for Civil Rights.
h) This Addendum may be modified or amended only by a writing signed by the party against which enforcement is sought.
i) Neither this Addendum nor any rights or obligations hereunder may be transferred or assigned by one party without the other party's prior written consent, and any attempt to the

contrary shall be void. Consent to any proposed transfer or assignment may be withheld by either party for any or no reason.

j) Waiver of any provision hereof in one instance shall not preclude enforcement thereof on future occasions.

k) For matters involving the HIPAA Regulations, this Addendum and the Agreement will be governed by the laws of the State of Louisiana, without giving effect to choice of law principles.

In witness whereof, the parties have executed this Addendum through their duly authorized representatives. This Addendum shall be effective as of the _____ day of _____,20___.

State of Louisiana,
Division of Administration
Office of Group Benefits

By:_____ By:_____

Name: Tommy D. Teague Name:_____

Title: Chief Executive Officer Title:_____

ATTACHMENT D

FILE REQUIREMENT & LAYOUT

Appendix A – OGB Standard File requirements and layout

The Contractor shall send and receive data files and act on the received data files as detailed in this section (Appendix A):

Files to be sent by the contractor to OGB:

The contractor shall provide the following three files to OGB on a monthly basis and no later than the 5th day of the following month. (For example, the files for January shall be received by OGB by the 5th of February). All files shall be constructed using the layout as described in Appendix A-1, A-2 and A-3. All files shall be sent electronically using FTP (File Transfer Protocol) and MUST be encrypted using PGP (Pretty Good Privacy).

1. **Medical Claims File (Appendix A-1)**
   The contractor shall send OGB all claims for which EOBs (Explanation of Benefits) or checks were sent or issued to the provider and/or claimant during a month. This is a file of records containing claim charge lines or service lines for a physician claim (CMS-1500), facility claim (UB-04), or a dental claim (ADA-1500) that has been received and processed. No claims in process are included.

2. **Provider File (Appendix A-2)**
   This is a file of providers that performed the medical services for which checks and EOB were issued in (1) above. This will include, for example, physicians, hospitals, urgent care facilities, etc.

3. **Check Register File (Appendix A-3)**
   This file will contain one record for each check issued during the month. The amount of money reflected on this file should match the invoice sent to OGB for payment each month.

Files to be sent to the contractor by OGB:

The contractor shall receive the following three files from OGB. Files shall be constructed using the layout as described in Appendix A-4 through A-6. Both files shall be sent electronically using FTP (File Transfer Protocol) and MUST be encrypted using PGP (Pretty Good Privacy).

4. **Eligibility File (Appendix A-4)**
   This file shall be received the evening of every work day by the contractor and posted to their system before the next day. It will contain the contractor's entire membership plus any terminations that have been done in the last two months.

5. **ASO Administrative Fee Billing files(Appendix A-5)**
   This file shall be received monthly by the contractor and will contain the amount per contract holder that OGB will pay the ASO for administrative fee. OGB will pay the ASO based on this file. The file will contain adjustments to prior months billing resulting from retroactive terminations and enrollment.

6. **Claims Paid By Contractor After Termination or Stop Payment(Appendix A-6)**
   This file shall be received monthly by the contractor and will contain the claims paid in error after the termination or stop payment date.

FILE REQUIREMENT & LAYOUT

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	CLAIM_ID	A/N	40	001-040	THE SOURCE SYSTEM'S UNIQUE IDENTIFIER FOR THIS CLAIM.
2	CLAIM_LINE_ID	A/N	40	041-080	THE SOURCE SYSTEM'S IDENTIFIER FOR THIS CLAIM LINE.
3	FROM_SERVICE_DATE	A/N	8	081-088	THE START DATE OF SERVICE ON THIS CLAIM. FORMAT- CCYYMMDD
4	THRU_SERVICE_DATE	A/N	8	089-096	THE THRU DATE OF SERVICE ON THIS CLAIM. FORMAT- CCYYMMDD
5	RECEIVED_DATE	A/N	8	097-104	THE DATE THIS CLAIM WAS RECEIVED IN THE MAIL OR VIA EDI. FORMAT- CCYYMMDD
6	PAID_DATE	A/N	8	105-112	THE DATE THE CLAIM PROCESSED WAS FINALIZED (PAID OR ADJUSTED).FORMAT- CCYYMMDD
7	SERVICE UNITS COUNT	N	11	113-123	THE NUMBER OF UNITS OF SERVICES DESCRIBED BY THE PROCEDURE RENDERED ON THIS CLAIM LINE.
8	INPATIENT DAYS COUNT	N	11	124-134	THE NUMBER OF INPATIENT HOSPITAL DAYS THIS CLAIM LINE INDICATES.
9	ANESTHESIA_MINUTES	N	11	135-145	THE NUMBER OF MINUTES OF ANESTHESIA THAT WAS RENDERED ON THIS CLAIM LINE.
10	CHARGE_AMOUNT	N	22	146-167	THE DOLLARS BILLED/CHARGED FOR THIS CLAIM LINE. FORMAT-ALL FINANCIAL FIELDS SHOULD BE 22 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE
11	ALLOWED_AMOUNT	N	22	168-189	THE AMOUNT OF THE CHARGE_AMOUNT THAT IS ALLOWED PER THE PROVIDERS PRICING CONTRACT (DETERMINED AFTER REPRICING AND APPLYING RATE TABLES) FORMAT-ALL FINANCIAL FIELDS SHOULD BE 22 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE
12	EXCLUDED_AMOUNT	N	22	190-211	THE AMOUNT OF THE CHARGE_AMOUNT THAT IS NOT ALLOWED DUE TO NEGOTIATED PROVIDER DISCOUNTS OR IN ELIGIBLE PORTIONS OF THE SERVICE LINE CHARGE. FORMAT-ALL FINANCIAL FIELDS SHOULD BE 22 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
13	WITHHELD_AMOUNT	N	22	212-233	THE AMOUNT THAT IS BEING WITHHELD FROM PAYMENT TO THE PROVIDER UNDER A RISK-SHARING ARRANGEMENT. THIS AMOUNT MAY BE PAID BACK TO THE PROVIDER UNDER OTHER MEANS BASED UPON PERFORMANCE OR OTHER RISK-SHARING EVALUATIONS ABOVE. FORMAT-ALL FINANCIAL FIELDS SHOULD BE 22 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE
14	COPAY_AMOUNT	N	22	234-255	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER BUT IS NOT DUE TO MEMBER COPAY ARRANGEMENTS. THIS AMOUNT SHOULD BE PAID TO THE PROVIDER BY THE MEMBER DIRECTLY SEPARATELY FROM THIS CLAIM. FORMAT-ALL FINANCIAL FIELDS SHOULD BE 22 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE
15	COINSURANCE AMOUNT	N	22	256-277	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER, BUT IS NOT DUE TO MEMBER COINSURANCE ARRANGEMENTS. THIS AMOUNT SHOULD BE PAID TO THE PROVIDER BY THE MEMBER DIRECTLY SEPARATELY FROM THIS CLAIM. ABOVE FORMAT-ALL FINANCIAL FIELDS SHOULD BE 22 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE
16	DEDUCTIBLE_AMOUNT	N	22	278-299	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER, BUT IS NOT DUE TO MEMBER COINSURANCE ARRANGEMENTS. THIS AMOUNT SHOULD BE PAID TO THE PROVIDER BY THE MEMBER DIRECTLY SEPARATELY FROM THIS CLAIM. FORMAT-ALL FINANCIAL FIELDS SHOULD BE 22 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE
17	COB_PAID_AMOUNT	N	22	300-321	THE AMOUNT PAID BY THE MEMBER'S OTHER CARRIER. FORMAT-ALL FINANCIAL FIELDS SHOULD BE 22 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
18	PROVIDER PAID AMOUNT	N	22	322-343	THE NET AMOUNT THAT WAS EVENTUALLY PAID TO THE PROVIDER FOR THIS CLAIM LINE. FORMAT-ALL FINANCIAL FIELDS SHOULD BE 22 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE
19	MEMBER PAID AMOUNT	N	22	344-365	THE NET AMOUNT THAT WAS EVENTUALLY PAID TO THE MEMBER, SUBSCRIBER OR EMPLOYEE FOR THIS CLAIM LINE. FORMAT-ALL FINANCIAL FIELDS SHOULD BE 22 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE
20	NET_PAID_AMOUNT	N	22	366-387	THE TOTAL NET AMOUNT THAT WAS PAID IN TOTAL BY THE HEALTH PLAN FOR THIS CLAIM LINE. FORMAT-ALL FINANCIAL FIELDS SHOULD BE 22 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE
21	TRANSACTION_TYPE	A/N	20	388-407	THE TRANSACTION TYPE (OUTCOME). 'APPROVED' 'DENIED' 'REVERSED' 'REVERSAL'
22	ADJUSTED FROM CLAIM ID	A/N	20	408-427	IF THIS CLAIM IS AN ADJUSTMENT FROM ANOTHER CLAIM, THIS FIELD **MUST** CONTAIN THE ID OF THE PRIOR OR ORIGINAL CLAIM.
23	PLACE_OF_SERVICE	A/N	20	428-447	THE HCFA STANDARD PLACE OF SERVICE CODE
24	SUBMITTED_DRG	A/N	20	448-467	THE DRG CODE THAT WAS SUBMITTED ON THE CLAIM
25	DENIED_REASON	A/N	20	468-487	THE DENIED REASON CODE FOR THIS CLAIM. CONTRACTOR MUST SEND THE LIST OF DENIED REASONS THAT THEY USE (THE CODE AND THE NAME)
26	DENIED REASON NAME	A/N	20	488-507	THE DESCRIPTION OF THE DENIED REASON FOR THIS CLAIM.
27	DISCHARGE STATUS	A/N	2	508-509	THE STANDARD DISCHARGE STATUS (ALSO KNOWN AS PATIENT STATUS) FROM FIELD 22 ON A UB-04 CLAIM FORM.
28	TYPE_OF_BILL	A/N	3	510-512	THE STANDARD TYPE OF BILL CODE FROM FIELD 4 ON A UB-04 CLAIM FORM
29	MEDICAL CLAIM DOC TYPE	A/N	20	513-532	THE TYPE OF DOCUMENT SUBMITTED ('UB-04', 'CMS-1500' OR 'ADA-1500')
30	TYPE_OF_SERVICE	A/N	20	533-552	THE HCFA STANDARD TYPE OF SERVICE CODE ON THE CLAIM.
31	EMPLOYEE_SSN	A/N	20	553-572	THE EMPLOYEE'S SOCIAL SECURITY NUMBER- LEFT JUSTIFIED AND FILLED WITH

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					SPACES TO THE RIGHT
32	EMPLOYEE LAST NAME	A/N	40	573-612	THE LAST NAME OF THE EMPLOYEE.
33	EMPLOYEE_SEX	A/N	20	613-632	THE GENDER OF THE EMPLOYEE. 'F' = FEMALE 'M' = MALE 'U' = UNKNOWN
34	EMPLOYEE DATE OF BIRTH	A/N	8	633-640	THE EMPLOYEE'S DATE OF BIRTH FORMAT- CCYYMMDD
35	EMPLOYEE_ZIP_CODE	A/N	20	641-660	THE EMPLOYEE'S FULL ZIP CODE (5 OR 9 DIGITS AS AVAILABLE)
36	MEMBER_SSN	A/N	20	661-680	THE MEMBER'S SOCIAL SECURITY NUMBER
37	MEMBER_FIRST_NAME	A/N	40	681-720	THE FIRST NAME OF THE MEMBER (PATIENT)
38	MEMBER_LAST_NAME	A/N	40	721-760	THE LAST NAME OF THE MEMBER (PATIENT)
39	MEMBER_SEX	A/N	20	761-780	THE GENDER OF THE MEMBER. 'F' = FEMALE 'M' = MALE 'U' = UNKNOWN
40	MEMBER DATE OF BIRTH	A/N	8	781-788	THE MEMBER'S DATE OF BIRTH. FORMAT- CCYYMMDD
41	MEMBER_ZIP_CODE	A/N	20	789-808	THE MEMBER'S FULL ZIP CODE (5 OR 9 DIGITS AS AVAILABLE)
42	RELATIONSHIP TO EMPLOYEE	A/N	2	809-810	THE RELATIONSHIP THIS MEMBER HAS WITH THE EMPLOYEE. '01 = EMPLOYEE '02' = SPOUSE '03' = OTHER DEPENDENTS
43	MEMBER ELIGIBILITY ID	A/N	20	811-830	THE MEMBER'S OGB MEMBER INTERNAL ID PROVIDED IN THE ELIGIBILITY FILE.
44	PRIMARY DIAG CODE	A/N	10	831-840	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE PRIMARY DIAGNOSIS FOR THE SERVICE
45	DIAGNOSIS_CODE_2	A/N	10	841-850	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE SECOND DIAGNOSIS FOR THE SERVICE
46	DIAGNOSIS_CODE_3	A/N	10	851-860	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE THIRD DIAGNOSIS FOR THE SERVICE
47	DIAGNOSIS_CODE_4	A/N	10	861-870	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE FOURTH DIAGNOSIS FOR THE SERVICE
48	DIAGNOSIS_CODE_5	A/N	10	871-880	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE FIFTH DIAGNOSIS FOR THE SERVICE
49	DIAGNOSIS_CODE_6	A/N	10	881-890	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE SIXTH DIAGNOSIS FOR THE SERVICE
50	DIAGNOSIS_CODE_7	A/N	10	891-900	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE SEVENTH DIAGNOSIS FOR THE SERVICE

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
51	DIAGNOSIS_CODE_8	A/N	10	901-910	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE EIGHTH DIAGNOSIS FOR THE SERVICE
52	DIAGNOSIS_CODE_9	A/N	10	911-920	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE NINTH DIAGNOSIS FOR THE SERVICE
53	ADMIT_DIAG CODE	A/N	10	921-930	THE ICD-9-CM DIAGNOSIS CODE WHICH IDENTIFIES THE ADMIT DIAGNOSIS FOR THIS CLAIM
54	ICD9_PROCEDURE CODE 1	A/N	10	931-940	THE PRIMARY ICD9 PROCEDURE CODE ORIGINATING FROM A UB-04 CLAIM (HEADER LEVEL)
55	ICD9_PROCEDURE CODE 2	A/N	10	941-950	THE SECOND ICD9 PROCEDURE CODE ORIGINATING FROM A UB-04 CLAIM (HEADER LEVEL)
56	ICD9_PROCEDURE CODE 3	A/N	10	951-960	THE THIRD ICD9 PROCEDURE CODE ORIGINATING FROM A UB-04 CLAIM (HEADER LEVEL)
57	ICD9_PROCEDURE CODE 4	A/N	10	961-970	THE FOURTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB-04 CLAIM (HEADER LEVEL)
58	ICD9_PROCEDURE CODE 5	A/N	10	971-980	THE FIFTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB-04 CLAIM (HEADER LEVEL)
59	ICD9_PROCEDURE CODE 6	A/N	10	981-990	THE SIXTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB-04 CLAIM (HEADER LEVEL)
60	PROCEDURE_CODE	A/N	10	991-1000	THE PROCEDURE CODE ORIGINATING AS THE CPT PROCEDURE CODE ON HCFA FORMS, HCPCS PROCEDURE CODE ON UB-04 FORMS OR ADA PROCEDURE CODE ON DENTAL FORMS.
61	REVENUE_CODE	A/N	10	1001-1010	THE 3 CHARACTER REVENUE CODE USED ON UB-04 CLAIM FORMS.
62	RX_DRUG_CODE	A/N	20	1011-1030	THE 13 CHARACTER PRESCRIPTION DRUG CODE
63	OCCURRENCE CODE 1	A/N	20	1031-1050	THE FIRST OCCURRENCE CODE ORIGINATING FROM A UB-04 CLAIM FORM
64	OCCURRENCE_DATE_1	A/N	8	1051-1058	CONTAINS THE DATE OF THE FIRST OCCURRENCE FROM A UB-04 CLAIM FORM. FORMAT- CCYYMMDD
65	OCCURRENCE CODE 2	A/N	20	1059-1078	THE SECOND OCCURRENCE CODE ORIGINATING FROM A UB-04 CLAIM FORM
66	OCCURRENCE_DATE_2	A/N	8	1079-1086	CONTAINS THE DATE OF THE SECOND OCCURRENCE FROM A UB-04 CLAIM FORM. FORMAT- CCYYMMDD
67	OCCURRENCE CODE 3	A/N	20	1087-1106	THE THIRD OCCURRENCE CODE ORIGINATING FROM A UB-04 CLAIM FORM
68	OCCURRENCE_DATE_3	A/N	8	1107-1114	CONTAINS THE DATE OF THE THIRD OCCURRENCE FROM A UB-04 CLAIM FORM. FORMAT- CCYYMMDD

Appendix A-1 Medical Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
69	OCCURRENCE CODE 4	A/N	20	1115-1134	THE FOURTH OCCURRENCE CODE ORIGINATING FROM A UB-04 CLAIM FORM
70	OCCURRENCE_DATE_4	A/N	8	1135-1142	CONTAINS THE DATE OF THE FOURTH OCCURRENCE FROM A UB-04 CLAIM FORM. FORMAT- CCYYMMDD
71	OCCURRENCE SPAN CODE	A/N	20	1143-1162	THE OCCURRENCE SPAN CODE ORIGINATING FROM A UB-04 CLAIM FORM
72	OCCUR SPAN FROM DATE	A/N	8	1163-1170	THE BEGINNING DATE OF THE OCCURRENCE SPAN CODE FORMAT- CCYYMMDD
73	OCCUR SPAN THRU DATE	A/N	8	1171-1178	THE ENDING DATE OF THE OCCURRENCE SPAN CODE FORMAT- CCYYMMDD
74	MODIFIER CODE 1	A/N	20	1179-1198	THE FIRST MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
75	MODIFIER CODE 1	A/N	20	1199-1208	THE SECOND MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
76	MODIFIER_CODE_3	A/N	20	1209-1228	THE THIRD MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
77	NETWORK INDICATOR	A/N	20	1229-1248	IDENTIFIES WHETHER THE PROVIDER FOR THIS CLAIM WAS 'IN' OR 'OUT' OF NETWORK AT THE TIME OF SERVICE 'I' = IN NETWORK 'O' = OUT OF NETWORK
78	PROVIDER INTERNAL ID	A/N	20	1249-1268	THE UNIQUE ID OF THE SERVICE PROVIDER AS ASSIGNED BY THE CLAIMS PROCESSING SYSTEM – **MUST** CORRESPOND TO ID IN PAYER'S PROVIDER FILE (APPENDIX A-2).
79	CLAIM SOURCE	A/N	2	1269-1270	SOURCE OF THE CLAIM: K = KEYED A = AUTOMATIC (ELECTRONIC)

FILE REQUIREMENT & LAYOUT

Appendix A-2 Provider File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	PROVIDER_INTERNAL_ID	A/N	20	001-020	THE UNIQUE ID OF THE PROVIDER AS ASSIGNED BY THE CLAIMS PROCESSING (SEE FIELD 78 IN APPENDIX A-1)
2	PROVIDER_TAX_ID	A/N	10	021-030	TAX ID OF THIS PROVIDER
3	PROVIDER_DEA_ID	A/N	10	031-040	THE FEDERAL DEA NUMBER OF THIS PROVIDER
4	PROVIDER_LAST_NAME	A/N	20	041-060	THE LAST NAME FOR THIS PROVIDER
5	PROVIDER_FIRST_NAME	A/N	20	061-080	THE FIRST NAME FOR THIS PROVIDER
6	PROVIDER_MIDDLE_INITIAL	A/N	1	081-081	THE MIDDLE INITIAL FOR THIS PROVIDER
7	PROVIDER_OFFICE_NAME	A/N	40	082-121	THE OFFICE NAME, CORPORATION NAME, OR LOCATION NAME OF THE OFFICE THIS PROVIDER OFFERS SERVICES.
8	PROVIDER_ADDRESS_LINE1	A/N	40	122-161	LINE 1 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
9	PROVIDER_ADDRESS_LINE2	A/N	40	162-201	LINE 2 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
10	PROVIDER_CITY	A/N	40	202-241	THE CITY PORTION OF THIS PROVIDER'S ADDRESS
11	PROVIDER_STATE	A/N	2	242-243	THE STATE PORTION OF THIS PROVIDER'S ADDRESS
12	PROVIDER_ZIP	A/N	10	243-253	THE ZIP PORTION OF THIS PROVIDER'S ADDRESS
13	PROVIDER_UPIN	A/N	20	254-273	THE UNIVERSAL PROVIDER IDENTIFICATION NUMBER FOR THIS PROVIDER
14	PROVIDER_MEDICARE_ID	A/N	20	274-293	THE MEDICARE IDENTIFIER FOR THIS PROVIDER
15	PROVIDER_SPECIALTY	A/N	20	294-313	THE SPECIALTY #1 CODE FROM THE SOURCE SYSTEM. CONTRACTOR SHOULD SEND SPECIALTY CODES AND NAMES THAT THEY USE TO OGB
16	PROVIDER_SPECIALTY NAME	A/N	40	314-353	THE DESCRIPTION FOR THE SPECIALTY #1 FROM THE SOURCE SYSTEM
17	PROVIDER_TYPE	A/N	20	354-373	PLACE OF TREATMENT: I = INPATIENT; O= OUTPAT.; P= PHYSICIANS OFFICE; X= OTHER POT; Z= TEMP DEFAULT
18	SOURCE_PAY_TO_ID	A/N	20	374-393	THE IDENTIFIER FROM THE SOURCE SYSTEM FOR THIS PROVIDERS TO WHICH THE CLAIMS PAYMENT IS MADE. ('PAY-TO" PROVIDER')

Appendix A-2 Provider File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
19	PAY_TO_LAST_NAME	A/N	20	394-413	THE LAST NAME FOR THE PAY-TO FOR THIS PROVIDER
20	PAY_TO_FIRST_NAME	A/N	20	414-433	THE FIRST NAME FOR THE PAY-TO FOR THIS PROVIDER
21	PAY_TO_MIDDLE_INITIAL	A/N	1	434-434	THE MIDDLE INITIAL NAME FOR THE PAY-TO FOR THIS PROVIDER
22	PAY_TO_OFFICE_NAME	A/N	40	435-474	THE OFFICE NAME, CORPORATION NAME, OR LOCATION NAME OF THE OFFICE NAME FOR THE PAY-TO FOR THIS PROVIDER
23	PAY_TO_ADDRESS_LINE 1	A/N	40	475-514	LINE 1 THE STREET ADDRESS PORTION OF THE PAY-TO FOR THIS PROVIDER
24	PAY_TO_ADDRESS_LINE 2	A/N	40	515-554	LINE 2 THE STREET ADDRESS PORTION OF THE PAY-TO FOR THIS PROVIDER
25	PAY_TO_CITY	A/N	40	555-594	THE CITY PORTION OF THIS ADDRESS FOR THE PAY-TO FOR THIS PROVIDER
26	PAY_TO_STATE	A/N	2	595-596	THE STATE PORTION OF THIS ADDRESS FOR THE PAY-TO FOR THIS PROVIDER
27	PAY_TO_ZIP	A/N	10	597-606	THE ZIP PORTION OF THIS ADDRESS FOR THE PAY-TO FOR THIS PROVIDER
28	PAY_TO_TAX_ID	A/N	9	607-615	THE TAX ID NUMBER FOR THE PAY-TO ENTITY FOR THIS PROVIDER.
29	NPI	A/N	10	616-625	NATIONAL PROVIDER ID (NPI)

FILE REQUIREMENT & LAYOUT

Appendix A-3 Check Register File					
NO	**Field Name**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	CHECK NUMBER	A/N	10	01-10	RIGHT JUSTIFY & FILL TO LEFT WITH ZEROS
2	CHECK ISSUE DATE	A/N	8	11-18	FORMAT = CCYYMMDD
3	CHECK ISSUE AMOUNT	N	22	19-40	FORMAT-Field should be 22 characters long, with an explicit decimal point and leading sign only when negative.
4	PAYEE NAME	A/N	30	41-70	MEMBER OR PROVIDER NAME

FILE REQUIREMENT & LAYOUT

Appendix A-4 Eligibility File					
NO	Field Name	TYPE	Len	LOC	DESCRIPTION
1	Contract Holder's SSN	A/N	9	001-009	Holder SSN
2	Member Last Name	A/N	20	010-029	Member Last Name
3	Member First Name	A/N	15	030-044	Member First Name
4	Member Middle Initial	A/N	1	045-045	Member Middle Initial
5	Address 1	A/N	35	046-080	Address Line 1
6	Address 2	A/N	35	081-115	Address Line 2
7	City	A/N	30	116-145	City
8	State	A/N	2	146-147	State
9	Zip Code	A/N	13	148-160	Zip Code
10	Birth Date	A/N	8	161-168	CCYYMMDD
11	Plan Effective Date	A/N	8	169-176	CCYYMMDD- earliest effective date of uninterrupt Coverage within the Health plan/Rate Table/Coverage Level Combination.
12	Termination Date	A/N	8	177-184	CCYYMMDD- Blank if active
13	Client / Agency Code	A/N	8	185-192	Code Client /Agent
14	Sub Client / Section of Agen	A/N	4	193-196	Sub Client or Section Agency
15	Type of Coverage	A/N	1	197-197	"e" – member only "c" – member and child(ren) "s" – member and spouse "f" – family
16	Medicare A Primary Effective Date	A/N	8	198-205	CCYYMMDD(can be blank)
17	Medicare B Primary Effective Date	A/N	8	206-213	CCYYMMDD(can be blank)
18	Sex Code	A/N	1	214-214	Male or Female(M/F)
19	Student Date	A/N	8	215-222	CCYYMMDD(can be blank)
20	Relation Code	A/N	2	223-224	01 – Enrollee 02 – Spouse 03 – Children or other dependents
21	Transaction Date	A/N	8	225-232	CCYYMMDD
22	Agency Employment Date	A/N	8	233-240	CCYYMMDD
23	Preexisting termination Date	A/N	8	241-248	CCYYMMDD- Preexisting termination date(can be Blank)
24	Contract Holder Phone	A/N	12	249-260	
25	Enrollee Status Field	A/N	1	261-261	C - for the whole family if the subscriber is on cob r- for the subscriber & spouse if the subscriber is retired and active for the children a-for the whole family if the subscriber is active
26	Handicapped indicator	A/N	1	262-262	"Y" = Yes "N" = No
27	Marriage Date	A/N	8	263-270	CCYYMMDD(can be blank)
28	HIC Number	A/N	12	271-282	Medicare card number.
29	COB DATE	A/N	8	283-290	CCYYMMDD- Beginning coverage by other carrie not including Medicare.
30	Medicare Primary	A/N	1	291-291	"Y" = Yes "N" = No

Appendix A-4 Eligibility File					
NO	**Field Name**	**TYPE**	**Len**	**LOC**	**DESCRIPTION**
31	Member SSN	A/N	9	292-300	Member SSN
32	Retiree 100	A/N	1	301-301	Switch is always blank for dependents Y/N
32	Last Change Date	A/N	8	302-309	CCYYMMDD- date the enrollment record was last changed
33	Member Record ID	A/N	8	310-317	OGB Internal id
34	Claim Payment Stop Date	A/N	8	318-325	CCYYMMDD- Date beyond with claims should no be Paid because of non-payment of premiums
35	Rate Table	A/N	2	326-327	AC – active CB - cobra CD - cobra disability CP - cobra part-time CS – Cobra State Subsidized R1 - retired Medicare 1 R2 - retired Medicare 2 RN - retired no Medicare This Field is always blank for dependents
36	Plan	A/N	4	328-331	
37	Lifetime Accum	N	10	332-341	9999999.99 Leading spaces: Sum of Drug and Medical, claims paid. Max: 5,000,000.00
38	Drug Accum	N	10	342-351	9999999.99 Leading spaces: Sum of Drug claims paid. Included in Lifetime Accum.

FILE REQUIREMENT & LAYOUT

APPENDIX-5 ASO ADMINISTRATIVE FEE BILLING FILE					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	Invoice Date	A/N	8	001-008	CCYYMMDD
2	Enrollee SSN	A/N	9	009-017	SOCIAL SECURITY NUMBER
3	Enrollee Last Name	A	20	018-037	Last Name
4	Enrollee First Name	A	20	038-057	First Name
5	Enrollee Middle Initial	A	1	058-058	Initial
6	Enrollee Coverage Type	A	2	059-060	"EE" -Employee Only "ES"-Employee and Spouse "EC"-Employee and Child(ren) "FM"-Family
7	Rate Table Code	A	2	061-062	"AC"- Active "CB"- Cobra "CD"- Cobra Disability "CP"- Cobra Part-Time "R1" - Retired Medicare 1 "R2"- Retired Medicare 2 "RN"- Retired No Medicare
8	Billing OR Coverage	A/N	8	063-070	CCYYMMDD
9	Premium Amount	N	7	071-80	FORMAT-SHOULD BE 7 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE EXAMPLE: 123.45 WOULD BE EXPRESSED AS "0000123.45" -123.45 WOULD BE EXPRESSED AS "-000123.45"

ATTACHMENT E

REQUIRED REPORTS

INTENT

The intent of the required reports is to provide the State sufficient detail to have an in-depth understanding of type of claim activity, frequency and impact on total cost.

A. Monthly Reports

Please provide, monthly, a report which consists of the elements noted below. Please report OGB statistics as well as your entire Organization statistics. **Monthly reports must be received by OGB and its Actuarial Consulting Firm no later than the end of business (5:00 p.m. CST) on the fifteenth of the month following the month in which you are reporting data.**

- **Financial Experience** (Premium Income, Expenses (non-capitated paid claims, capitation expense and administrative expense).
- **Claim Turnaround Time** percent paid within 30 days and report average lag time speed to answer by live voice (% of Participants who wait 30 seconds or less to speak with a live Participant service rep.)
- **Telephone Abandonment Rate** (% of calls where the caller hangs up after opting to speak with another service rep. and the call has been transferred to a Participant rep.)
- **PCP Turnover Rate** (% of PCPs leaving the network voluntarily or involuntarily during the month)
- **Open PCP/Participant Ratio** (ratio of open PCPs accepting new Participants to actual Participants)
- **Grievance Log (as requested in the NIC)**

If the report requests above are not able to be reported by your Organization due to plan or system limitations (e.g. phone system limitations not able to report %), please provide details on your monthly reports.

B. Legislative Auditor Required Audit Report

Annual SAS-70/Type II Audit Report.

C. Other Required Reports

OGB may determine during the term of the contract that other reports are needed.

EXHIBIT 8

2010-2011 BENEFIT MODIFICATIONS

PROPOSED 2010 – 2011 PLAN DESIGN CHANGES

- The initiation of a pre-authorization program for outpatient high-cost imaging (CAT scans, MRIs and PET scans) Each plan product will be responsible for administering its own pre-authorization program.

- The implementation of lab contracts for outpatient pathology specimens (Each plan product will be responsible for administering is own lab contracts.)

- The implementation of a Specialty Drug contract (excluding oncology), a mandatory generic provision and the inclusion of some OTC products to be bid as part of our prescription benefit management contract.

- The exclusion of coverage for spouses (of new employees hired after 7/1/2010) who have declined health coverage sponsored by their employer.

- The amendment of the plan document to comply with a new federal mandate (Michelle's law) to extend eligibility for up to one year to a dependent child over the age of 21 who is enrolled in an institution of higher education but who would otherwise lose coverage when a medically necessary leave of absence causes the dependent child to fall below full time status. COBRA rights would apply after the one year period has expired.

- An increase in the wellness benefit available to PPO members from $200 to $500.

- The modification of Mental Health/ Substance Abuse benefits to comply with the federal Mental Health Parity Act.

EXHIBIT 9

HOSPITAL LIST

Region	In-State Hospitals
01	CHILDREN'S HOSPITAL
	EAST JEFFERSON GENERAL HOSPITAL
	GULF STATES LTAC OF NEW ORLEANS, LLC
	JEFFERSON PARISH HOSPITAL SERVIC DIST #1
	LA EXTENDED CARE HOSPITAL OF KENNER
	LOUISIANA SPECIALTY HOSPITAL, LLC
	MEDICAL CENTER OF LOUISIANA @ NO
	NEW ORLEANS REHABILITATION HOSPITAL,LLC
	OCHSNER BAPTIST MEDICAL CENTER
	OCHSNER FOUNDATION HOSPITAL
	OCHSNER MEDICAL CENTER KENNER
	RIVER PARISHES HOSPITAL, LLC
	ST JAMES PARISH HOSPITAL
	ST. CHARLES PARISH HOSPITAL
	ST. THERESA SPECIALTY HOSPITAL ,LLC
	TOURO INFIRMARY
	TRANSITIONAL HOSPITAL CORP. OF LOUISIANA
	UNITED MEDICAL HEALTHWEST OF NEW ORLEANS
	UNIVERSITY HEALTHCARE SYSTEM, L.C.
02	LAFOURCHE PARISH HOSPITAL DISTRICT #1
	LEONARD J CHABERT MEDICAL CENTER
	OCHSNER BAYOU
	PHYSICIANS MEDICAL CENTER, LLC
	PREVOST MEMORIAL HOSPITAL
	ST ANNE'S REHABILITATION HOSPITAL
	TECHE REGIONAL MEDICAL CENTER
	TERREBONNE GENERAL MEDICAL CENTER
	THIBODAUX LASER & SURGERY CENTER,LLC
	THIBODAUX REGIONAL MEDICAL CENTER
03	FAIRWAY MEDICAL CENTER
	HOLY SPIRIT COMFORT AND HEALING CENTER
	HOOD MEMORIAL HOSPITAL
	LAKEVIEW REGIONAL MEDICAL CENTER
	LALLIE KEMP MEDICAL CENTER
	LOUISIANA HEART HOSPITAL
	LTAC HOSPITAL OF WASHINGTON ST. TAMMANY
	NORTH OAKS HEALTH SYSTEM
	NORTH OAKS REHABILITATION HOSPITAL
	NORTHSHORE REGIONAL MEDICAL CTR., REHAB
	OUR LADY OF THE LAKE ASSUMPTION COMMUNIT
	SLIDELL MEMORIAL HOSPITAL
	SLIDELL SPECIALTY HOSPITAL, LP
	ST HELENA PARISH HOSPITAL
	ST TAMMANY PARISH HOSPITAL SVS. DIST #1
	SUMMIT SURGERY CENTER, LLC
	UNITED MEDICAL HEALTHCARE, INC
	WASHINGTON - ST TAMMANY REGIONAL MEDICAL

Region	In-State Hospitals
	WASHINGTON PARISH HOSPITAL SERVICE #1
04	ABBEVILLE GENERAL HOSPITAL
	ABROM KAPLAN MEMORIAL HOSPITAL
	ACADIA ST LANDRY HOSPITAL
	AMERICAN LEGION HOSPITAL
	COMMUNITY REHABILITATION HOSPITAL
	CROWLEY REHAB HOSPITAL,LLC
	DAUTERIVE HOSPITAL
	FRANKLIN FOUNDATION HOSPITAL
	HEART HOSPITAL OF ACADIANA
	HOSP. SERVICE DIST. # 1 OF IBERIA PARISH
	IBERIA REHABILITATION HOSPITAL, LLC
	LAFAYETTE GENERAL MEDICAL CENTER
	LAFAYETTE GENERAL SURGICAL HOSPITAL, LLC
	LAFAYETTE PHYSICAL REHAB HOSPITAL
	LAFAYETTE SPECIALTY HOSPITAL, LLC
	LAFAYETTE SURGICAL HOSPITAL, LLC
	LAHAYE CENTER FOR ADVANCED EYE CARE
	LAHAYE CENTER FOR ADVANCED EYE CARE,APMC
	LASER & SURGERY CENTER OF ACADIANA
	LIFE POINT HOSPITAL, LLC
	LOUISIANA EXTENDED CARE HOSPITAL
	LSUMC UNIVERSITY MEDICAL CENTER
	LTAC OF ACADIANA, LLC
	OPELOUSAS GENERAL HOSPITAL AUTHORITY
	OUR LADY OF LOURDES REGIONAL MEDICAL CTR
	PALMS SURGERY CENTER, LLC
	PARK PLACE SURGERY HOSPITAL
	PHC-EUNICE, INC
	RAPIDES HEALTHCARE
	ST MARTIN HOSPITAL
	ST. LANDRY EXTENDED CARE HOSPITAL
	THE REGIONAL HEALTH SYSTEM OF ACADIANA
	THE REGIONAL HEALTH SYSTEM OF LOUISIANA
	WOMEN'S & CHILDREN'S HOSPITAL, INC.
05	ACADIA REHABILITATION HOSPITAL, LLC
	ALLEN PARISH HOSPITAL
	CALCASIEU CAMERON HOSPITAL SVC DISTRICT
	CHRISTUS HEALTH SOUTHWESTERN LOUISIANA
	CORNERSTONE HOSPITAL OF SW LOUISIANA
	DEQUINCY MEMORIAL HOSPITAL
	DUBUIS HEALTH SYSTEM
	JENNINGS AMERICAN LEGION
	LAKE CHARLES MEDICAL & SURGICAL CLINIC
	LAKE CHARLES MEMORIAL HOSPITAL
	PACER HEALTH MANAGEMENT CORPORATION
	W. O. MOSS REGIONAL MEDICAL CENTER

Region	In-State Hospitals
	WEST LOUISIANA HEALTH SERVICES, INC.
	WOMEN & CHILDREN'S HOSPITAL, LLC
06	ADVANCED SURGICAL CARE OF BATON ROUGE
	ADVANCED SURGICAL CONCEPTS, LLC
	BATON ROUGE GENERAL MEDICAL CENTER
	BETHESDA REHABILITATION HOSPITAL
	CLINTON REHABILITATION HOSPITAL, LLC
	EARL K LONG MEDICAL CENTER
	EAST BATON ROUGE MEDICAL CENTER, LLC
	FIRST CHOICE SURGERY CTR OF BATON ROUGE
	GREATER BATON ROUGE SURGICAL HOSPITAL
	HAMMOND REHABILITATION HOSPITAL, LLC
	HEALTHSOUTH REHABILITATION HOSPITAL
	LANE MEMORIAL HOSPITAL
	LTAC HOSPITAL OF FELICIANA, LLC
	LTAC HOSPITAL OF LOUISIANA DENHAM SPRING
	N. M. C. OPERATING COMPANY, LLC
	NEUROMEDICAL CENTER REHAB HOSPITAL
	NEW ORLEANS EAST REHABILITATION HOSPITAL
	OLOL ASCENSION COMMUNITY HOSPITAL
	OUR LADY OF THE LAKE REGIONAL MEDICAL
	POINTE COUPEE GENERAL HOSPITAL
	PROMISE HOSPITAL OF ASCENSION, INC
	REGIONAL EYE SURGERY CENTER
	ROCKWALL BATON ROUGE REHAB HOSPITAL, L.P
	SURGICAL SPECIALTY CENTER OF B. R.
	WEST FELICIANA HOSPITAL
07	ALLEGIANCE HOSPITAL OF MANY, LLC
	CALDWELL MEMORIAL HOSPITAL
	CENTRAL LA AMBULATORY SURGERY CENTER
	CHRISTUS CABRINI SURGERY CENTER, LLC
	CHRISTUS HEALTH CENTRAL LOUISIANA
	CITIZENS MEDICAL CENTER
	DOCTOR'S HOSPITAL AT DEER CREEK
	HEALTHSOUTH REHAB HOSPITAL OF ALEXANDRIA
	HOSPITAL SERVICES DISTRICT #1 AVOYELLES
	HUEY P. LONG REGIIONAL MEDICAL CENTER
	LASALLE HOSPITAL SERVICE DISTRICT NO 2
	LASALLE PARISH HOSPITAL SERVICE DIST #1
	LEESVILLE REHABILITATION HOSPITAL
	LOUISIANA EXTENDED CARE HOSPITAL
	NATCHITOCHES PARISH HOSPITAL
	NATIONAL HEALTHCARE OF LEESVILLE, INC.
	PROFESSIONAL REHABILITATION HOSPITAL,LLC
	PROGRESSIVE ACUTE CARE AVOYELLES,LLC
	PROGRESSIVE ACUTE CARE OAKDALE, LLC
	PROGRESSIVE ACUTE CARE WINN, LLC

Region	In-State Hospitals
	RAPIDES HELATHCARE SYSTEM, LLC
	RIVERLAND MEDICAL CENTER
	RIVERSIDE HOSPITAL OF LOUISIANA
	SPECIALTY HOSPITAL OF WINNFIELD
	THE ALEXANDRIA OPTHALMOLOGY ASC, LLC
	TRI PARISH REHABILITATION HOSPITAL, LLC
08	BIENVILLE MEDICAL CENTER, INC.
	BOSSIER SPECIALTY HOSPITAL, LLC
	CHRISTUS HEALTH CENTRAL LOUISIANA
	CORNERSTONE HOSPITAL OF BOSSIER, LLC
	DESOTO REGIONAL HEALTH SYSTEM
	HOMER MEMORIAL HOSPITAL
	LSU HEALTH SCIENCES CENTER-SHREVEPORT
	NORTH CADDO MEMORIAL HOSPITAL
	PHC-MINDEN, LP
	REGIONAL UROLOGY ASC LLC
	SHREVEPORT SURGERY CENTER
	SPECIALTY REHABILITATION HOSPITAL
	SPRINGHILL MEDICAL CENTER
	WILLIS KNIGHTON BOSSIER HEALTH CENTER
	WILLIS KNIGHTON MEDICAL CENTER
09	BASTROP REHABILITATION HOSPITAL
	CORNERSTONE HOSPITAL OF WEST MONROE, LLC
	EAST CARROLL PARISH HOSPITAL
	FRANKLIN PARISH HOSPITAL SRVC DISTRICT 1
	GARDNER SURGERY CENTER
	GREEN CLINIC SURGICAL HOSPITAL, LLC
	HOSPITAL SVS.DISTRICT #1A OF RICHLAND
	IASIS GLENWOOD REGIONAL MEDICAL CENTER
	IASIS OUACHITA COMMUNITY HOSPITAL, LP
	JACKSON PARISH HOSPITAL
	LHCG-X, LLC
	LSU HEALTH SCIENCES CENTER SHREVEPORT
	MADISON PARISH HOSPITAL
	MONROE SURGICAL HOSPITAL, LLC
	MOREHOUSE GENERAL HOSPITAL
	NORTH LOUISIANA REHAB CENTER
	P & S SURGERY CENTER, LLC
	RICHLAND PARISH HOSPITAL SERV. DIST. 1-B
	RUSTON LOUISIANA HOSPITAL, LLC
	ST FRANCIS MEDICAL CENTER
	ST. FRANCIS SPECIALTY HOSPITAL
	STERLINGTON CRITICAL ACCESS HOSPITAL,LLC
	TRI-WARD GENERAL HOSPITAL
	UNION GENERAL HOSPITAL
	WEST CARROLL HEALTH SYSTEM, LLC

OUT-OF-STATE HOSPITALS	State
BEACHAM MEMORIAL HOSPITAL	MS
BETTER LIVING ENDOSCOPY CENTER	MS
DSA SURGERY CENTER, INC	TX
FIELD MEMORIAL COMMUNITY HOSPITAL	MS
FIRST CHOICE SURGICAL CENTER, LLC.	MS
FORREST GENERAL HOSPITAL	MS
NATCHEZ COMMUNITY HOSPITAL, INC,	MS
NATCHEZ REGIONAL MEDICAL CENTER	MS
PROMISE HOSPITAL OF VICKSBURG, INC.	MS
RENAISSANCE HOSPITAL GROVES	TX
SOUTHERN EYE SURGERY CENTER	MS
SOUTHWEST MISSISSIPPI REGIONAL MED. CTR	MS
SURGICARE OF JACKSON, LTD	MS
VICKSBURG HEALTHCARE, LLC,	MS
WALTHALL COUNTY GENERAL HOSPITAL	MS
M. D. ANDERSON CANCER CENTER	TX
ST. JUDES CHILDRENS RESEARCH HOSPITAL	TN