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

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

HEALTH MAINTENANCE ORGANIZATION PLAN (HMO)

AND

PREFERRED PROVIDER ORGANIZATION (PPO)
AND

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)
WITH HEALTH SAVINGS ACCOUNT (HSA)

AND

LACHIP AFFORDABLE PLAN (LACHIP)

ISSUED
APRIL 30, 2012

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SECTION I

GENERAL INFORMATION, INSTRUCTIONS OF PROPOSAL FORMAT/CONTENT AND REQUIREMENTS

GENERAL INFORMATION:

A. Introduction/Purpose

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

Health Maintenance Organization (HMO) Plan
Preferred Provider Organization (PPO) Plan
High Deductible Health Plan (HDHP) with Health Savings Account (HSA)
LaCHIP Affordable Health Plan (LaCHIP)

- The HMO Plan of Benefits is currently administered by the following entity:

  Blue Cross Blue Shield of Louisiana

- The PPO Plan of Benefits is currently administered by the following entity:

  Office of Group Benefits, State of Louisiana

- The HDHP-HSA Plan of Benefits (including prescription drug services) is currently administered by the following entity:

  UnitedHealthcare

The services to be provided will also include the following:

- Administration of the LaCHIP Plan of Benefits - currently administered by the following entity:

  Office of Group Benefits, State of Louisiana

  The LaCHIP Plan of Benefits is an expansion of the children's health insurance program available to uninsured Louisiana children up to the age of 19 whose families have an annual income up to 250 percent of the Federal Poverty Level (FPL), for which OGB provides administrative services pursuant to an interagency agreement with the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing.

- Mental Health and Substance Abuse (MHSA) Services - currently provided by the following entity:

  ValueOptions

- Disease Management Services - currently provided by the following entity:

  Nurtur Health

Note: OGB reserves the right to reject any and all Proposals. Proposers must offer a nationwide provider network for all services sought by this NIC.

B. General Information

The State of Louisiana through OGB is authorized 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.

OGB is seeking a contract with 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 requirements as delineated in Requirements Section below.

C. GB Information Technology

Desktop:	Dell workstations running Windows XP
LAN:	10/100/1000 Ethernet using Cisco switches
Servers:	Windows servers, AIX UNIX servers, and LINUX servers
WAN:	VPN Tunnel 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:	
FileNet:	Oracle-based imaging and document management system

OGB uses Oracle databases as its standard.

OGB uses Imprivata - Bio-login, single-sign-on and centralized security system.

D. Term of Contract

The initial term of the contract will begin on January 1, 2013 through December 31, 2013 with an option to renew for up to two additional one-year terms, exercisable by OGB.

E. Standard Contract Provisions

See Exhibit 9 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 to be considered by OGB. 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

The maximum contribution of the State for enrollees in any OGB plan will be the amount contributed by the State for the PPO enrollees. See Exhibit 8 for OGB current 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. Eligibility

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

See OGB Contract, Exhibit 9 for OGB Eligibility Information and Requirements.

H. Plan of Benefits Summaries

See Exhibit 1-1 for the HMO Plan of Benefits
See Exhibit 2-1 for the PPO Plan of Benefits
See Exhibit 3-1 for the HDHP w/HSA Plan of Benefits
See Exhibit 3-3 for the HSA Plan of Benefits
See Exhibit 4-1 for the LaCHIP Plan of Benefits

I. 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, copayments, coinsurances and deductibles, 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. Directions to access an online directory of providers, which includes all physicians, hospitals and specialty facilities. Hard copies of provider directories and certificates of coverage must be available upon request.

3. Each plan participant shall receive one identification card for individual coverage or two cards for all other classes of coverage. Additional cards for family members shall be provided upon request and at no additional charge to OGB or the member.

4. Summary of Benefits and Coverage and Uniform Glossary:
   Prepare and distribute for each plan the Summary of Benefits and Coverage (SBC) and Uniform Glossary to plan participants and beneficiaries as required by the federal Affordable Care Act (ACA) and/or state law and/or rules and regulations promulgated pursuant thereto. Provide printed SBC documents to OGB for distribution to eligible but not enrolled employees.

5. ID cards shall be made of durable plastic material.

J. Plan Member Communication Materials, Advertisements and Marketing Materials

The Contractor shall submit copies of all plan member communications and promotional materials to OGB. All such materials shall be approved in writing by OGB prior to their use in promoting the health plans to eligible enrollees.

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

K. Grievance Procedure

Provide a grievance and appeals process encompassing all requirements for internal claims and appeals and external review under the federal Affordable Care Act (ACA) and/or state law and/or rules and regulations promulgated pursuant thereto. Appeal to OGB will remain an option for plan participants after all required grievances, appeals and external reviews have been exhausted.

The following reports must be submitted to the OGB CEO:

1. Monthly, quarterly, and annual grievances, appeals and external reviews;
2. Monthly, quarterly, and annual reports on SBC distribution; and
3. Monthly, quarterly and annual reports on anti-fraud activities.

L. Contractor Administrative Contact

The Contractor must designate at least one individual and at least one back-up staff member who will be responsible for coordinating all relevant administrative issues with OGB. This individual and their back-up must be approved by 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.

M. 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:

    a. employees to join a Plan;
    b. members to change coverage or;
    c. the addition of eligible dependents without regard to age, sex, or health condition.

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

3. OGB will schedule all enrollment meetings and will advise Contractor of the enrollment meeting logistics.

4. The Contractor shall provide sufficient knowledgeable personnel to attend scheduled informational and enrollment meetings during the initial and any other Annual Enrollment meetings.

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

6. All paper eligibility documents shall be processed at OGB's 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 OGB.

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

N. 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 9 for specific information regarding data information and for the 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.

O. Implementation

Provide an implementation work plan to outline all key steps for implementation. Please use a GANTT chart or similar tool to indicate the number of person-hours allocated to each task and the estimated resources, from the vendor and OGB, needed for each task.

Please provide the number of implementations that the assigned implementation manager handled for the previous 36 months and the size of each account.

INSTRUCTIONS OF PROPOSAL FORMAT / CONTENT

A. Instructions on Proposal Format

All Proposals must be prepared in accordance with the provisions of this NIC. Proposer must agree to meet all requirements as delineated in the Requirements Section below.

Proposers should respond thoroughly, clearly and concisely to all of the questions set forth in the NIC. Answers should specifically address current capabilities.

1. Submit an original (clearly marked "original"), a redacted copy, and ten (10) copies of a completed, numbered proposal placing each in a three-ring binder. Please include a copy of the proposal response in CD format with your "original" version.

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: (include in 3 ring binder)

   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.

Tab 1 - Confirmation of Cost Requirements
Section I

Tab 2 - Confirmation of Program Requirements
Section I

Tab 3 - Audited Financial Statements
Section 1

Tab 4 - Membership Satisfaction Survey
Section I

Tab 5 - Management Reports
Section I

Tab 6 - SAS-70/SSAE-16 Type II Audit Report
Section I

Tab 7 - HMO/PPO/LACHIP – Requirements/Questionnaire
Section III

Tab 8 - HDHP w/ HSA – Requirements/Questionnaire
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Tab 9 - Disease Management – Requirements/Questionnaire
Section VII

Tab 10 - Proposer Information
Section IX

Tab 11 - Mandatory Signature Page
Section X

Tab 12 - Administrative Fee Quotation Form
Section XI

Tab 13 - Provider Network – Hard Copy List and CD
Section III and Appendix A-11

Tab 14 - Re-Pricing Claims CD (Health Plans/MHSA)
Appendix A-1

Tab 15 - Disease Management CD – Savings Methodology
Appendix A-6

4. Answer questions directly. Where you cannot 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.

B. Ownership, Public Release and Costs of Proposals

1. All proposals submitted in response to this NIC become the property of OGB 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. OGB 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, OGB 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 OGB 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. OGB 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.

OGB reserves the right to make any proposal, including proprietary information contained therein, available to its primary consultant, personnel of the Office of the Governor, Division of Administration, Office of Contractual Review, or other state agencies or organizations for the purpose of assisting OGB in its evaluation of the proposal. OGB 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 Office of Group Benefits (OGB) 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.

REQUIREMENTS:

A. Cost Requirements

1. Commissions or finder's fees are **not payable** under this contract. Do you acknowledge that no commission or finder's fees of any type will be payable by you with 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 Plans must be included in your cost quotation. This communication material shall be subject to OGB advance approval. The Contractor will be responsible for issuing I.D. cards sufficient to ensure members access to all services provided, and any replacement cards directly to plan members. Cost associated with the above will not be separately reimbursed.

   Confirm that the above provisions are reflected in your cost quotation.

3. All services described in this NIC, including all necessary reports and any start-up costs must be included in your cost quotation. Furthermore, your cost quotation must take into account your expenses associated with attendance at all required meetings in Baton Rouge with the Board or its Committees and with 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.

   Confirm that the above provisions are reflected in your cost quotation.

4. The proposed administrative fees to be paid during the term of the Contract must include the following services:

a. After termination of the contract, Contractor will administer run out claims for a period of one year for all plans
b. Contractor will administer PPO run out claims for the prior year (1/1/012 – 12/31/2012) until termination of contract.

Confirm that the above services are reflected in your quoted administrative fees.

B. Program Requirements

To be eligible for consideration, a Proposer must attest to the following requirements and provide documentation, where indicated.

1. Confirm that your organization is in good standing with the Louisiana Department of Insurance.

2. Confirm that your organization is able to provide all services sought pursuant to this NIC.

3. Do you have a minimum of three (3) years of operational experience in providing nationwide health coverage services, immediately prior to the date proposals are due?

4. Do you agree to meet all of the criteria as explained in Statement E ("Standard Contract Provisions") of the General Information Section? If not, specifically and completely outline any deviations.

5. Do you agree to meet all of the criteria with regard to your OGB-designated staff members as explained in Statement L ("Contractor Administrative Contact") of the General Information Section?

6. Will a representative of your organization attend the Mandatory Proposer's Conference?

7. Do you agree to administer the Benefit Plans as outlined in this NIC, without exception?

8. Since subcontractors are subject to prior approval, do you acknowledge that any subcontractor 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?

9. Do you agree to meet all of the criteria pertaining to data and required reporting as explained in Statement N ("Reporting Requirements") of the General Information Section?

10. You must be able to provide an annual SAS-70/SSAE-16 Type II Audit Report each year of the contract term, as required by the Louisiana Legislative Auditor.

(Note: The State of Louisiana fiscal year is July 1 – June 30. The Louisiana Legislative Auditor requires that such report or reports covering the entire time that a contract is in effect during any fiscal year be submitted no later than September 30 following the end of the fiscal year.)

Confirm that you can provide this information no later than September 30 of each year.

11. You must currently be accepting HIPAA 837 electronic claims from clearinghouses and/or health care providers. Confirm.

12. You must currently have the system capability to generate electronic funds transfers (EFTs) to providers while generating the appropriate HIPAA 835 electronic remittance advice (ERA) to providers, clearinghouse and third parties. Does your current claims adjudication processing system have this capability?

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 OGB plan members. Does your current system have this capability?

C. Required Attachments to Proposal

Proposer must provide the following attachments to their Proposal:

1. Confirmation of Cost Requirements - Tab 1 of Proposal

Proposer must attest to each of the requirements outlined in Subsection A ("Cost Requirements") of the Requirements section of this NIC.

2. Confirmation of Program Requirements - Tab 2 of Proposal

Proposer must attest to each of the requirements outlined in Subsection B ("Program Requirements") of the Requirements section of this NIC.

3. Audited Financial Statements - Tab 3 of Proposal

Please provide a copy of your audited financial statements for your most recent two (2) fiscal years that include your entire Louisiana operation. If you are an insurer or HMO, you must also submit your two (2) most recent Annual Statements filed with the Louisiana Department of Insurance.

4. Membership Satisfaction Survey – Tab 4 of Proposal

Please provide 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.

5. **Management Reports – Tab 5 of Proposal**

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

6. **SAS-70/SSAE-16 Type II Audit Report – Tab 6 of Proposal**

   Please provide a copy of your current SAS-70/SSAE-16 Type II Audit Report or successor reports.

7. **HMO/PPO/LACHIP – Requirements/Questionnaire – Tab 7 of Proposal**

8. **HDHP – Requirements/Questionnaire – Tab 8 of Proposal**

9. **Disease Management – Requirements/Questionnaire – Tab 9 of Proposal**

10. **Proposer Information – Tab 10 of Proposal**

11. **Mandatory Signature Page – Tab 11 of Proposal**

12. **Administrative Fee Quotation Form – Tab 12 of Proposal**

13. **Provider Network – Hard Copy List and CD – Tab 13 of Proposal**

14. **Repricing Claims CD (Health Plans/MHSA) – Tab 14 of Proposal**

15. **Disease Management CD – Savings – Tab 15 of Proposal**

SECTION II

SCHEDULE OF EVENTS

A. Timeline

NIC Issued - Public Notice by Advertising in the Official Journal of the State/Posted OGB Website/Posted to LAPAC	Monday, April 30, 2012
NIC Mailed or Available to Prospective Proposers Posted to OGB Website; Posted to LAPAC	Monday, April 30, 2012
Deadline to Notify OGB of Interest to Submit a Proposal (MANDATORY)	Monday, May 7, 2012
Electronic Data Sent to Interested Proposers	Wednesday, May 9, 2012
Deadline to Receive Written Questions	Tuesday, May 15, 2012
Response to Written Questions	Friday, May 18, 2012
Proposer Conference- Attendance in Person (MANDATORY)	Tuesday, May 22, 2012
Deadline to Receive Additional Written Questions	Thursday, May 24, 2012
Response to Additional Written Questions	Tuesday, May 29, 2012
Proposals Due to OGB	Wednesday, June 6, 2012
Finalist's Interviews/Site Visits	TBD
Probable Selection and Notification of Award	TBD
Contract Effective Date	TBD

NOTE: OGB reserves the right to deviate from this schedule.

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

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

Chief Executive Officer
Office of Group Benefits

Delivery:
7389 Florida Blvd., Ste. 400
Baton Rouge, LA 70806

Mail:
Post Office Box 44036
Baton Rouge, LA 70804

Fax: (225) 922-0282

E-Mail: Patty.Rahl@la.gov

C. Written Questions

Written questions regarding the NIC are to be submitted to and received on or before 4:00 p.m., Central Time (CT) on the date listed in the Schedule of Events. Written questions should be directed to the address listed above (Subsection B).

D. Mandatory - Proposers Conference

The Proposers Conference will be held at OGB at 10:00 a.m. at the following location:

Office of Group Benefits
7389 Florida Blvd., Ste. 400
Baton Rouge, LA. 70806

A representative of your organization must participate in person at the Mandatory Proposers Conference scheduled for 10:00 a.m., Central Time on the date listed in the Schedule of Events. OGB staff will be available to discuss the proposal specifications with you and answer any questions you may have with regard to submitted questions.

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

The original proposal must be signed by an authorized representative of your firm/organization and delivered, together with the required number of copies, between the hours of 8:00 a.m. and 4:00 p.m. Central Time (CT) on or before the date listed in the Schedule of Events to this address:

Office of Group Benefits
7389 Florida Blvd., Ste. 400
Baton Rouge, LA. 70806

SECTION III

HMO, PPO, LACHIP AFFORDABLE PLANS ADMINISTRATIVE SERVICES REQUIREMENTS AND QUESTIONNAIRE

A. Plan of Benefits

Through this NIC, OGB seeks to contract with a third party administrator, insurer, or health maintenance organization for administrative services to administer a self-insured HMO, a self-insured PPO Plan, a self-insured High Deductible Health Plan with Health Savings Account and the LaCHIP Affordable Health Plan. Proposal must be based on a nationwide network for all services listed below.

Services must 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. Customer Service and Support;
6. Mental Health/Substance Abuse (MHSA)
7. Disease Management (DM)

B. Requirements

1. Contractor must be capable of providing all services and benefits set forth in the Plan of Benefits (Exhibits 1-4).

2. List of Network Providers – Tab 13 of Proposal

Provide both hard copy and electronic lists of network providers who will accept OGB members, with name and federal tax ID#, including but not limited to:

Participating hospitals, including, but not limited to: acute care, tertiary care and pediatric facilities.

Participating Primary Care Physicians: licensed medical doctors practicing in the areas of Family Practice, General Practice, Internal Medicine, Pediatrics and OBGYN.

Participating Physicians, listed by specialty, 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.

Participating types of MHSA providers: Psychiatrists, Addictionologists (non-psych), Psychologists, Developmental Behavioral Pediatricians, Psychoanalysts, Master Level Psychologists, Social Workers, Advanced Practice Nurse (Clinical Nurse Specialists or Nurse Practitioner), Physician Assistants, Professional Counselors/MH Counselors, Marriage and Family Therapists, Pastoral Counselors, Alcohol and Drug Counselors, Certified Behavioral Analysts, Certified Assistant/Associate Behavioral Assistant, EAP Counselor, Disability Assessment Specialists, Disability Treatment Specialists, and Fitness Duty Assessor.

Hospital-based physician services – You must also complete and submit electronically the spreadsheet entitled "Hospital-Based Physician Template.xlsx" (to be provided on CD), as follows:

- For each facility listed in the spreadsheet, indicate the current participating/non-participating status of the facility in your proposed network; and
- In the appropriate columns, list the tax identification number (TIN) for each of your current participating providers of pathology, anesthesiology, radiology, and emergency medicine services at each listed facility.

NOTE: All provider lists (both hard copy and electronic) submitted in Tab13 (hospitals, primary care physicians, specialty physicians, MHSA providers and hospital-based physicians) must include provider names and federal TINs.

C. Questionnaire

1. Will wellness services be included in your proposed program? If so, please describe.

2. Please describe other educational services offered in your fee quote.

3. Does your organization provide to its membership the ability to interactively (via website or otherwise) compare physicians and/or facilities on the basis of quality and cost? If so, explain fully.

4. What is your organization's current monthly claims volume? What percentage of these claims is received electronically? What percentage is electronically auto-adjudicated upon initial submission?

5. From what location will claims be paid?

6. From what location will customer service calls and correspondence be answered?

7. How many offices does your organization have in Louisiana which will be available to service OGB's members?

8. Does your organization subcontract any services related to the administration of the medical plan? If so, identify subcontractor(s) and the services provided.

9. To what extent will OGB be able to customize the online materials and website your firm provides?

SECTION IV

HDHP/HSA
ADMINISTRATIVE SERVICES AND QUESTIONNAIRE

A. HDHP including prescription drug services and HSA Account Capabilities

1. Please provide the following enrollment information on your 3 largest plans with HSA offerings:

Date	# of Employer Groups	# of Eligible Employees	# of Contracts
1/1/2010			
1/1/2011			
1/1/2012			
Additional comments:			

2. What is the membership in your single largest HSA plan?

3. How many plans do you have with greater than 3,000 members enrolled?

4. Do you administer HDHP/HSA programs for any State plans?

5. What are your target developments and priorities for HSA administration improvements in 2013 as well as future functionality improvements for 2014 and 2015?

6. Identify roles of your HSA partners. Also, please provide a high level overview of:

   The HSA account set up and funding process you propose. Specifically, can you automatically establish an HSA for members and then follow up to complete the verification process? Can a member sign up all online or is a wet signature required with your solution?

7. If your organization has been involved in a merger with or acquisition of an HDHP organization within the past three years, specify when the merger took effect, and how you have assimilated HDHP claims and customer service operations, account management and systems into your organization.

8. If you have or will be migrating HDHP clients from one claims system and/or operation into another claims system and/or operation, provide a high level description of the migration plan, including information on the claims and customer service operations, systems, number of clients transitioned or to be transitioned, and transition dates (actual or targeted).

9. Please provide the following information on your HDHP systems:

   - Specify the claims processing system platform that will be used to process HSA medical plan claims and account funding.
   - Will a single integrated system platform be used to process medical claims and administer HSA account funding? If not, briefly describe systems used for claims processing vs. account funding, and interface and timing between claims system and account funding system. Also, please provide a workflow chart.
   - What is the origin of the claims processing system (e.g. specially built to handle HDHP account based plan administration, a traditional medical claim processing system that was adapted to handle HDHP plans, or FSA system modified to handle HDHP)?
   - Does your HDHP claims processing system provide a single integrated explanation of benefits (EOB) statement for medical and pharmacy claims and account funding? Does your HDHP claims processing system provide a single integrated monthly, quarterly or annual member statement for medical and pharmacy claims and account funding? Please describe the mailings your HDHP claims processing system provides, including but checks from different sources for one service provided.

10. Are there specially designated claim–members in an HDHP, or are all claims processors and CSRs for this organization handling HDHP programs? Provide details on your proposed staffing for OGB.

11. Do the same CSRs handle questions about the insurance benefits as handle questions about the accounts in all cases? If not, please specify what circumstances would require separate representatives, the transfer and inquiry information handoff process, and the resolution and satisfaction tracking process.

12. Are available HSA funds automatically applied against pharmacy claims at the point of service and against medical claims after adjudication, or are there additional steps required to use HSA funds? Please describe processes.

13. How can members determine:

    - How much of their annual deductible has been satisfied?
    - How much of their annual out-of-pocket (OOP) maximum has been met?
    - What their current account balance is as well as see debit and credits from the account?
    - Are account transactions and insurance transactions displayed in one place online? If not in one place, are the transactions linked so members can see what claims the account funds have been applied against?
    - Are HDHP account balances for HSAs available online with a single sign-on in a single integrated portal? If not, is additional login/verification information required? Is there a link provided to the account information in a separate format/environment?

14. Assume that for an individual plan member, an HSA plan has:

    - $700 HSA fund,
    - $500 bridge deductible,
    - 90%/70% in-network (INN)/out-of-network (OON) coinsurance and
    - $1,500 member out-of-pocket (OOP) maximum.

    How does your standard EOB and monthly statement show the OOP maximum? Does it include just the account amount, just the bridge amount, or just the coinsurance maximum amount? What does the member see on all of their material? Is it consistent on all material (e.g. EOB, monthly statement, online member-specific balances, online general FAQs/information, CSR screens when answering member questions, etc.)?

15. Does your current claims system handle all aspects of HSA-qualifying HDHPs, as currently specified by the IRS, including:

Question	Confirmation
Is all cost sharing for covered expenses, including preventive pharmacy, subject to the plan's deductible and OOP limits?	
Aggregate family deductible?	
Imbedded individual deductible to family maximum, if single deductible is high enough to be HSA-compliant?	
Imbedded individual OOP max to family OOP max?	
Ability to administer family aggregate deductible with individual OOP maximum?	
Additional comments:	

16. Can HSA debit or stored value cards be offered? Advise on what is required vs. optional.

17. Describe your education/communication efforts to providers to help ensure that providers submit claims for adjudication and do not require upfront (non-discounted) payments from members. Do any of your provider contracts allow for up-front collection from members prior to adjudication? If so, please specify locations.

18. How do you communicate application of HSA funds vs. plan provisions (bridge deductible, coinsurance, OOP amounts) to members and providers? Please provide a sample EOB statement that illustrates communication of account funds vs. plan benefit provisions.

19. Does your EOB for HDHP plans:

EOB Components	Yes or No
Clearly show the status of the deductible, OOP and other inside plan limits?	

Clearly show the amount of charges that are the member's responsibility?	
Clearly show network savings?	
Clearly show HSA account payments at the claim line detail level and provide an overall summary?	
Clearly show deductible application at the claim line detail level and provide an overall summary?	
Show claim adjustment activity to members (online or hard copy) related to HDHP plan processing? If so, are adjustments clearly shown as such?	
Additional comments:	

20. Please also address the following HDHP EOB items:

    - Specify any known deficiencies of HDHP plan EOBs and specify your plans and timing for addressing these issues.
    - Please provide sample EOBs with standard messages for HDHP plans.
    - How quickly can EOBs be changed?
    - Do you provide plan members with the option to obtain or view EOBs online vs. receiving them via mail?
    - Do you automatically provide regular (monthly, quarterly or annual) statements of HDHP claims activity to members? Is the statement mailed, available online or both? Will all members receive a statement or is there some criteria for a statement being created/sent?
    - Provide samples of all monthly, quarterly and/or annual statements for HDHP medical plans, with all standard messaging.

B. HDHP Systems

1. Please specify the details of HDHP medical software system(s) you currently use for claims processing. Also, if your systems differ for traditional medical vs. HDHP medical, please describe those differences. If your systems differ for HDHP medical plan and HSA account processing, please specify any such differences.

2. What is the name of the system platform(s) (medical and account systems) used to process HDHP claims?

    - What is the genesis of the system(s)?
    - When was/were system(s) implemented and when was/were it/they last updated?
    - Specify how soon after plan changes are implemented, the system is updated to reflect those changes.

3. Can a claim with services funded by an HSA account and transitional plan benefits (bridge deductible and coinsurance) be processed on one claim transaction? If there are exceptions, describe system handling.

4. What percentage of HDHP medical plan claims auto-adjudicate without requiring handling by a claims examiner after claims are initially input via electronic feed or data entry? How does this level compare to traditional medical plans?

5. In the *initial* approach of promoting/marketing account-based plans during enrollment, members need to see the advantage of these accounts, build the skills and confidence to understand the accounts and then have good intuitive tools to let them really understand how the financial picture will look for them. Describe the communication approach (tools, messages, timing, channels, etc.) you would use for OBG to help them at this time.

6. In an *ongoing* approach, after enrollment, members begin to take control of their care, make consumerist decisions and see how their accounts are working. Describe the communication approach (tools, messages, timing, channels, etc.) you would use for OGB to help them at this time.

SECTION V

MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATIVE SERVICES

Contractor will provide a Managed Mental Health and Substance Abuse Program for OGB plan members that participate in its PPO, HMO, HDHP/HSA and LaCHIP Affordable Plan of benefits. This program should be integrated within the contractors medical program and be compliant with Mental Health Parity legislation. Program will include both in and out of network benefits.

Contractor will be responsible for providing and managing MHSA benefits through a network of providers and services to provide effective treatment and outcomes. In order for a plan member to receive full benefits, he or she must utilize the network for initial assessment and counseling as well as for ongoing MHSA treatment, both inpatient and outpatient. Contractor will provide all professional, technical, and administrative services in connection with the MHSA benefits, including, but not limited to, medical management, medical necessity reviews required under applicable laws and regulations, care management, claims adjudication and payment, customer services, and provider relations.

Contractor shall administer medically necessary managed mental health and substance abuse treatment services which are integrated within OGB's overall plan of benefits, subject to the deductibles, copayments, co-insurance, limitations, and exclusions set forth therein.

SECTION VI

DISEASE MANAGEMENT
ADMINISTRATIVE SERVICES/REQUIREMENTS AND QUESTIONNAIRE

Contractor will provide a Disease Management (DM) Program for OGB's self-insured health plans PPO, HMO, HDHP with HSA, and the LaCHIP Affordable Plan for the following diseases: Asthma, Diabetes, Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD) and Chronic Heart Failure (CHF).

The Disease Management Program will be an "Opt In" Model and does not apply to Medicare eligible members.

OGB participants who participate in OGB's Disease Management program are eligible to receive an incentive on their prescriptions and therefore the successful vendor must be able to coordinate this activity with the current PBM. Disease Management participants who complete at least one health coaching call every 90 days receive reduced co-pays on applicable prescription drugs.

Disease Management Incentive (participant must qualify for the incentive on a quarterly basis):

Co-Pay Brand - $15 per 31 day fill
Co-Pay Generic - $0 per 31 day fill

A. Qualifications and Experience

1. Please provide a **brief** summary of the background and history of your organization and the characteristics you believe differentiate your organization from your competitors in your ability to provide the services pursuant to this NIC and resulting contract.

2. Describe the role(s) and qualifications of individuals who will have direct interface with members. Please include qualifications for both clinical and non-clinical staff.

B. Disease Management Assumptions

1. Please indicate expected prevalence, participation, gross savings, and ROI. It is a requirement of this proposal that you complete the table below. **Please ensure you complete the last line of this table.**

Conditions Under Management	Estimated Lives with Condition Prevalence (#)	Estimated Number of Participants (#)	Total Cost of Diseased Participants ($)	Estimated Gross Dollar Savings ($)	Total Fees ($)	Estimated ROI	Fees Per Condition PPPM ($)
Asthma							
Congestive Heart Failure (CHF)							
Coronary Artery Disease (CAD)							
Chronic Obstructive Pulmonary Disease (COPD)							
Diabetes							
Total (Cumulative)							

2. Please complete the chart below with respect to your assumptions. Of the total participation, what percentage will be in high, moderate or low acuity programs? It is a requirement that you complete this table.

Conditions Under Management	Assumptions for Percentage Managed in High, Moderate and Low Acuity Programs		
	High	Moderate	Low
1) Asthma			
2) Congestive Heart Failure (CHF)			
3) Coronary Artery Disease (CAD)			
4) Chronic Obstructive Pulmonary Disease (COPD)			
5) Diabetes			

3. Please indicate the Disease Management components your organization is proposing for OGB in the base fee by checking the appropriate "included in summary pricing " or "additional fee" box next to the component listed below and provide the fee, all assumptions and partner/subcontractor where applicable. Also, under "Low Acuity," "Moderate Acuity," and "High Acuity," indicate what type(s) of participant outreach will be utilized in your proposed at risk targeted intervention programs (i.e., print, online, telephonic).

Incl. in Summary Pricing	Addtl Fee		Year 1 Fee and Unit Fee Basis	Estimated Number of Units/ Participants	Assumptions and Partner/ Subcontractor if Applicable
		Disease Management			
☐	☐	1) Low Acuity 2) ☐Mail-based 3) ☐Online 4) ☐Telephonic Outreach			
☐	☐	5) Moderate Acuity 6) ☐Mail-based 7) ☐Online 8) ☐Telephonic Outreach			
☐	☐	9) High Acuity 10) ☐Mail-based 11) ☐Online 12) ☐Telephonic Outreach			
☐	☐	13) Communication Strategy/ Campaign			
☐	☐	14) Total Population Standard Communication Materials			
☐	☐	15) Standard Communication Materials			
☐	☐	16) Total Population Customized Communication Materials			
☐	☐	17) Customized Communication Materials			
☐	☐	18) Standard Management Reports			
☐	☐	19) Customized Management Reports			
☐	☐	20) Ad Hoc Management Reports			
☐	☐	21) Online Set-up			
☐	☐	22) Online Maintenance			
☐	☐	23) Data Transfer – Inbound			
☐	☐	24) Data Transfer – Outbound			
☐	☐	25) Annual Predictive Modeling Report			
☐	☐	26) Other			

C. Functional Business Proposers' Questionnaire

1. Confirm which of the following programs or services are available through your organization, which services you are bidding on, and if your organization is the provider of these services.

Program or Service	Operational (List date it became operational)	In Development (List date it will become operational)	We are bidding on the following:	Delivery	List Sub-contractor/ Strategic Partner. Please describe your relationship if Strategic Partner.
Disease Management	☐	☐	☐	Internal Subcontracted Strategic partner	
Comprehensive Health Promotion Website	☐	☐	☐	Internal Subcontracted Strategic partner	
Member and Provider Communications	☐	☐	☐	Internal Subcontracted Strategic partner	
Incentive tracking and administration	☐	☐	☐	Internal Subcontracted Strategic partner	

2. Service approach: Provide program description for each of the following Disease Management Programs: (1) Cardiovascular (CAD, CHF); (2) Diabetes; (3) Pulmonary Diseases including COPD and Asthma.

3. What evidence-based clinical guidelines does your organization utilize for treatment decisions and developing a plan of care? If your guidelines are proprietary, please share how they were developed and the process and frequency of updates.

4. Please complete the following table by providing information for Disease Management services.

Program	Delivery	Accreditation (JCAHO, URAC and/or NCQA)
Asthma	Internally provided or Subcontracted to _____	N/A NCQA URAC JCAHO Other: _____
Congestive Heart Failure (CHF)	Internally provided or Subcontracted to _____	N/A NCQA URAC JCAHO Other: _____

Program	Delivery	Accreditation (JCAHO, URAC and/or NCQA)
Chronic Obstructive Pulmonary Disease (COPD)	Internally provided or Subcontracted to _____	N/A NCQA URAC JCAHO Other: _____
Coronary Artery Disease (CAD)	Internally provided or Subcontracted to _____	N/A NCQA URAC JCAHO Other: _____
Diabetes	Internally provided or Subcontracted to _____	N/A NCQA URAC JCAHO Other: _____

5. If you anticipate subcontracting any service or requirement of this Contract, please describe the services that will be subcontracted and how your firm will maintain quality oversight and guarantee performance standards.

6. Please describe how individuals are identified for Disease Management. Please provide the acuity levels your organization typically identifies in a client population and describe the criteria for acuity classification.

7. What type of activity would cause a member's stratification level to be modified? Be specific.

8. Please describe the data sources and information (health care utilization, health care claims and costs, co-morbid conditions, psychosocial factors, self-reported information, biometric and HRA information) used to identify and stratify program candidates.

9. How frequently is the data collected and refreshed (weekly, monthly, annually, real time as reported, per event, etc.)

10. Describe how your disease management program will integrate with other OGB programs?

    - Medical plan administration
    - Prescription Drug Program
    - Utilization management program
    - Mental health program

11. How are participants transitioned between programs? Please provide real life examples.

    Please attach any necessary flow charts or visual aids to clearly explain the level and type of integration between programs.

12. OGB would like to understand your organization's participation rates in Disease Management that you administer. Please complete the table below according to your Book of Business.

	Average rate of participation among all employer sizes	**Average rate of participation among large employers (>100,000 covered lives)**
Disease Management		

13. Does your Disease Management program use a team approach or a dedicated health coaching model?

14. How is clinical staff (disease managers) assigned to a particular participant (e.g., risk level, condition, geography)? At what point in the identification and program invitation process is clinical staff assigned to a particular participant (e.g., stratification, initial contact)?

15. OGB would like to understand the <u>delivery</u> of Disease Management education and outreach to program participants. Please complete the following table according to your standard program operation. If more than a three-tiered approach, please add additional risk levels.

Delivery	**Low Risk**	**Moderate Risk**	**High Risk**
Percent of program delivery that is mail-based			
Percent of program delivery that is online/electronic			
Percent of program delivery that is telephonic			
Percent of program delivery that is performed onsite			

16. Describe the frequency and type of outreach/educational support provided to program participants based on risk level. Please complete the table below according to standard program operation. Responses may include 1x per week, 4x per year, etc. as needed. If more than a three-tiered approach, please add additional risk levels.

Method	Low Risk	Moderate Risk	High Risk
Frequency of mail-based contact			
Frequency of electronic contact			
Frequency of telephonic contact			
Other			

17. OGB believes building patient-provider relationships is a key element of successful Disease Management. Please describe how your organization encourages the development of patient-provider relationships. Include in your discussion a description of resources and outreach to providers (patient statistic updates, outcomes of health coach/condition management calls, preventative guidelines, etc.). Please add rows to the table below to describe greater than three (3) communication pieces.

Education/Communication Piece – Name/Brief Description	Mode of Delivery	Frequency
[Name/Brief Description]	Mail-based E-mail Web-based Telephonic Print On site	One time Weekly Monthly As needed Other: _____
[Name/Brief Description]	Mail-based E-mail Web-based Telephonic Print On site	One time Weekly Monthly As needed Other: _____
[Name/Brief Description]	Mail-based E-mail Web-based Telephonic Print On site	One time Weekly Monthly As needed Other: _____

18. How do you track and report physician interaction events?

D. Communications

1. Please describe the options for customer-branded communication campaigns you would provide to OGB (print, online, on site, etc.). Please be specific as to what communication support you provide within your pricing [e.g., list annual deliverables (such as annual assessments), periodic deliverables (such as newsletters or e-

newsletters), meetings].

2. Please provide samples of communication materials you can provide for each product or component of the program(s) contained in your quote.

3. Please provide a sample communications plan for Year One of the programs. OGB would like weekly communication in months one and two after program launch and monthly thereafter. Please consider communications for new hires and special campaigns in your communications package and pricing.

E. Quality Assurance

1. With regards to call center management, please explain the infrastructure in place to support the monitoring and measurement of call center quality.

2. What are your key measures of quality?

3. How do you track, measure and report on key measures of quality? How do you use this information organizationally to improve care delivery, quality and efficiency?

4. What type of call monitoring do you use to monitor in-bound calls for speed of answer and hang ups?

5. What percent of staff calls are monitored/reviewed for quality and training purposes?

6. How are quality of care complaints handled?

7. What type of monitoring system do you have in place for tracking questions, complaints and issue resolution, and providing customer-specific results back to the customer?

8. Is there an automated mechanism to track issues/complaints/grievances to resolution?

9. What is the turnaround time for problem resolution?

10. Who is responsible for monitoring customer satisfaction?

11. Do you record calls? If so, what percentage of calls are recorded? How long are they retained?

F. Savings Methodology

1. Please describe your standard savings/ROI methodology (include definitions of all terms).

2. Describe any and all criteria a participant must achieve in order to be considered compliant and program eligible.

3. Please provide a blinded copy of a client report.

4. How often is a savings/ROI study performed for each client?

5. Please confirm your organization agrees to conduct a savings analysis using methodology guidelines outlined below. In addition, you may propose an alternative. If you do propose an alternative approach, please provide rationale for proposing this alternative.

   - Eligibility
     - Members categorized into Chronic and Non-Chronic members
     - Continuously enrolled in different populations for at least 6 months
   - Baseline costs
     - Service categories to be included in the claims analysis include inpatient hospital, emergency room, outpatient surgical, outpatient non-surgical, radiology, laboratory, professional office visits, professional other, prescription drugs.
     - Converted to per member per month
     - Propose trend methodology to be used from baseline to first year and subsequent years
   - Program year costs
     - Eligible member total medical and Rx claims for at least six months within the program year being measured
     - Converted to per member per month
   - Economic impact/ROI
     - Project chronic costs in baseline period to intervention period. Propose trend to us with justification for this trend
     - Compare trended chronic costs from baseline to actual chronic costs in the intervention period.
     - Difference between these costs represents the savings per chronic member.
   - ROI = Total chronic cost savings per member per month times chronic member months divided by the amount paid for disease management services.
   - 100% transparency included in savings analysis report

G. Required Evaluation and Savings Calculation

Evaluation of Three Year Savings

All proposals will be evaluated on their projected three year savings to the program. The vendor shall specifically and clearly state a projected cost savings to the OGB based on the following assumptions:

- Baseline medical and prescription paid claims data will be provided
- For the sake of these projections:

- Program year 1 is defined as 1/1/2013 – 12/31/2013
- Program year 2 is defined as 1/1/2014 – 12/31/2014
- Program year 3 is defined as 1/1/2015 – 12/31/2015

SECTION VII

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 ensure 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 at OGB's offices in Baton Rouge, Louisiana, 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 Proposer's understanding of 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.

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 both expected claims cost **(actuarially determined – Section III)** and the administrative services fee (Sections III, IV, V and VI) averaged over a maximum three year term.

2. Qualitative/Network Assessment (500 Points)

Assessment will be based on responses to the requirements and questions in Sections I, III, IV, V and VI of the NIC.

C. Cost Evaluation

The **maximum points** a finalist may receive is **1,000 points,** of which cost will account for 500 points. The maximum Cost Score for each of the allocated points will be awarded to the lowest cost.

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 VIII

PROPOSER INFORMATION
Tab 11 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 SERVICE including but not limited to Utilization Management, Mental Health and Substance Abuse, Disease Management.

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.

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 IX

MANDATORY SIGNATURE PAGE

Tab 12 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 X

ADMINISTRATIVE FEE AND FINANCIAL QUOTATION FORM
Tab 12 of Proposal

A. Administrative Fees

Proposer must provide a fixed monthly Administrative Fee to be paid to Proposer for administering the OGB Plans of Benefits.

Your fees must be all-inclusive of administrative expenses, travel, communication materials and any other requirement of this NIC.

The initial term of the contract will be January 1, 2013 through December 31, 2013 with an option to renew for up to two additional one-year terms, exercisable by OGB only.

Please complete the exhibits below for each of the indicated benefit plans.

Coverage: Medical (including MHSA and prescription drugs)
Benefit Plans: HMO & PPO (excluding HDHP/HSA)

Time Period	Per Employee Per Month (PEPM) Rates By Employee Type		
	Active	Retired w/out Medicare	Retired w/ Medicare
Jan 1, 2013 – Dec 31, 2013	$	$	$
Jan 1, 2014 – Dec 31, 2014	$	$	$
Jan 1, 2015 – Dec 31, 2015	$	$	$

Note: The Administrative Fees to be paid during the term of the Contract include services to be provided by the Contractor after termination of the contract for run out claims for a period of one year.

The Administrative Fees to be paid during the term of the Contract include services for prior year PPO run out claims.

Coverage: Medical (including MHSA and prescription drugs)
Benefit Plans: HDHP/HSA

Time Period	Per Employee Per Month (PEPM) Rates By Employee Type		
	Active	Retired w/out Medicare	Retired w/ Medicare
Jan 1, 2013 – Dec 31, 2013	$	n/a	n/a
Jan 1, 2014 – Dec 31, 2014	$	n/a	n/a
Jan 1, 2015 – Dec 31, 2015	$	n/a	n/a

Note: The Administrative Fees to be paid during the term of the Contract include services to be provided by the Contractor after termination of the contract for run out claims for a period of one year.

Coverage: Disease Management

Benefit Plans: HMO, PPO and HDHP/HSA

Time Period	Per Participant Per Month (PPPM) Rates By Employee Type		
	Active	Retired w/out Medicare	Retired w/ Medicare
Jan 1, 2013 – Dec 31, 2013	$	$	n/a
Jan 1, 2014 – Dec 31, 2014	$	$	n/a
Jan 1, 2015 – Dec 31, 2015	$	$	n/a

"Participant" as used herein is an eligible employee or eligible dependent who is identified as having one or more of the five conditions specified in Section VI and who agrees to engage in a condition management program provided by Contractor, completes an initial assessment with a nurse health coach, engages in one or more telephonic interactions with a nurse health coach and continues to engage in telephonic interactions with a nurse health coach at least once every 90 days.

B. Claims Re-pricing

Each Proposer will receive a CD containing claims incurred by OGB members. There will be separate CDs for medical, mental health/substance abuse and disease management. For the medical, mental health/substance abuse file, EVERY claim must be re-priced and sent back to OGB on a CD. For disease management, the claims file will be used to determine the number of participants in the proposed disease management program and the potential cost savings.

MEDICAL:

The claim record must be expanded to include an indicator that identifies in-network and out-of-network providers based on your CURRENT network.

Allowed amounts must be determined, using your current provider contractual arrangements, as follows:

- If a participating provider: allowed amount = applicable current contracted amount;
- If non-participating provider, but you have an existing contractual discount arrangement that will protect the plan participant from balance billing, allowed amount = contractual discount arrangement;
- If non-participating provider and you have no existing contractual discount arrangement that will protect the plan participant from balance billing, allowed amount = billed charge;
- Your response should include **no** $0.00 allowed amount at the claim level.

All of the above re-priced claims must be submitted with your proposal. Your initial submission must be complete.

Analysis and evaluation will be based upon allowed amount per claim, not per claim line, where claim is identified by "Claim Header ID."

SECTION XI

EXHIBITS

EXHIBIT 1-1 HMO Plan of Benefits
EXHIBIT 1-2 HMO Summary of Benefits

EXHIBIT 2-1 PPO Plan of Benefits
EXHIBIT 2-2 PPO Summary of Benefits

EXHIBIT 3-1 HDHP w/HSA Plan of Benefits
EXHIBIT 3-2 HDHP w/HSA Summary of Benefits
EXHIBIT 3-3 HSA Plan of Benefits

EXHIBIT 4-1 LaCHIP Summary of Benefits

EXHIBIT 5 Enrollment Information by Plan

EXHIBIT 6 Enrollment Form

EXHIBIT 7 Statewide Regions by City and Zip Codes

EXHIBIT 8 OGB Official Current Premium Rates

EXHIBIT 9 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 1-1

HMO PLAN OF BENEFITS

The HMO Plan of Benefits will be the same as those currently provided by Blue Cross Blue Shield of Louisiana. A copy of that Plan of Benefits can be attained from The Office of Group Benefits website: www.groupbenefits.org.

- On the OGB Home Page, under "Welcome to Group Benefits," click "A Visitor", then click "Health Plans", then click the appropriate plan link.

If you experience difficulty in this process please e-mail Patty.Rahl@la.gov.

EXHIBIT 1-2

OGB HMO SUMMARY OF BENEFITS

COVERED BENEFIT: IN-NETWORK	**HMO Plan *(nationwide)*** ***Administered by Blue Cross and Blue Shield of La.***
Lifetime Maximum Benefit (all eligible expenses)	Unlimited
Plan Year Deductible Employees & Dependents	None
Maximum Out-Pocket Expense In-Network	$1000 per person; $3000 per family
Hospital Services (inpatient)	$100 per day [2] $300 maximum per admission
Surgeon, Anesthesia, Lab, X-rays & Injections	$0 co-payment
Hospital Emergency Room (facility only)	$100 co-payment; waived if admitted (hospital co-payment applies) [2]
Ambulatory Surgical Facilities	$100 co-payment
Physician Visits	$15 PCP/$25 specialist (no referral required)
Maternity (physician only)	$90 co-payment
MRI/CAT Scan	$50 co-payment [2]
Sonograms	$25 co-payment
Chemical/Radiation Therapy	$15 co-payment
Pre-Admission Testing	$0 co-payment
Dialysis	$0 co-payment
Cardiac Rehabilitation Therapy	$15/$25 co-payment
Physical and Occupational Therapy	$15 co-payment
Speech Therapy [2]	$15 co-payment
Oral Surgery *(Refer to plan document)*	$25 co-payment
Routine Pap Test	$0 co-payment [3]
Routine Mammogram	$0 co-payment [3]
Routine PSA Screening	$0 co-payment [3]
Durable Medical Equipment	Member pays 20% of contracted rate [2]
Home Health Care [2]	$0 co-payment Limited to 150 visits per plan year
Hospice Care [2]	$0 co-payment
Preventive Care (Wellness) (See OGB website for list of preventive care services)	$0 co-payment
Annual Eye Exam	$15/$25 co-payment [3]
Prescription Drug Benefit In-Network (Retail)	Member pays 50%; max $50 per 31-day fill; after $1,200 p person per plan year, co-payment $15 brand, $0 generic **NOTE: Plan member who chooses brand-name drug fc which approved generic version is available pays cost difference between brand-name drug & generic drug, *plus* 50 percent co-pay for brand-name drug; cost difference does not apply to $1,200 out-of-pocket max.** *(Administered by Catalyst Rx)*
Mail Order Prescription Drug Program	Same as above
Mental Health/Substance Abuse - Inpatient [2]	$100 co-payment per day; $300 max per admit *(Administered by ValueOptions)*
Mental Health/Substance Abuse - Outpatient	$15 office visit co-payment *(Administered by ValueOptions)*
COVERED BENEFIT: OUT-OF-NETWORK	
Member resides in Louisiana	Member pays 30% of fee schedule [4] Separate $1,000 deductible
Member resides outside Louisiana	Member pays 30% of fee schedule [4] Separate $1,000 deductible

[1] Subject to plan year deductible and/or co-insurance
[2] Pre-authorization required
[3] Age and/or time restrictions apply
[4] Member pays difference between billed amount and fee schedule
[5] Limited to 50 visits per year
[6] Limited to 26 visits per year
[7] Within 6 months of qualifying event
[8] Member pays any amount above $500 maximum
[9] Not applicable to hospital-based ancillary providers at in-network facilities. Provider can balance bill patient
[10] Occupational and Speech Therapy combined for maximum 20 visits per plan year
[11] Tier I and Tier II networks available. All medical benefits shown are for the Tier I network. Tier II network benefits require an additional 20% coinsurance.

EXHIBIT 2-1

PPO PLAN OF BENEFITS

The PPO Plan of Benefits will be the same as those currently provided by OGB. A copy of that Plan of Benefits can be attained from The Office of Group Benefits website: www.groupbenefits.org.

- On the OGB Home Page, under "Welcome to Group Benefits," click "A Visitor", then click "Health Plans", then click the appropriate plan link.

If you experience difficulty in this process please e-mail Patty.Rahl@la.gov.

EXHIBIT 2-2

OGB PPO SUMMARY OF BENEFITS

COVERED BENEFIT: IN-NETWORK	**PPO Plan *(statewide)*** ***Administered by OGB***
Lifetime Maximum Benefit (all eligible expenses)	Unlimited
Plan Year Deductible	$500 active; $300 retired
Employees & 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, 9]
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, 2]
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, 7]
Physical and Occupational Therapy	Member pays 10% of contracted rate [1, 5]
Speech Therapy [2]	Member pays 10% of contracted rate [1, 6]
Oral Surgery *(Refer to plan document)*	Member pays 0% of contracted rate
Routine Pap Test	Member pays 0% of contracted rate [3]
Routine Mammogram	Member pays 0% of contracted rate [3]
Routine PSA Screening	Member pays 0% of contracted rate [3]
Durable Medical Equipment	Member pays 10% of contracted rate [1]
Home Health Care [2]	Case management required Member pays 30% of negotiated rate [1]
Hospice Care [2]	Member pays 20% of negotiated rate
Preventive Care (Wellness)	Member pays 0% of contracted rate [3]
(See OGB website for list of preventive care services)	**$500 limit no longer applies**
Annual Eye Exam	Not covered
Prescription Drug Benefit In-Network (Retail)	Member pays 50%; max $50 per 31-day fill; after $1,200 per person per plan year, co-payment $15 brand, $0 generic **NOTE: Plan member who chooses brand-name drug for which approved generic version is available pays cost difference between brand-name drug & generic drug, *plus* 50 percent co-pay for brand-name drug; cost difference does not apply to $1,200 out-of-pocket max.** *(Administered by Catalyst Rx)*
Mail Order Prescription Drug Program	Same as above
Mental Health/Substance Abuse - Inpatient [2]	Member pays 10% of contracted rate [1] *(Administered by ValueOptions)*
Mental Health/Substance Abuse - Outpatient	Member pays 10% of contracted rate [1] *(Administered by ValueOptions)*
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/or co-insurance
[2] Pre-authorization required
[3] Age and/or time restrictions apply
[4] Member pays difference between billed amount and fee schedule
[5] Limited to 50 visits per year
[6] Limited to 26 visits per year
[7] Within 6 months of qualifying event
[8] Member pays any amount above $500 maximum
[9] Not applicable to hospital-based ancillary providers at in-network facilities. Provider can balance bill patient
[10] Occupational and Speech Therapy combined for maximum 20 visits per plan year
[11] Tier I and Tier II networks available. All medical benefits shown are for the Tier I network. Tier II network benefits require an additional 20% coinsurance.

EXHIBIT 3-1

HDHP w/HSA PLAN OF BENEFITS

The HDHP w/HSA Plan of Benefits will be the same as those currently provided by United Healthcare. A copy of that Plan of Benefits can be attained from The Office of Group Benefits website: www.groupbenefits.org.

- On the OGB Home Page, under "Welcome to Group Benefits," click "A Visitor", then click "Health Plans", then click the appropriate plan link.

If you experience difficulty in this process please e-mail Patty.Rahl@la.gov.

EXHIBIT 3-2

OGB HDHP w/HSA SUMMARY OF BENEFITS

COVERED BENEFIT: IN-NETWORK	CDHP-HSA *(nationwide)* ***Consumer Driven Health Plan with Health Savings Account***** ***Administered by UnitedHealthcare***
Lifetime Maximum Benefit (all eligible expenses)	Unlimited
Plan Year Deductible Employees & Dependents	Must meet deductible before co-insurance applies Employee - $1,250 Employee plus one (spouse or child) - $2,500 * Family - $3,000 *
Maximum Out-Pocket Expense In-Network	Employee - $3,250; including deductible Employee plus one (spouse or child) - $6,500; including deductible Family - $9,000 for 3 members; $11,000 for 4 members; $11,900 for 5 or more due to statutory maximum; including deductible
Hospital Services (inpatient)	Member pays 20% of contracted rate [1, 2, 9]
Surgeon, Anesthesia, Lab, X-rays & Injections	Member pays 20% of contracted rate [1, 2]
Hospital Emergency Room (facility only)	Member pays 20% of contracted rate [1, 2]
Ambulatory Surgical Facilities	Member pays 20% of contracted rate [1, 2]
Physician Visits	Member pays 20% of contracted rate [1]
Maternity (physician only)	Member pays 20% of contracted rate [1]
MRI/CAT Scan	Member pays 20% of contracted rate [1, 2]
Sonograms	Member pays 20% of contracted rate [1, 2]
Chemical/Radiation Therapy	Member pays 20% of contracted rate [1, 2]
Pre-Admission Testing	Member pays 20% of contracted rate [1, 2]
Dialysis	Member pays 20% of contracted rate [1, 2]
Cardiac Rehabilitation Therapy	Member pays 20% of contracted rate [1, 2, 7]
Physical and Occupational Therapy	Member pays 20% of contracted rate [1, 2, 5]
Speech Therapy [2]	Member pays 20% of contracted rate [1, 6]
Oral Surgery *(Refer to plan document)*	Member pays 20% of contracted rate [1, 2]
Routine Pap Test	Member pays 0%, deductible does not apply [3]
Routine Mammogram	Member pays 0%, deductible does not apply [3]
Routine PSA Screening	Member pays 0%, deductible does not apply [3]
Durable Medical Equipment	Member pays 20% of contracted rate [1, 2]
Home Health Care [2]	Member pays 20% of contracted rate [1]
Hospice Care [2]	Member pays 20% of contracted rate [1]
Preventive Care (Wellness) (See OGB website for list of preventive care services)	Member pays 0%, deductible does not apply [3]
Annual Eye Exam	Member pays 0%, deductible does not apply [3]
Prescription Drug Benefit In-Network (Retail)	Level 1 - Generic; 31-day supply; $10 co-payment [1] Level 2 - Preferred brand; 31-day supply; $25 co-payment [1] Level 3 - Non-preferred brand; 31-day supply; $50 co-payment [1] Level 4 - Specialty; 31-day supply; $50 co-payment [1] Maintenance drugs: 31-day supply; not subject to deductible; subject to applicable co-payment levels 1 through 4 above; refer to myuhc.com for Maintenance Medication List *(Administered by UHC's PrescriptionSolutions)*
Mail Order Prescription Drug Program	Level 1 - Generic; 90-day supply; $10 co-payment [1] Level 2 - Preferred Brand; 90-day supply; $25 co-payment [1] Level 3 - Non-preferred Brand; 90-day supply; $50 co-payment [1] Level 4 - Specialty; 90-day supply; $50 co-payment [1] Maintenance drugs: 90-day supply; not subject to deductible; subject to applicable co-payment levels 1 through 4 above; refer to myuhc.com for Maintenance Medication List *(Administered by UHC's PrescriptionSolutions)*
Mental Health/Substance Abuse - Inpatient [2]	Member pays 20% of contracted rate [1] *(Administered by OptumHealth)*
Mental Health/Substance Abuse - Outpatient	Member pays 20% of contracted rate [1] *(Administered by OptumHealth)*
COVERED BENEFIT: OUT-OF-NETWORK	
Member resides in Louisiana	Member pays 30% of fee schedule [1, 2, 4] Wellness benefits - Member pays 0% of contracted rate; deductible does not apply [3, 4]
Member resides outside Louisiana	Member pays 30% of fee schedule [1, 2, 4] Wellness benefits - Member pays 0% of contracted rate; deductible does not apply [3, 4]

[1] Subject to plan year deductible and/or co-insurance
[2] Pre-authorization required
[3] Age and/or time restrictions apply
[4] Member pays difference between billed amount and fee schedule
[5] Limited to 50 visits per year
[6] Limited to 26 visits per year
[7] Within 6 months of qualifying event
[8] Member pays any amount above $500 maximum
[9] Not applicable to hospital-based ancillary providers at in-network facilities. Provider can balance bill patient
[10] Occupational and Speech Therapy combined for maximum 20 visits per plan year
[11] Tier I and Tier II networks available. All medical benefits shown are for the Tier I network. Tier II network benefits require an additional 20% coinsurance.

EXHIBIT 3-3

HSA PLAN OF BENEFITS

HSA Plan of Benefits

	CD-HSA	
	In-Network	**Out-of-Network**
Medical		
Deductible		
Employee	$1,250	$1,250
Employee + 1	$2,500	$2,500
Family	$3,000	$3,000
Out-of-pocket maximum		
Employee	$2,000 + deductible	No Maximum
Employee + 1	$4,000 + deductible	No Maximum
Family	$6,000 + deductible (3 members), $8,000 + deductible (4 members), $8,900 + deductible (5 or more members)	No Maximum
Lifetime maximum benefit	Unlimited	Unlimited
Annual adult physical*	Member pays 0% of eligible expenses	Member pays 0% of eligible expenses subject to reasonable and customary
Well-child visits*	Member pays 0% of eligible expenses	Member pays 0% of eligible expenses subject to reasonable and customary
Mammogram*	Member pays 0% / deductible does not apply	Member pays 0% / deductible does not apply
PSA tests*	Member pays 0% deductible does not apply	Member pays 0% subject to reasonable and customary, deductible does not apply
PCP visit	Member pays 20% of the contracted rate after deductible has been met	Member pays 30% of reasonable and customary after deductible has been met
Specialist visit	Member pays 20% of contracted rate after deductible has been met	Member pays 30% of reasonable and customary after the deductible has been met
Urgent care visit	Member pays 20% of the contracted rate after the deductible has been met	Member pays 30% of reasonable and customary after the deductible has been met
Emergency room	Member pays 20% of contracted rate after the deductible has been met	Member pays 30% of reasonable and customary after the deductible has been met
Ambulance	Member pays 20% of contracted rate after the deductible has been met	Member pays 30% of reasonable and customary after the deductible has been met
Outpatient surgery†	Member pays 20% of contracted rate after the deductible has been met	Member pays 30% of reasonable and customary after the deductible has been met
Lab and X-ray	Member pays 20% of contracted rate after the deductible has been met	Member pays 30% of reasonable and customary after the deductible has been met
Hospital stay†	Member pays 20% of contracted rate after the deductible has been met	Member pays 30% of reasonable and customary after the deductible has been met
Mental health services†	Member pays 20% of contracted rate after the deductible has been met	Member pays 30% of reasonable and customary after the deductible has been met
Pharmacy	Retail (up to a 31-day supply) Generic $10 co-payment after deductible has been met Preferred Brand $25 co-payment after deductible has been met Non-Preferred Brand $50 co-payment after deductible has been met Specialty $50 co-payment after deductible has been met Mail Order (up to a 90-day supply) Generic $10 co-payment after deductible has been met Preferred Brand $25 co-payment after deductible has been met Non-Preferred Brand $50 co-payment after deductible has been met Specialty $50 co-payment after deductible has been met	Retail (up to a 31-day supply) Generic $10 co-payment after deductible has been met Preferred Brand $25 co-payment after deductible has been met Non-Preferred Brand $50 co-payment after deductible has been met Specialty $50 co-payment after deductible has been met Mail Order (up to a 90-day supply) Generic $10 co-payment after deductible has been met Preferred Brand $25 co-payment after deductible has been met Non-Preferred Brand $50 co-payment after deductible has been met Specialty $50 co-payment after deductible has been met
Maintenance Drugs **Maintenance Drugs not subject to the deductible** **www.myuhc.com for list**	Retail (up to a 31-day supply) Generic $10 co-payment Preferred Brand $25 co-payment Non-Preferred Brand $50 co-payment Specialty $50 co-payment Mail Order (up to a 90-day supply) Generic $10 co-payment Preferred Brand $25 co-payment Non-Preferred Brand $50 co-payment Specialty $50 co-payment	Retail (up to a 31-day supply) Generic $10 co-payment Preferred Brand $25 co-payment Non-Preferred Brand $50 co-payment Specialty $50 co-payment Mail Order (up to a 90-day supply) Generic $10 co-payment Preferred Brand $25 co-payment Non-Preferred Brand $50 co-payment Specialty $50 co-payment

† Prior authorization is required for this service

* Age and/or time restrictions apply

** Only certain Prescription Drugs are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on your ID card for more information.

This information is a brief, general description of your coverage, and is not a contract and does not replace your Summary of Benefits. For a complete list of your coverage, including exclusions and limitations relating to your coverage, please read your Summary of Benefits. If descriptions, percentages, and dollar amounts conflict with official benefit coverage documents, the official benefits coverage documents prevail.

Summary of exceptions and exclusions*

Procedures and services that are NOT covered under this Plan, include, but are not limited to:

- Abortion (elective, nontherapeutic)
- Administrative fees, interest, penalties, or sales tax
- Artificial organ implants, penile implants, transplantation of other than Homo sapiens (human) organs and any surgery and other treatment, services or supplies, related to such procedures, or to complications related to such procedures
- Charges for services rendered over the telephone from a Physician to a Covered Person
- Charges in excess of the UnitedHealthcare contracted amount for services, supplies, and treatment
- Convalescent, skilled nursing, sanitarium, custodial or rest care
- Cosmetic surgery (unless necessary for the immediate repair of a nonoccupational disease, accident or injury and then only on the specific part of the body directly affected)
- Diagnostic or treatment measures that are not recognized as generally accepted medical practice
- Foot care: Expenses incurred for shoes and related items similar to wedges, cookies and arch supports
- Genetic testing, except when determined to be Medically Necessary
- Hair plugs and/or transplants
- Hearing aids (including examination to determine necessity or fitting) Limited Benefits provided for Hearing aids for covered dependents under age 18. See plan document for full details
- Injuries sustained while in an aggressor role.
- Expenses incurred as a result of a covered persons commission or attempted commission of an illegal act
- Marriage counseling and/or family relations counseling, divorce counseling, parental counseling, job counseling and career counseling
- Maternity expenses incurred by any person other than the Employee or the Employer's legal spouse
- Personal convenience items, including admission and bedside kits, telephone, guest meals and beds, etc.

*Please refer to your Plan Document for a detailed list of exceptions and exclusions to the Plan, or contact your area customer service office for specific questions and information.

Summary of exceptions and exclusions

- Radial keratotomy laser surgery and any other procedures, services and supplies for the correction of refractive errors of the eyes
- Routine physical examinations or immunizations not listed under Eligible Expenses
- Services and supplies in connection with or related to gender dysphoria
- Services and supplies related to obesity, surgery for excess fat in any area of the body, resection of excess skin or fat following weight loss or pregnancy
- Services of a private-duty Registered Nurse (R.N.) or of a private-duty Licensed Practical Nurse (L.P.N.)
- Services rendered for remedial reading and recreational, visual, and behavioral modification therapy, biofeedback, Pain Rehabilitation Control and/or Therapy, and dietary or educational instruction for all illnesses, other than diabetes
- Sleep disorder testing unless performed at a facility accredited by the American Academy of Sleep Medicine. No benefits are provided for sleep studies conducted in a patient's home, nor for surgical treatment of sleep disorders, except following demonstrated failure of non-surgical treatment and only upon specific case-by-case approval by the Plan. Sleep studies conducted at sleep centers located within health care facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations are covered.
- Speech therapy (except when prescribed to restore loss of speech resulting from accidental injuries or structural or neurologic disease)
- Treatment for Temporomandibular Joint Dysfunction (TMJ), except as listed in the Plan Document under Eligible Expenses
- Transportation of surgeons or family members in connection with organ transplants
- Treatment, services or medication prescribed without charge or obligation to pay Vitamins and minerals, appetite suppressants, Dietary supplements, nutritional or parenteral therapy, topical Minoxidil, Retin-A (past age 26), amphetamines (other than for Attention Deficit Disorder or Narcolepsy)
- Worker's Compensation (any expenses covered by a worker's compensation program)

EXHIBIT 4-1

LaCHIP PLAN OF BENEFITS

The LaCHIP Plan of Benefits will be the same as those currently provided by OGB. A copy of that Plan of Benefits can be attained from the Office of Group Benefits website:

https://www.groupbenefits.org/ogb-images/eligibility_benefits/lachip_summary_plan.pdf

- On the OGB Home Page, click on LaCHIP Affordable Health Plan

If you experience difficulty in this process please e-mail Patty.Rahl@la.gov.

EXHIBIT 4-2

OGB LaCHIP SUMMARY OF BENEFITS

LaCHIP Affordable Plan
Level 1 Summary of Benefits

Lifetime Maximum Benefit (all eligible expenses)	Unlimited
COVERED BENEFITS: IN-NETWORK	
Medical Benefits: In-Network	
Deductible	None
Hospital Services (inpatient) [1]	Member pays 10% of contracted rate
Surgeon, Anesthesia, Lab, X-rays & Injections	Member pays 10% of contracted rate
Hospital Emergency Room (facility only)	Member pays 10% of contracted rate & $150 copay
Ambulatory Surgical Facilities	Member pays 10% of contracted rate
Physician Visits	Member pays 10% of contracted rate
MRI/CAT Scan	Member pays 10% of contracted rate
Sonograms	Member pays 10% of contracted rate
Chemical/Radiation Therapy	Member pays 10% of contracted rate
Pre-Admission Testing	Member pays 10% of contracted rate
Dialysis	Member pays 10% of contracted rate
Cardiac Rehabilitation Therapy [5]	Member pays 10% of contracted rate
Physical and Occupational Therapy [3]	Member pays 10% of contracted rate
Speech Therapy [1, 4]	Member pays 10% of contracted rate
Oral Surgery (impacted tooth removal only)	Member pays 0% of fee schedule
Routine Pap Test [2]	Member pays 0% of contracted rate
Durable Medical Equipment	Member pays 10% of contracted rate
Home Health Care [1]	Case management required Member pays 30% of negotiated rate
Hospice Care [1]	Case management required Member pays 30% of negotiated rate
Wellness Program	
Baby/Child (Routine exams, scheduled immunizations)	Member pays 0% of eligible expenses
Adult (Physical exam, lab, X-ray) [2]	Member pays 0% of eligible expenses
Prescription Drug Benefits: In-Network *Administered by Catalyst Rx*	Member pays 50%; maximum $50 per 30 day fill; after $1200 per person per plan year, co-payment $15 brand, $0 generic
Mental Health / Substance Abuse Benefits: In-Network *Administered by ValueOptions*	
Mental Health / Substance Abuse[1]	Member pays 10% of contracted rate
COVERED BENEFITS: OUT-OF-NETWORK	Member pays 30% of fee schedule

[1] *Pre-authorization required*
[2] *Age and/or time restrictions apply*
[3] *Limited to 50 visits per year*
[4] *Limited to 26 visits per year*
[5] *Within 6 months of qualifying event*

Level 0 Summary of Benefits

Benefits will be paid at 100% (without co-pays or co-insurance).

This chart is a summary of plan features. For details, refer to LaCHIP Affordable Plan Summary Plan Description. To determine actual member cost for services, contact physician or medical care provider.

OGB Customer Service (toll-free) 1-800-272-8451 or 1-800-259-6771 (TDD)
or 225-925-6625 or 225-925-6770 (TDD)

EXHIBIT 5

ENROLLMENT INFORMATION BY PLANS

STS0010

Enrollees with Health Coverage by Region

Effective Date: 3/1/2012

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
BLUE CROSS (ST)											
	2,581	14,521	2,463	8,899	6,923	3,371	27,274	11,080	5,526	5,154	87,792
Region	46.66%	66.75%	54.29%	66.06%	56.06%	47.88%	73.26%	54.82%	49.69%	33.19%	59.01%
Plan	2.94%	66.75%	2.81%	10.14%	7.89%	3.84%	31.07%	12.62%	6.29%	5.87%	100.00%
FMOP-LEV1 NOAN											
		12	9	9	13	1	16	7	10	7	84
Region		0.06%	0.20%	0.07%	0.11%	0.01%	0.04%	0.03%	0.09%	0.05%	0.06%
Plan		0.06%	10.71%	10.71%	15.48%	1.19%	19.05%	8.33%	11.90%	8.33%	100.00%
FMOP-LEV1 WANS											
	1	15	16	19	19	12	25	12	24	5	148
Region	0.02%	0.07%	0.35%	0.14%	0.15%	0.17%	0.07%	0.06%	0.22%	0.03%	0.10%
Plan	0.68%	0.07%	10.81%	12.84%	12.84%	8.11%	16.89%	8.11%	16.22%	3.38%	100.00%
FMOP-LEV2 NOAN											
		18	6	8	8	7	7	6	7	7	74
Region		0.08%	0.13%	0.06%	0.06%	0.10%	0.02%	0.03%	0.06%	0.05%	0.05%
Plan		0.08%	8.11%	10.81%	10.81%	9.46%	9.46%	8.11%	9.46%	9.46%	100.00%

STS0010

Enrollees with Health Coverage by Region

Effective Date: 3/1/2012

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
FMOP-LEV2 WINS											
		16	13	19	26	14	29	12	13	7	149
Region		0.07%	0.29%	0.14%	0.21%	0.20%	0.08%	0.06%	0.12%	0.05%	0.10%
Plan		0.07%	8.72%	12.75%	17.45%	9.40%	19.46%	8.05%	8.72%	4.70%	100.00%
HUMANA HMO 65											
		293	5	204	4	1	403	18	65		993
Region		1.35%	0.11%	1.51%	0.03%	0.01%	1.08%	0.09%	0.58%		0.67%
Plan		1.35%	0.50%	20.54%	0.40%	0.10%	40.58%	1.81%	6.55%		100.00%
HUMANA PPO 65											
	14	9	7	6	12	2	6	10	3	1	70
Region	0.25%	0.04%	0.15%	0.04%	0.10%	0.03%	0.02%	0.05%	0.03%	0.01%	0.05%
Plan	20.00%	0.04%	10.00%	8.57%	17.14%	2.86%	8.57%	14.29%	4.29%	1.43%	100.00%
LACHIP-COPAY											
	2	420	190	266	328	201	356	195	194	132	2,284
Region	0.04%	1.93%	4.19%	1.97%	2.66%	2.86%	0.96%	0.96%	1.74%	0.85%	1.54%
Plan	0.09%	1.93%	8.32%	11.65%	14.36%	8.80%	15.59%	8.54%	8.49%	5.78%	100.00%

STS0010

Enrollees with Health Coverage by Region

Effective Date: 3/1/2012

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
LACHIP-NO COPAY											
		3	1	2	2	2	2	4			16
Region		0.01%	0.02%	0.01%	0.02%	0.03%	0.01%	0.02%			0.01%
Plan		0.01%	6.25%	12.50%	12.50%	12.50%	12.50%	25.00%			100.00%
LSU Health S10K											
	35	266	37	37	53	16	590	25	352	13	1,424
Region	0.63%	1.22%	0.82%	0.27%	0.43%	0.23%	1.58%	0.12%	3.16%	0.08%	0.96%
Plan	2.46%	1.22%	2.60%	2.60%	3.72%	1.12%	41.43%	1.76%	24.72%	0.91%	100.00%
LSU Health S5K											
	474	1,854	568	748	1,048	308	4,162	401	2,030	379	11,972
Region	8.57%	8.52%	12.52%	5.55%	8.49%	4.38%	11.18%	1.98%	18.25%	2.44%	8.05%
Plan	3.96%	8.52%	4.74%	6.25%	8.75%	2.57%	34.76%	3.35%	16.96%	3.17%	100.00%
MCOP-RANGE 1											
		34	8	8	31	5	21	19	18	9	153
Region		0.16%	0.18%	0.06%	0.25%	0.07%	0.06%	0.09%	0.16%	0.06%	0.10%
Plan		0.16%	5.23%	5.23%	20.26%	3.27%	13.73%	12.42%	11.76%	5.88%	100.00%

STS0010

Enrollees with Health Coverage by Region

Effective Date: 3/1/2012

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
MCOP-RANGE 2											
		8	4	7	9	4	6	7	7	2	54
Region		0.04%	0.09%	0.05%	0.07%	0.06%	0.02%	0.03%	0.06%	0.01%	0.04%
Plan		0.04%	7.41%	12.96%	16.67%	7.41%	11.11%	12.96%	12.96%	3.70%	100.00%
MED HOME HMO PL											
	2						3	104	12	2,562	2,683
Region	0.04%						0.01%	0.51%	0.11%	16.50%	1.80%
Plan	0.07%						0.11%	3.88%	0.45%	95.49%	100.00%
OGB PPO											
	2,378	4,047	1,155	3,097	3,565	2,965	3,906	7,782	2,705	6,759	38,359
Region	42.99%	18.60%	25.46%	22.99%	28.87%	42.12%	10.49%	38.50%	24.32%	43.53%	25.78%
Plan	6.20%	18.60%	3.01%	8.07%	9.29%	7.73%	10.18%	20.29%	7.05%	17.62%	100.00%
PEOPLE'S-MEDADV											
		137	4	69			162				372
Region		0.63%	0.09%	0.51%			0.44%				0.25%
Plan		0.63%	1.08%	18.55%			43.55%				100.00%

STS0010

Enrollees with Health Coverage by Region

Effective Date: 3/1/2012

	REGIONS										
	00	01	02	03	04	05	06	07	08	09	Totals
UNIT CONS DRIVE											
	9	31	10	16	22	7	79	5	15	27	221
Region	0.16%	0.14%	0.22%	0.12%	0.18%	0.10%	0.21%	0.02%	0.13%	0.17%	0.15%
Plan	4.07%	0.14%	4.52%	7.24%	9.95%	3.17%	35.75%	2.26%	6.79%	12.22%	100.00%
UNITED PPO 65											
	33	6	6	1	27	1	18	6	3	4	105
Region	0.60%	0.03%	0.13%	0.01%	0.22%	0.01%	0.05%	0.03%	0.03%	0.03%	0.07%
Plan	31.43%	0.03%	5.71%	0.95%	25.71%	0.95%	17.14%	5.71%	2.86%	3.81%	100.00%
VANTAGE - HMO											
							56	34	23	123	236
Region							0.15%	0.17%	0.21%	0.79%	0.16%
Plan							23.73%	14.41%	9.75%	52.12%	100.00%
VANTAGE -MEDADV											
	2	64	35	56	260	123	110	485	115	338	1,588
Region	0.04%	0.29%	0.77%	0.42%	2.11%	1.75%	0.30%	2.40%	1.03%	2.18%	1.07%
Plan	0.13%	0.29%	2.20%	3.53%	16.37%	7.75%	6.93%	30.54%	7.24%	21.28%	100.00%

STS0010

Enrollees with Health Coverage by Region

Effective Date: 3/1/2012

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
Grand Total	5,531	21,754	4,587	13,471	12,350	7,040	37,231	20,212	11,122	15,529	148,777

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 6

ENROLLMENT FORM

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS
ENROLLMENT/CHANGE FORM

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

PURPOSE

☐ Waiver of Coverage ☐ Agency Transfer (Receiving Agency) ☐ New Enrollment ☐ Reinstate Coverage ☐ Re-enrollment - Previous Employment ☐ Retired 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 _____

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

HEALTH PLAN SELECTED (Write in health plan selection)

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/yyyy)	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

C.O.B.R.A.

☐ Prior P/T Terminated ☐ Divorced Spouse ☐ Dependent

_____ (Name of Original Member) _____ (Social Security Number)

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

RETIREE 100

☐ Yes ☐ No ☐ Employee Only ☐ Dependant Only ☐ Employee & 1 Dependant

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

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

Date of Last Salary Increase _____

Annual Salary _____

Face Life _____

WAIVER OF COVERAGE

I waive all coverage offered through the Office of Group Benefits. I understand that if I enroll at a future date, the coverage I receive will be subject to evidence of insurability for life insurance and a pre-existing condition (PEC) exclusion for health insurance, and may be conditional.

NOTE TO AGENCY REPRESENTATIVE: If the employee waives his/her 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 the Office of Group Benefits.

EMPLOYEE SIGNATURE _____ DATE _____

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, consultations, examinations, diagnosis, care, or treatment was recommended or received within the previous 6 months. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins.

The pre-existing condition exclusion does not apply to pregnancy, or to a child who is enrolled in the plan or enrolled in other creditable coverage within 30 days after birth, adoption, or placement for adoption. Effective July 1, 2011, the pre-existing condition exclusion does not apply to any employee or dependent who is under age 19.

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days.

To reduce the 12-month exclusion period by your creditable coverage, you must give OGB a copy of any certificates of creditable coverage (HIPAA certificates) you have. If you do not have a certificate, but you do have prior health coverage, OGB will help you obtain a certificate from your prior plan or issuer. There are also other ways you can show that you have creditable coverage. Contact OGB if you need help demonstrating creditable coverage.

Each HIPAA certificate (or other evidence of creditable coverage) will be reviewed by OGB to determine its authenticity. Submission of a fraudulent HIPAA certificate is considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Office of Group Benefits, Eligibility Department, P. O. Box 66678, Baton Rouge, LA 70896, phone (225) 925-6934 or (toll-free) 1-800-272-8451 or (TDD) 1-800-259-6771 or fax (225) 925-6333.

ACKNOWLEDGMENT OF COVERAGE LIMITATIONS AND PRE-EXISTING CONDITION EXCLUSION

I understand that I must provide appropriate documents to OGB to verify eligibility of all covered dependents. I acknowledge that my application will be approved on a conditional basis.

I acknowledge that I have reviewed the descriptive literature about OGB health plans available to me. I apply for participation or a change in my participation in the named health plan and agree to be bound by its terms and conditions.

I authorize deductions from my earnings or retirement check to pay for insurance for myself and my dependents, if applicable.

I certify that the information provided on this form is true and correct. I understand that if I provide 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.

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

EMPLOYEE SIGNATURE _____ DATE _____

AGENCY REPRESENTATIVE SIGNATURE _____ DATE _____

OFFICE USE ONLY Life _____ Health _____ Specialist Int. _____ Date _____ GB-01

PAGE 2 OF 2 - PRINT BOTH PAGES OF THIS FORM - RETAIN COPY FOR YOUR RECORDS 3-11

EXHIBIT 7

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

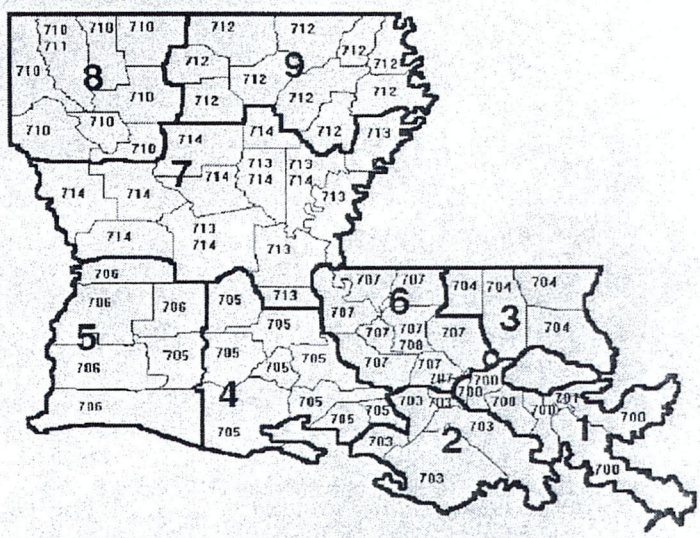
REGION 6
Addis
Baker
Baton Rouge
Brusly
Clinton
Denham Springs
Gonzales
Livingston
Livonia
Maringouin
New Roads
Plaquemine
Port Allen
Prairieville
St. Francisville
St. Gabriel
Sunshine
White Castle
Zachary

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 8

OGB CURRENT PREMIUM RATES

OFFICE OF GROUP BENEFITS
OFFICIAL SCHEDULE OF PREMIUM RATES

Effective January 1, 2012

	PPO *Administered by OGB*			HMO			CDHP with HSA *Administered by UnitedHealthcare*			Region 9 (10 northeast LA parishes) Medical Home HMO *Insured by Vantage Health Plan*			Regions 6, 7, 8 & 9 (Baton Rouge, Alexandria, Shreveport & Monroe) Regional HMO *Insured by Vantage Health Plan*		
	State Share	Employee Share	Total	State Share	Employee Share	Total	State Share	Employee Share	Total	State Share	Employee Share	Total	State Share	Employee Share	Total
ACTIVE EMPLOYEE															
SINGLE	464.46	154.82	619.28	438.82	146.26	585.08	360.54	120.18	480.72	456.82	152.26	609.08	414.96	138.32	553.28
WITH SPOUSE	812.50	502.86	1315.36	767.54	474.98	1242.52	630.72	390.32	1021.04	799.16	494.56	1293.72	717.48	440.84	1158.32
WITH CHILDREN	532.46	222.82	755.28	503.04	210.48	713.52	413.42	173.06	586.48	523.82	219.26	743.08	474.18	197.54	671.72
FAMILY	848.46	538.82	1387.28	801.48	508.92	1310.40	658.56	418.20	1076.76	834.46	529.90	1364.36	748.70	472.06	1220.76
RETIREE WITHOUT MEDICARE & RE-EMPLOYED RETIREE															
SINGLE	997.30	154.82	1152.12	945.66	146.26	1091.92	N/A	N/A	N/A	980.62	152.26	1132.88	877.88	138.32	1016.20
WITH SPOUSE	1531.58	502.86	2034.44	1453.06	474.98	1928.04	N/A	N/A	N/A	1506.26	494.56	2000.84	1342.40	440.84	1783.24
WITH CHILDREN	1060.50	222.82	1283.32	1005.64	210.48	1216.32	N/A	N/A	N/A	1042.74	219.26	1262.00	932.78	197.54	1130.32
FAMILY	1518.42	506.14	2024.56	1439.10	479.70	1918.80	N/A	N/A	N/A	1493.32	497.76	1991.08	1330.98	443.66	1774.64
RETIREE WITH 1 MEDICARE															
SINGLE	280.98	93.66	374.64	270.94	90.30	361.24	N/A	N/A	N/A	276.36	92.12	368.48	256.52	85.16	340.68
WITH SPOUSE	1038.22	346.06	1384.28	990.16	330.04	1320.20	N/A	N/A	N/A	1020.96	340.32	1361.28	913.56	304.52	1218.08
WITH CHILDREN	466.36	182.12	648.48	466.06	155.34	621.40	N/A	N/A	N/A	478.30	159.42	637.72	433.96	144.64	578.60
FAMILY	1383.34	461.10	1844.44	1317.96	439.32	1757.28	N/A	N/A	N/A	1360.38	453.46	1813.84	1213.50	404.50	1618.00
RETIREE WITH 2 MEDICARE															
WITH SPOUSE	505.08	168.36	673.44	485.64	161.88	647.52	N/A	N/A	N/A	496.56	165.52	662.08	450.10	150.02	600.12
FAMILY	625.38	208.46	833.84	601.30	200.42	801.72	N/A	N/A	N/A	614.86	204.96	819.84	554.64	184.88	739.52
C.O.B.R.A.															
SINGLE	0.00	631.68	631.68	0.00	596.78	596.78	0.00	490.32	490.32	0.00	621.28	621.28	0.00	564.04	564.04
WITH SPOUSE	0.00	1341.68	1341.68	0.00	1267.38	1267.38	0.00	1041.46	1041.46	0.00	1319.68	1319.68	0.00	1181.46	1181.46
WITH CHILDREN	0.00	770.40	770.40	0.00	727.80	727.80	0.00	598.20	598.20	0.00	757.72	757.72	0.00	684.62	684.62
FAMILY	0.00	1415.04	1415.04	0.00	1336.62	1336.62	0.00	1098.30	1098.30	0.00	1391.76	1391.76	0.00	1244.98	1244.98
DISABILITY C.O.B.R.A.															
SINGLE	0.00	928.92	928.92	0.00	877.62	877.62	0.00	721.08	721.08	0.00	916.08	916.08	0.00	824.58	824.58
WITH SPOUSE	0.00	1973.04	1973.04	0.00	1863.78	1863.78	0.00	1531.56	1531.56	0.00	1940.56	1940.56	0.00	1729.96	1729.96
WITH CHILDREN	0.00	1132.92	1132.92	0.00	1070.28	1070.28	0.00	879.72	879.72	0.00	1114.00	1114.00	0.00	999.52	999.52
FAMILY	0.00	2080.92	2080.92	0.00	1965.60	1965.60	0.00	1615.14	1615.14	0.00	2046.52	2046.52	0.00	1823.62	1823.62

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

2) All plan members who retired on or after July 1, 1997, must have Medicare Parts A and B to qualify for reduced premium rates.

Approved by: Brenda St. Romain

11/4/2011

EXHIBIT 9

CONTRACT/BUSINESS ASSOCIATE AGREEMENT/ DATA REPORTING/REQUIREMENTS

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 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 SCOPE OF SERVICES

a. The goal of 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 OGB is to provide quality, cost-effective hospital and health care services to Plan Participants.

c. See Services requested in Sections III, IV, V, and VI of the NIC.

d. The 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 the 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, copayments, 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) An electronic directory of providers, which includes all physicians, hospitals and specialists in the service area; and
c) Identification cards.

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, the Contractor will use claim procedures and standards that the Contractor has developed for benefit claim determinations.

   OGB authorizes the Contractor the discretion and authority to use such procedures and standards. The 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 the Contractor.

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

10. Based on information available to the 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 a grievance and appeals process encompassing all requirements for internal claims and appeals and external review under the federal Affordable Care Act (ACA) and/or state law and/or rules and regulations promulgated pursuant thereto. Appeal to OGB will remain an option for plan participants after all required grievances, appeals and external reviews have been exhausted.

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 B.

    Claims Data: The Contractor shall provide to OGB all claims data including Participant specific claims information, ("Confidential Claims Information") which the Contractor may obtain in the course of administering the Contract. The Contractor may also release certain Participant-related claims data at the 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 the 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. The Contractor will be responsible for payment of claims under the following conditions: (a) if the Contractor pays for a claim two (2) business days after OGB provided the Contractor a data eligibility file with changes in eligibility that would have affected the payment of the claims; and (b)

when the Contractor pays an out of network Provider an amount that exceeds the in network reimbursement rate.

Eligible Plan Participants: (a) Eligible Enrollee – The Contractor shall enroll as Participants those persons who have been specified to the 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 – 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.

OGB shall provide notice to the 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, Appendix A-1. 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 the Contractor. The 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. The 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 the Contractor shall submit a schedule to OGB outlining the days that the Contractor will be unable to accept a transmission. In the event any discrepancies, the 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 the 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 the Contractor shall convert and apply the transmitted data to its claims system as soon as possible.

Eligibility Suspension: The 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: The 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 the 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: The 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 the Contractor (1) prior to the date on which the Contractor received notice of termination; and (2) during the two (2) business day period following the date on which the Contractor received notice of termination. The Contractor acknowledges that it will be liable for all claims paid by the Contractor after the two (2) business day period following the date on which the 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 OGB's 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 the Contractor regarding the termination and the effective date thereof. Provided that OGB properly notifies the Contractor of a Participant's termination, if the Contractor processes a claim incurred after the termination effective date, then OGB shall not be financially liable for such claim.

Certificates of Creditable Coverage: The Contractor will 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.

Identification Cards: The Contractor will provide identification cards (ID cards) for delivery to Participants, including without limitation the initial issuance of ID cards, the issuance of ID cards to all newly hired or newly eligible Participants, the issuance of ID cards under OGB's Group Plans for retiree Participants following an eligible Participant's retirement from active service, and the issuance of ID cards shall be borne by the Contractor as part of its Administrative fees. The content of ID cards shall be agreed to by the parties.

Enrollment Reconciliation: OGB will provide a full and complete eligibility file to the Contractor at the beginning of January, April, July and October of

each Contract Year. The 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. The Contractor shall not replace its eligibility file with this full file. OGB and the 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.

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

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

g. The 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 3.0, in the amount and in the manner as provided in an amendment approved by Division of Administration, Director of Contractual Review.

h. See Attachment B for Performance Standards.

2.0 TERM OF CONTRACT

a. The initial term of the contract will be through December 31, 2013, and OGB shall have the option to renew this Contract for up to two additional one-year terms. The initial term, first optional renewal, and second optional renewal shall commence and terminate on the following dates:

Initial Term	January 1, 2013 – December 31, 2013
First Optional Renewal	January 1, 2014 – December 31, 2014
Second Optional Renewal	January 1, 2015 – December 31, 2015

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

3.0 ADMINISTRATIVE FEES; PAYMENT TERMS

a. During the term of this Contract, OGB shall pay the Contractor a monthly administrative services fee for services pursuant this Contract. See Attachment A.

b. If any amendment to the Plan of Benefits increases or decreases 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. The 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 the Contractor.

e. The maximum payable to the 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.

4.0 SAVINGS AGREEMENT; COST CONTAINMENT PROGRAMS

a. OGB shall receive one hundred percent (100%) of savings realized by the 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 the Contractor's cost containment programs shall be included in the Administrative Services Fee. As further consideration for OGB's participation in the Contractor's cost containment programs, OGB expressly waives any rights it may have in or to any cost containment the Contract or agreement between the Contractor and any health care or allied service provider.

5.0 PROVIDER NETWORK SAVINGS

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

6.0 CLAIMS LIABILITY

a. OGB assumes full liability for funding all payments made for Plan claims (except for claims paid by the Contractor after OGB provided the Contractor a two (2) business days notification of a change in eligibility and when the 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 the Contractor to CMS in response to demand letters for the recovery of Medicare payments to Plan Participants except for any claim paid by the Contractor after notification of an eligibility change. The 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 the Contractor, the 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 the 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 Article 1.0.

7.0 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. The 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 the 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 the Contractor under this Contract.

c. OGB shall reimburse the Contractor for any taxes, charges or fees which may be assessed against the 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 the Contractor as specified in Article 16.0.

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

e. OGB will notify the 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.

8.0 SINGLE PROGRAM, RIGHT TO ASSESS ALL PARTICIPANTS

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 OGB. In discharging its responsibility to administer the Plan and to assure that adequate health care coverage is available and affordable for all, OGB may, from time to time, impose a cost allocation, premium surcharge, and/or risk assessment upon Plan Participants enrolled in the Plan.

9.0 GOVERNING LAW, VENUE

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, and venue of any action brought under this contract shall be the Nineteenth (19^{th}) Judicial District Court for the parish of East Baton Rouge, Louisiana.

10.0 INSURANCE CERTIFICATE

a. The 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 the Contractor, its agents, representatives, employees or sub-contractors; 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. The Contractor shall on request furnish 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. 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. OGB shall not be held liable for claims for damages relating to any services rendered or arranged for by the Contractor.

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

12.0 PERFORMANCE BOND

The Contractor shall furnish a performance bond in the amount of $3,000,000 (three million) dollars.

13.0 INDEMNIFICATION

a. OGB and the State agrees to protect, defend, indemnify and hold harmless the Contractor, its subsidiaries and affiliates, their 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 the 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. The 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 the 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. The 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) OGB's Affiliated Indemnified Party has given reasonable notice to the Contractor of the claim or cause of action, and (b) no OGB Affiliated Indemnified Party has, by act or failure to act, compromised the Contractor's 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. The 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. The 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. The 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, the Contractor, in its discretion and at its sole option, may join in any such action in which it has a justifiable interest.

    3. The 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 the Contractor.

15.0 FUND USE

Contractor agrees not to use funds received for services rendered under this contract to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the Louisiana Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition on any election ballot or a proposition or matter having the effect of law being considered by the Louisiana Legislature or any local governing authority.

16.0 TAXES

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

OGB shall reimburse the Contractor for any taxes, charge of fees which may be assessed against the 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 the 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

a. Access. The Contractor grants OGB the nonexclusive, nontransferable right to access and use the functionalities contained within the 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 the Contractor's. In order to obtain access to the systems, OGB shall obtain, and responsible for maintaining, at no expense to the Contractor, the hardware, software and Internet browser requirements the 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.

b. Security Procedures. OGB shall use commercially reasonable physical and software based measures, and comply with the 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 the Contractor immediately if any breach of the security procedures, such as unauthorized use, is suspected.

c. System Access Termination. The 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 the Contractor, including any amendments thereto or (b) immediately on the date the 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 the Contractor shall deactivate OGB's identification numbers and passwords and access to the System.

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

20.0 ACKNOWLEDGEMENT OF PRIORITY POSITION

The 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 the organization

21.0 MOST FAVORED CUSTOMER GUARANTEE

The Contractor certifies and guarantees that the retention or other administrative charges to OGB, as forth in this Contract, are comparable to or better than the equivalent fees or charges being offered by the Contractor to any present or future customer or group of customers having a similar product design and of a comparable or lesser size. If the 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 the 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 OGB, with a retroactive finance adjusted to 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 the Contractor, the fees being charged to OGB by the Contractor are in full and complete compliance, in all respects, with the provisions of this Section. The Contractor shall provide such annual notice during the first quarter of each calendar year.

The 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, the Contractor offers a lower medical reimbursement fee schedule to any customer in the State of Louisiana it shall immediately notify 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 OGB dating back to the effective date of the lower medical reimbursement fee schedule.

22.0 WAIVER OF BREACH

The waiver by either party of a breach or violation of any provision of the contract shall not operate as, or be construed to be, a waiver of any subsequent breach of the contract.

23.0 SEVERABILITY

The invalidity or unenforceability of any terms or conditions of the contract shall in no way effect the validity or enforceability of any other terms or provisions.

24.0 NOTICE

Any notice, demand, communication or payment required under the contract shall be deemed effectively given when personally delivered or mailed, postage prepaid, as follows:

OGB:	Office of Group Benefits Program Attention: Chief Executive Officer 7389 Florida Blvd., Ste. 400 Baton Rouge, LA 70806 or Post Office Box 44036 Baton Rouge, LA 70804
CONTRACTOR:	TBD

25.0 PATENT, COPYRIGHT, AND TRADE SECRET INDEMNITY

The Contractor warrants that all materials and/or products produced by the 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 OGB, OGB shall promptly notify the Contractor, and the Contractor shall defend such claim, in OGB's name, but at the Contractor's expense, and shall indemnify OGB against any loss, expense, or liability arising out of such claim, whether or not such claim is successful.

26.0 INDEPENDENT CONTRACTOR RELATIONSHIP

No provision of this Contract is intended to create nor shall it be deemed or construed to create any relationship between the Contractor and 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.

27.0 PROJECT MANAGEMENT/MONITORING PLAN

a. If the Contractor is required to provide contract management functions in the scope of services set forth in Article 1.0, the Contractor shall provide, at a minimum, the following project management functions:

1. Routine Project Management: The 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: The 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: The 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: The Contractor will develop and implement with OGB approval, procedures and forms to monitor the identification and resolution of key project issues/problems.

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

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

2. Key Personnel: The Contractor shall assign Personnel to perform the services pursuant to this Contract that are qualified to perform the assigned

duties, and the Contractor will determine which personnel shall be assigned for any particular project and to replace and reassign such personnel doing such a project. The 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 the 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:

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 OGB and will be the principal point of contact for the Contractor concerning the Contractor's performance under this Contract.

28.0 MANAGEMENT OF HEALTH CARE SERVICES

The 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. The 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. The Contractor will review health care services and supplies to determine whether they are covered services under the Plan. If the Contractor determines that services or supplies are not covered under the Plan, then the Contractor will provide the appeal services outlined above in this Section.

2. The Contractor may provide, when appropriate for the individual Plan Participant, certain case management services, which are designed to provide a proactive, 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.

   The 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 the Contractor's use and administration of the ABP Program and authorizes the Contractor the discretion and authority to develop and revise ABP's. The 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, the Contractor will not provide these services.

b. Fraud & Abuse Management Services

   The Contractor will provide services related to the detection and prevention of fraudulent and abusive claims. The Contractor's Fraud and Abuse Management processes will be based upon proprietary and confidential procedures modes of analysis and investigations that the Contractor develops. The Contractor will use the procedures and standards in delivering Fraud and Abuse Management services to OGB and the 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 the Contractor decides to seek recovery, and under what circumstances to compromise a claim settle for less than the full amount. OGB authorizes the 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. OGB recognizes that the use of these procedures and standards may not result in recovery or in full recovery for any particular cases. The Contractor does not guarantee or warranty any particular level of prevention detection, or recovery. The 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 the Contractor's recovery costs and will be deducted from the actual recoveries. If the Contract terminates, or if the Contractor's claim recovery services terminate, the Contractor can elect to continue fraud and abuse recoveries. The contingency fees will continue to apply.

29.0 PERFORMANCE MEASURES

The Contract Supervisor will be responsible for the Performance Evaluation Report in regards to the scope of services provided by the 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 OGB's contract supervisor.

See Attachment B for Performance Standards.

30.0 SUSPENSION OF ADMINISTRATIVE SERVICES AND/OR CLAIMS PAYMENTS

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

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

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

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

3. The 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, the 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. The 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 1.0. OGB shall hold the 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 1.0 above that do not result from the Contractor's negligent, dishonest, fraudulent or criminal conduct.

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

31.0 TERMINATION FOR CAUSE

a. OGB may terminate this Contract for cause based upon the failure of the Contractor to comply with the material terms and/or conditions of the Contract; provided that OGB shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) days after receipt of such notice, the 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 OGB may, at its option, place the Contractor in default and this Contract shall terminate on the date specified in such notice.

b. The Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of OGB to comply with the terms and conditions of this Contract; provided that the Contractor shall give OGB written notice specifying OGB's failure. Furthermore, the 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 the Contractor upon failure of OGB to pay any of the amounts due under this Contract. The 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 the Contractor shall cease on the date of notification.

32.0 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.

33.0 CONTRACTOR'S DUTIES UPON TERMINATION

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

1. Administer run out claims for a period of one year from the date this Contract terminates. "Run out claims" refers to those claims for covered services performed prior to termination of the Contract, but not yet paid and/or not submitted for payment to Contractor prior to the termination of this Contract. No Administrative Fee will be paid for the administration of run out claims 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.

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 at the end of one year from the date this Contract terminates shall be returned to OGB which shall be responsible for any processing and the payment of the claims.

34.0 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.

35.0 OWNERSHIP OF PRODUCT

All records, reports, documents and other material delivered or transmitted to the Contractor by OGB shall remain the property of OGB, and shall be returned by the Contractor to OGB, at the Contractor's expense, at termination or expiration of this Contract. The 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 the Contractor specifically and exclusively for OGB in connection with the performance of the services contracted for herein shall become the property of OGB, and shall, upon request, be returned by the Contractor to OGB, at the Contractor's expense, at termination or expiration of this Contract.

36.0 ASSIGNMENT

The 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 OGB, provided however, that claims for money due or to become due to the Contractor from 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 OGB and to the Office of Contractual Review, Division of Administration.

37.0 RIGHT TO AUDIT

a. The 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. The Contractor shall comply with federal and/or state laws authorizing an audit of the 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 the 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 the Contractor. With respect to the 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 the Contractor will give access to confidential Plan Participation information. OGB will pay any expenses that OGB incurs regarding the audit. OGB shall provide the Contractor with a copy of any audit reports.

c. Upon request, the 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. The Contractor shall provide a copy or copies of annual independent audit(s) conducted on the processing of transactions SAS-70/SSAE-16, Type II, as required by the State's Legislative Auditor. The audit(s) must be received by OGB not later than September 30 of each year of the contract term. The Contractor will be subject to a $1,000 per day penalty until receipt of the audit by OGB.

e. Contractor shall comply with federal and/or state laws authorizing an audit of Contractor's operations as a whole, or of specific program activities. Any audit shall be conducted where the records are located during ordinary business hours and upon reasonable advance notice to Contractor.

38.0 RECORD RETENTION

The 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.

39.0 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.

40.0 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.

41.0 NON-DISCRIMINATION

The 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 the Contractor agrees to abide by the requirements of the Americans with Disabilities Act of 1990. The 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 the Contractor, or failure to comply with these obligations when applicable shall be grounds for termination of this Contract.

42.0 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 OGB except for payments which have been accrued prior to the termination.

43.0 HEADINGS

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

44.0 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.

45.0 SUBCONTRACTORS

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

46.0 ENTIRE AGREEMENT AND ORDER OF PRECEDENCE

a. This Contract (together with the NIC issued thereto by OGB, the Proposal submitted by the Contractor in response to 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)

(CONTRACTOR)

SIGNATURE:_____

NAME:_____

TITLE:_____

SIGNATURE:_____

NAME: _____

TITLE: _____

ATTACHMENT - A

FINANCIAL AGREEMENT

1. PAYMENT FACTORS:

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

Administrative Fees

TBD

The Contractor agrees that the Administrative Fees includes services to be provided by the Contractor to pay run out claims and continue reporting to OGB those claims and will also include services for prior year PPO run out claims.

2. CLAIM PAYMENT PROCEDURES

The Contractor will provide 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. The Contractor shall use its best efforts to forward the invoice and file to OGB no later than 2:00 p.m. on each day. 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 the Contractor, by wire transfer or other method acceptable to the Contractor.

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

The Contractor agrees to pay its providers within 48 hours from receipt of payment from OGB. If the contractor pays its network providers on other than a daily basis, OGB agrees to pay the contractor within 48 hours of contractor's payment date.

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

ATTACHMENT - B

PERFORMANCE STANDARDS

A. Health Plans (HMO/PPO/HDHP/LACHIP)

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

2. **Application:** The standards shall apply to the administration of OGB's plan under this Contract, including with respect to the 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 January 1, 2013 through December 31, 2013. The second period to be measured shall be January 1, 2014 through December 31, 2014. The third period to be measured shall be January 1, 2015 through December 31, 2015.

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 OGB. Inquiry Timeliness measures the average number of calendar days it takes the 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 Timeliness

Definition: "Clean claim" means an accepted claim that 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.

"Electronic claim" means a claim submitted by a health care provider or its agent to a health insurance issuer in compliance with the provisions of the Health Insurance Portability and Accountability Act (42 USC 1302d et seq. and 45 C.F.R. Parts 160 and 162) and in a format currently adopted by the United States Department of Health and Human Services or its successor.

"Nonelectronic claim" means a claim submitted by a health care provider or its agent to a health insurance issuer or its agent using a HCFA 1500 form or a Uniform Billing Form 92 (UB92), as appropriate, or a successor to either of these forms adopted by the National Uniform Billing Committee or its successor.

"Paid" means the transfer by the health insurance issuer or its agent of the amount of the health insurance issuer liability on either of the following dates:

(a) The date of mailing of a check via the United States Postal Service or a commercial carrier to the correct address.
(b) The date of electronic transfer of funds.

"Received" or "receipt" means:

(a) For a nonelectronic claim:
(i) For a claim mailed via the United States Postal Service for which no return receipt is requested, the physical receipt of the claim by the health insurance issuer or its agent designated for the receipt of claims at the correct claims address, as documented in accordance with claims filing procedures filed by the health insurance issuer with the department.
(ii) For a claim sent via a commercial carrier or via the United States Postal Service for which return receipt is requested, the date the delivery receipt is signed by the health insurance issuer or its agent designated for the receipt of claims at the correct claims address, as documented in accordance with claims filing procedures filed by the health insurance issuer with the department.

(b) For an electronic claim, either of the following:
(i) For a claim submitted by a health care provider directly to the health insurance issuer or its agent designated for receipt of claims, the date of an electronic receipt issued by the health insurance issuer or its agent to the provider for the electronic claim or a batch of claims that includes the claim, unless the claim appears on a related exception report or was included in a batch of claims for which a batch rejection report was issued.
(ii) For a claim submitted by a health care provider to a health care clearinghouse, the date of an electronic receipt issued by the health insurance issuer or its agent to the health care clearinghouse for the electronic claim or a batch of claims that includes the claim, unless the claim appears on a related exception report or was included in a batch of claims for which a batch rejection report was issued.

Standard: 98% of Electronic clean claims payment within 10 days from receipt of the claim. 98% of Nonelectronic claims payment within 15 days from receipt of a clean claim.

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.

Membership Identification Cards (Timeliness):

Definition: This measurement represents the percent of Participant identification cards that are issued prior to the Participant's effective date, providing the Contractor receives an enrollment file thirty (30) days prior to the Participant effective date. The first day of processing (FDP) is the date the electronic file is received. The last day of processing (LDP) is the date the Identification card is mailed to Participant.

This standard applies outside of any annual enrollment period.

Standard: 100% of new Participants will have ID cards generated prior to the effective date of coverage.

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 the Contractor fails to achieve the Performance Standards set forth below as measured separately over the Measurement Periods, the Contractor shall incur penalties not to exceed, in the aggregate, ten (10%) percent of the Administrative Fees charged to 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 services and requirements, excluding the penalty for Data Submission Timeliness which shall be based on a daily penalty of $10,000 per day and the penalty for missed annual enrollment meetings which shall be based on a penalty of $1,000 per meeting.

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

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

Access/Customer Services (OGB 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 Timeliness	**<98% for electronic clean claims paid within 10 days of receipt.**	**2.0%**
	<98% for nonelectronic clean claims paid within 15 days of receipt.	**2.0%**
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%**
Member ID Cards Timeliness	**<100% of new members will have ID cards issued prior to the effective date of coverage**	**1.0%**
Total Percentage at Risk	**(as a percent 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**
The Contractor shall be fined for enrollment meetings not attended.		**$1,000 Per meeting**

B. Disease Management

1. **Measurement Standards**

The measurement of clinical gaps related to the Targeted Chronic Conditions and the definition of Clinical Performance Standards shall follow the approach outlined below, with the specific measurement dimensions and target values to be selected by mutual agreement of the Parties after the appropriate data analysis is completed. At least two such metrics will be selected for focus initially, with the possibility that based on ongoing review and evaluation the Parties may mutually

agree to modify the selection of clinical gap measures as the CC Program needs and available data dictate. For all the Clinical Performance Standards together, there will be a total of six percent (6%) of Program Year Fees at risk.

a. The measure for HF shall be ACE/ARB prescription rate

b. The measure for CAD shall be one of following three possible measures, with the final determination of the specific measure to be used to be made by mutual agreement of the Parties after the baseline values are established by Contractor:

   -Beta Blocker Rx, or

   -Lipid Rx, or

   -Lipid test

c. The measure for Asthma shall be percentage with adherent use of asthma control medications (mild-severe persistent)

d. The measure for Diabetes shall be percentage with A1c regular testing ≥2x/yr

e. The measure for COPD shall be percentage with adherent use of short-acting bronchodilator medications

For each measure selected, the measurement structure will be as follows (with the specific target numbers to be agreed to by the Parties as part of the final determination of the measures):

Baseline Rate*	**Goal**
<20%	Select new measure
20-40%	Baseline plus 2 percentage points
41-60%	Baseline plus 3 percentage points
61-80%	Baseline plus 2 percentage points
>80%	Select new measure

* Measured at the population level

Each of the clinical performance measures shall be evaluated independently. As an example, if the initial baseline number for one of the measures is 42%, the goal would be to improve the value of this measure to 45% (i.e., initial value plus 3 percentage points). To continue this example, if the actual number for the initial Program Year is: (i) 45%, Contractor has achieved the goal so no repayment of fees is required, and the goal for the second Program Year would be 48%; (ii) 43%, Contractor has achieved one-third of the required improvement, so repayment of one-third of the fees at risk for this measure is required, and the goal for the Second Program Year is 46%; and (iii) 39%, Contractor has failed to achieve the goal so repayment of the full amount of fees at risk for this measure is required, and the goal for the Second Program Year is 41%.

2. **Satisfaction Standards:**

Contractor will conduct an annual Participant satisfaction survey (consisting of approximately 200 telephone interviews of Participants who have received Contractor Services) for each Program Year. Annual Participant satisfaction survey results will be measured by the question "What number would you use to rate your overall Health Coaching experience?" (with a "4" being "Satisfied" and a "5" being "Very Satisfied") and will be ≥ 85% for the total of the "Satisfied" or "Very Satisfied" answers.

3. **Participation Standards**

Greater than fifty percent (50%) of the Participants during each Program Year will complete 2 or more calls with a Health Coach.

C. Mental Health/Substance Abuse

PERFORMANCE STANDARD TOPIC	DESCRIPTION OF STANDARD	STANDARD EVIDENCED BY	TARGET	PENALTY (Fees At Risk)
Satisfaction Surveys	**Member Satisfaction Survey Scores**	Report to OGB. Member satisfaction survey administered at least annually with survey tool, methodology and sampling approved by OGB. Scores calculated by adding positive rating.	**≥ 90%**	**1.5%**
	Provider Satisfaction Survey Scores	Report to OGB. Provider satisfaction survey administered at least annually with survey tool, methodology and sampling approved by OGB. Scores calculated by adding positive rating.	**≥ 85%**	**1.5%**
Complaints	**Complaints acknowledged within one business day following receipt of complaint.**	Report to OGB, tracking time complaint is received verbally or in writing to time of acknowledgement, documented in writing to client.	**≥ 95%**	**0.5%**

	Complaints researched and resolved within 30 calendar days	Report to OGB, tacking time complaint is received verbally or in writing to time of resolution with client, documented in writing to client.	**≥ 95%**	**1.5%**
	Appeals resolved within time frame per MNRO standards	Report to OGB from Appeal log tracking receipt date, acknowledgement date, and resolution date for each level of appeal	**100%**	**1.5%**
Reporting Requirements	As specified in Section I(Y)	Receipt date of reports.	≥ 99%	1.5%
Claims Processing Accuracy	Percent of claims paid within 30 days	Monthly reports to OGB showing percentage of clean claims processed within 30 calendar days from receipt of claim (Subject to independent third party audit at discretion of OGB)	≥ 99%	1.5%
	Financial Payment (dollar) accuracy	Monthly report to OGB showing percentage of audited claims dollars paid accurately. (Subject to independent third party audit at discretion of OGB)	≥ 99%	1.0%
	Claim processing accuracy	Monthly report to OGB showing percentage of audited claims processed accurately (Subject to independent third party audit at discretion of OGB)	≥ 97%	1.0%

Clinical Standards	Ambulatory follow-up after acute hospitalization within 30 days after discharge	Ambulatory follow-up within 7 days of discharge from 24 hour acute facility using HEDIS specifications or modified HEDIS specification as approved by OGB	≥ 80%	1.5%
	Medical integration for members identified with major depressive, bipolar and psychotic disorders.	Percent of members identified with major depressive disorder, bipolar disorder, or psychotic disorders with annual medical visit with a primary care provider during the reporting year, using reporting specifications to be agreed upon during contract implementation	10% annual improvement from baseline	1.5%
	Readmission Rate with 30 days	Reported to OGB as measured through reporting based on discharge within the measurement period with readmission to an inpatient level of care within 30 days	≤ 8%	3.0%

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 _____, 20__, pursuant to which Business Associate is to provide certain services to OGB involving the use or disclosure of PHI, as defined below.

c) "ARRA" shall mean the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

d) "Business Associate" shall mean _____ _____.

e) "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.

f) "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

g) "HIPAA Regulations" shall mean the Privacy Rule, the Security Rule, and the regulations promulgated pursuant to ARRA.

h) "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).

i) "OGB" shall mean the State of Louisiana, Division of Administration, Office of Group Benefits, which is a covered entity under HIPAA, ARRA and the HIPAA Regulations, as defined below.

j) "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.

k) "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.

l) "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.

m) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.

n) "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

o) "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR § 164.304.
p) "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.
q) "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.
r) Any other terms used in this Addendum that are not defined herein but are defined in the HIPAA Regulations or ARRA shall have the same meaning as given in the HIPAA Regulations or ARRA.

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 HIPAA Regulations an ARRA.

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 Associate shall immediately notify OGB when Business Associate receives a subpoena related to PHI and shall cooperate with OGB, at OGB's expense, in any attempt to obtain a protective order. Business Associate shall immediately notify OGB when Business Associate discloses PHI in response to a subpoena. Such notice shall include all information that would be required for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

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.

r) Business Associate shall report to OGB any unauthorized acquisition, access, use or disclosure of PHI by Business Associate or its workforce or subcontractors immediately, but no later than five (5) business days after discovery or the date the breach should have been known to have occurred, and include with that report the remedial action taken or proposed to be taken with respect to such use or disclosure and account for such disclosure. Business Associate is responsible for any and all costs related to notification of individuals or next of kin (if the individual is deceased) of any security or privacy breach reported by Business Associate to OGB.

s) In the event of a breach of PHI, Business Associate shall provide a report to OGB including the date the breach was discovered, the plan participant(s) name(s), contact information, nature/cause of the breach, PHI breached and the date or period of time during which the breach occurred. Business Associate understands that such a report must be provided to OGB immediately but no later than five (5) business dates from the date of the breach or the date the breach should have been known to have occurred.

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).

f) Business Associate may not use PHI to make any communications about a product or service that encourages recipients of the communication to purchase or use the product or service unless the communication is made as described in subparagraph (i), (ii) or (iii) of the definition of "Marketing" in 45 CFR 164.501. Such communication must be permitted under and consistent with the Agreement, including this Addendum.

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 HIPAA, ARRA and the HIPAA Regulations.
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 HIPAA, ARRA and 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, ARRA 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, ARRA and 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:_____

Name:_____

Title: _____

CONTRACTOR

By:_____

Name:_____

Title:_____

ATTACHMENT D

FILE REQUIREMENTS & LAYOUT

Appendix A – 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 to the Contractor by OGB:

The contractor shall receive the following files from OGB. Files shall be constructed using the layout as described in specified appendices. All files from OGB shall be sent electronically using FTP (File Transfer Protocol) and WILL be encrypted using PGP (Pretty Good Privacy).

1. **Eligibility File (Appendix A-1)**
   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. Layout may be modified to meet needs of Contractor.

2. **Administrative Fee Billing files(Appendix A-2)**
   This file shall be received monthly by the contractor and will contain the amount per contract holder that OGB will pay the Contractor for administrative fee. OGB will pay the Contractor based on this file. The file will contain adjustments to prior months billing resulting from retroactive terminations and enrollment. File layout contains a product/plan indicator (HMO/PPO/CDHP). A single file can be provided or separate files depending on the Contractor's needs.

3. **Claims Paid By Contractor After Termination or Stop Payment(Appendix A-3)**
   This file shall be received monthly by the Contractor and will contain the claims paid in error after the termination or stop payment date – see fields 12 and 36 in eligibility layout. *(This file is only provided when OGB is invoiced for claims costs.)*

Files to be sent by the contractor to OGB:
Files are to be sent by the contractor to OGB on a monthly basis and no later than the 5th business day of the following month. All files shall be sent electronically using FTP (File Transfer Protocol) and must be encrypted using PGP (Pretty Good Privacy).

4. **Check Register File (Appendix A-4) -** This file will contain one record for each check issued during the month. The amount of money reflected on this file must match the invoice sent to OGB for payment each month. Check numbers shall correspond to checks referenced in the paid claims provided in (#7) below. Contractor may send one file for all product/plans/services (HMO/PPO/CDHP/MHSA,etc.) or multiple files depending on how the Contractor invoices OGB for claims costs.

5. **Disease Management Participation File (Appendix A-5)** This file contains all current participants in the Disease Management program. Only those members and dependents on this

file will receive any participation incentives. This file shall be transmitted monthly by the 5th business day of each month for the preceding month.

6. **DHH LaCHIP Financial Report (Appendix A-6)** Report required list amounts associated with Medical Claims, Mental Health Claims and Pharmacy Claims. The report will be in the format as described in specified appendix. This report must be completed by the processor of the claims and paid amounts must match the invoicing for the services for DHH LaChip members. Multiple reports may be created for each of the three claim types (Medical and Mental Health) if they are invoiced separately. *Note: OGB's Qualifying Criteria has been included on the documentation as an example.*

7. **Medical Claims File (Appendix A-7)** – the contractor shall send OGB all claims for which EOBs (Explanations of Benefits) or checks were sent or issued to the provider and/or claimant during a month. *This file shall include all products/plans. Contractor may send separate files for each product/plan, or send all in a single file. If one file is provided, a product/plan indicator may be added to the layout.* This is a file of records containing claim charge lines or service lines for a physician claim (CMS-1500), facility claim (UB-92), or a dental claim (ADA-1500) that has been received and processed for medical or mental health/substance abuse services. No claims in process are included. Additional details are provided below.

8. **Provider File (Appendix A-8) -** This is a file of medical service providers for which checks and EOBs were issued in (10) above. This will include, for example, physicians, hospitals, urgent care facilities, and physician groups. The file will also contain separate records relevant to the entity paid for a provider's services.

9. **Code Files (Appendix A-9)** – These files will contain codes used in claim processing that are not standard, universally accepted values. Codes that fall into this category include but are not limited to provider specialty codes, denial reason codes, types of service codes and override codes. Codes are subject to change over the life of this contract, and if a code changes, dates associated with the code are required for its meaning before and after the change. If the contractor's uses any other codes with which OGB is not familiar, the contractor will transmit a file of those codes in a file consistent with this format, if appropriate.

Regarding 7, 8, 9
Prior to any transmission of claims data from the contractor to OGB, we must have an understanding of their procedures for processing, paying and adjusting claims so that the financial and clinical care of our members can be accurately reflected in our data warehouse. Information provided to OGB is also transmitted to our Living Well Louisiana health management program for management of ongoing health conditions, including diabetes, heart disease, heart failure, asthma, and chronic obstructive pulmonary disease (COPD). To clarify OGB needs, the following will apply to all claims:

- **Only processed claims** – the contractor will transmit all paid and denied claims as indicated above for which bills were submitted for our members. Claim transmissions will include detail for each charge or service line on the patient's bill. All coding in each line will adhere to standard medical coding procedures.

- **Adjusted Claims** – Claims that are reprocessed and subsequently adjusted, whether for financial reasons or for changes related to services provided, will include a reference to the original or preceding claim in all claim lines. OGB must be able to reconstruct a representative processing history for each claim through final disposition.

- **Provider recognition** – Each provider must be clearly identified by their purpose in the data provided, specifically, service providers and "pay-to" providers must be distinguished from each other. Where possible, relationships between facilities, physician groups, physicians, and other ancillary service providers as it applies to patient care should be made available whenever possible.

- **Non-standard codes** – Codes and their meaning or description used to represent the contractor's processing data for which an industry standard does not exist will be transmitted to OGB separately from the monthly transmission, beginning with contract initiation. Any changes to these codes will be transmitted to OGB prior to transmission of claim records with these codes being used. Examples of these codes include but are not limited to the contractor's physician specialty codes and denial codes.

- **Data standards** – Numeric data will be right-justified and zero-filled. Money amounts will be 15 digits including an explicit decimal point and accurate to two decimal places (**000009999999.99**). Negative amounts will have a minus sign as the first character (**-00009999999.99**). Dates will be formatted **CCYYMMDD** and valid. All text will be left-justified and space-filled. All SSN's, ICD-9 codes, phone numbers, NDC's and zipcodes will be left-justified, with no dashes, commas, decimals or other formatting.

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-1 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 uninterrupte Coverage within Blue Cross
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 Agency	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 04 – Student
21	Transaction Date	A/N	8	225-232	CCYYMMDD
22	Agency Employment Date	A/N	8	233-240	CCYYMMDD
23	Portability Date	A/N	8	241-248	CCYYMMDD- Pre-existing Condition Ending
24	Contract Holder Phone	A/N	12	249-260	
25	Filler	A/N	1	261-261	Filler
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 carrier not including Medicare.
30	Medicare Primary	A/N	1	291-291	"Y" = Yes "N" = No
31	Member SSN	A/N	9	292-300	Member SSN
32	Filler	A/N	1	301-301	Blanks
32	Agency Change Date	A/N	8	302-309	CCYYMMDD- earliest effective date of uninterrupte Coverage within Agency
33	Member Record-ID	A/N	8	310-317	OGB Internal id

Appendix A-1 Eligibility File					
NO	**Field Name**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
34	Billing Rate Table(On Subscriber Only)	A/N	2	318-319	AC – active CB - cobra CD - cobra disability CP - cobra part-time CS – cobra subsidy D1 – Sponsored Dependent 1 on Medicare DN – Sponsored Dependent No Medicare R1 - retired Medicare 1 R2 - retired Medicare 2 RN - retired no Medicare This Field is always blank for dependents
35	Shared Accumulator OGB Record ID	A/N	9	320-328	Contains the 8 digit Record ID for Shared Accumulat
36	Claim Payment Stop Date	A/N	8	329-336	CCYYMMDD
37	Lifetime Accum	N	10	337-346	9999999.99 Leading spaces: Sum of Drugs, Medical Mental Health & DME claims paid
38	Drug Accum	N	10	347-356	9999999.99 Leading spaces: Sum of Drug claims pai Included in Lifetime accum
39	Mental Health Accum	N	10	357-366	9999999.99 Leading spaces: Sum of Mental Health claims paid. Included in Lifetime accum
40	Country Code	A/N	2	367-368	List of Values available on request
41	Pre-existing Start Date	A/N	8	369-376	CCYYMMDD- Pre-existing Condition Start Date
42	Coverage Level Effective Date	A/N	8	377-384	CCYYMMDD- Earliest Eff Date of Uninterrupted CoverageWithin HMO/Coverage Level
43	Rate Table Effective Date	A/N	8	375-392	CCYYMMDD- Earliest Eff Date of Uninterrupted CoverageWithin HMO/Rate Table

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-2 ASO Administrative Fee Billing					
FIELD	**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/N	20	018-037	LAST NAME
4	ENROLLEE FIRST NAME	A/N	20	038-057	FIRST NAME
5	ENROLLEE MIDDLE INITIAL	A/N	1	058-058	INITIAL
6	ENROLLEE COVERAGE TYPE	A/N	2	059-060	"EE" -EMPLOYEE ONLY "ES"-EMPLOYEE AND SPOUSE "EC"-EMPLOYEE AND CHILD(REN) "FM"-FAMILY
7	RATE TABLE CODE	A/N	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"
10	PLAN CODE	A/N	10	81-90	Product/Plan Indicator

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-3 Claims Paid by Contractor after Termination or Stop Payment					
FIELD	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	ASO CLAIM NUMBER	A/N	15	001-015	
2	TOTAL CHARGE	N	10	016-025	DECIMAL + 2 DECIMAL PLACES. IF NEGATIVE THE SIGN WILL BE IMMEDIATELY TO THE LEFT OF THE NUMBER
3	TOTAL PAID AMOUNT	N	10	026-035	DECIMAL + 2 DECIMAL PLACES. IF NEGATIVE THE SIGN WILL BE IMMEDIATELY TO THE LEFT OF THE NUMBER
4	PROVIDER OFFICE OR FULL NAME	A/N	30	036-065	
5	DATE OF SERVICE FROM	A/N	8	066-073	CCYYMMDD
6	TERM/STOP SENT DATE	A/N	8	074-081	CCYYMMDD
7	PAID DATE	A/N	8	082-089	CCYYMMDD
8	FAMILY SSN	A/N	9	090-098	
9	RELATION CODE	A/N	2	099-100	01-ENROLLEE 02-SPOUSE 03-DEPENDENT 05-GRANDCHILD 17-STEPCHILD 24- DEPENDENT CHILD OF A DEPENDENT CHILD
10	PATIENT FIRST NAME	A/N	15	101-115	
11	TERM/STOP DATE	A/N	8	116-123	CCYYMMDD
12	TERM/STOP FLAG	A/N	1	124-124	T-TERMINATED, S-STOP

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-4 Check Register						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: The check number should relate directly to the check number in the claim or claims paid by this check. This assumes that all claims for OGB members are paid from the same checking account. If this is not so, a separate account field will be required.						
1	*	CHECK NUMBER	A/N	10	1-10	THE NUMBER PRINTED ON THE CHECK
2	*	CHECK ISSUE DATE	A/N	8	11-18	DATE THE CHECK WAS ISSUED AS PAYMENT **FORMAT- CCYYMMDD**
Field 3: The amount of the check should equal the sum of the amounts on the claim or claims paid to the provider or member paid by this check.						
3	*	CHECK ISSUE AMOUNT	N	15	19-33	AMOUNT PAID BY THIS CHECK
4	*	PAYEE TYPE	A/N	1	34	'P' – PROVIDER, 'M' – MEMBER, 'O' - OGB
Field 5: If the check is to a provider, the provider ID must exist in the contractor's provider file transmitted with the check register. If the check is written to a member, the member ID must correspond to OGB's member ID provided in the related eligibility transmission to the contractor. Financial adjustments to payments from OGB to the contractor may or may not reference a distinct claim transaction. Payments to OGB by the contractor, if any, should reference the relevant line on the contractor's invoice.						
5	*	PAYEE ID	A/N	20	35-54	PROVIDER ID OR MEMBER ID TO WHOM THE CHECK WAS PAID. INVOICE LINE IF PAID TO OGB.
6		PLAN	A/N	10	55-64	PLAN FOR WHICH CHECK IS CUT REQUIRED ONLY FOR PAYERS OF MULTIPLE PLANS VALUES TO BE DETERMINED

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

A-5 Disease Management Participation File				
NO	**FIELD NAME**	**LEN**	**LOC**	**DESCRIPTION**
1	Patient Record ID	50	01-50	OGB Member Internal ID (1-8)
2	Subscriber Record ID	50	51-100	Contract Holder ID (51-58)
3	Relation Code	30	101-130	Relationship to Subscriber (101-102) 01 – subscriber 02 – spouse 03 – dependent
4	Birth Date	08	131-138	Birth Date (CCYYMMDD)
5	Gender	01	139	Gender Code M – Male F – Female
6	First Name	50	140-189	Patient First Name
7	Middle Initial	01	190-190	Patient Middle Initial
8	Filler	49	191-239	
9	Last Name	50	240-289	Patient Last Name
10	Filler	394	290-683	
11	Last Contact Date	08	684-691	CCYYMMDD
12	Participation Date	50	692-741	CCYYMMDD
13	Last Follow-Up	50	742-791	CCYYMMDD
14	Last Mailing Date	50	792-841	CCYYMMDD
15	Last Impact Date	50	842-891	CCYYMMDD
16	Filler	150	892-1041	
17	Heart Disease	01	1042	Condition Indicator
18	Diabetes	01	1043	Condition Indicator
19	CHF	01	1044	Condition Indicator
20	COPD	01	1045	Condition Indicator
21	Asthma	01	1046	Condition Indicator
22	File Creation Date	08	1047-1054	Date file was produced

APPENDIX-6 LACHIP Financial Report			
B. Line No	**REPORT HEADING**		**DESCRIPTION**
Line 1.C	**Gross Premiums Paid**		**Total Of Contract Holder Premiums**
Line 1.C.1	**Administration Fees**		**Admin fee Times Number Of Contract Holders**
Line 2.	**Inpatient Hospital Services - Regular Payments**		**Facility Claims**
OGB's Qualifying Criteria		Document Type	UB
		DRG Code	Not Null
Line 3.	**Inpatient Mental Health Facility Services - Regular Payments**		**UBH Claims**
OGB's Qualifying Criteria		Specialty	HOS
		Bill Type	I
Line 4.	**Nursing Care Services**		**Outpatient Facility Claims**
OGB's Qualifying Criteria		Document Type	H
		Specialty	NPR, MID, DBE, CNS
Line 5.	**Physician and Surgical Services**		**Inpatient And Outpatient Claims**
OGB's Qualifying Criteria		Specialty (All MD and OD)	ANS, CVA, CVT, DC, DER, DPM, EMR, END, ENT, FLY, GAS, GRM, HBM, HEM, HNS, INF, INT, MAS, MAX, MIC, NEO, NEP, NES, NEU, OBG, OD, ONC, OPH, ORT, PAT, PED, PES, PHM, PLS, PMG, PST, PUL, RAD, RDO, RHM, SOM, SUR
Line 6.	**Outpatient Hospital Services**		**Facility Claims**
OGB's Qualifying Criteria		Document Type	U
		DRG Code	Null
Line 7.	**Outpatient Mental Health Facility Services - Regular Payments**		**UBH Claims**
OGB's Qualifying Criteria		Specialty	HOS
		Bill Type	O
Line 8.	**Prescription Drugs**		**Catalyst Drug Claims**
OGB's Qualifying Criteria		CPT	All But Family Planning Drugs (Omit Catalyst GPI Codes For Family Planning)
		Omit Catalyst GPI Coding	Data Warehouse Table - CATALYST_FAMILY_PLANNING
Line 8.A.1.	**Drug Rebate Offset - National Agreement**		**Separate Reporting**
OGB's Qualifying Criteria		Per Tommy Teague	Calculated Rebate From Member List
Line 9.	**Dental Services**		**Medical Claims**
OGB's Qualifying Criteria		Specialty	DDS, All 1st Letter D
Line 10.	**Vision and Hearing Services**		**Vision And Hearing Aids When Billed By The Physician**
OGB's Qualifying Criteria		CPT	Data Warehouse Table - HEARING_AIDS
Line 11.	**Other Practitioners**		**Non-MD/OD, Non Facility Claims**
OGB's Qualifying Criteria		Specialty	AUD, PAS
			Social Workers, Licensed Professional Counselors, Doctor of Social Work
		Specialty	4, 5, 16 (MHSA Contractor)
Line 12.	**Clinic Services**		**Rural Health Clinic Services**
OGB's Qualifying Criteria		Document Type	U
		POS	72
			Mental Health Clinic Services
		Specialty	61 (UBH)
Line 13.	**Therapy Services**		**Physical/Occupational Therapy**

APPENDIX-6 LACHIP Financial Report			
B. Line No	**REPORT HEADING**		**DESCRIPTION**
OGB's Qualifying Criteria		Specialty	PHY
		POS	Not 12 Or 34
Line 14.	**Laboratory and Radiological Services**		**Inpatient And Outpatient Claims**
OGB's Qualifying Criteria		Document Type	H
		Specialty	Exclude DDS
		CPT	Starting With 7 Or 8
Line 15.	**Durable and Disposable Medical Equipment**		**Inpatient And Outpatient Claims**
OGB's Qualifying Criteria		Specialty	DME
		CPT	Data Warehouse Table - DME_CODES
Line 16.	**Family Planning**		**Inpatient And Outpatient Claims**
OGB's Qualifying Criteria		Therapeutic Class	
		Catalyst GPI Coding	Data Warehouse Table - CATALYST_FAMILY_PLANNING
		CPT	All Family Planning Drugs
		CPT/HCPCS (Seek Code)	J1055-J1056, J7300-J7302, 58300-58301, 57170
Line 18.	**Screening Services**		**Periodic Screenings**
			Health And Developmental History
			Comprehensive Unclothed Physical Exam
			Interperiodic Screenings
			Laboratory Tests
			Health Education
OGB's Qualifying Criteria		CPT/HCPCS	99381-99385, 99391-99395 (TS Modifier Is Interperiodic)
			Appropriate Immunizations
		CPT	Data Warehouse Table - IMMUNIZATIONS
Line 19.	**Home Health Services**		**Nursing Services, Supplies, and Therapy**
OGB's Qualifying Criteria		Document Type	H
		POS	12
		Specialty	HMH, PHY
OR			
OGB's Qualifying Criteria		Document Type	U
		CPT	Data Warehouse Table - HOME_HEALTH_BILL_TYPES
Line 22.	**Hospice Care Services**		**Inpatient Claims**
OGB's Qualifying Criteria		Document Type	H
		POS	34
		Specialty	HMH, PHY
OR			
OGB's Qualifying Criteria		Document Type	U
		Bill Type	810 thru 82A
Line 25.	**Other Services**		**Skilled Nursing Facility, Rehab Facility, Other**
OGB's Qualifying Criteria		Specialty	SKN
OR			
OGB's Qualifying Criteria		Document Type	U
		Specialty	RHB, LTA
OR			
			All Other Charges Not Attributed To Any Of The Above
Line 26.	**Total**		**Sum of Lines 1-25.**

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-7 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: The Claim ID is the contractor's distinct identifier for all charges and services associated with a patient bill. Whenever OGB contacts the contractor relevant to information on a medical claim, this identifier will be used as reference to the specific claim.						
1	*	CLAIM ID	A/N	40	1-40	THE CONTRACTOR'S UNIQUE IDENTIFIER FOR THIS CLAIM.
Field 2: A service line references a discrete charge or service in a submitted claim. OGB uses service line detail for its reporting for the State of Louisiana whenever we are asked to study the potential effects of a change to existing benefits, whether financial or clinical.						
2	*	CLAIM LINE ID	A/N	40	41-80	THE CONTRACTOR'S IDENTIFIER FOR A PARTICULAR CHARGE OR SERVICE LINE.
Fields 3-4: Service Dates apply to the claim line, not the duration of the stay referenced for inpatient facility claims.						
3	*	FROM SERVICE DATE	D	8	81-88	THE START DATE OF SERVICE REFERENCED ON THIS LINE. **FORMAT- CCYYMMDD**
4	*	THRU SERVICE DATE	D	8	89-96	THE LAST/FINAL DATE OF SERVICE. **FORMAT- CCYYMMDD**
Field 5: For keyed claims, the date received, not the date keyed. For electronic claims, the date the contractor received the transmission.						
5	*	RECEIVED DATE	D	8	97-104	THE DATE THE CLAIM WAS RECEIVED BY THE CONTRACTOR **FORMAT- CCYYMMDD**
6	*	CLAIM SOURCE	A/N	1	105	"K": KEYED INPUT "A": AUTOMATIC/ELECTRONIC INPUT
7	*	SYSTEM ENTRY DATE	D	8	106-113	THE DATE THE CONTRACTOR FIRST ENTERED THE CLAIM INTO THE CLAIM PAYMENT SYSTEM **FORMAT- CCYYMMDD**
Field 8: For each action affecting the payment status or clinical information on a claim, the date that action was taken.						
8	*	ADJUDICATION DATE	D	8	114-121	THE DATE THE CONTRACTOR PROCESSED AN ORIGINAL CLAIM. FOR ADJUSTMENTS, THE DATE REPROCESSED **FORMAT- CCYYMMDD**
9	*	PAID DATE	D	8	122-129	THE DATE THE PROCESSED CLAIM WAS PAID OR ADJUSTED. FOR DENIED CLAIMS, THE DATE DENIED. **FORMAT- CCYYMMDD**
10	*	MEDICAL CLAIM DOC TYPE	A/N	10	130-139	THE TYPE OF DOCUMENT SUBMITTED, EITHER THE HCFA OR UB DESIGNATION.
11		SUBMITTED DRG	A/N	20	140-159	FOR INPATIENT CLAIMS, THE V25 DRG CODE THAT WAS SUBMITTED ON THE CLAIM
Field 12: Revenue code is required for UB-92 claims. OGB will calculate the patient's length of stay for our data warehouse reports based on revenue coding.						

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-7 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
12		REVENUE CODE	A/N	10	160-169	THE 3 CHARACTER REVENUE CODE USED ON UB92 CLAIM FORMS.
Field 13: The original billed charge for each claim line will be provided on all activity affecting the claim or claim line.						
13	*	CHARGE AMOUNT	N	15	170-184	THE DOLLARS BILLED/CHARGED BY THE PROVIDER FOR THIS CLAIM LINE.
Field 14: For in-network providers, the allowed amount is determined after repricing and applying rate tables. For out-of-network providers, the allowed amount is determined from the contractor's fee schedule for that service.						
14	*	ALLOWED AMOUNT	N	15	185-199	THE AMOUNT THAT IS ALLOWED PER THE PROVIDERS PRICING CONTRACT OR FOR OUT-OF-NETWORK PROVIDERS
Field 15: Copay is a fixed component of the member's cost share to be paid to the provider by or for the member directly and separately from other claim payments. Copays are established by the state and are listed in the plan benefits document.						
15	*	COPAY AMOUNT	N	15	200-214	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER AT THE TIME OF SERVICE SEPARATE FROM THE AMOUNT PAID BY THE CONTRACTOR.
Field 16: Coinsurance is a variable component of the member's cost share to be paid to the provider by or for the member directly and separately from other claim payments. This value is normally zero except for out-of network providers.						
16	*	COINSURANCE AMOUNT	N	15	215-229	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER, BUT NOT BY THE CONTRACTOR DUE TO THE MEMBER'S COINSURANCE ARRANGEMENTS.
Field 17: The deductible is a component of the member's cost share to be paid to the provider by or for the member directly and separately from other claim payments. This value is normally zero except for out-of network providers for which the member is subject to an annual limit.						
17	*	DEDUCTIBLE AMOUNT	N	15	230-244	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER, BUT NOT BY THE CONTRACTOR BASED ON PLAN BENEFITS.
18	*	COB PAID AMOUNT	N	15	245-259	THE AMOUNT PAID BY ANOTHER INSURER AGAINST THE MEMBER'S CLAIM, (COORDINATION OF BENEFITS)
19	*	WITHHELD AMOUNT	N	15	260-274	THE AMOUNT WITHHELD FROM PAYMENT DUE TO TERMS OF THE PROVIDER'S CONTRACT OR ACCOUNT.
20	*	PROVIDER PAID AMOUNT	N	15	275-289	THE NET AMOUNT THAT WAS EVENTUALLY PAID DIRECTLY BY THE CONTRACTOR TO THE PAY-TO PROVIDER FOR THIS CLAIM LINE.
21	*	MEMBER PAID AMOUNT	N	15	290-304	THE NET AMOUNT THAT WAS EVENTUALLY PAID DIRECTLY BY THE CONTRACTOR TO THE MEMBER, SUBSCRIBER OR EMPLOYEE FOR THIS CLAIM LINE.
Field 22: The net paid amount must equal the total of the provider paid amount and the member paid amount.						

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-7 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
22	*	NET PAID AMOUNT	N	15	305-319	THE NET AMOUNT THAT WAS PAID IN TOTAL FOR THIS CLAIM LINE BY THE CONTRACTOR.
23	*	TRANSACTION TYPE	A/N	20	320-339	THE TRANSACTION TYPE (OUTCOME). SPECIFICALLY, 'APPROVED', 'DENIED', 'DUPLICATE', 'REVERSED', 'REVERSAL', 'ADJUSTMENT'.
Field 24: The Adjusted From Claim ID field is blank for the first activity or transaction against a patient's bill, the "original claim". Depending on the contractor's procedures, for reprocessed claims this field will either contain the claim number of the original transaction or the claim number of the immediately prior transaction against the originally submitted claim. OGB will use this field to reconstruct a transaction history against the original claim. Note: Claim Line IDs remain the same throughout the transaction history of a member's claim (see Field 2 above).						
24		ADJUSTED FROM CLAIM ID	A/N	40	340-379	IF THIS CLAIM IS A REPROCESSING OF A MEMBER'S CLAIM, THIS FIELD WILL CONTAIN THE CLAIM ID OF THE PRIOR CLAIM.
Field 25: The contractor will provide OGB a file of their denial codes and the corresponding descriptions for the reasons a claim may be denied. Codes provided on denied claims will exist in the list provided, and any changes to the list will be provided to OGB in a timely manner. All denial reasons will be clear and accurately reflect the actual condition causing the denial. Note: The denial reason code is required for all denied claims						
25		DENIED REASON	A/N	20	380-399	IF DENIED, THE REASON CODE FOR THIS DENIAL.
26		BILL TYPE CODE	A/N	3	400-402	CREATED BY HCFA AND PROVIDES THREE SPECIFIC PIECES OF INFORMATION. THE FIRST CHARACTER IDENTIFIES THE TYPE OF FACILITY. THE SECOND CLASSIFIES THE TYPE OF CARE. THE THIRD INDICATES THE SEQUENCE OF THIS BILL IN THIS PARTICULAR EPISODE OF CARE.
27	*	PLACE OF SERVICE	A/N	20	403-422	THE HCFA STANDARD PLACE OF SERVICE CODE
28	*	TYPE OF SERVICE	A/N	20	423-442	THE HCFA STANDARD TYPE OF SERVICE CODE ON THE CLAIM.
29	*	SERVICE UNITS COUNT	N	11	443-453	THE NUMBER OF UNITS OF SERVICE DESCRIBED BY THE PROCEDURE REFERENCED ON THIS CLAIM LINE.
30		ANESTHESIA MINUTES	N	11	454-464	WHEN APPROPRIATE, THIS CLAIM LINE LISTS THE NUMBER OF MINUTES OF ANESTHESIA THAT WAS RENDERED.
Fields 31-36: Employee refers to the contract holder (subscriber), identified as relation = '01' in the State of Louisiana's eligibility file provided to the contractor in a daily transmission.						
31	*	EMPLOYEE SSN	A/N	11	465-475	THE CONTRACT HOLDER'S SOCIAL SECURITY NUMBER - LEFT JUSTIFIED AND FILLED WITH SPACES TO THE RIGHT. NO DASHES. THE FOREIGN WORKER NUMBER, WHEN APPROPRIATE.

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-7 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
32	*	EMPLOYEE LAST NAME	A/N	40	476-515	THE LAST NAME OF THE CONTRACT HOLDER.
33	*	EMPLOYEE SEX	A/N	1	516	THE GENDER OF THE CONTRACT HOLDER. 'F' = FEMALE; 'M' = MALE; 'U' = UNKNOWN
34	*	EMPLOYEE DATE OF BIRTH	D	8	517-524	THE CONTRACT HOLDER'S DATE OF BIRTH **FORMAT- CCYYMMDD**
35	*	EMPLOYEE ZIP CODE	A/N	9	525-533	THE CONTRACT HOLDER'S FULL ZIP CODE, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
Fields 36-45: Member refers to the patient for whom the charge or service was provided. For a claim to be paid, a member must be eligible as of the date of the service. Member information must correspond to OGB's eligibility transmission.						
36	*	UNIQUE MEMBER ID	A/N	8	534-541	THE MEMBER'S UNIQUE IDENTIFIER FROM THE STATE OF LOUISIANA'S ELGIBILITY FEED.
37		MEMBER SSN	A/N	11	542-552	THE MEMBER'S SOCIAL SECURITY NUMBER - LEFT JUSTIFIED AND FILLED WITH SPACES TO THE RIGHT. NO DASHES. THE FOREIGN WORKER NUMBER, WHEN APPROPRIATE.
38	*	MEMBER FIRST NAME	A/N	40	553-592	THE FIRST NAME OF THE MEMBER (PATIENT)
39	*	MEMBER LAST NAME	A/N	40	593-632	THE LAST NAME OF THE MEMBER (PATIENT)
40	*	MEMBER SEX	A/N	1	633	THE GENDER OF THE MEMBER. 'F' = FEMALE; 'M' = MALE; 'U' = UNKNOWN
41	*	MEMBER DATE OF BIRTH	D	8	634-641	THE MEMBER'S DATE OF BIRTH. **FORMAT- CCYYMMDD**
42	*	MEMBER ZIP CODE	A/N	9	642-650	THE MEMBER'S FULL ZIP CODE, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
Field 43: The relationship code will be consistent with that provided to the contractor in the daily eligibility transmission.						
43	*	RELATIONSHIP TO EMPLOYEE	A/N	2	651-652	THE RELATIONSHIP THIS MEMBER HAS TO THE CONTRACT HOLDER. '01 = EMPLOYEE/CONTRACT HOLDER '02' = SPOUSE '03' AND ABOVE= OTHER DEPENDENTS
Fields 44-45: The following should relate directly to a check written to a member in the check register transmitted along with the month's claim file.						
44		MEMBER CHECK NUMBER	A/N	10	653-662	FOR PAID CLAIMS, THE NUMBER OF THE CHECK USED TO PAY THE MEMBER
45		MEMBER CHECK AMOUNT	N	15	663-677	THE AMOUNT ON THE MEMBER'S CHECK
FIELDS 46-56 AND 60-65: DIAGNOSIS AND PROCEDURE CODING WILL ADHERE TO ICD-9 STANDARD CODING. ONCE A PLAN AND SCHEDULE FOR TRANSITION TO ICD-10 CODING IS ESTABLISHED, DIAGNOSIS CODES AND PROCEDURE CODES WILL BE REVISITED TO PROVIDE OGB WITH AN ACCURATE REPRESENTATION OF THE CLINICAL ASPECTS OF THE CLAIM.						

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-7 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
46	*	PRIMARY DIAGNOSIS CODE	A/N	10	678-687	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE PRIMARY DIAGNOSIS FOR THE SERVICE PROVIDED
47		DIAGNOSIS CODE 2	A/N	10	688-697	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SECOND DIAGNOSIS FOR THE SERVICE
48		DIAGNOSIS CODE 3	A/N	10	698-707	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE THIRD DIAGNOSIS FOR THE SERVICE
49		DIAGNOSIS CODE 4	A/N	10	708-717	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE FOURTH DIAGNOSIS FOR THE SERVICE
50		DIAGNOSIS CODE 5	A/N	10	718-727	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE FIFTH DIAGNOSIS FOR THE SERVICE
51		DIAGNOSIS CODE 6	A/N	10	728-737	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SIXTH DIAGNOSIS FOR THE SERVICE
52		DIAGNOSIS CODE 7	A/N	10	738-747	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SEVENTH DIAGNOSIS FOR THE SERVICE
53		DIAGNOSIS CODE 8	A/N	10	748-757	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE EIGHTH DIAGNOSIS FOR THE SERVICE
54		DIAGNOSIS CODE 9	A/N	10	758-767	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE NINTH DIAGNOSIS FOR THE SERVICE
55		ADMIT DIAGNOSIS CODE	A/N	10	768-777	FOR INPATIENT CLAIMS, THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE ADMIT DIAGNOSIS FOR THIS CLAIM
56	*	PROCEDURE CODE	A/N	10	778-787	THE ACTUAL PROCEDURE PERFORMED: - THE CPT PROCEDURE CODE ON HCFA FORMS - THE HCPCS PROCEDURE CODE ON UB92 FORMS - THE ADA PROCEDURE CODE ON DENTAL FORMS.
57		MODIFIER CODE 1	A/N	5	788-792	THE FIRST MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
58		MODIFIER CODE 2	A/N	5	793-797	THE SECOND MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
59		MODIFIER CODE 3	A/N	5	798-802	THE THIRD MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
60		ICD9 PROCEDURE CODE 1	A/N	10	803-812	THE PRIMARY ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
61		ICD9 PROCEDURE CODE 2	A/N	10	813-822	THE SECOND ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-7 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
62		ICD9 PROCEDURE CODE 3	A/N	10	823-832	THE THIRD ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
63		ICD9 PROCEDURE CODE 4	A/N	10	833-842	THE FOURTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
64		ICD9 PROCEDURE CODE 5	A/N	10	843-852	THE FIFTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
65		ICD9 PROCEDURE CODE 6	A/N	10	853-862	THE SIXTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
66		RX DRUG CODE	A/N	11	863-873	FOR DRUGS ADMINISTERED, THE PRESCRIPTION DRUG CODE (NDC) FOR THE CLAIM LINE, FORMATTED 542, NO DASHES
Fields 67-68: The service provider must exist in the provider file transmitted along with the month's claim file.						
67	*	SERVICE PROVIDER ID	A/N	20	874-893	THE UNIQUE ID OF THE SERVICE PROVIDER ASSIGNED IN THE CONTRACTOR'S CLAIMS PROCESSING SYSTEM.
68	*	NPI	A/N	10	894-903	THE SERVICE PROVIDER'S NPI
Fields 69-71: The pay-to provider must exist in the provider file transmitted along with the month's claim file.						
69		PAY-TO PROVIDER ID	A/N	20	904-923	THE UNIQUE ID OF THE PAY-TO PROVIDER ASSIGNED IN THE CONTRACTOR'S CLAIMS PROCESSING SYSTEM. THIS MAY BE THE SAME ID LISTED FOR THE SERVICE PROVIDER IF A SEPARATE PAYMENT ENTITY IS NOT ESTABLISHED. **NOTE: REQUIRED UNLESS ONLY MEMBER PAID OR CLAIM DENIED.**
70		NETWORK INDICATOR	A/N	1	924	AT THE TIME OF SERVICE, THE PROVIDER'S STATUS: 'I' = IN NETWORK; 'O' = OUT OF NETWORK **NOTE: REQUIRED UNLESS ONLY MEMBER PAID OR CLAIM DENIED.**
71		PAY-TO TAX ID	A/N	10	925-934	THE TAX ID NUMBER FOR THE PAY-TO ENTITY FOR THIS PROVIDER IF PROVIDER PRESCRIBED DRUGS.
Fields 73-74: The following should relate directly to a check written to a provider in the check register transmitted along with the month's claim file.						
72		PROVIDER CHECK NUMBER	A/N	10	935-944	FOR PAID CLAIMS, THE NUMBER OF THE CHECK USED TO PAY THE PROVIDER
73		PROVIDER CHECK AMOUNT	N	15	945-959	THE AMOUNT ON THE PROVIDER'S CHECK

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-7 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
74		OVERRIDE CODE	A/N	3	960-962	IDENTIFIES THAT THE APPROVER OVERRODE THE SYSTEM-GENERATED PAYMENT AMOUNT. IDENTIFIES THE REASON THE APPROVER OVERRODE THE SYSTEM (CLAIM RELATED TO DETOXIFICATION, PAY BENEFIT FROM CREDIT-RESERVE, REJECTED LINE ITEM. ETC.)
75		BENEFIT LEVEL CAUSE CODE	A/N	2	963-964	IDENTIFIES THE REASON THE PATIENT SOUGHT MEDICAL CARE BLANK=N/A 0=GENERAL SICKNESS 1=PSYCHIATRIC 2=NORMAL MATERNITY 3=EMERGENCY ILLNESS 4=ROUTINE CARE 5=COMPLICATIONS OF PREGNANCY 6=ALCOHOLISM AND DRUG ADDICTION A=ACCIDENT
76		DISCHARGE STATUS CODE	A/N	2	965-966	IDENTIFIES THE STATUS OF THE MEMBER'S INPATIENT STAY AS OF THE LAST SERVICE DATE ON THE CLAIM, RIGHT JUSTIFIED AND PREFIXED WITH ZERO

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Appendix A-8 Provider File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: To simplify references, a provider may have more than one entry in the provider file. Specifically, a provider must be identified by services performed but may be paid as a separate entity from its identity as a service provider. Multiple entries may be caused by different addresses, tax requirements, and/or contractual responsibility to a group. Service providers are referenced in Fields 67 and 68 of Appendix A-1, Medical Claims File. Pay-to providers are referenced in Fields 69 through 73 of Appendix A-1.						
1	*	PROVIDER INTERNAL ID	A/N	20	1-20	THE UNIQUE ID FOR SERVICE OR PAY-TO PROVIDER ASSIGNED BY CONTRACTOR IN CLAIMS PROCESSING
2	*	PROVIDER TAX ID	A/N	10	21-30	TAX ID OF THIS PROVIDER
3	*	NPI	A/N	10	31-40	THIS PROVIDER'S NATIONAL PROVIDER IDENTIFIER
4		PROVIDER DEA ID	A/N	10	41-50	THE FEDERAL DEA NUMBER OF THIS PROVIDER IF PROVIDER PRESCRIBES DRUGS.
Fields 5-8: A provider may refer to a physician, a facility, or another care provider. Either an office (Field 8) or a person (Fields 5-7) or both must be named in the following 4 fields.						
5		PROVIDER LAST NAME	A/N	40	51-90	THE LAST NAME FOR THIS PROVIDER
6		PROVIDER FIRST NAME	A/N	40	91-130	THE FIRST NAME FOR THIS PROVIDER
7		PROVIDER MIDDLE INITIAL	A/N	1	131	THE MIDDLE INITIAL FOR THIS PROVIDER
8		PROVIDER OFFICE NAME	A/N	40	132-171	THE OFFICE NAME, CORPORATION NAME, OR LOCATION NAME OF THE OFFICE THIS PROVIDER OFFERS SERVICES.
9	*	PROVIDER ADDRESS LINE1	A/N	40	172-211	LINE 1 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
10		PROVIDER ADDRESS LINE2	A/N	40	212-251	LINE 2 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
11	*	PROVIDER CITY	A/N	40	252-291	THE CITY PORTION OF THIS PROVIDER'S ADDRESS
12	*	PROVIDER STATE	A/N	2	292-293	THE STATE PORTION OF THIS PROVIDER'S ADDRESS
13	*	PROVIDER ZIP	A/N	9	294-302	THE ZIPCODE OF THIS PROVIDER'S ADDRESS, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
14		PROVIDER UPIN	A/N	20	303-322	THE UNIVERSAL PROVIDER IDENTIFICATION NUMBER FOR THIS PROVIDER
15		PROVIDER MEDICARE ID	A/N	20	323-342	THE MEDICARE IDENTIFIER FOR THIS PROVIDER
Fields 16-19: The contractor will send initially and keep current a file of specialty codes and descriptions used in their claims processing to OGB						
16	*	PROVIDER SPECIALTY	A/N	10	343-352	THE CODE FOR THE PROVIDER'S PRIMARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
17		PROVIDER SPECIALTY 2	A/N	10	353-362	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
18		PROVIDER SPECIALTY 3	A/N	10	363-372	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE THE CONTRACTOR'S SYSTEM.
19		PROVIDER SPECIALTY 4	A/N	10	373-382	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

						FROM THE CONTRACTOR'S SYSTEM.
20	*	PROVIDER TYPE	A/N	1	383	**"F" – FACILITY, "P" – PHYSICIAN, "O" – OTHER, "Y" – PAY-TO, "G" - GROUP**
Appendix A-9 Code Files						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: A Code is the contractor's distinct identifier for all codes of a type used in the data transferred to OGB. Code files are named by their type and must be transferred to OGB initially and whenever any changes to the codes of a type change or when codes are added. There are code tables for each non-standard code type, currently including provider specialties, denial reasons, types of service and override codes. Other non-standard coding may be discovered in the future, and, if so, this format may be used if appropriate for that use.						
1	*	CODE	A/N	20	1-20	THE CONTRACTOR'S UNIQUE IDENTIFIER FOR THIS CODE TYPE.
2	*	SHORT DESCRIPTION	A/N	100	21-120	THE CONTRACTOR'S MEANING FOR THE CODE IDENTIFIED.
3		LONG DESCRIPTION	A/N	400	121-520	IF NECESSARY, A MORE THOROUGH DESCRIPTION OF THE MEANING OF THE CODE DESCRIBED ABOVE.
Fields 3-4: Effective and Termination Dates may or may not apply to the code referenced. These fields may be left blank.						
4		EFFECTIVE DATE	D	8	521-528	THE FIRST DATE THE CODE CAME INTO USE. **FORMAT- CCYYMMDD**
5		TERMINATION DATE	D	8	529-536	THE LAST/FINAL DATE THE CODE WAS USED. **FORMAT- CCYYMMDD**

ATTACHMENT E

REQUIRED REPORTS

A. Monthly Report

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.

1. **Financial Experience:** Summary of Paid claims (separate for capitated and non-capitated claims) for the most recent month and cumulative for the fiscal year by active, non-Medicare retirees and Medicare retirees.

2. **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 representative).

3. **Telephone Abandonment Rate:** Percent of calls where the caller hangs up after opting to speak with another service representative and the call has been transferred to a participant service representative.

4. **PCP Turnover Rate:** Percent of PCPs leaving the network voluntarily or involuntarily during the month.

5. **Open PCP/Participant Ratio:** Ratio of open PCPs accepting new participants to actual participants.

6. **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

SAS-70/SSAE-16, Type II

C. Other Required Reports

Disease Management-

Data Systems

Contractor will deliver the Disease Management Services using a proprietary system that Contractor has developed to operationally support and manage the Disease Management Services, and to provide data for evaluation and reports of operating performance and outcomes.

Standard Reporting

The initial reporting and analysis for the Disease Management Program will consist of a series of Contractor's standard activity-based reports As the Disease Management Program evolves, other reports may be added as mutually agreed by the Parties in the Planning Meetings.

Contractor will provide OGB with its standard "**Member Level Return File**", which includes selected demographic and activity information for Eligible Members with Targeted Chronic Conditions (such as information related to Eligible Members who have had telephonic contact with Contractor during the most recent time period). The Member Level Return File will also contain information to identify Participants for a specific month and will be delivered to OGB monthly.

Contractor will conduct a total-population-level annual member satisfaction survey, using Contractor's standard telephone-based survey tool and process to collect responses from an appropriate group of individuals, including Participants who have been engaged with the Health Coaching process. The timing of this survey will be subject to mutual agreement of the Parties.

Operational Performance Standards

Contractor shall deliver the Health Coaching Services consistent with the operational service standards set forth below, measured on a calendar quarterly average basis for the primary health coaching center supporting Eligible Members, and based on Contractor's standard reports for such activities:

Operational Service Standard
Average telephone answer time ≤ 40 seconds
Average internal telephone hold time ≤ 40 seconds

Clinical, Satisfaction and Participation Performance Standards

Contractor will provide the Disease Management Services described in a manner that is consistent with the Performance Standards.

Medical Cost Savings Measurement and Performance Standards

For each Program Year, Contractor will measure the medical cost savings that are the result of the Contractor Services provided. Contractor will utilize the medical cost savings measurement and reconciliation methodology as approved by OGB.

Mental Health/Substance Abuse-

1. Monthly Reports (Must be received within 30 days following the end of the month), Monthly reports must contain an Executive Summary.

   a. Enrollment -- Number enrolled sorted by active, retiree, (Medicare and non-Medicare), dependent, LACHIP by age and sex. Average age of plan members to be included, sorted by active, retiree, dependents and LACHIP.

   b. Authorization – Admission and units of service authorized by level of care and network status (participating vs. out of network) and reported separately for MH, SA and Total combined MH and SA; displayed by number and per 1000 members annualized.

   c. Financial -- Provider charges and paid claims amounts for current month and cumulative year-to-date broken into categories by actives, retirees (Medicare and non-Medicare), dependents, LACHIP and level of care.

   d. Claims Processing -- Number of claims received, paid, pended and denied by type of service; dollar amount of claims paid and denied; number and percent processed within 14 days and within 30 days. The number and amounts of payments for the LaCHIP claims must be reported separately.

   e. Appeals and Denials by level of care and level of appeal Report should include break-out by clinical (medical necessity) and administrative denials reason type, providing data on number of denials, number/percent that are appealed at each level; resolution of appeal and % resolved within timeframe standards.

   f. Member and Provider Complaints

   g. Telephone Service – To include number of calls received (by type and combined), average speed of answer, percent answered within 30 seconds, average hold time, number of calls placed on hold that exceeded three (3) minutes, average abandonment rate and number of calls actually abandoned.

2. Quarterly Reports (Must be received within 45 days following the end of the each quarter). Quarterly reports must contain an Executive Summary.

   a. Roll-up of monthly reports and year to date

   b. Cost and Utilization of Care:
      - total charges and total paid (incurred during qtr and YTD and paid though run date of report) claims by level of care and broken out for MH and SA;
      - penetration rate, PMPM expense, PEPM expense, utilizers per 1000; members per 1000 by level of care;
      - paid (incurred during qtr and YTD and paid though run date of report) admits per 1000 and days/visits per 1000 by level of care;
      - average cost (amount claims paid) per day/visit, per admission by level of care and total;
      - Charges and paid by level of care and member category (active, dependents, retirees (with Medicare, retirees without Medicare), LACHIP;
      - Top 15 diagnosis report with claims paid, unique member count, utilizer per 1000 for quarter and YTD; Report should detail top 15 for Inpatient (total days and average length of stay, average amount paid per day and per admission); top 15 for outpatient (ambulatory) and combined.

   c. Care Management:
      - High cost report – number of members accumulating > $10,000 in paid claims during period and > $25,000 YTD with number of patients, average paid per patient, total paid amount, percent of total paid claims, distribution by diagnosis and member category (active, dependents, retirees with Medicare, retirees without Medicare and LaCHIP Members).
      - Number screened for Intensive management programs (case management, disease management, etc); number admitted to intensive management programs
      - In-patient Follow-Up Program Metrics – number of discharges, number members with attempted calls, number members with calls completed; number and percent of discharged with ambulatory follow-up appointment within 7 days of discharge and 30 days of discharge.
      - Readmissions within 30 day, 90 days and 365 days; should include comparison across quarters/years
      - number of IP admission reviews, and number of concurrent reviews;

   d. Network:
      - Claim charges and paid for participating versus non-participating providers by level of care and broken out for MH and SA;
      - Total claim charges submitted, amount paid, member responsibility, disallowment amount and net paid;

- Number of providers and facilities in network by type (MD, Psychologist, Masters level, Intensive Outpatient, Partial Hospital, Acute Hospital, CD Rehab, Residential);
- Number provider and facility terminations by type during report period;
- Number of new and re-contracted contracted providers and facilities by type during report period.

e. Claims Quality Report – number of claims reviewed/audited, dollar amount of claims reviewed; percent financial payment accuracy and percent claims processing accuracy.

f. COB/Subrogation - Report by active, retiree with Medicare and retiree without Medicare, type of service, amount of claim and amount recovered;

g. Quality Report – Report of status and/or progress on performance standards and quality improvement projects

h. "ALERT" Report – Over-utilization or abuse by plan member or provider, fraud, etc. with number of cases identified and disposition, number of cases under review.

i. Fraud and Abuse Report

3. Semi-Annual Reports (Must be received 30 days following the end of every 6 months) Semi-Annual Reports must contain an Executive Summary).

   a. Geo Access Report for rural and urban, displayed for inpatient facility, partial, hospital, outpatient provider and MD

4. Annual Reports (Must be received within 60 days following the end of the fiscal year) Annual reports must contain an Executive Summary. and cumulative monthly and quarterly reports.

   a. Financial – Charges billed and paid claims amounts for each metropolitan area for current month and cumulative year-to-date broken into categories by:
      - level of care, service type (MH, SA, Combined MHSA)
      - employee category (actives, dependents, retirees (Medicare and non-Medicare), LACHIP
      - age group.

   b. Claims -- Lag report showing month of service and month of payment.

   c. Clinical Trend Report-- List of 25 most common inpatient diagnoses, (charges and paid) and list of outpatient diagnosis with paid charges and paid (include cost/member, sorted by geographic location and in the aggregate.

d. Clinical Quality Metrics
   - Follow-up care for children prescribed ADHD medication (can be submitted for last calendar year ending within the contract year)
   - Follow-up after hospitalization for mental illness – 7 days, 30 days.
   - Antidepressant Medication Management (can be submitted for last calendar year ending within the contract year)
   - Results of selected performance improvement projects

e. Network:
   - List of 50 most utilized network providers in Louisiana by geographic region, by average number of visits
   - List of top 25 most utilized facilities by number of admissions, average length of stay, 30 and 90 day readmission rate and 30 day ambulatory follow-up rate.
   - In-network versus out-of network analysis for each level of care.

f. Geo Access for inpatient, outpatient and MD (based on performance standards)

g. Patient Satisfaction Survey Results

h. Provider Satisfaction Survey Results

i. Savings – Savings summary by COB, subrogation, other.

In general, periodic reports must contain sufficient data to allow the reader to quickly analyze current period utilization as compared to previous periods and comparative benchmarks. The reports should contain a one-page overview of the period's activity noting the following key elements for mental health care alone, substance abuse alone, and mental health/substance abuse combined:

Inpatient (by facility type and combined)

1. Number of admissions
2. Number of total beds in acute facility
3. Average length of stay in acute facility
4. Average cost/day
5. Average cost per inpatient case
6. Total inpatient claim cost
7. Number of readmits within 30 days, 90 days and 365 days
8. Percentage of readmits with 30 days, 90 days and 365 days
9. Number of treatments within 30 days, 90 days and 365 days
10. Percentage of readmits with 30 days, 90 days and 365 days

Outpatient (by service type and combined)

11. Total number of patients receiving outpatient sessions
12. Total number of outpatient sessions
13. Average number sessions/patients
14. Average cost/session
15. Average cost per outpatient episode/case
16. Number of outpatient visits/1000 plan participants

A sample report layout which would include this information plus a trend of activity might look like:

Key	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter			Year-to-Date		
Elements	P	S	C	P	S	C	P	S	C	P	S	C	P	S	C
# of admissions															

P=psychiatric S=substance abuse C=combined

Included with your quarterly reports should be information as suggested by the following formats:

Utilization	Benchmark (using your firm's goal data)	Quarter beginning _____ and ending _____
Acute Inpatient Admissions		Combined Mental Health Substance Abuse
IP Average Length of Stay		Combined Mental Health Substance Abuse
IP Days/1000 lives		Combined Mental Health Substance Abuse
Residential Admissions		
Residential Average Length of Stay		
Residential Days/1000 lives		
Partial Hospital (PH) Admissions		

Utilization	Benchmark (using your firm's goal data)	Quarter beginning _____ and ending _____
PH Average Length of Stay		
PH Days/1000 lives		
Intensive Outpatient (IOP) Admissions		
IOP Average Length of Stay		
IOP sessions/1000 lives		
Outpatient visits/patient		Combined Mental Health Substance Abuse
Outpatient visits/1000 lives		Combined Mental Health Substance Abuse

Paid Claims

Claim Type	Requested Amount	Allowed Amount	Provider Discount	COB	Copay	Deductible	Amount Paid
Inpatient							
CD Rehab							
Residential							
Partial Hospital							
Intensive Outpatient							
Outpatient							
Other							
Totals							

j. Other

1. Ad hoc reports other than those listed above may be required by OGB from time to time.

In preparing your response, bear in mind that this section is intended to illustrate the types of reports that might be required on a periodic basis. You should consider this the minimum data that you will be required to collect and maintain. The final report formats will be determined based upon mutual discussion and agreement among OGB staff, its consulting firm and the successful proposer prior to contract implementation.