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

NOTICE OF INTENT TO CONTRACT (NIC)

FOR

FULLY INSURED

HEALTH MAINTENANCE ORGANIZATION (HMO)

ISSUED

October 22, 2010

TABLE OF CONTENTS

SECTION I

GENERAL INFORMATION AND INSTRUCTIONS OF PROPOSAL FORMAT

A. Introduction and Purpose

The State of Louisiana, Office of Group Benefits (hereinafter called "OGB" or "the Program") requests proposals from any Louisiana HMO (hereinafter called "Proposer") to provide fully-insured HMO coverage on a regional basis.

"C. As used herein the term "Louisiana HMO" shall have the meaning set forth in La. R.S. 42:802.1(C), enacted by Act 479 of 2007,as follows:

"The term "Louisiana HMO" means a health maintenance organization which meets all of the following criteria:
(1) Offers fully insured commercial and/or Medicare Advantage products;
(2) Is domiciled, licensed, and operating within the state;
(3) Maintains its primary corporate office and at least seventy percent of its employees in the state; and
(4) Maintains within the state its core business functions which include utilization review services, claim payment processes, customer service call centers, enrollment services, information technology services, and provider relations."

OGB is vested by statute with responsibility for providing 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 to contract with Proposers that can work with the Program to accomplish its 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.

B. OGB Information Technology

Desktop: Dell 450 Workstations running Windows XP
LAN: 10/100/1000 Ethernet using Cisco switches
Servers: Windows servers, AIX UNIX servers, and LINUX servers
WAN: 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, MS Exchange, FileNet (Oracle based imaging and document management system). OGB uses Oracle databases as its standard.

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

C. Term of Contract

The initial term of the contract will be twenty-four months (July 1, 2011 – June 30, 2013) with an option to renew for an additional one-year term, exercisable by OGB only if the actuarial analysis conducted in accordance with the provisions of La. R.S. 42:802.1(E), enacted by Act 479 of 2007, indicates no additional cost to OGB's plans of benefits.

D. Standard Contract Provisions

See Exhibit 6 for the State of Louisiana, Office of Group Benefits Contract. 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 successful 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.

E. State Contribution to Cost

See Exhibit 6 for OGB Official 2010-2011 Insurance Premium Rates.

As the primary OGB plan, the PPO Plan provides the benchmark for the state contribution to premiums for all other plans:

The contribution of the state for HMO enrollees will not exceed the lower of the following:

1. The same percentage of the HMO premium as the percentage of the premiums contributed by the State for the OGB PPO plan for the enrollee's class of coverage; or

2. The dollar amount contributed on behalf of participants in the OGB PPO plan.

F. Instructions on Proposal Format

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

Proposers should respond thoroughly, clearly and concisely to all of the questions set forth in the Notice of Intent to Contract (NIC). Answers should specifically address current capabilities separately from anticipated capabilities.

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

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

3. Order of presentation:

   - Cover Letter & Executive Summary. Your Executive Summary should not exceed three (3) pages.

   - Proposer Requirements/Attachments/Checklist
     Tab 1 – General Questionnaire
     Tab 2 – Audited Financial Statements/Department of Insurance Annual Statements
     Tab 3 – Membership Satisfaction Survey
     Tab 4 – Management Reports
     Tab 5 – List of Network Providers
     Tab 6 – Proposal Checklist – Completed
     Tab 7 - Proposer Information
     Tab 8 - Mandatory Signature Page
     Tab 9 – Premium Quotation Forms (**Include in three-ring binder**)

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.

G. Ownership, Public Release and Costs of Proposals

1. All proposals submitted in response to this NIC become the property of the 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. 44:1et.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 redacted proposal available for inspection and/or copying upon the request of any individual pursuant to the Louisiana Public Records Law without notice to you.

SECTION II

SCHEDULE OF EVENTS

A. Time Line

NIC Issued - Public Notice by Advertising in the Official Journal of the State/Posted OGB Website/Posted to LAPAC	October 22, 2010
NIC Mailed or Available to Prospective Proposers Posted to OGB Website; Posted to LAPAC	October 22, 2010
Deadline to Notify OGB of Interest to Submit a Proposal (**MANDATORY)**	November 1, 2010
Deadline to Receive Written Questions	November 1, 2010
Electronic Data Sent to Interested Proposers	November 4, 2010
Response to Written Questions	November 9, 2010
Proposer Conference- Attendance in Person (**MANDATORY)**	November 16, 2010
Proposals Due to OGB	November 30, 2010
Finalist's Interviews/Site Visits	TBD
Probable Selection and Notification of Award	TBD
Contract Effective Date	July 1, 2011

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:

Tommy D. Teague
Chief Executive Officer
Office of Group Benefits
Post Office Box 44036

Delivery:
7389 Florida Blvd., Suite 400
Baton Rouge, LA 70804

Mail:
Post Office Box 44036
Baton Rouge, LA 70804

Fax: (225) 925-6716

E-mail: lclack@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 Standard Time (CST) on the date listed in the Schedule of Events. Written questions should be directed to the address listed above (Section B).

D. Mandatory Proposers Conference

The Proposers Conference will be held in conference room 2 at 10:00 a.m. CST at the following location:

Office of Group Benefits
7389 Florida Blvd., Suite 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., CST 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 in regards 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 Standard Time (CST) on or before the date listed in the Schedule of Events at the address listed above (Section B).

SECTION III

SCOPE OF SERVICES

A. Plan of Benefits

Through this NIC, OGB seeks to contract with a health maintenance organization to offer fully-insured HMO coverage on a Regional basis. Services would commence July 1, 2011, with a thirty day enrollment period during the month of April.

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. Mental Health/Substance Abuse Services;
6. Prescription Drugs;
7. Utilization Management and Medical Management;
8. Disease Management (Asthma, Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease and Chronic Heart Failure)
9. Claim Payment Processes, Customer Service Call Centers, Enrollment Services, Information Technology Services, Provider Relations, and all other services required to administer the coverage to be provided.

B. Eligibility, Premium Collection, OGB Administrative Fee

OGB determines eligibility of plan participants.

The HMO must agree to maintain identical eligibility requirements and continued coverage provisions as the OGB, as may be amended from time to time. No exceptions or variations will be allowed.

See OGB Contract, Exhibit 6 for OGB Eligibility Information and Requirements.

OGB retains responsibility for billing and collection of premiums for all plan participants.

OGB shall impose a monthly administrative fee of $15.00 for each HMO enrollee/subscriber. The monthly administrative fee will be billed and collected by OGB as an addition to your premium charge. **The monthly administrative fee must NOT be included in your premium quotations provided in the Premium Quotation Forms.**

C. Plan of Benefits

See Exhibit 1 for OGB's Plan of Benefits.

In order to ensure, to the greatest extent practicable, that the plans for benefits and coverages available for employees in all parts of the state are comparable with respect to coverages offered, as required by La.R.S. 42.802(B)(6), as amended and re-enacted by Act 479 of 2007, your plan of benefits must conform exactly with the plan of benefits set forth in Exhibit 1. A plan that includes benefits different from those specified in the Exhibit 1, whether reduced or enhanced, will be considered non-responsive.

D. Use of Non-Contracted Providers

If the Contractor cannot deliver all the benefits and services required by this NIC through contracted providers, the Contractor shall arrange and pay for such services to be rendered by non-contracted providers. When the Contractor or one of its contracted providers arrange for non-contracted services covered under the master benefit plan, the plan member's financial liability is limited to the amount the member would have had to pay, if any, had the service been rendered by a contract provider. Balance billing is prohibited. A violation of this requirement shall result in a fine of $1,000 per documented occurrence.

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

E. Required Membership Materials

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

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

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

3. One identification card for individual coverage and 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. An interlink to Contractor's Website which includes Provider Directory, etc.

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

F. Plan Member Communication Material, Advertisements and Marketing Material

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

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

The Contractor must be aware that the premium quoted must include cost of services to be provided by Contractor to process run off health claims at the termination of the contract.

G. Grievance Procedure

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

H. Contractor Administrative Contact

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

I. Enrollment Procedures

The Contractor must agree to the following Enrollment procedures:

1. Enrollment shall be the period announced by OGB to allow employees to join a Plan, members to change coverage, or to add eligible dependents without regard to age, sex, or health condition. It is anticipated that the Initial Enrollment for an effective date of July 1, 2011 will be conducted April 1, 2011 through April 30, 2011. Thereafter, the regular Annual Enrollment will be conducted during the month of April for an effective date of July 1.

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

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

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

5. The Contractor shall provide a summary description of its Plan in easy-to-understand language to plan members during the Enrollment meetings. This health plan summary is intended to provide some basic and general information about the special benefits of membership in the Plan, including plan limitations and exclusions, to enable eligible plan members to make an informed decision when selecting among available health plan options. This summary descriptions hall be approved by OGB prior to printing.

6. All enrollment documents shall be processed at the OGB office, including data entry into the billing and eligibility system. Electronic eligibility data will be transferred to Contractor daily.

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

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

J. Reporting Requirements

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

See OGB Contract Exhibit 6 for specific information regarding data information and description and layout of the required reports, including a penalty provision for failure to provide reports on a timely basis.

K. Premium Quotations Requirements

1. Commissions or finder's fees are <u>not payable</u> under this contract.

2. The cost to develop, print and disseminate materials to communicate with employees, retirees and providers as necessary to effectively implement and manage the Plan must be included in your Premium Quotation. This communication material shall be subject to OGB advance approval. The Contractor will be responsible for issuing I.D. cards and any replacement cards directly to plan members. Costs associated with the above will not be separately reimbursed.

3. All services described in this NIC, including all necessary reports and any start-up costs must be included in your proposed premium proposals. Furthermore, your cost proposal must take into account your expenses associated with attendance at all required meetings in Baton Rouge with the Group Benefits Policy and Planning Board or its Committees and with the OGB management, staff and its Actuarial Services Contractor. You may assume 4-6 meetings per year. No pass-through of costs will be permitted.

4. HMO Premium

   You must provide a fixed monthly rate for a single, active employee coverage for the initial contract period of July 1, 2011 to June 30, 2013 for all proposed regions (I.e. If you are quoting all nine regions, you will provide nine monthly rates utilizing the forms provided in this NIC.) You must provide the maximum percentage of increase or maximum percentage of decrease for the renewal period in the space provided. The percentage will be computed against the rate for the initial contract period. If the blanks for the maximum percentage of increase or decrease for the renewal period are not completed, prices during renewal period will be the same as the original.

   Premium rates will be subject to all federal regulations pursuant to the Patient Protection and Affordable Care Act (PPACA).

   The premiums for all other classes of coverage will be derived from the single, active employee rate utilizing the following factors applied to OGB's self-insured PPO and HMO plans:

Active	**Factor**
Single	1.000
With Spouse	2.124
With Child (Children)	1.220
Family	2.240
Retired w/o Medicare and Rehired Retirees	
Single	1.860
With Spouse	3.285
With Child (Children)	2.072
Family	3.269
Retired 1 w/ Medicare	
Single	0.605
With Spouse	2.235
With Child (Children)	1.047
Family	2.978

Retired 2 w/ Medicare	**Factor**
With Spouse	1.087
Family	1.346

COBRA	
Single	1.020
With Spouse	2.167
With Child (Children)	1.244
Family	2.285

Disability COBRA	
Single	1.504
With Spouse	3.186
With Child (Children)	1.829
Family	3.360

SECTION IV

PROPOSAL REVIEW AND CONTRACT AWARD

A. Proposal Review

Each Proposal will be reviewed by an Evaluation Committee to insure all requirements and criteria set forth in the NIC have been met. Failure to meet all of the Proposer Requirements will result in rejection of the proposal.

B. Contract Award

In accordance with the provisions of La. R.S. 42:802.1(A), enacted by Act 479 of 2007, contracts will be awarded on a regional basis to any Louisiana HMO that submits a competitive proposal. However, if more than three different Louisiana HMOs submit competitive proposals for a region, OGB will select at least three Louisiana HMOs for that region. The selection shall be based on a comparison of the quotes of each competitor for coverage of an active single insured which have been adjusted to an actuarially equivalent basis.

A proposal will be deemed competitive if the proposed premium rate is not higher than the current rates for OGB's self-insured HMO.

SECTION V

PROPOSERS REQUIREMENTS/ATTACHMENTS/CHECKLIST

A. Proposers Requirements

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

1. You are a “Louisiana HMO” as defined in La. R.S. 42:802.1(C), enacted by Act 479 of 2007, as follows:

   The term "Louisiana HMO" means a health maintenance organization which meets all of the following criteria:
   (1) Offers fully insured commercial and/or Medicare Advantage products;
   (2) Is domiciled, licensed, and operating within the state;
   (3) Maintains its primary corporate office and at least seventy percent of its employees in the state; and
   (4) Maintains within the state its core business functions which include utilization review services, claim payment processes, customer service call centers, enrollment services, information technology services, and provider relations.

2. A certificate of good standing from the Louisiana Department of Insurance.

3. You have a minimum of three (3) years of operation experience in providing HMO coverage to plan members within the State of Louisiana immediately prior to the date proposals are due.

4. The initial term of any Contract award pursuant to this NIC will be twenty-four (24) months commencing July 1, 2011 and ending June 30, 2013.

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

6. You must submit your firm’s audited financial statements for your most recent two (2) fiscal years together with your two (2) most recent Annual Statements filed with the Louisiana Department of Insurance.

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

B. Required Attachments to Proposal

Proposer must provide the following attachments with the Proposal:

1. Audited Financial Statements, DOI Annual Statements - Tab 1 of Proposal

Copies of your audited financial statements for the most recent two (2) fiscal years that includes your entire Louisiana operation.

Copies of your two (2) most recent Louisiana Department of Insurance annual statements.

2. Membership Satisfaction Survey – Tab 2 of Proposal

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

3. Management Reports – Tab 3 of Proposal

Please provide a sample of your current management reports.

4. List of Network Providers – Tab 4 of Proposal

Electronic copy of network providers, including but not limited to:

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

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

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

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

C. Proposer Checklist – Tab 6 of Proposal

Answers may be handwritten on the Checklist form. Explanations can be attached or added onto the back of the Checklist if desired. This Checklist will be Tab 1 in your submitted Proposal.

Requirements – Questions	Yes	No
1. Are you a Louisiana HMO as defined by La. R.S. 42:802.1(C), enacted by Act 479 of 2007? a. Do you offer fully insured commercial HMO products? b. Are you domiciled, licensed, and operating within the State of Louisiana? c. Do you maintain your primary corporate office and at least seventy percent of your employees in Louisiana? d. Do you maintain within the State of Louisiana your core business functions, including utilization review services, claim payment processes, customer service call centers, enrollment services, information technology services, and provider relations?		
2. Do you have at least three years of operational experience in providing the required services within the State of Louisiana?		
3. Do you agree to meet all of the General Contractual Requirements set forth in Exhibit 6 Contract/Business Associate Agreement?		
4. Do you agree to meet all of the requirements set forth in this NIC?		
5. Is your organization certified in Louisiana in compliance with L.A.R.S. 40:2721 et seq. ?		
6. Will you designate one key person and at least one back-up staff member as the contacts to OGB for all daily operational questions related to your operations statewide?		
7. Did a representative from your organization attend the Mandatory Proposers Conference?		
8. Do you agree to provide the exact Plan of Benefits which matches the benefit plan required by the NIC?		

9. Do you acknowledge that any Sub-Contractor hired by you will be clearly identified in your Proposal and that OGB will be notified in advance if you intend to subcontract any other services or change the way in which you contract with current subcontracted vendors during the course of the contract since Sub-Contractors are subject to prior approval.

10. Do you agree to provide all of the required reports and data for the data warehouse requested in the NIC?

11. Do you acknowledge that no commission or finder fees of any type will be payable by you with this contract?

12. Have you included in your NIC response copies of your organization's audited financial statements for the 2 most recent fiscal years?

13. Have you included in your NIC response complete copies of your 2 most recent annual statements filed with the Louisiana Department of Insurance?

14. Have you submitted a complete response to all questions set forth in the Narrative Section of this NIC?

15. Have you included all of the required attachments requested in the NIC?

16. Are you URAC Accredited?

17. Are you NCQA Accredited?

SECTION VI

GENERAL QUESTIONNAIRE
TAB 1 of PROPOSAL

Please answer each of the following questions. Repeat each number and question and make your answers as concise as possible. Please use this file when completing your response. Your quote will not be considered unless this questionnaire is answered in its entirety.

A. Organizational Background

1. Please provide your company's latest financial rating.

Rating Agency	Rating	Date Reviewed
A.M. Best		
Moody's		
Standard & Poor's		
Weiss		

2. How long has your organization offered fully-insured HMO plans?

3. Please identify the number of current members enrolled by plan type with your organization:

Product	Number of Members
Employer-sponsored HMO	
Individual HMO	
Employer-sponsored PPO	
Individual HMO	
Other	
Other	

B. Account Management

1. From what office will the account be managed?

2. Do you have a reporting system that is available to clients for use via the Internet for standard and ad hoc reporting?

C. Member Service

For the following questions, please make your responses specific to the member service location you are proposing for OGB.

1. Where will member services be handled?

2. Will staff be dedicated/designated to OGB? Please define dedicated/designated.

3. What are the hours of operation?

4. For the office that will handle the OGB account, please provide the following service statistics:

	Standard	2009 Actual	2010 1st 6 months
Telephone average speed of answer			
Percentage of calls abandoned			
Average waiting time			
Average call time			
Average time for problem resolution from initial notification			
Telephone quality			
Percentage of problems resolved during first call/contact (member does not need to call back)			

5. During OGB's open enrollment period, are you willing to extend customer service hours for potential participants? If yes, what extended hours of operation do you propose?

D. Claims Processing/Administration

1. Where will claim processing be handled?

2. Please provide claim adjudication statistics for the proposed claim office in the table below.

	Standard	2009 Actual	2010 1st 6 months
Financial accuracy (percent of dollars paid correctly)			
Overall accuracy			
Turnaround time in 14 calendar days			
Turnaround time in 28 calendar days			

3. What percent of overall claims are auto-adjudicated?

4. When was the last major upgrade of your claim processing system?

5. Are there any upgrades to your claim processing system planned for the next 24 months? If so, please explain.

6. Please describe your account structure parameters/limits for OGB's billing breakdown.

E. Web Tools

1. Which of the following services are currently or will be available by 2011 through your Web-site? (Please √ *Yes* or *No*.)

	Current		2011	
Member Self-Service – Can members:	**Yes**	**No**	**Yes**	**No**
a. access provider information?				
b. access provider directories?				
c. access provider directories with driving instructions?				
d. participate in community forums?				
▪ If no, does your Web site link to this type of site?				
e. access benefit plan summaries?				
f. enroll on-line?				
g. check eligibility?				
h. order replacement ID cards?				
i. order replacement ID cards?				
j. "talk" to providers (i.e., "Ask-the-Physician")?				
k. file a claim?				
l. download printable versions of claim forms?				

	Current		2011	
m. check claim status?				
n. submit appeals?				
o. submit inquiries to customer service via email?				
p. determine whether hospital-based doctors are in-network at each in-network facility?				
Provider Support - Can providers:	**Yes**	**No**	**Yes**	**No**
q. verify in “real-time” the eligibility status of members?				
r. create virtual medical records for their patients?				
s. access drug and medical history for their patients?				
t. access lab values or other encounter data?				
u. submit claims?				
v. submit precertification information/extended LOS information?				
Health Management – Can members:	**Yes**	**No**	**Yes**	**No**
w. access disease management program information?				
x. access educational information?				
y. complete a health risk assessment?				
z. develop and save a health profile?				
Plan Sponsor/Employer Support	**Yes**	**No**	**Yes**	**No**
aa. Can plan sponsors check participants online?				
bb. Can plan sponsors update eligibility online?				

2. Please describe any planned upgrades to your reporting systems.

F. Health Management

1. Please provide brief descriptions for all of the health management programs (health promotion, health risk management, chronic disease management, high cost case management, care coordination, etc.) your organization offers for HMO enrollees that are included in the quoted premiums.

2. Are clients able to access case management, care coordination and disease management program information and statistics via a secure internet site/web database (program reporting, downloadable communication materials, etc.)?

3. Is your organization able to report population health risk status and changes to the client on a regular basis using claim data and/or information from another health risk

assessment vendor? If so, please describe.

4. What tools are provided to behavior modification program participants to encourage interaction with their physician?

5. Please describe the outreach methods to those participants eligible to participate in a structured program?

G. Prescription Drugs

1. Provide a listing of the top 100 drugs that are included in your formulary.

2. Describe any dosage or imposed dispensing limits.

3. Provide information regarding the therapeutic management programs currently in place.

4. Provide details on your mail-order functionality/process.

5. How will transition of care issues be handled?

H. Communications

1. Please provide an overview and samples of any communication pieces that may be used during the enrollment process.

2. Please provide samples of any communication campaigns or monthly/quarterly newsletters sent to plan participants.

SECTION VII

PROPOSER INFORMATION
Tab 7 of Proposal

A. PRIMARY PROPOSER

Please provide the following for your Organization:

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

B. PARENT COMPANY

SAME INFORMATION AS LISTED IN (A).

C. SUBSIDIARIES/AFFILIATES TO PERFORM SIGNIFICANT SERVICES

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

D. HMO Client References

Please provide three (3) references for your organization's three largest existing fully insured HMO 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 Number of Employees and Total Number 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 Number of Employees and Total Number of Members
- Plan Design
- Services Provided For This Account
- Reason Services Terminated

SECTION VIII

MANDATORY SIGNATURE PAGE

Tab 8 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 IX

PREMIUM QUOTATION FORM

Tab 9 of Proposal

HMO PREMIUM QUOTATION FORM

You must provide a fixed monthly premium for a single active employee for the initial contract period of July 1, 2011 to June 30, 2013 for all proposed regions (I.e. If you are quoting all nine regions, you will provide nine monthly premiums utilizing the form below.) You must provide the maximum percentage of increase or maximum percentage of decrease for the renewal period in the space below. The percentage will be computed against the premium for the initial contract period. If the following blanks are not completed, prices during renewal period will be the same as the original.

Region 1 – New Orleans Area (ZIP Codes 70000-70199)

	Fixed Monthly Premium, Fully Insured
Single Active Employee Premium for 07/01/11 – 06/30/13	$_____ **Do not include OGB's Administrative Fee of $15.00 in your Quote above.**
	Maximum Percentage Increase or Decrease:
Renewal: 07/01/13 – 06/30/14	_____%

Name of HMO_____

Signature of Authorized Representative_____

Title_____ Date _____

You must provide a fixed monthly premium for a single active employee for the initial contract period of July 1, 2011 to June 30, 2013 for all proposed regions (I.e. If you are quoting all nine regions, you will provide nine monthly premiums utilizing the form below.) You must provide the maximum percentage of increase or maximum percentage of decrease for the renewal period in the space below. The percentage will be computed against the premium for the initial contract period. If the following blanks are not completed, prices during renewal period will be the same as the original.

Region 2 – Houma/Thibodaux Area (ZIP Codes 70300-70399)

	Fixed Monthly Premium, Fully Insured
Single Active Employee Premium for 07/01/11 – 06/30/13	$_____ **Do not include OGB's Administrative Fee of $15.00 in your Quote above.**
	Maximum Percentage Increase or Decrease:
Renewal: 07/01/13 – 06/30/14	_____%

Name of HMO_____

Signature of Authorized Representative_____

Title_____ Date _____

You must provide a fixed monthly premium for a single active employee for the initial contract period of July 1, 2011 to June 30, 2013 for all proposed regions (I.e. If you are quoting all nine regions, you will provide nine monthly premiums utilizing the form below.) You must provide the maximum percentage of increase or maximum percentage of decrease for the renewal period in the space below. The percentage will be computed against the premium for the initial contract period. If the following blanks are not completed, prices during renewal period will be the same as the original.

Region 3 – Hammond Area (ZIP Codes 70400-70799)

	Fixed Monthly Premium, Fully Insured
Single Active Employee Premium for 07/01/11 – 06/30/13	$_____ **Do not include OGB's Administrative Fee of $15.00 in your Quote above.**
	Maximum Percentage Increase or Decrease:
Renewal: 07/01/13 – 06/30/14	_____%

Name of HMO_____

Signature of Authorized Representative_____

Title_____ Date _____

You must provide a fixed monthly premium for a single active employee for the initial contract period of July 1, 2011 to June 30, 2013 for all proposed regions (I.e. If you are quoting all nine regions, you will provide nine monthly premiums utilizing the form below.) You must provide the maximum percentage of increase or maximum percentage of decrease for the renewal period in the space below. The percentage will be computed against the premium for the initial contract period. If the following blanks are not completed, prices during renewal period will be the same as the original.

Region 4 – Lafayette Area (ZIP Codes 70500-70599, excluding all of Jefferson Davis Parish)

	Fixed Monthly Premium, Fully Insured
Single Active Employee Premium for 07/01/11 – 06/30/13	$_____ **Do not include OGB's Administrative Fee of $15.00 in your Quote above.**
	Maximum Percentage Increase or Decrease:
Renewal: 07/01/13 – 06/30/14	_____%

Name of HMO_____

Signature of Authorized Representative_____

Title_____ Date _____

You must provide a fixed monthly premium for a single active employee for the initial contract period of July 1, 2011 to June 30, 2013 for all proposed regions (I.e. If you are quoting all nine regions, you will provide nine monthly premiums utilizing the form below.) You must provide the maximum percentage of increase or maximum percentage of decrease for the renewal period in the space below. The percentage will be computed against the premium for the initial contract period. If the following blanks are not completed, prices during renewal period will be the same as the original.

Region 5 – Lake Charles Area (ZIP Codes 70600-70699, including all of Jefferson Davis Parish)

	Fixed Monthly Premium, Fully Insured
Single Active Employee Premium for 07/01/11 – 06/30/13	$_____ **Do not include OGB's Administrative Fee of $15.00 in your Quote above.**
	Maximum Percentage Increase or Decrease:
Renewal: 07/01/13 – 06/30/14	_____%

Name of HMO_____

Signature of Authorized Representative_____

Title_____ Date _____

You must provide a fixed monthly premium for a single active employee for the initial contract period of July 1, 2011 to June 30, 2013 for all proposed regions (I.e. If you are quoting all nine regions, you will provide nine monthly premiums utilizing the form below.) You must provide the maximum percentage of increase or maximum percentage of decrease for the renewal period in the space below. The percentage will be computed against the premium for the initial contract period. If the following blanks are not completed, prices during renewal period will be the same as the original.

Region 6 – Baton Rouge Area (70700 -70899)

	Fixed Monthly Premium, Fully Insured
Single Active Employee Premium for 07/01/11 – 06/30/13	$_____ **Do not include OGB's Administrative Fee of $15.00 in your Quote above.**
	Maximum Percentage Increase or Decrease:
Renewal: 07/01/13 – 06/30/14	_____%

Name of HMO_____

Signature of Authorized Representative_____

Title_____ Date _____

You must provide a fixed monthly premium for a single active employee for the initial contract period of July 1, 2011 to June 30, 2013 for all proposed regions (I.e. If you are quoting all nine regions, you will provide nine monthly premiums utilizing the form below.) You must provide the maximum percentage of increase or maximum percentage of decrease for the renewal period in the space below. The percentage will be computed against the premium for the initial contract period. If the following blanks are not completed, prices during renewal period will be the same as the original.

Region 7– Alexandria Area (ZIP Codes 71300-71499)

	Fixed Monthly Premium, Fully Insured
Single Active Employee Premium for 07/01/11 – 06/30/13	$_____ **Do not include OGB's Administrative Fee of $15.00 in your Quote above.**
	Maximum Percentage Increase or Decrease:
Renewal: 07/01/13 – 06/30/14	_____%

Name of HMO_____

Signature of Authorized Representative_____

Title_____ Date _____

You must provide a fixed monthly premium for a single active employee for the initial contract period of July 1, 2011 to June 30, 2013 for all proposed regions (I.e. If you are quoting all nine regions, you will provide nine monthly premiums utilizing the form below.) You must provide the maximum percentage of increase or maximum percentage of decrease for the renewal period in the space below. The percentage will be computed against the premium for the initial contract period. If the following blanks are not completed, prices during renewal period will be the same as the original.

Region 8– Shreveport Area (ZIP Codes 71000-71199)

	Fixed Monthly Premium, Fully Insured
Single Active Employee Premium for 07/01/11 – 06/30/13	$_____ **Do not include OGB's Administrative Fee of $15.00 in your Quote above.**
	Maximum Percentage Increase or Decrease:
Renewal: 07/01/13 – 06/30/14	_____%

Name of HMO_____

Signature of Authorized Representative_____

Title_____ Date _____

You must provide a fixed monthly premium for a single active employee for the initial contract period of July 1, 2011 to June 30, 2013 for all proposed regions (I.e. If you are quoting all nine regions, you will provide nine monthly premiums utilizing the form below.) You must provide the maximum percentage of increase or maximum percentage of decrease for the renewal period in the space below. The percentage will be computed against the premium for the initial contract period. If the following blanks are not completed, prices during renewal period will be the same as the original.

Region 9 – Monroe Area (ZIP Codes 71200-71299)

	Fixed Monthly Premium, Fully Insured
Single Active Employee Premium for 07/01/11 – 06/30/13	$_____ **Do not include OGB's Administrative Fee of $15.00 in your Quote above.**
	Maximum Percentage Increase or Decrease:
Renewal: 07/01/13 – 06/30/14	_____%

Name of HMO_____

Signature of Authorized Representative_____

Title_____ Date _____

SECTION X
EXHIBITS

EXHIBIT 1 Plan of Benefits

EXHIBIT 2 Enrollment Information By Plans

EXHIBIT 3 Enrollment Form

EXHIBIT 4 Statewide Regions By City and Zip Codes

EXHIBIT 5 OGB Official 2010 - 2011 Premiums

EXHIBIT 6 Contract/Required Data Files (Attachments) & Reports

- Attachment A File Requirements & Layout
- Attachment B Required Reports

EXHIBIT 1

HMO Plan of Benefits

STATE OF LOUISIANA **OFFICE OF GROUP BENEFITS** **HMO Plan of Benefits**	**In-Network** **Plan pays for services provided by *PARTICIPATING* providers**	**Out-of-Network** **Plan pays for services provided by *NON-PARTICIPATING* providers**
Preventive Care		
• Immunizations	100%	70% after deductible
• Well-baby care • Routine physical exams *(adult and child)* • Well-woman exam	100%	70% after deductible
• Health education programs	100% after a $15 co-payment per visit (may apply)	Not covered
• Vision exams *(limited* to *one visit per plan year. Expenses for eyeglasses, lenses, or contact lenses as* a *result of bilateral cataract surgery limited* to *annual maximum benefit of $50)*	100% after a $15 co-payment per visit	Not covered
Physician Services		
• Office visits	100% after a $15 co-payment per visit to primary care physician or $25 co-payment per visit to specialist	70% after deductible
• Diagnostic lab testing and X-rays (1)	100%	70% after deductible
Hospital Services		
• Inpatient care (semiprivate room, intensive care, coronary care, newborn care, maternity, surgery and physician visits) • Inpatient physical rehabilitation	100% after a $100 co-payment per day up to a $300 maximum per admission	70% after deductible
• Emergency care (emergency room, emergency services) (2)	100% after a $100 co-payment per visit (*co-payment waived if admitted*)	100% after $100 copay; waived if admitted
Outpatient Services		
• Outpatient hospital care (outpatient surgery, outpatient procedures, and medically necessary services and supplies)	100% after a $100 co-payment per procedure	70% after deductible
Other Medical Services		
• Family planning	100% after a $15 co-payment per visit to primary care physician or $25 co-payment per visit to OB/GYN	Not covered
• Norplant & Depo Provera	90%	70% after deductible
• Ambulance (covered for emergency medical transportation only) (2)		
- Ground transportation	100% after $50 co-payment up to $300 per occurrence (maximum benefit $350)	100% after $50 copay up to $300 per occurrence after deductible (maximum benefit $350)

STATE OF LOUISIANA **OFFICE OF GROUP BENEFITS** **HMO Plan of Benefits**	**In-Network** **Plan pays for services provided by *PARTICIPATING* providers**	**Out-of-Network** **Plan pays for services provided by *NON-PARTICIPATING* providers**
Other Medical Services (continued**)**		
- Air ambulance	100% after $50 co-payment up to $1,250 per occurrence (maximum benefit $1,500)	100% after $50 co-payment up to $1,250 per occurrence (maximum benefit $1,500)
• Organ tissue transplant (non-experimental)	100% after a $100 co-payment per day up to $300 maximum per admission	Not covered
• Durable medical equipment ($50,000 maximum per lifetime)	80% then 100% after $5,000 eligible expenses met for plan year	70% after deductible
• Immunosuppressive drugs	80%	Not covered
• Skilled nursing facility (maximum of 120 days per plan year)	100% after a $100 co-payment per day up to a $300 maximum per admission	70% after deductible
• Home health care (up to 150 days per plan year) • Hospice services	100%	70% after deductible
• Physical, occupational and speech therapy	100% after a $15 co-payment per visit	70% after deductible
• MRI/CAT scan	100% after a $50 co-payment per procedure	70% after deductible
• Sonograms/Ultrasounds	100% after a $25 co-payment per procedure	70% after deductible
• Radiation therapy	100% after a $15 co-payment (waived if physician not seen)	70% after deductible
• Cardiac rehabilitation (36 visits per plan year for first episode/12 visits far subsequent episodes)	100% after a $15 co-payment per visit	70% after deductible
• Maternity (all prenatal OB visits and one postnatal OB visit)	100% after a $90 co-payment (one time charge)	70% after deductible
Deductible (per calendar year)		
• Individual	N/A	$1000
• Family	N/A	$3000
Maximum Out-of-Pocket Expense Limit		
• Individual	$1000	$3000
• Family	$3000	$9000

Prior authorization - The HMO may require preauthorization far some services and procedures your physician or other provider may recommend for you. The HMO does this solely to determine whether the service or procedure qualifies for payment under your benefit plan. You and your health care provider decide whether you should have such services or procedures. The HMO's preauthorization determination relates solely to payment by the HMO. Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

(1) Professional Fees associated with computer automated pathology services are processed under the primary lab fee. This service is automated, with no manual intervention necessary. If a separate professional fee is billed, it is not considered by The HMO as a separately reimbursable expense.

(2) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.

The above is a brief summary of coverage offered by the HMO. The Summary Plan Description contains the controlling terms and provisions of the benefits, including full descriptions of the exclusions and limitations. Maximum benefit limitations are not intended as a guaranteed benefit. The coverage is based on medical necessity as determined by the HMO Medical Director as detailed in the Summary Plan Description.

Member responsibility payments, i.e. co-payments and coinsurance, accrue to a maximum out-of-pocket of $1,000 per member per contract year for covered in network services and/or $3,000 per member per contract year for covered out-of-network services.

Member payments for the following services do not apply toward the satisfaction of the out-of-pocket maximum: substance abuse services; prescription drugs; organ and tissue transplants; vision care; durable medical equipment, amounts billed by non-participating providers which exceed The HMO's usual, customary and reasonable expenses; and deductibles. Members may be responsible for any difference between The HMO's payment of usual, customary and reasonable expenses and a nonparticipating provider's billed charges.

Participating primary care and specialist physicians and other providers in The HMO's networks are not the agents, employees or partners of The HMO or any of its affiliates or subsidiaries. They are independent contractors. The HMO is not a provider of medical services. The HMO does not endorse or control the clinical judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

To be covered, expenses must be medically necessary and specified as covered. Please see your Summary Plan Description for more information on medical necessity and other specific plan benefits.

<table>
<tr><th colspan="4">Pharmacy Benefit Summary</th></tr>
<tr><td rowspan="4">Copayments
Copayments are the same at both retail pharmacies & through mail order</td><td>DAYS SUPPLY</td><td colspan="2">COPAYMENT AMOUNT</td></tr>
<tr><td>1- 30-Day Supply</td><td colspan="2">50% - maximum of $50 copayment per Rx</td></tr>
<tr><td>31- 60-Day Supply</td><td colspan="2">50% - maximum of $100 copayment per Rx</td></tr>
<tr><td>61- 90-Day Supply</td><td colspan="2">50% - maximum of $150 copayment per Rx</td></tr>
<tr><td rowspan="5">Maximum Out-of-Pocket (OOP Max)
OOP Max copayments are the same at both retail pharmacies & through mail order</td><td colspan="3">$1,200 per member
After the $1,200 out-of-pocket limit is reached, copayments are:</td></tr>
<tr><td>DAYS SUPPLY</td><td>GENERICS</td><td>BRANDS</td></tr>
<tr><td>1- 30-Day Supply</td><td>$0</td><td>$15 per Rx</td></tr>
<tr><td>31- 60-Day Supply</td><td>$0</td><td>$30 per Rx</td></tr>
<tr><td>61- 90-Day Supply</td><td>$0</td><td>$45 per Rx</td></tr>
<tr><td>Formulary</td><td colspan="3">No formulary</td></tr>
</table>

Mental Health (MH) and Substance Abuse (SA) Program		
Coinsurance	**In-Network Treatment**	**Out-of-Network Treatment**
Outpatient Care	$15 PCP copay/$25 Specialist copay	70% of network contracted rates after deductible
Inpatient Care **Prior Authorization Required**	100% after $100 per day copay – maximum 3 days per admittance	70% of network contracted rates after deductible
Deductibles		
Annual Deductible	None	$1,000/plan year
Inpatient Deductible/Co-pay	$100/day deductible, maximum 3 days ($300 maximum per admittance)	70% of network contracted rates after deductible
Maximums	**Combined with Medical**	
Out-of-Pocket Maximum	$1,000 annually per person, then plan pays 100% $3,000 annually per family, then plan pays 100%.	$3,000 annually per person, then plan pays 100% $9,000 annually per family, then plan pays 100%.

EXHIBIT 2

ENROLLMENT INFORMATION BY PLAN

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 10/1/2010

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
BLUE CROSS (ST)											
	3,745	24,311	4,620	16,196	12,747	6,082	49,022	19,990	9,589	8,294	154,596
Region	45.59%	67.40%	55.17%	67.58%	56.91%	48.11%	74.51%	56.98%	50.14%	30.78%	59.78%
Plan	2.42%	67.40%	2.99%	10.48%	8.25%	3.93%	31.71%	12.93%	6.20%	5.36%	100.00%
FMOP-LEV1 NO/IN											
		12	25	2	33	2	36	8	20	8	146
Region		0.03%	0.30%	0.01%	0.15%	0.02%	0.05%	0.02%	0.10%	0.03%	0.06%
Plan		0.03%	17.12%	1.37%	22.60%	1.37%	24.66%	5.48%	13.70%	5.48%	100.00%
FMOP-LEV1 W/INS											
		24	18	34	44	38	44	21	24	10	257
Region		0.07%	0.21%	0.14%	0.20%	0.30%	0.07%	0.06%	0.13%	0.04%	0.10%
Plan		0.07%	7.00%	13.23%	17.12%	14.79%	17.12%	8.17%	9.34%	3.89%	100.00%
FMOP-LEV2 NO/IN											
		21	10	18	27	6	18	9	20	6	135
Region		0.06%	0.12%	0.08%	0.12%	0.05%	0.03%	0.03%	0.10%	0.02%	0.05%
Plan		0.06%	7.41%	13.33%	20.00%	4.44%	13.33%	6.67%	14.81%	4.44%	100.00%

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 10/1/2010

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
FMOP-LEV2 W/INS											
		27	28	23	40	33	42	28	24	11	256
Region		0.07%	0.33%	0.10%	0.18%	0.26%	0.06%	0.08%	0.13%	0.04%	0.10%
Plan		0.07%	10.94%	8.98%	15.63%	12.89%	16.41%	10.94%	9.38%	4.30%	100.00%
HUMANA FFS 65											
	52	22	22	18	39	7	32	49	12	6	259
Region	0.63%	0.06%	0.26%	0.08%	0.17%	0.06%	0.05%	0.14%	0.06%	0.02%	0.10%
Plan	20.08%	0.06%	8.49%	6.95%	15.06%	2.70%	12.36%	18.92%	4.63%	2.32%	100.00%
HUMANA HMO 65											
		335	5	258			462	13	78		1,151
Region		0.93%	0.06%	1.08%			0.70%	0.04%	0.41%		0.45%
Plan		0.93%	0.43%	22.42%			40.14%	1.13%	6.78%		100.00%
HUMANA(ST WIDE)											
							1				1
Region							0.00%				0.00%
Plan							100.00%				100.00%

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 10/1/2010

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
LACHIP-COPAY											
	6	972	444	555	834	535	846	534	493	408	5,627
Region	0.07%	2.69%	5.30%	2.32%	3.72%	4.23%	1.29%	1.52%	2.58%	1.51%	2.18%
Plan	0.11%	2.69%	7.89%	9.86%	14.82%	9.51%	15.03%	9.49%	8.76%	7.25%	100.00%
LACHIP-NO COPAY											
		6	14	4	11	2	2	3			42
Region		0.02%	0.17%	0.02%	0.05%	0.02%	0.00%	0.01%			0.02%
Plan		0.02%	33.33%	9.52%	26.19%	4.76%	4.76%	7.14%			100.00%
LSU Health $10K											
	73	472	65	84	93	28	995	41	557	31	2,439
Region	0.89%	1.31%	0.78%	0.35%	0.42%	0.22%	1.51%	0.12%	2.91%	0.12%	0.94%
Plan	2.99%	1.31%	2.67%	3.44%	3.81%	1.15%	40.80%	1.68%	22.84%	1.27%	100.00%
LSU Health $5K											
	839	3,258	1,099	1,517	2,161	565	7,840	782	3,748	840	22,649
Region	10.21%	9.03%	13.12%	6.33%	9.65%	4.47%	11.92%	2.23%	19.60%	3.12%	8.76%
Plan	3.70%	9.03%	4.85%	6.70%	9.54%	2.49%	34.62%	3.45%	16.55%	3.71%	100.00%

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 10/1/2010

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
MCOP-RANGE 1											
		28	8	4	31	9	21	12	11	6	130
Region		0.08%	0.10%	0.02%	0.14%	0.07%	0.03%	0.03%	0.06%	0.02%	0.05%
Plan		0.08%	6.15%	3.08%	23.85%	6.92%	16.15%	9.23%	8.46%	4.62%	100.00%
MCOP-RANGE 2											
		6	1	2	6	2	4	3	5	2	31
Region		0.02%	0.01%	0.01%	0.03%	0.02%	0.01%	0.01%	0.03%	0.01%	0.01%
Plan		0.02%	3.23%	6.45%	19.35%	6.45%	12.90%	9.68%	16.13%	6.45%	100.00%
MED HOME HMO PL											
	10						2	198	19	5,260	5,489
Region	0.12%						0.00%	0.56%	0.10%	19.52%	2.12%
Plan	0.18%						0.04%	3.61%	0.35%	95.83%	100.00%
OGB PPO											
	3,463	6,424	1,942	5,078	5,924	5,152	6,033	12,769	4,327	11,611	62,723
Region	42.15%	17.81%	23.19%	21.19%	26.45%	40.75%	9.17%	36.40%	22.63%	43.09%	24.25%
Plan	5.52%	17.81%	3.10%	8.10%	9.44%	8.21%	9.62%	20.36%	6.90%	18.51%	100.00%

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 10/1/2010

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
PEOPLE'S-MEDADV											
		48	1	42			107				198
Region		0.13%	0.01%	0.18%			0.16%				0.08%
Plan		0.13%	0.51%	21.21%			54.04%				100.00%
UNIT CONS DRIVE											
	6	19	14	33	47	9	85	8	23	22	266
Region	0.07%	0.05%	0.17%	0.14%	0.21%	0.07%	0.13%	0.02%	0.12%	0.08%	0.10%
Plan	2.26%	0.05%	5.26%	12.41%	17.67%	3.38%	31.95%	3.01%	8.65%	8.27%	100.00%
UNITED -MEDADV											
	18	3	11	2	31	3	26	16	3	8	121
Region	0.22%	0.01%	0.13%	0.01%	0.14%	0.02%	0.04%	0.05%	0.02%	0.03%	0.05%
Plan	14.88%	0.01%	9.09%	1.65%	25.62%	2.48%	21.49%	13.22%	2.48%	6.61%	100.00%
VANTAGE -MEDADV											
	3	83	47	94	330	169	172	596	171	421	2,086
Region	0.04%	0.23%	0.56%	0.39%	1.47%	1.34%	0.26%	1.70%	0.89%	1.56%	0.81%
Plan	0.14%	0.23%	2.25%	4.51%	15.82%	8.10%	8.25%	28.57%	8.20%	20.18%	100.00%

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 10/1/2010

REGIONS										
00	01	02	03	04	05	06	07	08	09	Totals
Grand Total										
8,215	36,071	8,374	23,964	22,398	12,642	65,790	35,080	19,124	26,944	258,602

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 3

ENROLLMENT FORM

GB-01
06/09

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS
ENROLLMENT/CHANGE FORM

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

A. PURPOSE

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

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

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

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

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

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

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

C. HEALTH PLAN SELECTED:

D. LEVEL OF MEDICAL COVERAGE SELECTED

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

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

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

Policy Holder's Name	Social Security No.	Birth Date	Policy Number	Group Number	Coverage Type	Effect. Date

Employer/Company	Insurance Company/HMO (Name/Address/Phone)	Persons covered under other policy

E. COBRA

☐ Prior F/T Terminated ☐ Divorced Spouse ☐ Dependent

_____ (Name of original member) _____ (Social Security Number)

F. MEDICARE

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

A COPY OF MEDICARE CARD MUST BE ATTACHED

G. RETIREE 100

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

H. MENTAL HEALTH RIDER

☐ Yes ☐ No

I. LIFE INSURANCE (Check only one)

☐ No Coverage Employee/Dependent

BASIC	BASIC PLUS SUPPLEMENTAL
☐ Employee/No Dependent Coverage	☐ Employee/No Dependent
☐ Employee/Dependent Coverage Eligible Spouse $1,000 Eligible Child $500	☐ Employee/Dependent Coverage Eligible Spouse $2,000 Eligible Child $1,000
☐ 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 _____

Medical Release

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

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

Plan Members With Enrolled Children Please Note:

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

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

New Hires and Acknowledgements

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

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

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

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

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

J. WAIVER OF COVERAGE

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

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

EMPLOYEE SIGNATURE _____ DATE _____

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

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

X _____ _____

Employee Signature Date

_____ _____

Agency Rep. Date

OFFICE USE ONLY

_____ _____ _____ _____

Life Health Specialist Int. Date

Print Form Reset Form

EXHIBIT 4

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

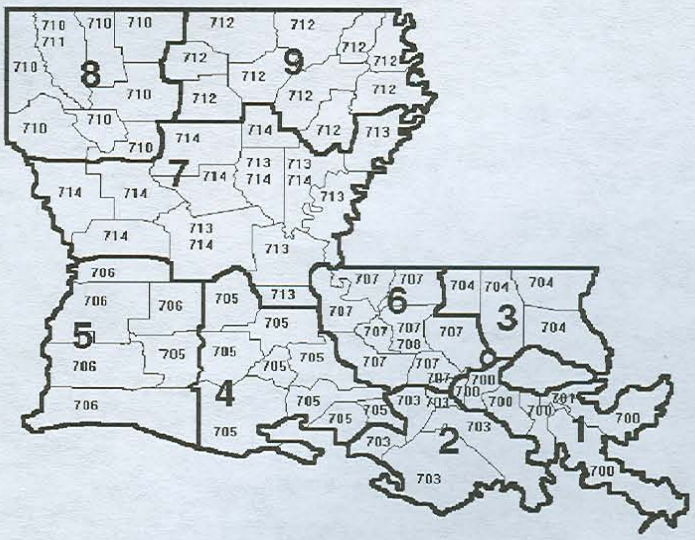
REGION 6
- Addis
- Baker
- Baton Rouge
- Brusly
- Clinton
- Denham Springs
- Gonzales
- Livingston
- Livonia
- Maringouin
- New Roads
- Plaquemine
- Port Allen
- Prairieville
- St. Francisville
- St. Gabriel
- Sunshine
- White Castle
- Zachary

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 5

OGB OFFICIAL 2010 - 2011 PREMIUM RATES

OFFICE OF GROUP BENEFITS

OFFICIAL SCHEDULE OF RATES

Effective July 1, 2010

		Available Statewide **PPO Plan** *Administered by OGB*			Available Nationwide **HMO Plan** *Administered by Blue Cross & Blue Shield of LA*			Available Nationwide **CD-HSA Plan** *Administered by UnitedHealthcare*			Available Statewide **Medical Home HMO Plan** *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
ACTIVE EMPLOYEE													
	SINGLE	418.98	139.66	558.64	395.82	131.94	527.76	325.24	108.40	433.64	399.00	133.00	532.00
	WITH SPOUSE	732.94	453.62	1186.56	692.36	428.48	1120.84	568.94	352.10	921.04	697.98	431.98	1129.96
	WITH CHILDREN	480.32	201.00	681.32	453.76	189.88	643.64	372.94	156.10	529.04	457.52	191.52	649.04
	FAMILY	765.36	486.04	1251.40	722.98	459.10	1182.08	594.08	377.24	971.32	728.84	462.84	1191.68
RETIREE WITH NO MEDICARE & RE-EMPLOYED RETIREE													
	SINGLE	899.62	139.66	1039.28	853.06	131.94	985.00	698.44	108.40	806.84	856.52	133.00	989.52
	WITH SPOUSE	1381.58	453.62	1835.20	1310.76	428.48	1739.24	1072.46	352.10	1424.56	1315.62	431.98	1747.60
	WITH CHILDREN	956.64	201.00	1157.64	907.32	189.88	1097.20	742.82	156.10	898.92	910.76	191.52	1102.28
	FAMILY	1369.74	456.58	1826.32	1298.20	432.72	1730.92	1063.20	354.40	1417.60	1304.34	434.78	1739.12
RETIREE WITH 1 MEDICARE													
	SINGLE	253.48	84.48	337.96	244.42	81.46	325.88	N/A	N/A	N/A	241.38	80.46	321.84
	WITH SPOUSE	936.54	312.18	1248.72	893.20	297.72	1190.92	N/A	N/A	N/A	891.76	297.24	1189.00
	WITH CHILDREN	438.72	146.24	584.96	420.40	140.12	560.52	N/A	N/A	N/A	417.76	139.24	557.00
	FAMILY	1247.86	415.94	1663.80	1188.90	396.30	1585.20	N/A	N/A	N/A	1188.22	396.06	1584.28
RETIREE WITH 2 MEDICARE													
	WITH SPOUSE	455.62	151.86	607.48	438.10	146.02	584.12	N/A	N/A	N/A	433.70	144.58	578.28
	FAMILY	564.12	188.04	752.16	542.44	180.80	723.24	N/A	N/A	N/A	537.06	179.02	716.08
C.O.B.R.A.													
	SINGLE	0.00	569.82	569.82	0.00	538.32	538.32	0.00	442.32	442.32	0.00	542.64	542.64
	WITH SPOUSE	0.00	1210.30	1210.30	0.00	1143.28	1143.28	0.00	939.46	939.46	0.00	1152.84	1152.84
	WITH CHILDREN	0.00	694.96	694.96	0.00	656.52	656.52	0.00	539.62	539.62	0.00	661.80	661.80
	FAMILY	0.00	1276.44	1276.44	0.00	1205.72	1205.72	0.00	990.76	990.76	0.00	1215.60	1215.60
DISABILITY C.O.B.R.A.													
	SINGLE	0.00	839.96	839.96	0.00	791.64	791.64	N/A	N/A	N/A	0.00	800.12	800.12
	WITH SPOUSE	0.00	1779.84	1779.84	0.00	1681.28	1681.28	N/A	N/A	N/A	0.00	1694.96	1694.96
	WITH CHILDREN	0.00	1021.98	1021.98	0.00	965.44	965.44	N/A	N/A	N/A	0.00	973.04	973.04
	FAMILY	0.00	1877.10	1877.10	0.00	1773.12	1773.12	N/A	N/A	N/A	0.00	1787.52	1787.52

NOTE: 1) The breakdown between the state share and the employee share may not be accurate for certain School Board employees due to local funding affecting contributions. The total premium columns are correct for all agencies.

2) All employees who retire on or after July 1, 1997, must have Medicare Part A and Part B to qualify for the reduced premium rates.

Approved by:

4/30/2010

EXHIBIT 6

CONTRACT
REQUIRED DATA/REPORTING

STATE OF LOUISIANA

OFFICE OF GROUP BENEFITS (OGB)

FULLY INSURED
HEALTH MAINTENANCE ORGANIZATION (HMO)

CONTRACT

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

1.0 DEFINITIONS

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

b. "Plan" means the Health Maintenance Organization (HMO) Plan of the group health and accident insurance benefits plan adopted by OGB for the benefit of state employees, retirees and their dependents.

c. "Plan Participant" means a state employee or retiree who is entitled to benefits under the Plan or any dependent of the employee or retiree who is entitled to benefits under the Plan.

d. "Savings" means the difference between the amount of benefits that would be paid in the absence of a negotiated rate with a provider for a particular service or supply and the amount of the negotiated rate actually paid for that service.

2.0 SCOPE OF SERVICES

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

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

c. The Contractor will provide a Health Maintenance Organization (HMO) Physician and Hospital Provider Network to OGB Plan Participants, including behavioral health and pharmacy benefits, in the Region ____ Service Areas (Zip Codes _____) on a fully insured basis and will provide certain services to OGB in connection with its Plan as follows:

1. Consult with OGB with regard to benefits provided under the Plan and any changes thereto made during the term of this Contract.

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

3. Prepare and print, subject to OGB's prior approval, the following member materials:

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

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

   c) Identification cards.

4. Distribute member 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 open enrollment meeting. Provide each prospective enrollee a summary description in each open 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.

7. Pay eligible claims pursuant to the terms of the Plan as construed by Contractor.

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

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

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

11. Provide review of Plan Participants' appeals and grievances and provide Contractor's Appeals and Grievances Policies and Procedures to OGB.

12. Remit payments on behalf of OGB to the Centers for Medicare and Medicaid Services (CMS) in response to 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 authorization services, discharge planning, and verification of provided services, utilization management and quality assurance.

14. Submit standardized data to OGB to be used for the purpose of evaluating Plan Participant demographics, financial experience and other aspects of the Contractor's performance.

15. Provide OGB with the required reports as set forth in Attachment I (which was Exhibit 2 in the NIC).

16. Provide services related to subrogation as specified in Article 14.0.

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

d. Medicare Part D Services

Contractor shall provide prescription drug claims data to the Office of Group Benefits for the purpose of administration and communication with CMS and the Retiree Drug Subsidy (RDS) Center to assist the Office of Group Benefits and facilitate receipt of the Medicare Part D subsidy throughout the year.

The Medicare Part D Services shall include the following:

- Upon receipt by Contractor of the CMS standard eligibility files from the Office of Group Benefits, Contractor will provide monthly the necessary claims data.

e. Contractor may agree to perform or otherwise provide special services to OGB by endorsement to this Contract or by letter agreement between the parties. The fee for any such special services shall be paid by OGB in addition to the monthly administrative services fee assessed in Article 4.0, in the amount and in the manner as provided in the endorsement or letter agreement.

3.0 TERM OF CONTRACT

a. The initial term of this Contract will be two years subject to paragraph 3.0(c), commencing on July 1, 2011, and shall end on June 30, 2013.

b. This Contract may be extended for up to one additional year. If marketplace dynamics change, OGB has the right to review current contract terms and pricing at the end of each twelve (12) month period, subject to more favorable contract terms to OGB. At the term's end (regardless of cause): (a) a Party will not be relieved of any remaining unfulfilled obligations; (b) Contractor will perform its claims run-off obligations; and (c) all warranties, indemnifications, and other provisions will survive and be enforceable to the extent necessary to protect the Party in whose favor they run.

c. In the event that the Contractor does not wish to renew the Contract for a third year**,** notice of such intent must be delivered to the OGB not later than 4:00 p.m. Central Time, on December 1, prior to the open enrollment period for the subsequent year.

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

4.0 INSURANCE PREMIUM; PAYMENT TERMS

a. During the term of this Contract, OGB shall pay Contractor insurance premiums monthly for services pursuant this Contract. These rates do not include the OGB fifteen dollar ($15.00) administration fee.

July 1, 2011 – June 30, 2013

	HMO Premium Per Covered Employee-Retiree Per Month
Active	
Single	X
With Spouse	2.124X
With Child (Children)	1.220X
Family	2.240X
Retired w/o Medicare	
Single	1.860X
With Spouse	3.285X
With Child (Children)	2.072X
Family	3.269X

Retired 1 w/ Medicare	
Single	0.605X
With Spouse	2.235X
With Child (Children)	1.047X
Family	2.978X
Retired 2 w/ Medicare	
With Spouse	1.087X
Family	1.346X
COBRA	
Single	1.020
With Spouse	2.167
With Child (Children)	1.244
Family	2.285
Disability COBRA	
Single	1.504
With Spouse	3.186
With Child (Children)	1.829
Family	3.360

b. Maximum percentage increase (decrease) for optional renewal period, July 1, 2013 – June 30, 2014 is ___ %.

c. Contractor shall negotiate with OGB to adjust the insurance premium due under this Article to reflect any increase in the cost of providing services pursuant to this Contract, due to Plan benefit changes or any other changes in services or procedures provided.

d. Failure of OGB to remit payment of the monthly insurance premiums by the fifteenth day of each month will result in the suspension of all services performed.

e. The maximum payable to Contractor for insurance premiums pursuant to this Contract shall not exceed $____ for the initial contract term.

5.0 CLAIMS LIABILITY AND REIMBURSEMENT

Contractor assumes full liability for funding all payments made for Plan claims on or after the effective date of this Contract including payments remitted by Contractor to CMS in response to demand letters for the recovery of Medicare payments to Plan Participants. OGB shall not be responsible under any circumstances for ensuring Contractor's compliance with federal or state laws which may apply to the establishment and/or maintenance of these funds, or for advising Contractor of any such federal or state laws.

6.0 SINGLE PROGRAM, RIGHT TO ASSESS ALL MEMBERS

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

7.0 INSURANCE CERTIFICATE

a. Contractor shall procure and maintain for the duration of the Contract liability insurance, including coverage for but not limited to: claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by Contractor, its agents, representatives, employees or 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. Contractor shall on request furnish the OGB with certificate(s) of insurance effecting coverage required by this Contract. The certificate(s) for each insurance policy is to be signed by a person authorized by that insurer to bind coverage on its behalf. The OGB reserves the right to require complete, certified copies of all required insurance policies, at any time.

8.0 LIABILITY FOR DAMAGES BY THE CONTRACTOR

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

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

c. Contractor agrees to hold any Plan Participant harmless from any liability or cost for health services rendered during enrollment in the HMO Plan, if covered under the Plan, and except as provided in the Plan.

9.0 INDEMNIFICATION

a. Contractor agrees to protect, defend, indemnify and hold harmless the OGB, the State of Louisiana, all State Departments, Agencies, Boards and Commissions, their respective officers, directors, agents, servants and/or employees, including volunteers (each a State Affiliated Indemnified Party), from and against any and all claims, demands, expense and liability arising out of or in any way growing out of any act or omission of Contractor, its agents, servants, and employees, together with any and all costs, expenses and/or attorney fees reasonably incurred as a result of any such claim, demands, and/or causes of action

except those claims, demands and/or causes of action for which this Contractor is held harmless under this Contract and those arising out of the act or omission of the OGB, the State of Louisiana, all State Departments, Agencies, Boards and Commissions, their respective officers, directors, agents, servants and/or employees, including volunteers.

b. Contractor agrees to investigate, handle, respond to, provide defense for and defend any such claims, demand, or suit at its sole expense, even if it (claims, etc.) is groundless, false or fraudulent, provided that (a) the State Affiliated Indemnified Party has given reasonable notice to the Contractor of the claim or cause of action, and (b) no State 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. Contractor's obligations under this Article shall not apply to claims for benefits related to the Plan.

c. OGB shall indemnify and hold harmless Contractor and its directors, officers and employees against all claims, judgments, settlements, court costs, penalties and expenses, including attorney fees, or other losses or damage arising or resulting from or in connection with a claim for benefits or related to the Plan, whether said claim arises under any federal or state law, unless the liability therefore is judicially determined to be the direct consequence of dishonest, fraudulent, criminal or negligent conduct of Contractor or its directors, officers, employees, agents, or sub-contractors.

d. OGB shall have the duty to defend any legal action arising from a claim for benefits related to the Plan at its expense. OGB shall use its best efforts to have Contractor dismissed from any litigation involving a claim for benefits unless an independent cause of action against Contractor is alleged.

10.0 RESPONSIBILITIES AND OTHER RIGHTS; THIRD PARTY LIABILITY

Each of the parties shall 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.

11.0 TAXES

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

12.0 SECURITY

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

13.0 CONFIDENTIALITY

a. The parties, their agents, staff members and employees agree to maintain as confidential all individually identifiable information regarding Louisiana Office of OGB Benefits Plan Participants, including but not limited to patient records, demographic information and claims history. All information obtained by Contractor from the OGB shall be maintained in accordance with state and federal law, specifically including but not limited to the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health (HITECH) Act within the American Recovery and Reinvestment Act of 2009, and any regulations promulgated thereunder (collectively, "HIPAA").

b. Further, the parties agree that all financial, statistical, personal, technical and other data and information relating to either party's operations which are designated confidential by such party and made available to the other party in carrying out this Contract, shall be protected by the receiving party from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the OGB and/or Contractor. Neither party shall be required to keep confidential any data or information which is or becomes publicly available, is already rightfully in the party's possession, is independently developed by the party outside the scope of this Contract, or is rightfully obtained from third parties. OGB shall notify Contractor immediately of any request made by any person under state or federal law for inspection of any record, writing, account, recording, letter, exhibit, data charts, memoranda or any other document in any form of media which relates to this Contract or Contractor's performance under this Contract, including the identity of the requestor.

14.0 REPRODUCTION, PUBLICATION AND USE OF MATERIAL

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

15.0 ACKNOWLEDGEMENT OF PRIORITY POSITION

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

16.0 PATENT, COPYRIGHT, AND TRADE SECRET INDEMNITY

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

17.0 INDEPENDENT CONTRACTOR RELATIONSHIP

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

18.0 PROJECT MANAGEMENT/MONITORING PLAN

a. Contractor shall provide, at a minimum, the following project management functions:

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

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

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

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

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

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

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

    Contract Supervisor: OGB shall appoint a Contract Supervisor for this Contract that will provide oversight of the activities conducted hereunder. The assigned Contract Supervisor

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

19.0 PERFORMANCE MEASURES

The Contract Supervisor will be responsible for the Performance Evaluation Report in regards to the scope of services provided by Contractor pursuant to this Contract.

20.0 TERMINATION FOR CAUSE

a. OGB may terminate this Contract for cause based upon the failure of Contractor to comply with the material terms and/or conditions of the Contract; provided that the OGB shall give the Contractor written notice specifying Contractor's failure. If within thirty (30) days after receipt of such notice, Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the OGB may, at its option, place Contractor in default and this Contract shall terminate on the date specified in such notice.
b. Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the OGB to comply with the terms and conditions of this Contract; provided that the Contractor shall give the OGB written notice specifying the OGB's failure. Furthermore, Contractor shall be entitled to suspend any and all services until such time as when OGB is not in default of its obligations under this Contract.

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

21.0 TERMINATION FOR CONVENIENCE

OGB may terminate the Contract at any time without penalty by giving thirty (30) 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.

22.0 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.

23.0 OWNERSHIP OF PRODUCT

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

24.0 ASSIGNMENT

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

25.0 RIGHT TO AUDIT

a. Contractor grants to the Office of the Legislative Auditor, Inspector General's Office, the Federal Government, and any other duly authorized agency of the State the right to inspect and review all books and records pertaining to services rendered under this Contract. Contractor shall comply with federal and/or state laws authorizing an audit of Contractor's operation as a whole, or of specific program activities. Any audit shall be conducted during ordinary business hours and upon reasonable advance notice to the Contractor. OGB's auditors shall abide by any state and federal laws regarding confidentiality of a Plan Participant's medical records and agrees to hold in confidence any information or data designated as proprietary by Contractor. This obligation of confidentiality shall survive termination of this Contract

b. Contractor shall have the right, at reasonable times and upon reasonable notice, to audit and inspect any of OGB's personnel and payroll records which are relevant to the performance of Contractor's duties under the Contract. Contractor agrees to abide by any state and federal laws regarding confidentiality of OGB's personnel and payroll records and agrees to hold in confidence any information or data designated as proprietary by OGB. This obligation of confidentiality shall survive termination of the Contract. Upon request, Contractor shall prepare an annual accounting report consisting of a summary of benefits provided during each twelve (12) consecutive month period for which this Contract remains in effect, which shall be forwarded to OGB within one hundred twenty (120) days after the end of said period.

c. OGB shall approve or disapprove in writing said report within one hundred twenty (120) days of its receipt thereof. Failure to submit timely disapproval of the accounting report shall render the report conclusively correct and OGB shall be presumed conclusively to have accepted Contractor's financial performance of its duties.

26.0 RECORD RETENTION

Contractor agrees to retain all books, records, and other documents relevant to this Contract and the funds expended hereunder for at least three years after project completion of Contract, or as required by applicable Federal law, whichever is longer.

27.0 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.

28.0 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.

29.0 NON-DISCRIMINATION

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

30.0 AVAILABILITY OF FUNDS

The continuation of this Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract. If the legislative fails to appropriate sufficient monies to provide for the continuation of the Contract, or if such appropriation is reduced by veto of the Governor or by any means provided in the appropriation act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of

such reductions to provide insufficient monies for the continuation of the Contract, the Contract shall terminate on the date of the beginning of the first fiscal year for which funds have not been appropriated. Such termination shall be without penalty or expense to the OGB except for payments which have been accrued prior to the termination.

31.0 HEADINGS

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

32.0 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.

33.0 PERFORMANCE BOND

The initial amount of the bond will be established following the open enrollment period in September-October 2007, and will be based upon the premium payable for Plan Participants effective January 1, 2008. In the event that the parties agree to renew the Contract for one additional one-year term, the amount of the bond for the renewal term will be adjusted following the annual open enrollment and will be based upon the premiums payable for Plan Participants effective at the commencement of the term. The performance bond must be delivered to the OGB not later than 4:30 p.m., Central Time, on June 15 prior to the commencement of the initial term and each subsequent renewal term of the Contract. The OGB will notify the Contractor not later than June 1 regarding enrollment and premium charges upon which the bond amount is to be determined.

34.0 ENTIRE AGREEMENT AND ORDER OF PRECEDENCE

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

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

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

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

STATE OF LOUISIANA **DIVISION OF ADMINSTRATION** **OFFICE OF GROUP BENEFITS**	**CONTRACTOR**
SIGNATURE: _____	**SIGNATURE:** _____
NAME: Tommy D. Teague	**NAME:** _____
TITLE: Chief Executive Officer	**TITLE:** _____

ATTACHMENTS

ATTACHMENT A
FILE REQUIREMENTS AND LAYOUT

ATTACHMENT B
REQUIRED REPORTS

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 by the contractor to OGB:

Files are to be sent by the contractor to OGB on a monthly basis and between the 5th and 10th of the following month. For example, the files for January shall be received by OGB by the 10th of February. All files shall be sent electronically using FTP (File Transfer Protocol) and must be encrypted using PGP (Pretty Good Privacy).

1. **Medical Claims File (Appendix A-1) –** the contractor shall send OGB all claims for which EOBs (Explanations of Benefits) or checks were sent or issued to the provider and/or claimant during a month. This is a file of records containing claim charge lines or service lines for a physician claim (CMS-1500), facility claim (UB-92), or a dental claim (ADA-1500) that has been received and processed. No claims in process are included.

2. **Provider File (Appendix A-2) -** This is a file of medical service providers for which checks and EOBs were issued in (1) 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.

3. **Code Files (Appendix A-3)** – 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.

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 zip codes will be left-justified, with no dashes, commas, decimals or other formatting.

4. **Drug Claims File (Appendix A-4)**
   This file contains all drugs for which prescriptions were filled during the month.

5. **Drug Subsidy Interim Monthly file(Appendix A-5)**
   This file contains file header, application header, detail total of drugs, application trailer, and file trailer for all drugs for which prescriptions were filled during the month for which OGB is claiming drug subsidy. Contractor will know what these dates for each individual are from the Drug Subsidy Eligibility file in A-6 below. This file will be sent to OGB the beginning of the month for the previous month's drugs.

6. **Drug Subsidy Reconciliation Yearly file (Appendix A-5)**
   This file contains file header, application header, detail of drugs by member, application trailer, and file trailer for all drugs for which prescriptions were filled during the month for which OGB is claiming drug subsidy. Contractor will know what these dates for each individual are from the Drug Subsidy Eligibility file in A-8 below. This file will be sent on request several months after the end of the plan year.

Files to be sent to the contractor by OGB:

The contractor shall receive the following three files from OGB. Files shall be constructed using the layout as described in Appendix A-6 through A-8. All files from OGB shall be sent electronically using FTP (File Transfer Protocol) and WILL be encrypted using PGP (Pretty Good Privacy).

7. **Eligibility File (Appendix A-6)**
   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.

8. **Administrative Fee Billing files(Appendix A-7)**
   This file shall be received monthly by the contractor and will contain the amount per contract holder that contractor will pay the OGB for administrative fee. Contractor will pay OGB based on this file. The file will contain adjustments to prior months billing resulting from retroactive terminations and enrollment.

9. **Drug Subsidy Eligibility (Appendix A-8)**
   This file shall be sent to Contractor Monthly giving the Drug Subsidy eligibility from and thru dates for with Contractor will report their Interim (Appendix A-1) and Reconciled (Appendix A-2) files. Each month eligibility from the beginning of the plan year to the end of the month being reported.

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

Appendix A-1 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.						
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.

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

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
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.						
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).						

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

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
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.
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.

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

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
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.						
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

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

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
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)
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.						

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

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
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
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-2 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 CONTRACTOR'S SYSTEM.
19		PROVIDER SPECIALTY 4	A/N	10	373-382	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
20	*	PROVIDER TYPE	A/N	1	383	**"F" – FACILITY, "P" – PHYSICIAN, "O" – OTHER, "Y" – PAY-TO, "G" - GROUP**

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

Appendix A-3 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**

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

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD IDENTIFIER	N	1	001-001	0=PROCESSOR RECORD
2	PROCESSOR NUMBER	N	10	002-011	THIS NUMBER IS ASSIGNED BY NCPDP TO IDENTIFY THE SOURCE OF THE TAPE, I.E. PHARMACY, WHOLESALER, HOSPITAL, SERVICE BUREAU, ETC.
3	BATCH NUMBER	N	5	012-016	THIS NUMBER IS ASSIGNED BY THE PROCESSOR. FORMAT=YYDDD YY=YEAR DDD=JULIAN DATE I.E. 92252=SEPT. 8, 1992
4	PROCESSOR NAME	A/N	20	017-036	PROCESSOR NAME
5	PROCESSOR ADDRESS	A/N	20	037-056	PROCESSOR ADDRESS
6	PROCESSOR LOCATION CITY	A/N	18	057-074	PROCESSOR CITY
7	PROCESSOR LOCATION STATE	A/N	2	075-076	PROCESSOR STATE
8	PROCESSOR ZIP CODE	A/N	9	077-085	PROCESSOR ZIP CODE, EXPANDED
9	PROCESSOR TELEPHONE NUMBER	N	10	086-095	TELEPHONE NUMBER FORMAT=AAAEEENNNN AAA=AREA CODE EEE=EXCHANGE CODE NNNN=NUMBER
10	RUN DATE	A/N	8	096-103	DATE ON WHICH TAPE WAS GENERATED BY CARRIER FORMAT=CCYYMMDD
11	THIRD PARTY TYPE	A/N	1	104-104	TYPE OF CLAIM M=GOVERNMENT P=PRIVATE
12	VERSION/RELEASE NUMBER	N	2	105-106	A NUMBER TO IDENTIFY THE FORMAT OF THE TRANSACTION SENT OR RECEIVED 10=1981 FORMAT TAPE 20=1991 FORMAT TAPE
13	EXPANSION AREA	A/N	187	107-293	RESERVED FOR FUTURE NCPDP CONTINGENCIES
14	UNIQUE FREE FORM	A/N	415	294-708	FILLER

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

Appendix A-4 Drug Claims File

NO	FIELD NAME	TYPE	LEN	LOC	DESCRIPTION
1	RECORD IDENTIFIER	N	1	001-001	2=PHARMACY RECORD
2	PROCESSOR NUMBER	N	10	002-011	THIS NUMBER IS ASSIGNED BYNCPDP TO IDENTIFY THE SOURCE OF THE TAPE, I.E. PHARMACY, WHOLESALER, HOSPITAL, SERVICE BUREAU, ETC.
3	BATCH NUMBER	N	5	012-016	THIS NUMBER IS ASSIGNED BY THE PROCESSOR. FORMAT=YYDDD YY=YEAR DDD=JULIAN DATE I.E. 92252=SEPT. 8, 1992
4	PHARMACY NUMBER	A/N	12	017-028	ID ASSIGNED TO A PHARMACY
5	PHARMACY NAME	A/N	20	029-048	NAME OF PHARMACY
6	PHARMACY ADDRESS	A/N	20	049-068	ADDRESS OF PHARMACY
7	PHARMACY LOCATION CITY	A/N	18	069-086	CITY OF PHARMACY
8	PHARMACY LOCATION STATE	A/N	2	087-088	STATE OF PHARMACY
9	PHARMACY ZIP CODE	A/N	9	089-097	ZIP CODE OF PHARMACY EXPANDED
10	PHARMACY TELEPHONE NUMBER	A/N	10	098-107	TELEPHONE NUMBER OF PHARMACY
11	EXPANSION AREA	A/N	211	108-318	RESERVED FOR FUTURE NCPDP CONTINGENCIES
12	UNIQUE FREE FORM	A/N	390	319-708	FILLER

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

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD IDENTIFIER	N	1	1-1	4=CLAIM RECORD
2	PROCESSOR NUMBER	N	10	2-11	THIS NUMBER IS ASSIGNED BY NCPDP TO IDENTIFY THE SOURCE OF THE TAPE, I.E. PHARMACY, WHOLESALER, HOSPITAL, SERVICE BUREAU, ETC.
3	BATCH NUMBER	N	5	12-16	THIS NUMBER IS ASSIGNED BY THE PROCESSOR. FORMAT=YYDDD YY=YEAR DDD=JULIAN DATE I.E. 92252=SEPT. 8, 1992
4	PHARMACY NUMBER	A/N	12	17-28	ID ASSIGNED TO A PHARMACY
5	PRESCRIPTION NUMBER	A/N	7	29-35	
6	DATE FILLED	A/N	8	36-43	DISPENSING DATE OF RX **FORMAT=CCYYMMDD**
7	NDC NUMBER	N	11	44-54	FOR LEGEND COMPOUNDS USE: 99999999999 SCHEDULE II: 99999999992 SCHEDULE III: 99999999993 SCHEDULE IV: 99999999994 SCHEDULE V: 99999999995 COMPOUNDS: 99999999996
8	DRUG DESCRIPTION	A/N	30	55-84	LABELNAME
9	NEW/REFILL CODE	N	2	85-86	00=NEW PRESCRIPTION 01-99=NUMBER OF REFILLS
10	METRIC QUANTITY	N	6	87-92	NUMBER OF METRIC UNITS OF MEDICATION DISPENSED (LEADING SIGN IF NEGATIVE)
11	DAYS SUPPLY	N	4	92-96	ESTIMATED NUMBER OF DAYS THE PRESCRIPTION WILL LAST
12	BASIS OF COST DETERMINATION	A/N	2	97-98	00=NOT SPECIFIED 01=AWP 02=LOCAL WHOLESALER 03=DIRECT 04=EAC 05=ACQUISITION 06=MAC 6X=BRAND MEDICALLY NECESSARY 07=USUAL AND CUSTOMARY 08=UNIT DOSE 09=OTHER USED ON TAPE AND DISKETTE ONLY
13	INGREDIENT COST	N	10	99-108	COST OF THE DRUG DISPENSED. FORMAT-All financial fields should be 10 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”

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

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
14	DISPENSING FEE SUBMITTED	N	10	109-118	FORMAT-All financial fields should be 10 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"
15	CO-PAY AMOUNT	N	10	119-128	CORRECT CO-PAY FOR PLAN BILLED FORMAT-All financial fields should be 10 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"
16	SALES TAX	N	10	129-138	SALES TAX FOR THE PRESCRIPTION DISPENSED FORMAT-All financial fields should be 10 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"
17	AMOUNT BILLED	N	10	139-148	FORMAT-All financial fields should be 10 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"
18	PATIENT FIRST NAME	A/N	12	149-160	FIRST NAME OF PATIENT
19	PATIENT LAST NAME	A/N	15	161-175	LAST NAME OF PATIENT
20	DATE OF BIRTH	A/N	8	176-183	DATE OF BIRTH OF PATIENT **FORMAT=CCYYMMDD**
21	SEX CODE	A/N	1	184-184	0=NOT SPECIFIED 1=MALE 2=FEMALE
23	EMPLOYEE SSN	A/N	9	185-193	
24	OGB Internal Id-	A/N	8	194-201	See Appendix E (Eligibility File) Field number-33
25	FILLER	A/N	1	202-202	
26	RELATIONSHIP CODE	A/N	1	203-203	1=CARDHOLDER 2=SPOUSE 3=CHILD 4=OTHER
27	GROUP NUMBER	A/N	15	204-218	ID ASSIGNED TO CARDHOLDER GROUP OR EMPLOYER GROUP
28	PRESCRIBER ID	A/N	10	219-228	IDENTIFICATION ASSIGNED TO THE PRESCRIBER
29	DIAGNOSIS CODE	A/N	6	229-234	ICD-9 STANDARD DIAGNOSIS CODES
30	Document number	A/N	15	235-249	Document Number becomes relevant if the pharmacy made a mistake on the original script and instead of the original claim getting corrected, a new one was submitted
30	FILLER	A/N	12	250-261	
31	RESUBMISSION CYCLE	A/N	2	262-263	0 = ORIGINAL SUBMISSION

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

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
	COUNT				1 = FIRST RE-SUBMISSION 2 = SECOND RE-SUBMISSION
32	DATE PRESCRIPTION WRITTEN	A/N	8	264-271	DATE PRESCRIPTION WAS WRITTEN
33	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	A/N	1	272-272	0 = NO PRODUCT SELECTION INDICATED 1 = SUBSTITUTION NOT ALLOWED BY PRESCRIBER 2 = SUBSTITUTION ALLOWED - PATIENT REQUESTED PRODUCT DISPENSED 3 = UBSTITUTION ALLOWED PHARMACIST SELECTED PRODUCT DISPENSED 4 = SUBSTITUTION ALLOWED - GENERIC DRUG NOT IN STOCK 5 = SUBSTITUTION ALLOWED - BRAND DRUG DISPENSED AS A GENERIC 6 = OVERRIDE 7 = SUBSTITUTION NOT ALLOWED - BRAND DRUG MANDATED BY LAW 8 = SUBSTITUTION ALLOWED - GENERIC DRUG NOT AVAILABLE IN MARKETPLACE 9 = OTHER
34	ELIGIBILITY CLARIFICATION CODE	A/N	1	273-273	CODE INDICATING THAT THE PHARMACY IS CLARIFYING ELIGIBILITY BASED ON DENIAL 0 = NOT SPECIFIED 1 = NOT OVERRIDE 2 = OVERRIDE 3 = FULL TIME STUDENT 4 = DISABLED DEPENDENT 5 = DEPENDENT PARENT
35	COMPOUND CODE	A/N	1	274-274	CODE INDICATING WHETHER OR NOT THE PRESCRIPTION IS A COMPOUND 0=NOT SPECIFIED 1=NOT A COMPOUND 2=COMPOUND
36	NUMBER OF REFILLS AUTHORIZED	N	2	275-276	NUMBER OF REFILLS AUTHORIZED BY PRESCRIBER
37	DRUG TYPE	A/N	1	277-277	CODE TO INDICATE THE TYPE OF DRUG DISPENSED 0=NOT SPECIFIED 1=SINGLE SOURCE BRAND 2=BRANDED GENERIC 3=GENERIC 4=O.T.C. (OVER THE COUNTER)
38	PRESCRIBER LAST NAME	A/N	15	278-292	PRESCRIBER LAST NAME
39	POSTAGE AMOUNT CLAIMED	N	4	293-296	DOLLAR AMOUNT OF POSTAGE CLAIMED FORMAT- Field should be 4 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 1.23 would be expressed as “01.23” -1.23 would be expressed as “-1.23”

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

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
40	UNIT DOSE INDICATOR	A/N	1	297-297	CODE INDICATING THE TYPE OF UNIT DOSE DISPENSING DONE 0=NOT SPECIFIED 1=NOT UNIT DOSE 2=MANUFACTURER UNIT DOSE 3=PHARMACY UNIT DOSE
41	OTHER PAYOR AMOUNT	N	6	298-303	DOLLAR AMOUNT OF PAYMENT KNOWN BY THE PHARMACY FROM OTHER SOURCES FORMAT=positive 123.56 negative -12.45
42	FILLER	A/N	35	304-338	RESERVED FOR FUTURE NCPDP CONTINGENCIES
43	CONTRACT SSN	A/N	9	339-347	(Contract Holder's SSN)- RxClaim map from 1st nine digits of member ID number
44	COVERED AMOUNT	N	10	348-357	FORMAT-All financial fields should be 10 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"
45	PAID AMOUNT	N	10	358-367	FORMAT-All financial fields should be 10 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"
46	PAID DATE	A/N	8	368-375	Date of payment FORMAT = CCYYMMDD
47	FILLER	A/N	2	376-377	Spaces
48	Prescribe First Name	A/N	15	378-392	
49	Prescribe Last Name	A/N	25	393-417	
50	Prescribe MI	A/N	1	418-418	
51	Prescribe Address-1	A/N	55	419-473	
52	Prescribe Address-2	A/N	55	474-528	
53	Prescribe City	A/N	20	529-548	
54	Prescribe State	A/N	2	549-550	
55	Prescribe Zip Code	A/N	10	551-560	
56	Medicare D Eligible Indicator	A/N	1	561-561	Y = Medicare D eligible N = NOT Medicare D eligible
57	Filler	A/N	147	562-708	Spaces

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

Appendix A-5 Drug Subsidy – File Header					
NO.	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD TYPE	A	1	001-001	VALUE 'H'
2	APPLICATION NUMBER	A	10	002-011	VALUE TBD
3	CREATION DATE	N	8	012-019	DATE FILE WAS CREATED. CCYYMMDD
4	CREATION TIME	N	6	020-025	TIME OF DAY FILE WAS CREATED.(HH:MM:SS)
5	FILLER	A	175	026-200	FILL WITH SPACES

Appendix A-5 Drug Subsidy – Application Header					
NO.	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD TYPE	A	4	001-004	VALUE 'AHDR'
2	APPLICATION ID	A	10	005-014	VALUE TBD
3	FILLER	A	96	015-110	

Appendix A-5 Drug Subsidy – Detail					
NO.	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD TYPE	A	01	001-001	VALUE 'D'
2	SSN	N	09	002-010	SOCIAL SECURITY NUMBER FOR EACH INDIVIDUAL WHOM THE PLAN SPONSOR IS SEEKING THE SUBSIDY. MAY CONTAIN SPACES IF HICN IS PROVIDED.
3	HICN	N	12	011-022	MEDICARE HEALTH INSURANCE CLAIM NUMBER FOR EACH INDIVIDUAL WHOM THE PLAN SPONSOR IS SEEKING THE SUBSIDY. MAY CONTIAN SPACES IF SSN IS PROVIDED.
4	FIRST NAME	A	30	023-052	
5	MIDDLE INITIAL	A	01	053-053	OPTIONAL
6	LAST NAME	A	40	054-093	
7	DATE OF BIRTH	N	08	094-101	CCYYMMDD
8	GENDER	A	01	102-102	0=UNKNOWN,1=MALE,2-FEMALE
9	COVERAGE EFFECTIVE DATE	N	08	103-110	DRUG SUBSIDY EFFECTIVE.CCYYMMDD
10	COVERAGE TERMINATION DATE	N	08	111-118	DRUG SUBSIDY TERM.CCYYMMDD
11	UNIQUE BENEFIT OPTION IDENTIFIER	N	20	1119-138	VALUE TBD
12	RELATIONSHIP TO RETIREE	A	02	139-140	01=SELF,02=SPOUSE,03=OTHER
13	TRANSACTION TYPE	A	03	141-143	ADD,DEL
14	FILLER	A	57	144-200	SPACES

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

Appendix A-5 Drug Subsidy Application Trailer					
NO.	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD TYPE	A	1	001-001	VALUE ‘T”
2	APPLICATION NUMBER	N	10	002-011	VALUE ‘0000004572’
3	CREATION DATE	N	8	012-019	DATE FILE CREATED. CCYYMMDD
4	CREATION TIME	N	06	020-025	TIME FILE CREATED.HHMMSS
5	NUMBER OF DETAIL RECORDS	N	07	026-032	PIC9(07) IN COBOL. RIGHT JUSTIFIED AND ZERO FILLED
6	FILLER	A	168	033-200	

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

Appendix A-6 Eligibility File					
FIELD	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	CONTRACT HOLDER'S SSN	A/N	9	001-009	CONTRACT HOLDER'S 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 UNINTERRUPTED COVERAGE WITHIN THE HEALTH PLAN/RATE TABLE/COVERAGE LEVEL COMBINATION.
12	TERMINATION DATE	A/N	8	177-184	CCYYMMDD- BLANK IF ACTIVE
13	CLIENT / AGENCY CODE	A/N	8	185-192	CODE CLIENT /AGENT
14	SUB CLIENT / SECTION OF 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 OR OTHER DEPENDENTS
21	TRANSACTION DATE	A/N	8	225-232	CCYYMMDD
22	AGENCY EMPLOYMENT DATE	A/N	8	233-240	CCYYMMDD
23	PREEXISTING TERMINATION DATE	A/N	8	241-248	CCYYMMDD- PREEXISTING TERMINATION DATE(CAN BE BLANK)
24	CONTRACT HOLDER PHONE	A/N	12	249-260	
25	ENROLLEE STATUS FIELD	A/N	1	261-261	C - FOR THE WHOLE FAMILY IF THE SUBSCRIBER IS ON COBRA

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

Appendix A-6 Eligibility File					
FIELD	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					R- FOR THE SUBSCRIBER AND SPOUSE IF THE SUBSCRIBER IS RETIRE AND ACTIVE FOR THE CHILDREN A-FOR THE WHOLE FAMILY IF THE SUBSCRIBER IS ACTIVE
26	HANDICAPPED INDICATOR	A/N	1	262-262	"Y" = YES "N" = NO
27	MARRIAGE DATE	A/N	8	263-270	CCYYMMDD(CAN BE BLANK)
28	HIC NUMBER	A/N	12	271-282	MEDICARE CARD NUMBER.
29	COB DATE	A/N	8	283-290	CCYYMMDD- BEGINNING COVERAGE BY OTHER 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	RETIREE 100	A/N	1	301-301	SWITCH IS ALWAYS BLANK FOR DEPENDENTS Y/N
32	LAST CHANGE DATE	A/N	8	302-309	CCYYMMDD- DATE THE ENROLLMENT RECORD WAS LAST CHANGED
33	MEMBER RECORD ID	A/N	8	310-317	OGB INTERNAL ID
34	CLAIM PAYMENT STOP DATE	A/N	8	318-325	CCYYMMDD- DATE BEYOND WITH CLAIMS SHOULD NOT BE PAID BECAUSE OF NON-PAYMENT OF PREMIUMS
35	RATE TABLE	A/N	2	326-327	AC – ACTIVE CB - COBRA CD - COBRA DISABILITY CP - COBRA PART-TIME CS – COBRA STATE SUBSIDIZED R1 - RETIRED MEDICARE 1 R2 - RETIRED MEDICARE 2 RN - RETIRED NO MEDICARE THIS FIELD IS ALWAYS BLANK FOR DEPENDENTS
36	PLAN	A/N	4	328-331	
37	LIFETIME ACCUM	N	10	332-341	9999999.99 LEADING SPACES: SUM OF DRUG AND MEDICAL, CLAIMS PAID. MAX: 5,000,000.00
38	DRUG ACCUM	N	10	342-351	9999999.99 LEADING SPACES: SUM OF DRUG CLAIMS PAID. INCLUDED IN LIFETIME ACCUM.

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

Appendix A-7 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"

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

APPENDIX A-8 DRUG SUBSIDY ELIGIBILITY					
NO.	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	Record Type	A/N	01	001-001	"H'
2	Application Number	N	10	009-011	Number assigned to the application by RDS Secure Website. Include leading zeroes as needed to Completely fill field. Value TBD
3	Creation Date	N	08	012-019	Date file was created. CCYYMMDD
4	Creation Time	N	06	020-025	Time of day file was created. HHMMSS
5	Filler	A/N	175	026-200	

APPENDIX A-8 DRUG SUBSIDY ELIGIBILITY					
NO.	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	Record Type	A	01	001-001	"D"
2	SSN	N	09	002-010	Social Security Number for each individual whom the Plan Sponsor is seeking the subsidy. May contain spaces if HICN is provided.
3	HICN	N	12	011-022	Medicare Health Insurance Claim Number for each Individual whom the Plan Sponsor is seeking the Subsidy. May contain spaces if SSN is provided.
4	First Name	A	30	023-052	
5	Middle Initial	A	01	053-053	Optional
6	Last Name	A	40	054-093	
7	Date of Birth	N	08	094-101	CCYYMMDD
8	Gender	A	01	102-102	0=unknown, 1=male, 2=female
9	Coverage Effective Date	N	08	103-110	Start date of coverage under the Plan Sponsor's prescription drug benefit option. CCYYMMDD
10	Coverage Termination Date	N	08	112-118	End date of coverage under the Plan Sponsor's Prescription drug benefit option. CCYYMMDD. If coverage is ongoing, fill with 99999999
11	Unique Benefit Option Identifier	N	20	120-138	Group number corresponding to the benefit option for the retiree; RX group number assigned by benefit option administrator or plan sponsor defined. Must match one of the benefit options on the application.
12	Relationship to Retire	N	02	140-140	01=self 02=spouse 03=other
13	Transaction Type	A	03	142-143	Add
14	Determination Indicator	A	01	145-144	Y=Yes, the record was accepted by RDS N= No, the record was rejected by RDS due to error, no match, or not eligible for subsidy
15	Filler	A	2	146-146	Spaces
16	Subsidy Period Effective Date	N	8	148-154	CCYYMMDD, The effective date that the retiree can be claimed under the subsidy.
18	Subsidy Period Termination Date	N	8	156-162	CCYYMMDD, The termination date that the retiree can be claimed under the subsidy.
19	Filler	N	38	164-200	Spaces

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

APPENDIX A-8 DRUG SUBSIDY ELIGIBILITY					
NO.	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	Record Type	N	01	001-001	"T"
2	Application Number	N	10	002-011	Number assigned to the application by RDS Secure Website. Includes leading zeroes as needed to completely fill field.
3	Creation Date	N	08	012-019	Date file was created. CCYYMMDD
4	Creation Time	N	06	020-025	Time file was created. HHMMSS
5	Number of Detail Records	N	07	026-032	Right justified and zero filled.
6	Filler	N	168	033-200	

ATTACHMENT B
REQUIRED REPORTS

INTENT

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

A. Monthly Reports

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

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

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

B. Other Required Reports

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