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

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

HEALTH MAINTENANCE ORGANIZATION PLAN (HMO)

ISSUED

August 4, 2011

TABLE OF CONTENTS

SECTION I

GENERAL INFORMATION AND INSTRUCTIONS OF PROPOSAL FORMAT

A. Introduction/Purpose

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

Health Maintenance Organization Plan (HMO)

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

Blue Cross Blue Shield of Louisiana

Note: OGB reserves the right to reject any and all Proposals.

Proposal must be based on a nationwide medical provider network.

B. General Information

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

Exhibit 1 – HMO Plan of Benefits
Exhibit 2 – OGB HMO Summary of Benefits Chart
Exhibit 3 – Enrollment Information by Plan
Exhibit 4 – Enrollment Form
Exhibit 5 – Statewide Regions by City and Zip Codes
Exhibit 6 – OGB Current Premium Rates
Exhibit 7 – Contract/Business Associate Agreement/Data Reporting/Requirements

OGB is seeking a contract with a Proposer/Contractor that can work with the agency to accomplish key objectives which are to provide high quality cost effective health care to members, to control escalating health care costs, to achieve greater uniformity of coverage, and to minimize administrative efforts.

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

C. GB 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, FileNet (Oracle based imaging and document management system). OGB uses Oracle databases as its standard.

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

D. Term of Contract

The initial term of the contract will be for twelve months (January 1, 2012 through December 31, 2012) with an option to renew for up to two additional one-year terms, exercisable by OGB.

E. Standard Contract Provisions

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

F. State Contribution to Cost

The maximum contribution of the State for enrollees in any OGB plan will be the amount contributed by the State for the PPO enrollees. See Exhibit 6 for OGB current Premium Rates.

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

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

G. 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.

1. Submit an original (clearly marked "original"),a redacted copy, and eight (8) copies of a completed, numbered proposal placing each in a three-ring binder. Please include a copy of the proposal response in CD format with your "original" version.

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

3. Order of presentation:

   Cover Letter & Executive Summary

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

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

   Section VI – Tab 6 - Proposer Information

   Section VII – Tab 7 - Mandatory Signature Page

   Section VIII- Tab 8 - Administrative Fee Quotation Form **(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.

H. Ownership, Public Release and Costs of Proposals

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

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

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

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

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

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

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

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

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

individuals to protect the confidentiality of any specifically identified proprietary information or privileged business information obtained as a result of their participation.

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

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

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	Thursday, August 4, 2011
NIC Mailed or Available to Prospective Proposers Posted to OGB Website; Posted to LAPAC	Thursday, August 4, 2011
Deadline to Notify OGB of Interest to Submit a Proposal **(MANDATORY)**	Thursday, August 11, 2011
Deadline to Receive Written Questions	Thursday, August 11,2011
Electronic Data Sent to Interested Proposers	Tuesday, August 16, 2011
Response to Written Questions	Tuesday, August 16, 2011
Proposer Conference- Attendance in Person **(MANDATORY)**	Thursday, August 18, 2011
Proposals Due to OGB	Tuesday, September 6, 2011
Finalist's Interviews/Site Visits	TBD
Probable Selection and Notification of Award	TBD
Contract Effective Date	January 1, 2012

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

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

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

Chief Executive Officer
Office of Group Benefits

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

Mail:
Post Office Box 44036
Baton Rouge, LA 70804

Fax: (225) 922-0282

E-Mail: Patty.Rahl@la.gov

C. Written Questions

Written questions regarding the NIC are to be submitted to and received on or before 4:00 p.m., Central 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 at OGB at 10:00 a.m. at the following location:

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

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

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

SECTION III

SCOPE OF SERVICES

A. Plan of Benefits

Through this NIC, OGB seeks to contract with a third party administrator, insurer, or health maintenance organization for administrative services only to administer a self-insured HMO Plan. Proposal must be based on a nationwide medical provider network.

Services will commence January 1, 2012 after annual enrollment.

Services should include the following:

1. Inpatient Hospital Services (including hospital based ancillary services);
2. Outpatient Hospital Services (including hospital based ancillary services);
3. Ambulatory Surgical Services (including ASC based ancillary services);
4. Physician Services (including Chiropractic services);
5. Customer Service and Support;
6. A statewide network of providers in Louisiana;
7. A nationwide network of providers outside Louisiana.

Contractor must be capable of providing all services and benefits set forth in the Plan of Benefits (Exhibit 1) except for retail and mail order pharmaceutical and mental health and substance abuse benefits.

B. Eligibility

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

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

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

C. Plan of Benefits

See Exhibit 1 for the HMO Plan of Benefits.

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

D. 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. Directions to access an on-line directory of providers, which includes all physicians, hospitals, and specialty facilities.

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

E. Plan Member Communication Material, Advertisements and Marketing Material

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

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

F. Grievance Procedure

The Contractor shall maintain appeal, grievance and review procedures in compliance with federal and state law. A Plan Member whose appeal, grievance or request for review is not satisfactorily resolved by Contractor's final determination may request further review through OGB's administrative review process.

G. Contractor Administrative Contact

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

H. Annual Enrollment Procedures

The Contractor must agree to the following Annual Enrollment procedures:

1. Annual Enrollment shall be the period announced by OGB to allow employees to join a Plan, members to change coverage, or to add eligible dependents without regard to age, sex, or health condition.

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

3. OGB will schedule all enrollment meetings and will advise Contractor of the enrollment meeting logistics. Past meetings have numbered between three hundred and four hundred during the annual enrollment periods. A penalty shall be assessed to the Contractor for missed meetings.

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

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

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

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

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

I. Reporting Requirements

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

See OGB Contract Exhibit 7 for specific information regarding data information and description and layout of the required reports, including a penalty provision for failure to

provide reports on a timely basis. Contractor shall strictly adhere to the prescribed format and content requirements established by OGB.

J. Cost Quotations Requirements

1. Commissions or finders fees are not payable under this contract.

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

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

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

SECTION IV

PROPOSAL EVALUATIONS

A. Proposal Evaluation

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

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

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

B. Evaluation Criteria

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

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

1. Cost of Coverage (500 Points)

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

2. Qualitative/Network Assessment (500 Points)

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

C. Cost Evaluation

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

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

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

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

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

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

SECTION V

PROPOSERS REQUIREMENTS/ATTACHMENTS/CHECKLIST

A. Proposers Requirements

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

1. You are a licensed Third Party Administrator (TPA), Health Maintenance Organization (HMO), or Insurer pursuant to Title 22 of the Louisiana Revised Statutes.

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

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

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

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

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

7 You must provide a copy of your current SAS-70 Type II Audit Report with your proposal and be able to provide an annual SAS-70 Type II Audit Report not later than December 1 of each year of the contract term, as required by the Louisiana Legislative Auditor.

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

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

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

B. Required Attachments to Proposal

Proposer must provide the following attachments to their Proposal:

1. **Audited Financial Statements - Tab 1 of Proposal**

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

2. **Membership Satisfaction Survey – Tab 2 of Proposal**

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

3. **Management Reports – Tab 3 of Proposal**

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

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

   A list (also electronic copy) of network providers who will accept OGB members with their name and federal ID # including but not limited to:

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

   Provide a list of participating hospitals for which all ancillary service providers are not contracted participating providers in your network, identifying the specific hospital-based ancillary services not under contract at each such facility.

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

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

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

C. Proposer Checklist – Tab 5 of Proposal

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

	Requirements - Questions	Yes	No
1.	Do you have at least three years of operational experience in providing the required services within the State of Louisiana?		
2.	Do you agree to meet all of the General Contractual Requirements set forth in Exhibit 7 Contract/Business Associate Agreement?		
3.	Do you agree to meet all of the requirements set forth in this NIC and the attached proposed contract?		
4.	Is your organization in compliance with the Louisiana Medical Necessity Review Organization (MNRO) Act, La. R.S. 22:1121 et seq., and the rules promulgated pursuant thereto?		
5.	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?		
6.	Did a representative from your organization attend the Mandatory Proposers Conference?		
7.	Do you agree to administer the Plan of Benefits which meets the benefit plan requested in the NIC without exception?		
8.	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's fees of any type will be payable by you with this contract?		

	Requirements - Questions	Yes	No
12.	Have you included in your NIC response a complete copy of your audited financial statements for your most recent (2) two fiscal years that include your entire Louisiana operation?		
13.	Have you included in your NIC response a complete copy of your last two annual Department of Insurance filings?		
14.	Have you submitted a complete response to all questions set forth in the Narrative Section of this NIC?		
15.	Have you included all of the required attachments requested in the NIC?		
16.	Have you included a copy of your most recent SAS-70 Type II Audit report with your proposal?		
17.	Can you provide a SAS-70 Type II Audit report no later than December 1 each year of the contract term as required by the State of Louisiana Legislative Auditor?		
18.	Do you agree to reprice the attached claims utilizing the discounts contained in your existing signed contracts with the identified providers?		
19.	Are you currently accepting HIPAA 837 electronic claims from clearinghouses and/or health care providers?		
20.	Does the claims processing system you currently use for claims adjudication currently have the capability to recognize a claim for mental health or substance abuse (MHSA), deny claims, then forward that claim to OGB's MHSA vendor and notify the provider of this action?		
21.	Is the claims processing system you currently use for claims adjudication generating electronic funds transfers (EFTs) to providers while generating the appropriate HIPAA 835 electronic remittance advice (ERA) to providers, clearinghouse and third parties?		

Requirements - Questions		Yes	No
22.	Does your company receive a HIPAA 837 file from Medicaid for claims reconciliation purposes?		
23.	Does your company currently interface with outside Disease Management vendors?		

SECTION VI

PROPOSER INFORMATION
Tab 6 of Proposal

A. PRIMARY PROPOSER

Please provide the following for your Organization:

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

B. PARENT COMPANY

SAME INFORMATION AS LISTED IN (A).

C. SUBSIDIARIES/AFFILIATES TO PERFORM SIGNIFICANT SERVICES

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

D. ASO Client References

Please provide three (3) references for your organization's three largest existing ASO clients.

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

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

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

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

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

F. Additional Proposer Information

1. Does your organization support the concept of Medical Homes? If so, please describe, in detail, the incentives your organization currently provides to primary care doctors to obtain NCQA recognition as a medical home?

2. Are any physicians in your network currently paid any fees on a pay-for-performance basis? If so, please describe.

3. Does your organization currently offer any incentives for network professionals to adopt the use of electronic health records? If so, please describe.

4. Please describe all wellness programs currently available to your membership.

5. Does your organization offer any incentives to network providers to use minimally invasive surgical procedures? If so, please explain.

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

7. Do you support the use of evidenced-based guidelines by physicians? If so, how is this support incorporated into network incentives or credentialing.

8. What is your organization's currently monthly claims volume? What percentage of these claims are received electronically? What percentage are adjudicated electronically?

9. From what location will claims be paid?

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

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

SECTION VII

MANDATORY SIGNATURE PAGE

Tab 7 of Proposal

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

Proposer:_____

I hereby certify that:

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

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

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

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

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

Date:_____ Printed Name:_____

Title:_____ Signature:_____

SECTION VIII

ADMINISTRATIVE FEE QUOTATION FORM

Tab 8 of Proposal

1. Administrative Fee

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

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

The initial term of the contract will be twelve-months (January 1, 2012 through December 31, 2012) with an option to renew for up to two additional one-year terms, exercisable by OGB only.

HMO	Fixed Monthly Administrative Fee Per Employee Per Month (PEPM)	
1/1/2012 – 12/31/2012	**$**	**PEPM**
1/1/2013 – 12/31/2013	**$**	**PEPM**
1/1/2014 – 12/31/2014	**$**	**PEPM**

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

2. Claims Re-pricing

Each proposer will receive a CD containing claims incurred by OGB members. EVERY claim on this CD must be re-priced and sent back to OGB on a CD. The claim record must be expanded to include an indicator that identifies in and out of network providers. In network provider pricing should reflect your current signed contract pricing. Out of network provider pricing should reflect allowable expenses. These re-priced claims must be submitted with your proposal.

Proposer_____

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

Signature_____ **Date**_____

SECTION IX

EXHIBITS

EXHIBIT 1 HMO Plan of Benefits

EXHIBIT 2 OGB Summary of Benefits Chart

EXHIBIT 3 Enrollment Information by Plans

EXHIBIT 4 Enrollment Form

EXHIBIT 5 Statewide Regions by City and Zip Codes

EXHIBIT 6 OGB Official Current Premium Rates

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

- Attachment A Financial Agreement
- Attachment B Performance Standards
- Attachment C Business Associate Agreement (BAA)
- Attachment D File Requirement & Layout
- Attachment D-6 Required Reports

EXHIBIT 1

HMO PLAN OF BENEFITS

The HMO Plan of Benefits will be the same as those currently provided under OGB's self-insured HMO Plan. A copy of that Plan of Benefits can be attained from The Office of Group Benefits website: www.groupbenefits.org.

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

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

EXHIBIT 2

OGB HMO SUMMARY OF BENEFITS CHART

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

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

EXHIBIT 3

ENROLLMENT INFORMATION BY PLAN

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 7/31/2011

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
BLUE CROSS (ST)											
	3,988	24,986	4,700	16,786	13,303	6,505	50,535	20,689	9,870	9,227	160,589
Region	47.70%	68.33%	55.86%	68.60%	58.66%	50.85%	75.05%	58.88%	51.35%	33.87%	61.24%
Plan	2.48%	68.33%	2.93%	10.45%	8.28%	4.05%	31.47%	12.88%	6.15%	5.75%	100.00%
FMOP-LEV1 NO/IN											
		20	18	2	32	4	49	14	26	10	175
Region		0.05%	0.21%	0.01%	0.14%	0.03%	0.07%	0.04%	0.14%	0.04%	0.07%
Plan		0.05%	10.29%	1.14%	18.29%	2.29%	28.00%	8.00%	14.86%	5.71%	100.00%
FMOP-LEV1 W/INS											
		27	23	42	44	35	54	24	37	11	297
Region		0.07%	0.27%	0.17%	0.19%	0.27%	0.08%	0.07%	0.19%	0.04%	0.11%
Plan		0.07%	7.74%	14.14%	14.81%	11.78%	18.18%	8.08%	12.46%	3.70%	100.00%
FMOP-LEV2 NO/IN											
		32	12	12	29	9	12	14	17	6	143
Region		0.09%	0.14%	0.05%	0.13%	0.07%	0.02%	0.04%	0.09%	0.02%	0.05%
Plan		0.09%	8.39%	8.39%	20.28%	6.29%	8.39%	9.79%	11.89%	4.20%	100.00%

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 7/31/2011

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
FMOP-LEV2 W/INS											
		33	27	48	42	28	55	27	34	15	309
Region		0.09%	0.32%	0.20%	0.19%	0.22%	0.08%	0.08%	0.18%	0.06%	0.12%
Plan		0.09%	8.74%	15.53%	13.59%	9.06%	17.80%	8.74%	11.00%	4.85%	100.00%
HUMANA HMO 65											
	1	358	8	274	1	1	496	17	81		1,237
Region	0.01%	0.98%	0.10%	1.12%	0.00%	0.01%	0.74%	0.05%	0.42%		0.47%
Plan	0.08%	0.98%	0.65%	22.15%	0.08%	0.08%	40.10%	1.37%	6.55%		100.00%
HUMANA PPO 65											
	18	13	6	7	11	2	7	10	6	3	83
Region	0.22%	0.04%	0.07%	0.03%	0.05%	0.02%	0.01%	0.03%	0.03%	0.01%	0.03%
Plan	21.69%	0.04%	7.23%	8.43%	13.25%	2.41%	8.43%	12.05%	7.23%	3.61%	100.00%
LACHIP-COPAY											
	13	947	461	604	883	546	821	480	501	385	5,641
Region	0.16%	2.59%	5.48%	2.47%	3.89%	4.27%	1.22%	1.37%	2.61%	1.41%	2.15%
Plan	0.23%	2.59%	8.17%	10.71%	15.65%	9.68%	14.55%	8.51%	8.88%	6.83%	100.00%

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 7/31/2011

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
LACHIP-NO COPAY											
		5	7	5	6		6	8	4	9	50
Region		0.01%	0.08%	0.02%	0.03%		0.01%	0.02%	0.02%	0.03%	0.02%
Plan		0.01%	14.00%	10.00%	12.00%		12.00%	16.00%	8.00%	18.00%	100.00%
LSU Health $10K											
	65	446	70	89	105	39	1,035	45	543	22	2,459
Region	0.78%	1.22%	0.83%	0.36%	0.46%	0.30%	1.54%	0.13%	2.83%	0.08%	0.94%
Plan	2.64%	1.22%	2.85%	3.62%	4.27%	1.59%	42.09%	1.83%	22.08%	0.89%	100.00%
LSU Health $5K											
	893	3,273	1,143	1,549	2,165	566	8,037	791	3,717	831	22,965
Region	10.68%	8.95%	13.58%	6.33%	9.55%	4.42%	11.94%	2.25%	19.34%	3.05%	8.76%
Plan	3.89%	8.95%	4.98%	6.75%	9.43%	2.46%	35.00%	3.44%	16.19%	3.62%	100.00%
MCOP-RANGE 1											
		29	10	6	24	8	21	17	17	8	140
Region		0.08%	0.12%	0.02%	0.11%	0.06%	0.03%	0.05%	0.09%	0.03%	0.05%
Plan		0.08%	7.14%	4.29%	17.14%	5.71%	15.00%	12.14%	12.14%	5.71%	100.00%

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 7/31/2011

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
MCOP-RANGE 2											
		7	2	4	5	2	7	5	4	3	39
Region		0.02%	0.02%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.01%	0.01%
Plan		0.02%	5.13%	10.26%	12.82%	5.13%	17.95%	12.82%	10.26%	7.69%	100.00%
MED HOME HMO PL											
	9						12	188	21	5,295	5,525
Region	0.11%						0.02%	0.54%	0.11%	19.44%	2.11%
Plan	0.16%						0.22%	3.40%	0.38%	95.84%	100.00%
OGB PPO											
	3,323	6,175	1,852	4,860	5,597	4,865	5,673	12,126	4,145	10,882	59,498
Region	39.74%	16.89%	22.01%	19.86%	24.68%	38.03%	8.42%	34.51%	21.57%	39.95%	22.69%
Plan	5.59%	16.89%	3.11%	8.17%	9.41%	8.18%	9.53%	20.38%	6.97%	18.29%	100.00%
PEOPLE'S-MEDADV											
		94	4	66			154				318
Region		0.26%	0.05%	0.27%			0.23%				0.12%
Plan		0.26%	1.26%	20.75%			48.43%				100.00%

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 7/31/2011

	REGIONS										
	00	01	02	03	04	05	06	07	08	09	Totals
UNIT CONS DRIVE											
	13	39	16	26	52	10	144	10	24	31	365
Region	0.16%	0.11%	0.19%	0.11%	0.23%	0.08%	0.21%	0.03%	0.12%	0.11%	0.14%
Plan	3.56%	0.11%	4.38%	7.12%	14.25%	2.74%	39.45%	2.74%	6.58%	8.49%	100.00%
UNITED PPO 65											
	36	7	9	1	32	3	25	9	2	6	130
Region	0.43%	0.02%	0.11%	0.00%	0.14%	0.02%	0.04%	0.03%	0.01%	0.02%	0.05%
Plan	27.69%	0.02%	6.92%	0.77%	24.62%	2.31%	19.23%	6.92%	1.54%	4.62%	100.00%
VANTAGE - HMO											
							38	32	12	48	130
Region							0.06%	0.09%	0.06%	0.18%	0.05%
Plan							29.23%	24.62%	9.23%	36.92%	100.00%
VANTAGE -MEDADV											
	2	77	46	89	346	170	158	634	159	449	2,130
Region	0.02%	0.21%	0.55%	0.36%	1.53%	1.33%	0.23%	1.80%	0.83%	1.65%	0.81%
Plan	0.09%	0.21%	2.16%	4.18%	16.24%	7.98%	7.42%	29.77%	7.46%	21.08%	100.00%

STS0009

Enrollees and Dependents with Health Coverage by Region

Effective Date: 7/31/2011

	REGIONS									
	00	01	02	03	04	05	06	07	08	09	Totals
Grand Total	8,361	36,568	8,414	24,470	22,677	12,793	67,339	35,140	19,220	27,241	262,223

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

EXHIBIT 4

ENROLLMENT FORM

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS
ENROLLMENT/CHANGE FORM

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

PURPOSE

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

PERSONAL INFORMATION - EMPLOYEE (Please print or type)

Name	Social Security Number	Date of Birth	
Address	City	State	Zip Code

Home Phone ( )	Work Phone ( )	Extension	Sex 1. ☐ Male 2. ☐ Female	Marital Status 1. ☐ Single 2. ☐ Married	Date of Marriage	Date of Divorce

HEALTH PLAN SELECTED (Write in health plan selection)

LEVEL OF MEDICAL COVERAGE SELECTED ☐ No Coverage ☐ Employee Only ☐ Employee + Child/Children ☐ Employee + Spouse ☐ Family

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

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

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

Employer/Company	Insurance Company/HMO (Name/Address/Phone)	Persons Covered Under Other Policy

C.O.B.R.A.

☐ Prior F/T Terminated ☐ Divorced Spouse ☐ Dependent

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

MEDICARE

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

A COPY OF MEDICARE CARD MUST BE ATTACHED

RETIREE 100

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

LIFE INSURANCE (Check only one)

☐ No Coverage Employee/Dependent

BASIC

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

Date of Last Salary Increase _____

BASIC PLUS SUPPLEMENTAL

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

Annual Salary _____
Face Life _____

PAGE 1 OF 2
CONTINUE ON REVERSE SIDE

GB-01
3-11

WAIVER OF COVERAGE

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

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

_____ _____

EMPLOYEE SIGNATURE DATE

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

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

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

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

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

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

ACKNOWLEDGMENT OF COVERAGE LIMITATIONS AND PRE-EXISTING CONDITION EXCLUSION

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

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

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

I certify that the information provided on this form is true and correct. I understand that if I provide false information on this form, it may result in denial or recision of coverage retroactive to the initial day of coverage. A copy of my signature is as valid as the original.

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

_____ _____

EMPLOYEE SIGNATURE DATE

_____ _____

AGENCY REPRESENTATIVE SIGNATURE DATE

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

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

EXHIBIT 5

STATEWIDE REGIONS BY CITY AND ZIP CODES

Regions by City and Zip Code

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

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

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

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

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

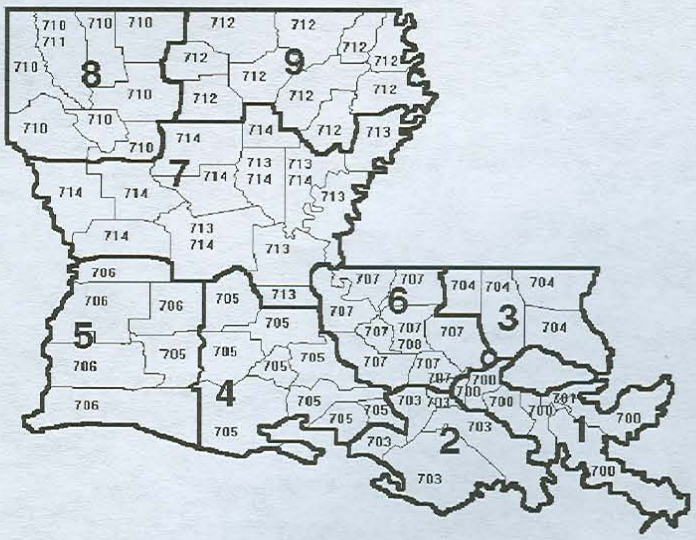
REGION 6
- Addis
- Baker
- Baton Rouge
- Brusly
- Clinton
- Denham Springs
- Gonzales
- Livingston
- Livonia
- Maringouin
- New Roads
- Plaquemine
- Port Allen
- Prairieville
- St. Francisville
- St. Gabriel
- Sunshine
- White Castle
- Zachary

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

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

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

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



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

EXHIBIT 6

OGB CURRENT PREMIUM RATES

OFFICE OF GROUP BENEFITS

OFFICIAL SCHEDULE OF PREMIUM RATES

Effective July 1, 2011

	PPO *Administered by OGB*			HMO *Administered by Blue Cross & Blue Shield*			CDHP with HSA *Administered by UnitedHealthcare*			Region 8 (10 northeast LA parishes) Medical Home HMO *Insured by Vantage Health Plan*			Regions 6, 7, 8 & 9 (Baton Rouge, Alexandria, Shreveport & Monroe) Regional HMO *Insured by Vantage Health Plan*		
	State Share	Employee Share	Total	State Share	Employee Share	Total	State Share	Employee Share	Total	State Share	Employee Share	Total	State Share	Employee Share	Total
ACTIVE EMPLOYEE															
SINGLE	442.36	147.44	589.80	417.90	139.30	557.20	343.38	114.46	457.84	426.94	142.30	569.24	414.96	138.32	553.28
WITH SPOUSE	773.82	478.90	1252.72	730.98	452.38	1183.36	600.66	371.74	972.40	746.86	462.22	1209.08	717.48	440.84	1158.32
WITH CHILDREN	507.12	212.20	719.32	479.06	200.46	679.52	393.74	164.82	558.56	489.56	204.92	694.48	474.18	197.54	671.72
FAMILY	808.06	513.14	1321.20	763.30	484.70	1248.00	627.20	398.28	1025.48	779.88	495.24	1275.12	748.70	472.06	1220.76
RETIREE WITHOUT MEDICARE & RE-EMPLOYED RETIREE															
SINGLE	949.80	147.44	1097.24	900.62	139.30	1039.92	N/A	N/A	N/A	916.50	142.30	1058.80	877.88	138.32	1016.20
WITH SPOUSE	1458.66	478.90	1937.56	1383.86	452.38	1836.24	N/A	N/A	N/A	1407.74	462.22	1869.96	1342.40	440.84	1783.24
WITH CHILDREN	1010.00	212.20	1222.20	957.94	200.46	1158.40	N/A	N/A	N/A	974.56	204.92	1179.48	932.78	197.54	1130.32
FAMILY	1446.12	482.04	1928.16	1370.58	456.86	1827.44	N/A	N/A	N/A	1395.66	465.22	1860.88	1330.98	443.66	1774.64
RETIREE WITH 1 MEDICARE															
SINGLE	267.60	89.20	356.80	258.04	86.00	344.04	N/A	N/A	N/A	258.30	86.10	344.40	255.52	85.16	340.68
WITH SPOUSE	988.78	329.58	1318.36	943.00	314.32	1257.32	N/A	N/A	N/A	954.18	318.06	1272.24	913.56	304.52	1218.08
WITH CHILDREN	463.20	154.40	617.60	443.86	147.94	591.80	N/A	N/A	N/A	447.00	149.00	596.00	433.96	144.64	578.60
FAMILY	1317.46	439.14	1756.60	1255.20	418.40	1673.60	N/A	N/A	N/A	1271.40	423.80	1695.20	1213.50	404.50	1618.00
RETIREE WITH 2 MEDICARE															
WITH SPOUSE	481.02	160.34	641.36	462.52	154.16	616.68	N/A	N/A	N/A	464.08	154.68	618.76	450.10	150.02	600.12
FAMILY	595.60	198.52	794.12	572.68	190.88	763.56	N/A	N/A	N/A	574.66	191.54	766.20	554.64	184.88	739.52
C.O.B.R.A.															
SINGLE	0.00	569.82	569.82	0.00	538.32	538.32	N/A	N/A	N/A	0.00	542.64	542.64	0.00	564.04	564.04
WITH SPOUSE	0.00	1210.30	1210.30	0.00	1143.28	1143.28	N/A	N/A	N/A	0.00	1152.84	1152.84	0.00	1181.46	1181.46
WITH CHILDREN	0.00	694.96	694.96	0.00	656.52	656.52	N/A	N/A	N/A	0.00	661.80	661.80	0.00	684.62	684.62
FAMILY	0.00	1276.44	1276.44	0.00	1205.72	1205.72	N/A	N/A	N/A	0.00	1215.60	1215.60	0.00	1244.98	1244.98
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	0.00	824.58	824.58
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	0.00	1729.96	1729.96
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	0.00	999.52	999.52
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	0.00	1823.62	1823.62

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

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

3) COBRA rates for the PPO, HMO and MH-HMO plans have remained unchanged from July 1, 2010, for the 6-month plan year in accordance with federal guidelines.

Approved by:

3/17/2011

EXHIBIT 7

CONTRACT/BUSINESS ASSOCIATE AGREEMENT/ DATA REPORTING/REQUIREMENTS

STATE OF LOUISIANA

OFFICE OF GROUP BENEFITS (OGB)

ADMINISTRATIVE SERVICES ONLY (ASO)

CONTRACT

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

1.0 DEFINITIONS

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

b. "Plan" shall mean OGB's **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" (Participant) shall mean a state employee or retiree who is entitled to Benefits under the Plan or any dependent of the employee or retiree who is entitled to Benefits under the Plan.

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

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

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

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

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

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

j. “Network Provider” shall mean a health care provider who participates in the Contractor’s Managed Care Network.

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

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

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

n. “Bank” shall mean a bank chosen by the Contractor.

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

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

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

2.0 SCOPE OF SERVICES

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

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

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

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

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

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

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

    a) A booklet during annual enrollment describing all covered services under the Plan, including but not limited to, Plan Benefits, limitations, exclusions, coinsurance, 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) An electronic directory of providers, which includes all physicians, hospitals and specialists in the service area; and

    c) Identification cards.

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

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

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

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

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

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

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

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

11. Provide all levels of reviews and appeals for matters that fall within the scope of the Louisiana Medical Necessity Review Organization (MNRO) Act and the rules promulgated pursuant thereto. Provide initial review of all other Plan Participants' appeals and grievances and provide the Contractor's Appeals and Grievances Policies and Procedures to OGB. OGB retains the right for final appeals and final discretionary authority and responsibility for claims payment decisions.

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

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

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

Claims Data: The Contractor shall provide to OGB all claims data including Participant-specific claims information, ("Confidential Claims Information") which the Contractor may obtain in the course of administering the Contract. The Contractor may also release certain Participant-related claims data at the Contractor's discretion to certain vendors or other third parties. The Contractor shall treat all Confidential Claims Information in accordance with the applicable federal and state laws and regulations, including but not limited to 42 C.F.R. Part 2 (confidentiality of alcohol and drug abuse patient records). Any use or disclosure of Confidential Claims Information or other information pursuant to this Section shall be subject to the terms and conditions of the HIPAA Business Associate Agreement attached hereto as Attachment C to the Contract.

15. Provide OGB with the required reports as set forth in Attachment D-6.

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

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

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

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

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

    OGB shall report eligibility activity in the format attached hereto as Attachment D-4. Each Eligibility transmission shall contain data pertinent to all Participants for which the Contractor has received updated eligibility information since the last transmission received by the Contractor. The Contractor will establish and maintain a single, uniform system to update eligibility records for Participants. This system

shall accept eligibility data from OGB in accordance with its standard eligibility protocols through an online electronic transfer and perform eligibility file matches, and identify and correct discrepancies. Eligibility transmissions shall take place between 10:00 p.m. and 3:00 a.m. following each regularly scheduled OGB business days, barring unforeseen software or hardware complications. The Contractor shall notify OGB by 12:00 p.m. of the day following an unsuccessful transmission so that OGB can reschedule the transmission. Each contract year the Contractor shall submit a schedule to OGB outlining the days that the Contractor will be unable to accept a transmission. In the event any discrepancies, the Contractor shall notify OGB thereof and its correction of such discrepancies. The transmitted data (data not requiring additional follow-up or investigation) shall be converted and applied to the Contractor's claims system for purposes of claims payment within two (2) business days of receipt of a successful transmission. The two (2) business day deadline shall not apply during annual enrollment or file match periods, although the Contractor shall convert and apply the transmitted data to its claims system as soon as possible.

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

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

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

Prospective Member Terminations: A Participant's coverage will terminate when a Participant ceases to be an Eligible Person or and Eligible Dependent under the terms of OGB's Plan Document. OGB shall be responsible for notifying all Participants of the termination of coverage; however, coverage will be terminated regardless of whether OGB provides the notice. OGB shall be responsible for notifying the Contractor regarding the termination and the effective date thereof. Provided that OGB properly notifies the Contractor of a Participant's termination, if

the Contractor processes a claim incurred after the termination effective date, then OGB shall not be financially liable for such claim.

Certificates of Creditable Coverage: The Contractor will produce or furnish certificates of creditable coverage which meet the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), on an automatic basis or on demand for former Participants.

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

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

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

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

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

g. See Attachment B for Performance Standards.

3.0 TERM OF CONTRACT

a. This contract shall begin January 1, 2012 and end December 31, 2012. The initial term of the contract will be one year and OGB shall have the option to renew this Contract for up to two additional one-year terms. The initial term, first optional renewal, and second optional renewal shall commence and terminate on the following dates:

Initial Term	January 1, 2012 – December 31, 2012
First Optional Renewal	January 1, 2013 – December 31, 2013
Second Optional Renewal	January 1, 2014 – December 31, 2014

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

4.0 ADMINISTRATIVE FEES; PAYMENT TERMS

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

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

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

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

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

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

5.0 SAVINGS AGREEMENT; COST CONTAINMENT PROGRAMS

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

b. The cost for access to the Contractor's cost containment programs shall be included in the Administrative Services Fee. As further consideration for OGB's participation in the Contractor's cost containment programs, OGB expressly waives any rights it may have in or to any cost containment the Contract or agreement between the Contractor and any health care or allied service provider.

6.0 PROVIDER NETWORK SAVINGS

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

7.0 CLAIMS LIABILITY

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

b. If, for any reason, a provider fails to or is unable to render services it has agreed to provide through a Contract with the Contractor, the Contractor will honor a claim for services equivalent to those agreed to by the defaulting provider while an individual continues to be a plan Participant. The claim shall be included in the billing of claims payment to OGB and shall be reimbursed by OGB as provided by this Article.

c. OGB shall hold the Contractor harmless from any penalties or fines that may be assessed as a result of the suspension of the payment of claims as set forth in Article 4.0 (d) above.

8.0 OGB PLAN RESPONSIBILITY

a. Except as specifically provided to the contrary, OGB retains final authority and responsibility for the Plan and its operation, including if applicable, compliance with any state and federal laws, and payment of claims filed under the Plan. The Contractor is empowered to act on behalf of OGB only in an administrative capacity for the services specified herein, subject to the direction and authority of OGB. Any decision or action of

the Contractor regarding this Contract or the Plan which does not result from its grossly negligent, dishonest, fraudulent or criminal conduct and which is not overridden or otherwise modified by OGB in writing shall be deemed to be the exercise of OGB's discretionary power to make final decisions or conclusive action.

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

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

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

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

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

9.0 SINGLE PROGRAM, RIGHT TO ASSESS ALL PARTICIPANTS

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

10.0 GOVERNING LAW, VENUE

The validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties hereunder, shall be construed pursuant to, and in accordance with, the laws of the State of Louisiana, and venue of any action brought under this contract shall be the Nineteenth (19^{th}) Judicial District Court for the parish of East Baton Rouge, Louisiana.

11.0 INSURANCE CERTIFICATE

a. The Contractor shall procure and maintain for the duration of the Contract liability insurance, including coverage for but not limited to: claims for injuries to persons or damages to property which may arise from or in connection with the performance of the

work hereunder by the Contractor, its agents, representatives, employees or sub-contractors; liability and insolvency protection, with a combined single limit liability of not less than Ten Million ($10,000,000.00) Dollars. The State of Louisiana, Office of OGB Benefits must be named as a loss payee.

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

12.0 LIABILITY FOR DAMAGES BY THE CONTRACTOR

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

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

13.0 PERFORMANCE BOND

The Contractor shall furnish a performance bond in the amount of $1,000,000 (one million) dollars.

14.0 INDEMNIFICATION

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

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

15.0 RESPONSIBILITIES AND OTHER RIGHTS; THIRD PARTY LIABILITY

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

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

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

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

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

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

16.0 FUND USE

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

17.0 TAXES

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

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

18.0 SYSTEM ACCESS SECURITY/PREMISES SECURITY

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

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

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

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

19.0 CONFIDENTIALITY

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

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

20.0 REPRODUCTION, PUBLICATION AND USE OF MATERIAL

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

21.0 ACKNOWLEDGEMENT OF PRIORITY POSITION

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

22.0 MOST FAVORED CUSTOMER GUARANTEE

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

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

23.0 WAIVER OF BREACH

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

24.0 SEVERABILITY

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

25.0 NOTICE

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

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

CONTRACTOR: TBD

26.0 PATENT, COPYRIGHT, AND TRADE SECRET INDEMNITY

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

27.0 INDEPENDENT CONTRACTOR RELATIONSHIP

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

28.0 PROJECT MANAGEMENT/MONITORING PLAN

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

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

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

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

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

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

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

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

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

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

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

29.0 MANAGEMENT OF HEALTH CARE SERVICES

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

a. Care Coordination Services

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

2. The Contractor may provide, when appropriate for the individual Plan Participant, certain case management services, which are designed to provide a proactive, systematic process of coordination of health care services, including the evaluation of inpatient, outpatient and ancillary services, Participant education, the review of the short term outpatient care needs and where appropriate, coordination and facilitation of discharge planning needs. These services address the unmet health care needs of Plan Participants who are not eligible for a disease management program under the Plan but are at significant risk for declining health status and high medical expense.

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

to develop a program of benefit coverage with appropriate and cost-effective health care services and supplies for the diagnosis and/or treatment of the Plan Participant's condition. If the Plan Participants and health care provider are not willing to participate in the process, the Contractor will not provide these services.

b. Fraud & Abuse Management Services

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

30.0 COOPERATION WITH MENTAL HEALTH/SUBSTANCE ABUSE VENDOR

The Contractor understands that OGB has carved out the treatment of those diagnoses recognized by ICD9 as diagnosis codes for mental health and/or substance abuse disorders. The Contractor agrees to coordinate benefit coverage of Participants diagnosed with such mental health and/or substance abuse disorders with OGB's Mental Health and Substance Abuse (MHSA) vendor.

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

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

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

31.0 DISEASE MANAGEMENT VENDOR

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

32.0 PERFORMANCE MEASURES

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

See Attachment B for Performance Standards.

33.0 SUSPENSION OF ADMINISTRATIVE SERVICES AND/OR CLAIMS PAYMENTS

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

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

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

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

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

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

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

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

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

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

34.0 TERMINATION FOR CAUSE

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

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

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

35.0 TERMINATION FOR CONVENIENCE

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

36.0 CONTRACTOR'S DUTIES UPON TERMINATION

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

1. Administer run out claims for a period of one year from the date this Contract terminates. "Run out claims" refers to those claims for covered services performed prior to termination of the Contract, but not yet paid and/or not submitted for payment to Contractor prior to the termination of this Contract. No Administrative Fee will be paid for the administration of run out claims after termination of contract.
2. Provide OGB with a copy of the register that identifies the deductible and coinsurance accumulations by Plan Participant that correspond to the termination date.
3. Provide OGB with a hard copy of the register of its claims by provider that are unprocessed at the time of termination.
4. Provide OGB with all statistical reports for the current Plan year up to the date of termination.
5. Provide OGB with a hard copy register of any Coordination of Benefits or Third Party Liability recovery initiative that is in progress at the time of the termination.

b. All claims, including demands from the Centers for Medicare and Medicaid Services for the recovery of Medicare payments, remaining unpaid in whole or in part at the end of one year from the date this Contract terminates shall be returned to OGB which shall be responsible for any processing and the payment of the claims.

37.0 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.

38.0 OWNERSHIP OF PRODUCT

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

39.0 ASSIGNMENT

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

40.0 RIGHT TO AUDIT

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

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

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

d. The Contractor shall provide a copy of a annual independent audit conducted on the processing of transactions, pursuant to Statement on Auditing Standards (SAS – 70- Type II Audit), as required by the State's Legislative Auditor. The audit must be received by OGB not later than December 1 of each year of the contract term. The Contractor will be subject to a $1,000 per day penalty until receipt of the audit by OGB.

41.0 RECORD RETENTION

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

42.0 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.

43.0 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.

44.0 NON-DISCRIMINATION

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

45.0 AVAILABILITY OF FUNDS

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

46.0 HEADINGS

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

47.0 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.

48.0 SUBCONTRACTORS

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

49.0 ENTIRE AGREEMENT AND ORDER OF PRECEDENCE

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

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

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

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

STATE OF LOUISIANA **OFFICE OF GROUP BENEFITS (OGB)**	**(CONTRACTOR)**
SIGNATURE: _____	**SIGNATURE:** _____
NAME: _____	**NAME:** _____
TITLE: **Chief Executive Officer**	**TITLE:** _____

ATTACHMENT - A

FINANCIAL AGREEMENT

1. PAYMENT FACTORS:

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

Administrative Fees

HMO

Plan Year 1/1/12-12/31/12	$ PEPM
Plan Year 1/1/13 -12/31/13	$ PEPM
Plan Year 1/1/14- 12/31/14	$ PEPM

The Contractor agrees that the Administrative Fees includes services to be provided by the Contractor to pay run out claims and continue reporting to OGB those claims.

2. CLAIM PAYMENT PROCEDURES

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

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

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

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

3. FINAL SETTLEMENT

Within sixteen (16) months of the Contract termination date there shall be a final settlement between OGB and the Contractor. At the final settlement, the Contractor

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

ATTACHMENT - B

PERFORMANCE STANDARDS

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

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

3. **Measurement Periods:** The first period to be measured shall be January 1, 2012 through December 31, 2012. The second period to be measured shall be January 1, 2013 through December 31, 2013. The third period to be measured shall be January 1, 2014 through December 31, 2014.

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

Average Speed to Answer:

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

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

Inquiry Timeliness:

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

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

Financial Accuracy:

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

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

Claims Timeliness

Definition: "Clean claim" means an accepted claim that has no defect or impropriety including any lack of required substantiating documentation or other particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

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

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

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

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

(b) The date of electronic transfer of funds.

"Received" or "receipt" means:

(a) For a nonelectronic claim:

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

(ii) For a claim sent via a commercial carrier or via the United States Postal Service for which return receipt is requested, the date the delivery receipt is signed by the health insurance issuer or its agent designated for the receipt of claims at the correct claims address, as documented in accordance with claims filing procedures filed by the health insurance issuer with the department.

(b) For an electronic claim, either of the following:

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

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

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

Claims Accuracy:

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

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

Eligibility Accuracy:

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

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

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

Membership Identification Cards (Timeliness):

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

This standard applies outside of any annual enrollment period.

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

Data Submission (Timeliness):

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

Standard: $10,000 Per Day Penalty.

5. **Performance Penalties:** If the Contractor fails to achieve the Performance Standards set forth below as measured separately over the Measurement Periods, the Contractor shall incur penalties not to exceed, in the aggregate, ten (10%) percent of the Administrative Fees charged to OGB as specified in the Contract. It is the intent of the parties that the ten (10%) percent cap on penalties shall apply jointly to all services and requirements, excluding the penalty for Data Submission Timeliness which shall be based on a daily penalty of $10,000 per day and the penalty for missed annual enrollment meetings which shall be based on a penalty of $1,000 per meeting.

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

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

Access/Customer Services (OGB Specific)

Measurement	Performance Standard	Penalty
Average Speed of Answer	**>45 Seconds**	**2.0%**
	30-44 Seconds	**1.0%**

Abandon Call Rate	**> 5% of Calls Abandoned**	**1.0%**
Inquiry Timeliness	**>90% of all inquiries answered within seven calendar days on average**	**1.0%**
Financial Accuracy	**<96%**	**2.0%**
	96% - 97%	**1.0%**
Claims Timeliness	**<98% for electronic clean claims paid within 10 days of receipt.**	**2.0%**
	<98% for nonelectronic clean claims paid within 15 days of receipt.	**2.0%**
Claims Accuracy	**<96%**	**2.0%**
	96% - 97%	**1.0%**
Eligibility Timeliness	**<98% of membership files updated within 2 business days of receipt of enrollment file**	**1.0%**
Member ID Cards Timeliness	**<100% of new members will have ID cards issued prior to the effective date of coverage**	**1.0%**
Total Percentage at Risk (as a percent of the administrative expense portion of retention)		**10%**
Data Reporting Timeliness	**100% reporting within five (5) days after the following month.**	**$10,000 Per Day**
The Contractor shall be fined for enrollment meetings not attended.		**$1,000 Per meeting**

ATTACHMENT C

BUSINESS ASSOCIATE AGREEMENT (BAA)

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

I. Definitions

a) "Administrative Safeguards" shall mean administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's workforce in relation to the protection of that information., as more particularly set forth in 45 CFR § 164.308.
b) "Agreement" shall mean the agreement between Business Associate and OGB, dated _____, 20___, pursuant to which Business Associate is to provide certain services to OGB involving the use or disclosure of PHI, as defined below.
c) "ARRA" shall mean the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
d) "Business Associate" shall mean _____.
e) "ePHI" shall have the same meaning as the term "electronic protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of OGB.
f) "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
g) "HIPAA Regulations" shall mean the Privacy Rule, the Security Rule, and the regulations promulgated pursuant to ARRA.
h) "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
i) "OGB" shall mean the State of Louisiana, Division of Administration, Office of Group Benefits, which is a covered entity under HIPAA, ARRA and the HIPAA Regulations, as defined below.
j) "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of OGB.
k) "Physical Safeguards" shall mean physical measures, policies, and procedures to protect a covered entity's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion as more particularly set forth in 45 CFR § 164.310.
l) "Privacy Rule" shall mean the regulations promulgated pursuant to HIPAA regarding Privacy of Individually Identifiable Health Information at 45 CFR, Part 160 and Part 164, Subparts A and E.
m) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.
n) "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
o) "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR § 164.304.

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

II. Obligations and Activities of Business Associate

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

k) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for OGB to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
l) Business Associate agrees to provide to OGB or an Individual, in a time and manner designated by OGB, information collected in accordance with Section II.j of this Addendum, to permit OGB to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
m) At any time(s) requested by OGB, Business Associate agrees to return to OGB or destroy such PHI in its possession as directed by OGB.
n) Business Associate shall defend and indemnify OGB from and against any and all claims, costs, and/or damages arising from a breach by Business Associate of any of its obligations under this Addendum. Any limitation of liability provision set forth in the Agreement, including but not limited to any cap on direct damage liability and any disclaimer of liability for any consequential, indirect, punitive, or other specified types of damages, shall not apply to the defense and indemnification obligation contained in this Addendum.
o) Business Associate shall immediately notify OGB when Business Associate receives a subpoena related to PHI and shall cooperate with OGB, at OGB's expense, in any attempt to obtain a protective order. Business Associate shall immediately notify OGB when Business Associate discloses PHI in response to a subpoena. Such notice shall include all information that would be required for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
p) Business Associate shall:
    1. Implement and document Administrative Safeguards, Physical Safeguards, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of OGB, specifically including, but not limited to, the following:
        i) Ensuring the confidentiality, integrity, and availability of all ePHI that it creates, receives, maintains, or transmits on behalf of OGB;
        ii) Protecting against any reasonably anticipated threats or hazards to the security or integrity of such information;
        iii) Protecting against any reasonably anticipated uses or disclosures of such information that are not permitted or required by this Addendum or Required by Law; and
        iv) Ensuring compliance with these requirements by its workforce;
    2. Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate safeguards to protect it;
    3. Report to OGB any Security Incident of which it becomes aware. If no Security Incidents are reported, Business Associate shall certify to OGB in writing within ten (10) days of each anniversary date of the Agreement that there have been no Security Incidents during the previous twelve months.
q) Business Associate shall not permit PHI to be disclosed to or used by any individual or entity outside of the territorial and jurisdictional limits of the fifty United States of America.
r) Business Associate shall report to OGB any unauthorized acquisition, access, use or disclosure of PHI by Business Associate or its workforce or subcontractors immediately, but no later than five (5) business days after discovery or the date the breach should have

been known to have occurred, and include with that report the remedial action taken or proposed to be taken with respect to such use or disclosure and account for such disclosure. Business Associate is responsible for any and all costs related to notification of individuals or next of kin (if the individual is deceased) of any security or privacy breach reported by Business Associate to OGB.

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

III. Permitted Uses and Disclosures by Business Associate

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

b) Except as otherwise limited in this Addendum, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

c) Except as otherwise limited in this Addendum, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that such disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that it will remain confidential and be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person promptly notifies the Business Associate of any known instances of breach of the confidentiality of the PHI.

d) Except as otherwise limited in this Addendum, Business Associate may use PHI to provide Data Aggregation services to OGB as permitted by 45 CFR § 164.504(e)(2)(i)(B), provided that such services are contemplated by the Agreement.

e) Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1).

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

IV. Obligations and Activities of OGB

a) With the exception of Data Aggregation services as permitted by 45 CFR § 164.504(e)(2)(i)(B), OGB shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by OGB.

b) OGB shall notify Business Associate of any limitation(s) in OGB's Notice of Privacy Practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
c) OGB shall notify Business Associate of any changes in, or revocation of, permission by any Individual to use or disclose PHI, to the extent such changes may affect Business Associate's use or disclosure of PHI.
d) OGB shall notify Business Associate of any restriction to the use or disclosure of PHI that OGB has agreed to in accordance with 45 CFR § 164.522, to the extent such restriction may affect Business Associate's use or disclosure of PHI.

V. Term and Termination

a) Term. The Term of this Addendum shall commence on the effective date set forth below, and shall terminate when all of the PHI provided by OGB to Business Associate, or created or received by Business Associate on behalf of OGB, is destroyed or returned to OGB, or, if it is not feasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.
b) Termination of Agreement for Cause. In the event that OGB learns of a material breach of this Addendum by Business Associate, OGB shall, in its discretion:
    1. Provide a reasonable opportunity for Business Associate to cure the breach to OGB's satisfaction. If Business Associate does not cure the breach within the time specified by OGB, OGB may terminate the Agreement for cause; or
    2. Immediately terminate the Agreement if Business Associate has breached a material term of this Addendum and cure is not possible; or
    3. If neither termination nor cure is feasible, OGB may report the violation to the Secretary.
c) Effect of Termination.
    1. Except as provided in paragraph (2) below, upon termination of the Agreement for any reason, Business Associate shall return or destroy all PHI received from OGB, or created or received by Business Associate on behalf of OGB. Business Associate shall retain no copies of the PHI. This provision shall also apply to PHI that is in the possession of subcontractors or agents of Business Associate.
    2. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to OGB written notification of the conditions that make return or destruction not feasible. Upon mutual agreement of the parties that return or destruction of PHI is not feasible, Business Associate shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction not feasible, for so long as Business Associate maintains such PHI.

VI. Miscellaneous

a) A reference in this Addendum to a section in the HIPAA Regulations means the section as in effect or as amended, and for which compliance is required.
b) The parties agree to amend this Addendum from time to time as necessary for OGB to comply with the requirements of HIPAA, ARRA and the HIPAA Regulations.

c) If applicable, the obligations of Business Associate under Section V.c.2 of this Addendum shall survive the termination of this Addendum.
d) Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits OGB to comply with HIPAA, ARRA and the HIPAA Regulations. It is the intent of the parties that neither this Addendum, nor any provision in this Addendum, shall be construed against either party pursuant to the common law rule of construction against the drafter.
e) Except as expressly stated herein, the parties to this Addendum do not intend to create any rights in any third parties. Nothing in this Addendum shall confer upon any person other that the parties and their respective successors or assigns any rights, remedies, obligations, or liabilities whatsoever.
f) In the event of any conflict between the terms of the Agreement and the terms of this Addendum, the terms of this Addendum will control, with the exception that if the Agreement contains any provisions relating to the use or disclosure of PHI that are more protective of the confidentiality of PHI than the provisions of this Addendum, then the more protective provisions will control. The provisions of this Addendum are intended to establish the minimum limitations on Business Associate's use and disclosure of PHI.
g) The terms of this Addendum shall be construed in light of any applicable interpretation or guidance on HIPAA, ARRA and/or the HIPAA Regulations issued from time to time by the Department of Health and Human Services or the Office for Civil Rights.
h) This Addendum may be modified or amended only by a writing signed by the party against which enforcement is sought.
i) Neither this Addendum nor any rights or obligations hereunder may be transferred or assigned by one party without the other party's prior written consent, and any attempt to the contrary shall be void. Consent to any proposed transfer or assignment may be withheld by either party for any or no reason.
j) Waiver of any provision hereof in one instance shall not preclude enforcement thereof on future occasions.
k) For matters involving the HIPAA, ARRA and the HIPAA Regulations, this Addendum and the Agreement will be governed by the laws of the State of Louisiana, without giving effect to choice of law principles.

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

State of Louisiana, **Division of Administration** **Office of Group Benefits**	**CONTRACTOR**
By:_____	**By:**_____
Name:_____	**Name:**_____
Title: Chief Executive Officer	**Title:**_____

ATTACHMENT D

FILE REQUIREMENT & LAYOUT

Appendix A – File requirements and layout

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

Files to be sent by the contractor to OGB:

Files are to be sent by the contractor to OGB on a monthly basis and no later than the 5th day of the following month. For example, the files for January shall be received by OGB by the 5th of February. All files shall be 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. **Check Register File (Appendix A-3) -** This file will contain one record for each check issued during the month. The amount of money reflected on this file should match the invoice sent to OGB for payment each month. Check numbers shall correspond to checks referenced in the paid claims provided in (1) above.

4. **Code Files (Appendix A-4)** – 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 zipcodes will be left-justified, with no dashes, commas, decimals or other formatting.

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-5 through A-7. All files from OGB shall be sent electronically using FTP (File Transfer Protocol) and WILL be encrypted using PGP (Pretty Good Privacy).

5. **Eligibility File (Appendix A-5)**
   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.

6. **ASO Administrative Fee Billing files(Appendix A-6)**
   This file shall be received monthly by the contractor and will contain the amount per contract holder that OGB will pay the ASO for administrative fee. OGB will pay the ASO based on this file. The file will contain adjustments to prior months billing resulting from retroactive terminations and enrollment.

7. **Claims Paid By Contractor After Termination or Stop Payment(Appendix A-7)**
   This file shall be received monthly by the contractor and will contain the claims paid in error after the termination or stop payment date. (This file is only provided when OGB is invoiced for claims.)

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**

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**
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.
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.

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 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.

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**
32	*	EMPLOYEE LAST NAME	A/N	40	476-515	THE LAST NAME OF THE CONTRACT HOLDER.
33	*	EMPLOYEE SEX	A/N	1	516	THE GENDER OF THE CONTRACT HOLDER. 'F' = FEMALE; 'M' = MALE; 'U' = UNKNOWN
34	*	EMPLOYEE DATE OF BIRTH	D	8	517-524	THE CONTRACT HOLDER'S DATE OF BIRTH **FORMAT- CCYYMMDD**
35	*	EMPLOYEE ZIP CODE	A/N	9	525-533	THE CONTRACT HOLDER'S FULL ZIP CODE, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
Fields 36-45: Member refers to the patient for whom the charge or service was provided. For a claim to be paid, a member must be eligible as of the date of the service. Member information must correspond to OGB's eligibility transmission.						
36	*	UNIQUE MEMBER ID	A/N	8	534-541	THE MEMBER'S UNIQUE IDENTIFIER FROM THE STATE OF LOUISIANA'S ELGIBILITY FEED.
37		MEMBER SSN	A/N	11	542-552	THE MEMBER'S SOCIAL SECURITY NUMBER - LEFT JUSTIFIED AND FILLED WITH SPACES TO THE RIGHT. NO DASHES. THE FOREIGN WORKER NUMBER, WHEN APPROPRIATE.
38	*	MEMBER FIRST NAME	A/N	40	553-592	THE FIRST NAME OF THE MEMBER (PATIENT)
39	*	MEMBER LAST NAME	A/N	40	593-632	THE LAST NAME OF THE MEMBER (PATIENT)
40	*	MEMBER SEX	A/N	1	633	THE GENDER OF THE MEMBER. 'F' = FEMALE; 'M' = MALE; 'U' = UNKNOWN
41	*	MEMBER DATE OF BIRTH	D	8	634-641	THE MEMBER'S DATE OF BIRTH. **FORMAT- CCYYMMDD**
42	*	MEMBER ZIP CODE	A/N	9	642-650	THE MEMBER'S FULL ZIP CODE, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
Field 43: The relationship code will be consistent with that provided to the contractor in the daily eligibility transmission.						
43	*	RELATIONSHIP TO EMPLOYEE	A/N	2	651-652	THE RELATIONSHIP THIS MEMBER HAS TO THE CONTRACT HOLDER. '01 = EMPLOYEE/CONTRACT HOLDER '02' = SPOUSE '03' AND ABOVE= OTHER DEPENDENTS
Fields 44-45: The following should relate directly to a check written to a member in the check register transmitted along with the month's claim file.						

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**
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
53		DIAGNOSIS CODE 8	A/N	10	748-757	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE EIGHTH 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**
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)

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**
64		ICD9 PROCEDURE CODE 5	A/N	10	843-852	THE FIFTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
65		ICD9 PROCEDURE CODE 6	A/N	10	853-862	THE SIXTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
66		RX DRUG CODE	A/N	11	863-873	FOR DRUGS ADMINISTERED, THE PRESCRIPTION DRUG CODE (NDC) FOR THE CLAIM LINE, FORMATTED 542, NO DASHES
Fields 67-68: The service provider must exist in the provider file transmitted along with the month's claim file.						
67	*	SERVICE PROVIDER ID	A/N	20	874-893	THE UNIQUE ID OF THE SERVICE PROVIDER ASSIGNED IN THE CONTRACTOR'S CLAIMS PROCESSING SYSTEM.
68	*	NPI	A/N	10	894-903	THE SERVICE PROVIDER'S NPI
Fields 69-71: The pay-to provider must exist in the provider file transmitted along with the month's claim file.						
69		PAY-TO PROVIDER ID	A/N	20	904-923	THE UNIQUE ID OF THE PAY-TO PROVIDER ASSIGNED IN THE CONTRACTOR'S CLAIMS PROCESSING SYSTEM. THIS MAY BE THE SAME ID LISTED FOR THE SERVICE PROVIDER IF A SEPARATE PAYMENT ENTITY IS NOT ESTABLISHED. **NOTE: REQUIRED UNLESS ONLY MEMBER PAID OR CLAIM DENIED.**
70		NETWORK INDICATOR	A/N	1	924	AT THE TIME OF SERVICE, THE PROVIDER'S STATUS: 'I' = IN NETWORK; 'O' = OUT OF NETWORK **NOTE: REQUIRED UNLESS ONLY MEMBER PAID OR CLAIM DENIED.**
71		PAY-TO TAX ID	A/N	10	925-934	THE TAX ID NUMBER FOR THE PAY-TO ENTITY FOR THIS PROVIDER IF PROVIDER PRESCRIBED DRUGS.

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**
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

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

13	*	PROVIDER ZIP	A/N	9	294-302	THE ZIPCODE OF THIS PROVIDER'S ADDRESS, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
14		PROVIDER UPIN	A/N	20	303-322	THE UNIVERSAL PROVIDER IDENTIFICATION NUMBER FOR THIS PROVIDER
15		PROVIDER MEDICARE ID	A/N	20	323-342	THE MEDICARE IDENTIFIER FOR THIS PROVIDER
Fields 16-19: The contractor will send initially and keep current a file of specialty codes and descriptions used in their claims processing to OGB						
16	*	PROVIDER SPECIALTY	A/N	10	343-352	THE CODE FOR THE PROVIDER'S PRIMARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
17		PROVIDER SPECIALTY 2	A/N	10	353-362	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
18		PROVIDER SPECIALTY 3	A/N	10	363-372	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE THE CONTRACTOR'S SYSTEM.
19		PROVIDER SPECIALTY 4	A/N	10	373-382	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY 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 Check Register						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: The check number should relate directly to the check number in the claim or claims paid by this check. This assumes that all claims for OGB members are paid from the same checking account. If this is not so, a separate account field will be required.						
1	*	CHECK NUMBER	A/N	10	1-10	THE NUMBER PRINTED ON THE CHECK
2	*	CHECK ISSUE DATE	A/N	8	11-18	DATE THE CHECK WAS ISSUED AS PAYMENT **FORMAT- CCYYMMDD**
Field 3: The amount of the check should equal the sum of the amounts on the claim or claims paid to the provider or member paid by this check.						
3	*	CHECK ISSUE AMOUNT	N	15	19-33	AMOUNT PAID BY THIS CHECK
4	*	PAYEE TYPE	A/N	1	34	'P' – PROVIDER, 'M' – MEMBER, 'O' - OGB
Field 5: If the check is to a provider, the provider ID must exist in the contractor's provider file transmitted with the check register. If the check is written to a member, the member ID must correspond to OGB's member ID provided in the related eligibility transmission to the contractor. Financial adjustments to payments from OGB to the contractor may or may not reference a distinct claim transaction. Payments to OGB by the contractor, if any, should reference the relevant line on the contractor's invoice.						
5	*	PAYEE ID	A/N	20	35-54	PROVIDER ID OR MEMBER ID TO WHOM THE CHECK WAS PAID. INVOICE LINE IF PAID TO OGB.
6		PLAN	A/N	10	55-64	PLAN FOR WHICH CHECK IS CUT REQUIRED ONLY FOR PAYERS OF MULTIPLE PLANS VALUES TO BE DETERMINED

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

Appendix A-4 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-5 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	Contract Holder's SSN	A/N	9	001-009	Holder SSN
2	Member Last Name	A/N	20	010-029	Member Last Name
3	Member First Name	A/N	15	030-044	Member First Name
4	Member Middle Initial	A/N	1	045-045	Member Middle Initial
5	Address 1	A/N	35	046-080	Address Line 1
6	Address 2	A/N	35	081-115	Address Line 2
7	City	A/N	30	116-145	City
8	State	A/N	2	146-147	State
9	Zip Code	A/N	13	148-160	Zip Code
10	Birth Date	A/N	8	161-168	CCYYMMDD
11	Plan Effective Date	A/N	8	169-176	CCYYMMDD- earliest effective date of uninterrupted Coverage within Blue Cross
12	Termination Date	A/N	8	177-184	CCYYMMDD- Blank if active
13	Client / Agency Code	A/N	8	185-192	Code Client /Agent
14	Sub Client / Section of Agency	A/N	4	193-196	Sub Client or Section Agency
15	Type of Coverage	A/N	1	197-197	"e" – member only "c" – member and child(ren) "s" – member and spouse "f" – family
16	Medicare A Primary Effective Date	A/N	8	198-205	CCYYMMDD(can be blank)
17	Medicare B Primary Effective Date	A/N	8	206-213	CCYYMMDD(can be blank)
18	Sex Code	A/N	1	214-214	Male or Female(M/F)
19	Student Date	A/N	8	215-222	CCYYMMDD(can be blank)
20	Relation Code	A/N	2	223-224	01 – Enrollee 02 – Spouse 03 – Children 04 – Student
21	Transaction Date	A/N	8	225-232	CCYYMMDD
22	Agency Employment Date	A/N	8	233-240	CCYYMMDD
23	Portability Date	A/N	8	241-248	CCYYMMDD- Pre-existing Condition Ending
24	Contract Holder Phone	A/N	12	249-260	
25	Filler	A/N	1	261-261	Filler
26	Handicapped indicator	A/N	1	262-262	"Y" = Yes "N" = No
27	Marriage Date	A/N	8	263-270	CCYYMMDD(can be blank)

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

Appendix A-5 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
28	HIC Number	A/N	12	271-282	Medicare card number.
29	COB DATE	A/N	8	283-290	CCYYMMDD- Beginning coverage by othe carrier not including Medicare.
30	Medicare Primary	A/N	1	291-291	"Y" = Yes "N" = No
31	Member SSN	A/N	9	292-300	Member SSN
32	Filler	A/N	1	301-301	Blanks
32	Agency Change Date	A/N	8	302-309	CCYYMMDD- earliest effective date of uninterrupted Coverage within Agency
33	Member Record-ID	A/N	8	310-317	OGB Internal id
34	Billing Rate Table(On Subscriber Only)	A/N	2	318-319	AC – active CB - cobra CD - cobra disability CP - cobra part-time CS – cobra subsidy D1 – Sponsored Dependent 1 on Medicare DN – Sponsored Dependent No Medicare R1 - retired Medicare 1 R2 - retired Medicare 2 RN - retired no Medicare This Field is always blank for dependents
35	Shared Accumulator OGB Record ID	A/N	9	320-328	Contains the 8 digit Record ID for Shared Accumulators
36	Claim Payment Stop Date	A/N	8	329-336	CCYYMMDD
37	Lifetime Accum	N	10	337-346	9999999.99 Leading spaces: Sum of Drugs Medical, Mental Health & DME claims pai
38	Drug Accum	N	10	347-356	9999999.99 Leading spaces: Sum of Drug claims paid Included in Lifetime accum
39	Mental Health Accum	N	10	357-366	9999999.99 Leading spaces: Sum of Mental Health claims paid. Included in Lifetime accum
40	Country Code	A/N	2	367-368	Values: AD ANDORRA AE UNITED ARAB EMIRATES AF AFGHANISTAN

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

Appendix A-5 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					AG ANTIGUA AND BARBUDA AI ANGUILLA AL ALBANIA AM ARMENIA AN NETHERLANDS ANTILLES AO ANGOLA AQ ANTARCTICA AR ARGENTINA AS AMERICAN SAMOA AT AUSTRIA AU AUSTRALIA AW ARUBA AZ AZERBAIJAN BA BOSNIA AND HERZEGOVINA BB BARBADOS BD BANGLADESH BE BELGIUM BF BURKINA FASO BG BULGARIA BH BAHRAIN BI BURUNDI BJ BENIN BM BERMUDA BN BRUNEI DARUSSALAM BO BOLIVIA BR BRAZIL BS BAHAMAS BT BHUTAN BV BOUVET ISLAND BW BOTSWANA BY BELARUS BZ BELIZE CA CANADA CC COCOS (KEELING) ISLANDS CD CONGO, THE DEMOCRATIC REPUBLIC OF THE CF CENTRAL AFRICAN REPUBLIC

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

Appendix A-5 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					CG CONGO CH SWITZERLAND CI COTE D'IVOIRE CK COOK ISLANDS CL CHILE CM CAMEROON CN CHINA CO COLOMBIA CR COSTA RICA CU CUBA CV CAPE VERDE CX CHRISTMAS ISLAND CY CYPRUS CZ CZECH REPUBLIC DE GERMANY DJ DJIBOUTI DK DENMARK DM DOMINICA DO DOMINICAN REPUBLIC DZ ALGERIA EC ECUADOR EE ESTONIA EG EGYPT EH WESTERN SAHARA ER ERITREA ES SPAIN ET ETHIOPIA FI FINLAND FJ FIJI FK FALKLAND ISLANDS (MALVINAS FM MICRONESIA, FEDERATED STATES OF FO FAROE ISLANDS FR FRANCE GA GABON GB UNITED KINGDOM GD GRENADA GE GEORGIA GF FRENCH GUIANA GH GHANA GI GIBRALTAR

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

Appendix A-5 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					GL GREENLAND GM GAMBIA GN GUINEA GP GUADELOUPE GQ EQUATORIAL GUINEA GR GREECE GS SOUTH GEORGIA AND THE SOUT SANDWICH IS GT GUATEMALA GU GUAM GW GUINEA-BISSAU GY GUYANA HK HONG KONG HM HEARD ISLAND AND MCDONAL ISLANDS HN HONDURAS HR CROATIA HT HAITI HU HUNGARY ID INDONESIA IE IRELAND IL ISRAEL IN INDIA IO BRITISH INDIAN OCEAN TERRITORY IQ IRAQ IR IRAN, ISLAMIC REPUBLIC OF IS ICELAND IT ITALY JM JAMAICA JO JORDAN JP JAPAN KE KENYA KG KYRGYZSTAN KH CAMBODIA KI KIRIBATI KM COMOROS KN SAINT KITTS AND NEVIS KP KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF

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

Appendix A-5 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					KR KOREA, REPUBLIC OF KW KUWAIT KY CAYMAN ISLANDS KZ KAZAKSTAN LA LAO PEOPLE'S DEMOCRATIC REPUBLIC LB LEBANON LC SAINT LUCIA LI LIECHTENSTEIN LK SRI LANKA LR LIBERIA LS LESOTHO LT LITHUANIA LU LUXEMBOURG LV LATVIA LY LIBYAN ARAB JAMAHIRIYA MA MOROCCO MC MONACO MD MOLDOVA, REPUBLIC OF MG MADAGASCAR MH MARSHALL ISLANDS MK MACEDONIA, THE FORMER YUGOSLAV REPUBLIC ML MALI MM MYANMAR MN MONGOLIA MO MACAU MP NORTHERN MARIANA ISLANDS MQ MARTINIQUE MR MAURITANIA MS MONTSERRAT MT MALTA MU MAURITIUS MV MALDIVES MW MALAWI MX MEXICO MY MALAYSIA MZ MOZAMBIQUE NA NAMIBIA

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

Appendix A-5 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					NC NEW CALEDONIA NE NIGER NF NORFOLK ISLAND NG NIGERIA NI NICARAGUA NL NETHERLANDS NO NORWAY NP NEPAL NR NAURU NU NIUE NZ NEW ZEALAND OM OMAN PA PANAMA PE PERU PF FRENCH POLYNESIA PG PAPUA NEW GUINEA PH PHILIPPINES PK PAKISTAN PL POLAND PM SAINT PIERRE AND MIQUELON PN PITCAIRN PR PUERTO RICO PS PALESTINIAN TERRITORY, OCCUPIED PT PORTUGAL PW PALAU PY PARAGUAY QA QATAR RE REUNION RO ROMANIA RU RUSSIAN FEDERATION RW RWANDA SA SAUDI ARABIA SB SOLOMON ISLANDS SC SEYCHELLES SD SUDAN SE SWEDEN SG SINGAPORE SH SAINT HELENA SI SLOVENIA SJ SVALBARD AND JAN MAYEN

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

Appendix A-5 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					SK SLOVAKIA SL SIERRA LEONE SM SAN MARINO SN SENEGAL SO SOMALIA SR SURINAME ST SAO TOME AND PRINCIPE SV EL SALVADOR SY SYRIAN ARAB REPUBLIC SZ SWAZILAND TC TURKS AND CAICOS ISLANDS TD CHAD TF FRENCH SOUTHERN TERRITORIE TG TOGO TH THAILAND TJ TAJIKISTAN TK TOKELAU TM TURKMENISTAN TN TUNISIA TO TONGA TP EAST TIMOR TR TURKEY TT TRINIDAD AND TOBAGO TV TUVALU TW TAIWAN, PROVINCE OF CHINA TZ TANZANIA, UNITED REPUBLIC O UA UKRAINE UG UGANDA UM UNITED STATES MINOR OUTLYING ISLANDS US UNITED STATES UY URUGUAY UZ UZBEKISTAN VA HOLY SEE (VATICAN CITY STAT

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

Appendix A-5 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					VC SAINT VINCENT AND THE GRENADINES VE VENEZUELA VG VIRGIN ISLANDS, BRITISH VI VIRGIN ISLANDS, U.S. VN VIET NAM VU VANUATU WF WALLIS AND FUTUNA WS SAMOA YE YEMEN YT MAYOTTE YU YUGOSLAVIA ZA SOUTH AFRICA ZM ZAMBIA ZW ZIMBABWE
41	Pre-existing Start Date	A/N	8	369-376	CCYYMMDD- Pre-existing Condition Star Date
42	Coverage Level Effective Date	A/N	8	377-384	CCYYMMDD- Earliest Eff Date of Uninterrupted CoverageWithin HMO/Coverage Level
43	Rate Table Effective Date	A/N	8	375-392	CCYYMMDD- Earliest Eff Date of Uninterrupted CoverageWithin HMO/Rate Table

ATTACHMENT D-6

REQUIRED REPORTS

INTENT

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

A. Monthly Reports

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

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

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

B. Legislative Auditor Required Audit Report

Annual SAS-70/Type II Audit Report.

C. Other Required Reports

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