STATE OF LOUISIANA

OFFICE OF GROUP BENEFITS

REQUEST FOR PROPOSALS
FOR

FULLY INSURED

MEDICARE ADVANTAGE PLANS

PROPOSAL DUE DATE: AUGUST 3, 2015

ISSUED:

JULY 2, 2015

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1 GENERAL INFORMATION

1.1 Purpose

The State of Louisiana, Office of Group Benefits (hereinafter called "OGB" or the "Program") requests proposals from any Louisiana HMO approved by the Centers for Medicare and Medicaid Services (CMS) to offer a fully insured Medicare Advantage Health Maintenance Organization medical plan(s) with an option to include prescription drug benefits on a by parish basis for Medicare eligible OGB retired plan members.

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

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

OGB is seeking a Contractor that will partner with the agency to provide high quality cost effective health care to members, including efficient claims processing, network management, and all other services required to administer the Medicare Advantage HMO Plan coverage to be provided. The Contractor shall drive health risk improvement and mitigation of rising healthcare costs in order for OGB to continue to provide the best value to its members.

In order to ensure, to the greatest extent practicable, that the plans for benefits and coverages available for employees in all parts of the state are comparable with respect to coverages offered, as required by La. R.S. 42:802(B)(6), as amended and re-enacted by Act 479 of 2007, the Contractor's plan(s) of benefits must, at minimum, conform with OGB's plan of benefits and coverage provisions set forth in Attachment I: HMO Plan Design. The Contractor must maintain identical eligibility requirements and continued coverage provisions of the OGB, which the OGB may amend from time to time.

1.2 Background

The Office of Group Benefits is responsible for the administration and management of state health and welfare benefit programs to over 230,000 active and retired State of Louisiana employees and their dependents, as well as the employees and dependents of other government entities that have selected to participate in the OGB plan of benefits. Offered benefits include health coverage, and prescription drug coverage. OGB currently offers a fully insured plan (Vantage Medical Home HMO), Self-funded plans (Administered by BCBS) and Medicare Retiree specific fully insured plans (Administered by OneExchange, Vantage Health Plan, and Peoples Health).

Plan participant eligibility includes employees of state agencies, institutions of higher education, school boards and charter schools that elect to participate, and certain political subdivisions. Eligibility does not include local government entities, parishes or municipalities.

Disease Management is currently offered on an opt-in model for self-insured non-Medicare eligible members for the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Chronic Heart Failure, Asthma, and Coronary Artery Disease.

1.3 Scope of Services

Attachment II details the scope of services and deliverables or desired results that the OGB requires of the Contractor.

1.4 Blackout Period

The Blackout Period is a specified period of time during a competitive sealed procurement process in which any Proposer, bidder, or its agent or representative, is prohibited from communicating with any state employee or contractor of the OGB involved in any step in the procurement process about the affected procurement. The Blackout Period shall apply not only to state employees, but also to any contractor of the OGB. "Involvement" in the procurement process shall include but shall not be limited to project management, design, development, implementation, procurement management, development of specifications, and evaluation of proposals for a particular procurement. All solicitations for competitive sealed procurements will identify a designated contact person. All communications to and from potential Proposers, bidders, vendors and/or their representatives during the Blackout Period must be in accordance with this solicitation's defined method of communication with the designated contact person. The Blackout Period will begin upon posting of the solicitation. The Blackout Period will end when the contract is awarded.

In those instances in which a prospective vendor is also an incumbent vendor, the OGB and the incumbent vendor shall contact each other with respect to the existing contract only. Under no circumstances shall the OGB and the incumbent vendor and/or its representative(s) discuss the blacked-out procurement.

Any bidder, Proposer, or OGB contractor who violates the Blackout Period may be liable to the OGB in damages and/or subject to any other remedy allowed by law. Further, failure to comply with these requirements may result in the proposal's disqualification.

Any costs associated with cancellation or termination will be the responsibility of the Proposer or bidder.

Notwithstanding the foregoing, the Blackout Period shall not apply to:

1. A protest to a solicitation submitted pursuant to La. R.S. 39:1671, et seq. or LAC 34:V.2545, as amended April 7, 2015;
2. Duly noticed site visits and/or conferences for bidders or Proposers;
3. Oral presentations during the evaluation process; and,
4. Communications regarding a particular solicitation between any person and staff of the procuring agency provided the communication is limited strictly to matters of procedure. Procedural matters shall include deadlines for decisions or submission of proposals and the proper means of communicating regarding the procurement, but shall not include any substantive matter related to the particular procurement or requirements of the RFP.

The Blackout Period begins on July 2, 2015 and concludes upon the announcement of the awarded Contractor.

1.5 RIGHT TO PROTEST

Any person who is aggrieved in connection with the request for proposal or award may protest and appeal pursuant to the provisions of La. R.S. 39:1671, 1672.1-1672.4, 1681, 1683, 1691, and 1692.

2 ADMINISTRATIVE INFORMATION

2.1 Term of Contract

The period of any contract resulting from this RFP is tentatively scheduled to begin on or about January 1, 2016 and to continue through December 31, 2016. The OGB has the right to contract for up to three years upon approval.

2.2 Pre-proposal Conference

The Office of Group Benefits will not hold a Pre-proposal conference.

2.3 Proposer Inquiries

Written questions regarding RFP requirements or Scope of Services must be submitted to the OGB RFP Coordinator/Blackout Period Contact at OGB.Proposals@la.gov.

The OGB will only consider written Proposer inquiries and requests for clarification of the content of this RFP received from potential Proposers. The OGB reserves the right to modify the RFP should a change be identified that is in the best interest of OGB or the State.

To be considered, written inquiries and requests for clarification of the content of this RFP must be received via email, OGB.Proposals@la.gov, by 4:00 pm CT on the date specified in the Schedule of Events. Any and all questions directed to the OGB RFP Coordinator/Blackout Period Contact require an official response.

Only the OGB RFP Coordinator/Blackout Period Contact has the authority to officially respond to Proposer's questions on behalf of the OGB. Any communications from any other individuals are not binding to the OGB.

Official responses to all questions submitted by potential Proposers will be posted by the date specified in the Schedule of Events, Section 2.5 and can be accessed using the sites listed below.

http://wwwprd1.doa.louisiana.gov/osp/lapac/pubmain.cfm
https://www.groupbenefits.org/portal/page/portal30/SHARED/O/OGBWEB/EXPLORE_OGB

2.4 Definitions

Contractor- The successful Proposer who is awarded a contract and assumes full responsibility and liability for completion of the deliverables.

Proposer - An individual or organization submitting a proposal in response to an RFP.

Shall, Must, Will - Words used to denote a mandatory requirement.

Should, May, Can - Words used to denote an advisable or permissible action.

2.5 Schedule of Events

EVENT	DATE
Post RFP to LaPAC	July 2, 2015
Deadline for receipt of written inquiries	4PM CT, July 9, 2015
Issue responses to written inquiries	July 17, 2015
Deadline for receipt of proposals	4PM CT, August 3, 2015
Announce award of Contractor selection	TBD
Begin implementation	Week of August 17, 2015
Contract Effective Date	January 1, 2016

NOTE: The State of Louisiana reserves the right to change this schedule of RFP events, as it deems necessary. Any changes to this RFP will be done by Addendum.

3 PROPOSAL INFORMATION

3.1 Minimum Qualifications of Proposer

Proposers must meet or exceed the following qualifications. A Proposer should provide documentation of its:

- Certificate of Authority from the Secretary of State to conduct business in the State of Louisiana if the Proposer is a foreign corporation;
- Ability to meet all criteria set forth in La. R.S. 42:802.1(C), enacted by Act 479 of 2007 for a "Louisiana HMO";
- Plan of benefits which shall, at minimum, conform to OGB's plan of benefits and coverage provisions set forth in Attachment I: HMO Plan Design;
- Approval by the Centers for Medicare and Medicaid Services (CMS) to offer one or more Medicare Advantage HMO Plans in the State of Louisiana; and
- Licensing authority provided by the Louisiana Department of Insurance in accordance and compliance with La. R.S. 22:241, et seq.

3.2 Determination of Responsibility:

Determination of the Proposer's responsibility relating to this RFP shall be made according to the standards set forth in LAC 34:V.2536. The OGB must find that the selected Proposer:

- Has adequate financial resources for performance, or has the ability to obtain such resources as required during performance;
- Has the necessary experience, organizations, technical qualifications, skills, and facilities, or has the ability to obtain them;
- Is able to comply with the proposed or required time of delivery or performance schedule;
- Has a satisfactory record of integrity, judgment, and performance; and
- Is otherwise qualified and eligible to receive an award under applicable laws and regulations.

Proposers should ensure that their proposals contain sufficient information for the OGB to make its Determination of Responsibility by presenting acceptable evidence of the above to perform the contracted services.

3.2.1 Right to Prohibit Award

In accordance with the provisions of La. R.S. 39:2192, in awarding contracts after August 15, 2010, any public entity is authorized to reject a proposal or bid from, or not award the Contract to, a business in which any individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or nolo contendere to any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or bid awarded under the following provisions of the Louisiana Revised Statutes of 1950 governing public contracts: Title 38, Chapter 10 (public contracts); or Title 39, Chapter 17 (Louisiana Procurement Code).

3.3 RFP Addenda

OGB reserves the right to change the schedule of events or revise any part of the RFP by issuing an addendum to the RFP at any time. Addenda, if any, will be posted at the following locations:

http://wwwprd1.doa.louisiana.gov/osp/lapac/pubmain.cfm

https://www.groupbenefits.org/portal/page/portal30/SHARED/O/OGBWEB/EXPLORE_OGB

It is the responsibility of the Proposer to check the website for addenda to the RFP, if any.

3.4 Waiver of Administrative Informalities

The OGB reserves the right, at its sole discretion, to waive minor administrative informalities contained in any proposal.

3.5 Proposal Rejection/RFP Cancellation

Issuance of this RFP in no way constitutes a commitment by the OGB to award a contract. The OGB reserves the right to take any of the following actions that it determines to be in the best interest of the OGB and the State:

- Reject all proposals received in response to this solicitation;
- Cancel this RFP; or
- Cancel or decline to enter into a contract with the successful Proposer at any time after the award is made and before the Contract receives final approval from the Division of Administration, Office of State Procurement.

3.6 Withdrawal of Proposal

A Proposer may withdraw a proposal that has been submitted at any time up to the date and time the proposal is due. To accomplish this, a written request signed by the authorized representative of the Proposer must be submitted to the OGB RFP Coordinator/Blackout Period Contact.

3.7 Subcontracting Information

The OGB will have a single prime Contractor as the result of any contract negotiation, and that prime Contractor shall be responsible for all deliverables specified in the RFP and proposal. Notwithstanding, Contractor(s) may enter into subcontractor arrangements; however, Proposers

shall acknowledge this general requirement of total responsibility for the entire contract and its proposals.

If the proposer intends to subcontract for portions of the work, the Proposer should identify any subcontractor relationships and include specific designations of the tasks to be performed by each subcontractor. Information required of the Proposer under the terms of this RFP shall also be required for each subcontractor. The prime Contractor shall be the single point of contact for all subcontract work.

Unless provided for in the contract with the OGB, the prime Contractor shall not contract with any other party for any of the services herein contracted without the express prior written approval of the OGB.

3.8 Ownership of Proposal

All materials submitted in response to this request shall become the property of the OGB. Selection or rejection of a proposal does not affect this right.

3.9 Confidential, Trade Secrets, and Proprietary Information

As a general rule, after award of the Contract, all proposals shall be considered public record and shall be available for public inspection and copying pursuant to the Louisiana Public Records Law, La. R.S. 44:1, et. seq., during regular business hours. To claim protection, if any, from disclosure, the Proposer is required to clearly designate the part of the proposal that contains a trade secret and/or privileged or confidential proprietary information as "confidential." The Proposer shall mark the cover sheet of the proposal with the following legend, specifying the specific section(s) of the proposal sought 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, the OGB shall have the right to use or disclose the data therein to the extent provided in the Contract. This restriction shall 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 page containing such data shall be specifically identified and marked **"CONFIDENTIAL".**

The Proposer is advised to use such designation only when appropriate and necessary. A blanket designation of an entire proposal as Confidential is **NOT** appropriate. Any proposal copyrighted or marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse. The designation of certain information as trade secrets and/or privileged or confidential proprietary information shall only apply to the **technical portion** of the proposal. **The cost proposal shall not be Confidential under any circumstance.**

Proposers must be prepared to defend the reasons why the designated material should be held confidential. If a competing Proposer or other person seeks review or copies of another Proposer's confidential data, the OGB will notify the owner of the designated material of the request. If the owner of the designated material does not want the information disclosed, the Proposer must agree to indemnify the state and hold the state harmless against all actions or court

proceedings that may ensue (including attorney's fees), which seek to order the state to disclose the information. If the owner of the designated material refuses to indemnify and hold the state harmless, the state may disclose the information.

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, La. R.S. 44:1, et. seq. The OGB and/or State assumes no liability for disclosure or use of unmarked data and may use or disclose such data for any purpose. It should be noted that any resultant contract will become a matter of public record.

The OGB reserves the right to make any proposal, including proprietary information contained therein, available to Office of State Procurement personnel, the Office of the Governor, Division of Administration, or other state agencies or organizations for the purpose of assisting the OGB in its evaluation of the Proposal. The 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 these evaluations.

Additionally, any proposal that fails to follow this section and/or La. R.S. 44:3.2D(1) shall have failed to properly assert the designation of trade secrets and/or privileged or confidential proprietary information and the information may be considered public records.

If a proposal contains confidential information, the Proposer should provide a redacted version of the proposal omitting those responses (or options thereof) and attachments that the Proposer determines are within the scope of the exception to the Louisiana Public Records Law. In a separate document, the Proposer shall provide the justification for each omission. If the Proposer does not submit the redacted copy, the Proposer waives any claim to keep information confidential. When submitting the redacted copy, the Proposer shall clearly mark the cover as such – "REDACTED COPY" –to avoid having this copy reviewed by an evaluation committee member. The redacted copy should also state which sections or information has been removed. The Proposer should also provide one (1) electronic redacted copy of its Proposal on a flash drive or CD.

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

Proposers should refer to the Louisiana Public Records Act for further clarification.

3.10 Cost of Preparing Proposals

The OGB shall not be liable for any costs incurred by Proposers prior to issuance of or entering into a contract. Costs associated with developing the proposal, preparing for oral presentations, and any other expenses incurred by the Proposer in responding to this RFP are entirely the responsibility of the Proposer and shall not be reimbursed in any manner by the OGB.

3.11 Errors and Omissions in Proposal

The OGB will not be liable for any errors in proposals. The OGB reserves the right to make corrections or amendments due to minor errors identified in proposals by OGB or the Proposer. The OGB, at its option, has the right to request clarification or additional information from the Proposers.

3.12 Best and Final Offers (BAFO)

The State reserves the right to conduct a BAFO with one or more Proposers determined by the committee to be reasonably susceptible of being selected for award. If conducted, the Proposers selected to participate will receive written notification of their selection, with a list of specific items to be addressed in the BAFO along with instructions for submittal. The BAFO negotiation may be used to assist the state in clarifying the scope of work or obtain the most cost effective pricing available from the Proposers.

The written invitation will not obligate the state to a commitment to enter into a Contract.

3.13 Contract Award and Execution

In accordance with the provisions set forth in La. R.S.42:802.1(A), enacted by Act 479 of 2007, contracts shall be awarded on a regional basis. If more than three (3) different Louisiana HMOs submit competitive proposals for a region, OGB will select at least three (3) Louisiana HMOs for that region. The selection shall be based on an evaluation of the criteria set forth in the RFP which includes a comparison of the proposed cost of each proposer.

The OGB reserves the right to enter into a contract without further discussion of the proposal submitted based on the initial offers received.

The OGB reserves the right to contract for all or a partial list of services offered in the proposal.

The RFP and proposal of the selected Proposer shall become part of any contract initiated by the OGB.

The selected Proposer shall be expected to enter into a contract that is substantially the same as the sample contract included in Attachment IX. The contract will include provisions included in the winning proposal relative to services provided. In no event shall a Proposer submit its own standard contract terms and conditions as a response to this RFP. The Proposer should submit with its proposal any exceptions or exact contract deviations that it wishes to negotiate. Additionally, the selected Proposer shall execute a Protected Health Information Addendum that is substantially the same as Attachment X.

Negotiations may begin with the announcement of the selected Proposer. The "Notice of Intent to Award" letter is the notification of the award, contingent upon successful negotiation and execution of a written Contract and approval by the Division of Administration, Office of State Procurement and by the appropriate standing committees of the Louisiana legislature having jurisdiction over review of OGB agency rules as designated by La. R.S. 49:968B(21)(c). The protest period commences upon the announcement of the selected Proposer.

If the contract negotiation period exceeds *20* business days or if the selected Proposer fails to sign the final contract within *10* business days of delivery, the OGB may elect to cancel the award and award the contract to the next-highest-ranked Proposer.

3.14 Code of Ethics

Proposers are responsible for determining that there will be no conflict or violation of the Ethics Code if their company is awarded the contract. The Louisiana Board of Ethics is the only entity which can officially rule on ethics issues.

3.15 Governing Law

All activities associated with this RFP process shall be interpreted under Louisiana Law. All proposals and contracts are subject to provisions of the laws of the State of Louisiana including but not limited to La. R.S. 39:1551-1736 (Louisiana Procurement Code); purchasing rules and regulations; executive orders; standard terms and conditions; special terms and conditions; and specifications listed in this RFP. After the exhaustion of administrative remedies, venue of any action brought with regard to the Contract shall be in the Nineteenth Judicial District Court, Parish of East Baton Rouge, State of Louisiana.

4 RESPONSE INSTRUCTIONS

4.1 Proposal Delivery

Firms/individuals who are interested in providing services requested under this RFP must submit a proposal containing the mandatory information specified in this RFP. The proposal must be received in hard copy (printed) version by the OGB RFP Coordinator/Blackout Period Contact on or before 4:00 PM Central Time on the date specified in the Schedule of Events. FAX or e-mail submissions are not acceptable. Proposers mailing their proposals should allow sufficient mail delivery time to ensure receipt of their proposal by the time specified.

The Proposer should label proposal submissions as follows:

Medicare Advantage Plan

Proposer's Name and Proposed Parishes located in selected Region(s)

The proposal package must be delivered at the Proposer's expense to:

OGB RFP Coordinator/Blackout Period Contact
Office of Group Benefits
1201 N. 3rd Street
Claiborne Building, Suite G-159
Baton Rouge, LA 70802

It is solely the responsibility of each Proposer to ensure that their proposal is delivered at the specified place and prior to the deadline for submission. Proposals received after the deadline will not be considered. Proposers are hereby advised that the U.S. Postal Service does not make deliveries to OGB's physical location.

4.2 Proposal Submission

The OGB requests the following to be provided to the OGB RFP Coordinator/Blackout Period Contact at the address specified:

- One (1) Original (clearly marked "Original"), Five (5) numbered copies, and, Two (2) CDs in PDF and Word Format of the Technical proposal.
- One (1) Original, Two (2) copies, and two (2) CDs or portable drives of the Cost proposal in Word and Excel format.
- If applicable, Proposer should also submit an electronic redacted version of the proposal per Section 3.9 of this RFP.

4.3 Proposal Format

The original copy of the proposal should contain original signatures of those company officials or agents duly authorized to sign proposals or contracts on behalf of the organization. A certified copy of a board resolution granting such authority should be submitted if Proposer is a corporation. The copy of the proposal with original signatures will be retained for incorporation in any contract resulting from this RFP.

4.4 Cover Letter

A cover letter should be submitted on the Proposer's official business letterhead explaining the intent of the Proposer.

4.5 Technical and Cost Proposal

Proposals should be submitted as specified in Section 5, and should include enough information to satisfy evaluators that the Proposer has the appropriate experience and qualifications to perform the scope of services as described herein. Proposers should respond to all requested areas. Proposers should respond to this RFP with a separate Technical Proposal and Cost Proposal. No pricing information should be included in the Technical Proposal.

4.6 Certification Statement

The Proposer must sign and submit the Certification Statement shown in Attachment VIII.

5 PROPOSAL CONTENT

5.1 Executive Summary

This section should serve to introduce the scope of the proposal. It should include administrative information including, at a minimum, Proposer contact name and phone number, and the stipulation that the proposal is valid for a time period of at least 90 days from the date of submission. This section should also include a summary of the Proposer's qualifications and ability to meet the OGB's overall requirements in the timeframes set by OGB.

It should include a positive statement of compliance with the contract terms. If the Proposer cannot comply with any of the contract terms, an explanation of each exception should be supplied. The Proposer should address the specific language in Attachment IX, Sample Contract, and submit whatever exceptions or exact contract modifications that it may seek. While final wording will be resolved during contract negotiations, the intent of the provisions in the Sample Contract will not be substantially altered.

5.2 Corporate Background, Financial Condition and Experience

The Proposer should give a brief description of their company including a brief history, corporate structure and organization, number of years in business, and copies of its latest financial statement, preferably audited. The Proposer should provide a statement of whether, in the last ten years, the Proposer has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors, and if so, the explanation providing relevant details.

The Proposer should provide a statement of whether there are any pending Securities Exchange Commission investigations involving the Proposer, and if such are pending or in progress, an explanation providing relevant details and an attached opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a Contract under this RFP. Also, a statement should be provided documenting all open or pending litigation initiated by Proposer or where Proposer is a defendant in a customer matter. Nevertheless, Proposer must identify any and all litigation in which Proposer is a party and in which the amount in controversy exceeds $1,000,000. Proposer should provide detail around any mergers or acquisitions scheduled for the next twelve (12) months.

Proposer should provide information regarding the company's last financial audit and SOC 1, Type II report resulting from its most recent SSAE 16 engagement. The state reserves the right to request any additional information to assure itself of a Proposer's financial status. As an alternative to the SSAE 16 engagement and resulting SOC 1, Type II and/or SOC 2, Type II report, the Contractor may provide other independent assurances of the financial and operational viability of the outsourced program, including testing of the policies and procedures placed into operation, by submitting a quality control plan [such as third party Quality Assurance (QA) or an Independent Verification and Validation (IV&V)]; or, any other financial and performance audits from outside companies.

Proposer should provide a detailed discussion of its prior experience in working on projects similar in size, scope, and function to the proposed contract. Proposers should describe their experience in providing medical plan coverage with other states and/or with corporate/governmental entities of comparable size and diversity with references from three (3) of its largest clients including name, address, industry, contact person and title, telephone number and extension, email address, total number of employees and total number of plan participants, services provided for the account, number of years service provided to organization, and Proposer's account executive assigned to the account.

Proposer should indicate current number of clients currently being serviced and provide an approximate number of medical participants currently being served under the fully insured Medicare Advantage HMO plan coverage.

5.2.1 Request for Proposal (RFP) Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) Programs

The State of Louisiana Veteran and Hudson Initiatives are designed to provide additional opportunities for Louisiana-based small entrepreneurships (sometimes referred to as LaVet's and SE's respectively) to participate in contracting and procurement with the state. A certified Veteran-Owned and Service-Connected Disabled Veteran-Owned small entrepreneurship (LaVet) and a Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) small entrepreneurship are businesses that have been certified by the Louisiana Department of Economic Development. All eligible vendors are encouraged to become certified. Qualification requirements and online certification are available at: http://smallbiz.louisianaeconomicdevelopment.com.

Ten percent (10%) of the total evaluation points on this RFP are reserved for Proposers who are themselves a certified Veteran or Hudson Initiative small entrepreneurship or who will engage the participation of one or more certified Veteran or Hudson Initiative small entrepreneurships as subcontractors.

Reserved points shall be added to the applicable Proposer's evaluation score as follows:

Proposer Status and Reserved Points

- Proposer is a certified small entrepreneurship: Full amount of the reserved points
- Proposer is not a certified small entrepreneurship but has engaged one or more certified small entrepreneurships to participate as subcontractors or distributors. Points will be allocated based on the following criteria:
  - Number of certified small entrepreneurships to be utilized
  - Experience and qualifications of the certified small entrepreneurship(s)
  - Anticipated earnings to accrue to the certified small entrepreneurship(s)

If a Proposer is not a certified small entrepreneurship as described herein, but plans to use certified small entrepreneurship(s), Proposer shall include in their proposal the names of their certified Veteran Initiative or Hudson Initiative small entrepreneurship subcontractor(s), a description of the work each will perform, and the dollar value of each subcontract.

During the term of the contract and at expiration, the Contractor will also be required to report Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship subcontractor or distributor participation, and the dollar amount of each.

The statutes (R.S 39:2171 *et. seq.)* concerning the Veteran Initiative may be viewed at http://legis.la.gov/lss/lss.asp?doc=671504; and the statutes (R.S 39:2001 *et. seq.)* concerning the Hudson Initiative may be viewed at http:/legis.la.gov/lss/lss.asp?doc=96265. The rules for the Veteran Initiative (LAC 19:IX) and for the Hudson Initiative (LAC 19:VIII) may be viewed at http://www.doa.louisiana.gov/osp/se/se.htm.

A current list of certified Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurships may be obtained from the Louisiana Economic Development Certification System at http://smallbiz.louisianaeconomicdevelopment.com.

Additionally, a list of Hudson and Veteran Initiative small entrepreneurships, which have been certified by the Louisiana Department of Economic Development and who have opted to register in the State of Louisiana LaGov Supplier Portal, https://lagoverpvendor.doa.louisiana.gov/irj/portal/anonymous?guest_user=self_reg, may be accessed from the State of Louisiana Procurement and Contract (LaPAC) Network, http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm. When using this site, determine the search criteria (i.e. alphabetized list of all certified vendors, by commodities, etc.) and select SmallE, VSE, or DVSE.

5.3 Proposed Project Staff

The Proposer should provide detailed information about the experience and qualifications of the Proposer's assigned Account Executive, Account Management Team, including but not limited to, an Implementation Manager, Account Manager, Accounting Specialist, Senior Operations Specialist, and Compliance Analyst as well as any other assigned personnel considered key to the success of the project. This includes the Proposer's own staff and staff from any

subcontractor to be used. The Account Executive will provide day-to-day management of project tasks and activities, coordination of proposer's employees, and possess the technical and functional knowledge to direct all aspects of the project. Also, the Account Executive must have at least one (1) back-up staff member designated to handle the overall responsibility of the OGB. The Proposer should demonstrate that their staff and/or subcontractor(s) have the necessary experience and knowledge to successfully perform the services listed in Attachment II: Scope of Services. This information should include education, training, technical experience, functional experience, specific dates and names of employers, relevant and related experience, past and present projects with dates and responsibilities, and any applicable certifications. Customer references (name, title, company name, address, email address, and telephone number) should be provided for the cited projects in individual résumés.

Proposer should also provide an organizational and staffing plan that includes the role and responsibilities of the Account Executive, Account Management Team, and any other key personnel on this project, their planned level of effort, their anticipated duration of involvement, and their on-site availability.

5.4 Approach and Methodology

The Proposer should provide their approach and methodology in providing required services and identifying the tasks necessary to meet requirements described within Attachment II, Scope of Services. If there is any variation in the approach and methodology for each respective region proposed, such variation should be indicated in this section. This section should:

- Describe the Proposer's Proposed Project Work Plan that reflects the approach and methodology, tasks and services to be performed, deliverables, timetables, and staffing;
- Describe annual account management strategy, training of key personnel and customer service line, IT/data file feed implementation, billing processes, and reporting/data analytics (health informatics technology/population health);
- Include a comparison of the MAPD HMO networks to Proposer's non-Medicare provider networks by parish within the state of Louisiana including separate comparisons for both hospital and physician providers;
- Describe approach to Quality Assurance, specifically for claims administration and customer service;
- Describe current procedures in place to handle Protected Health Information;
- Provide samples of the following: 1) Annual Strategic Calendar; 2) Claims Reporting; 3) Utilization report with executive dashboard; 4) Explanation of Benefits; 5) Population Health Reporting and 6) Plan Participant Satisfaction Survey Format/Tool **(Note: Successful Proposer must possess ability to distribute this information electronically)**; and
- Respond to all questions in Attachment VI: Technical Questionnaire.

5.5 Cost Information

The Proposer shall provide a fixed monthly premium inclusive of all services per enrollee per month (PEPM) for the first year of the initial contract period of January 1 to December 31, 2016, for all proposed parishes included in each selected Region(s) using Attachment VII: Cost

Proposal. The monthly premium shall be fully burdened and inclusive of all travel and project expenses. See Attachment III for a description of the regions by city and zip code. **All 705 zip codes are to be included in Region 4, except for 70532, 70546, 70549, 70581 & 70591**. See Attachment IV for enrollment information by plan and Attachment V for enrollment information by region. For OGB's monthly premium rates effective July 1, 2015, reference: https://www.groupbenefits.org/portal/page/portal30/SHARED/O/OGBWEB/OGB_PUBLICATIONS.

The **total** cost for each proposed region will be scored separately from the technical proposal using the methodology detailed in Section 6.5. Commissions or finder's fees are not payable under this Contract. The successful Proposer/Contractor will submit proposed rates for each 12 month renewal option period no later than September 1st of the preceding year. Note: Premium rates proposed for each 12 month renewal option period must be approved by the Centers for Medicare and Medicaid Services (CMS).

5.6 Proposer's Eligibility

A statement of the Proposer's involvement in litigation and any suspension or debarment proceedings that could affect this work should also be included in your proposal. A suspension or debarment proceeding which could affect this work is any proceeding, whether pending or concluded, that involves a governmental entity. If no such litigation, suspension or debarment exists, Proposer should so state.

6 EVALUATION AND SELECTION

6.1 Evaluation Team

The evaluation of proposals will be accomplished by an evaluation team, to be designated by the OGB, which will determine the proposal most advantageous to the OGB and the State, taking into consideration price and the other evaluation factors set forth in the RFP.

6.2 Administrative and Mandatory Screening

All proposals will be reviewed to determine compliance with administrative and mandatory requirements as specified in the RFP. Proposals that are not in compliance will be rejected from further consideration.

6.3 Clarification of Proposals

The OGB reserves the right to seek clarification of any proposal for the purpose of identifying and eliminating irregularities or informalities.

6.4 Oral Presentations/Discussions

Oral presentations will not be required.

6.5 Evaluation and Review

Proposals that pass the preliminary screening and mandatory requirements review will be evaluated based on information provided in the proposal according to the following criteria:

CRITERIA	MAXIMUM SCORE
PHASE 1: TECHNICAL APPROACH	
Quality of Services	15
Experience and Staff Qualifications	10
TECHNICAL APPROACH SCORE	***25***
PHASE 2: VETERAN AND HUDSON	
Veteran and Hudson Initiative	5
VETERAN AND HUDSON SCORE	***5***
PHASE 3: COST PROPOSAL	
Total Region Premium	20
COST SCORE	***20***
TOTAL SCORE	**50**

Phase 1 – Technical Approach

Quality of Services

- Understanding of the work, including a thoroughness shown in understanding the objectives of the Scope of Services (Attachment II) and specific services and planned execution of the project
- Plans/procedures to fulfill required services
- Training methodology for project staff to understand current practices, and for ongoing training needs to address changes in policy and procedures

Experience and Staff Qualifications

- Evidence that the insurance carrier has the current capabilities and can assure performance
- Demonstration of successful past firm experience that is similar to that necessary to perform services included in Attachment II and/or with public entity accounts
- Subcontractor Qualifications and Experience
- Current and relevant knowledge, and quality and depth of experience of the proposed project staff through completed and ongoing efforts similar in nature to this effort

Phase 2 – Veteran and Hudson Initiatives

Participation in Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) Programs (Value of 10% of the total evaluation points)

Ten percent (10%) of the total evaluation points on this RFP are reserved for Proposers who are themselves a certified Veteran or Hudson Initiative small entrepreneurship or who will engage the participation of one or more certified Veteran or Hudson Initiative small entrepreneurships as subcontractors.

Reserved points shall be added to the applicable Proposer's evaluation score as follows:

Proposer Status and Reserved Points:

- Proposer is a certified small entrepreneurship: Full amount of the reserved points.
- Proposer is not a certified small entrepreneurship but has engaged one or more certified small entrepreneurships to participate as subcontractors or distributors. Points will be allocated based on the following criteria:
    - the number of certified small entrepreneurships to be utilized
    - the experience and qualifications of the certified small entrepreneurship(s)
    - the anticipated earnings to accrue to the certified small entrepreneurship(s)

Phase 3 – Cost

Cost Proposals for all Proposers will be evaluated and an absolute score calculated. Proposal with the lowest proposed cost will receive 20 points. Points will be assigned for cost using a calculation-based evaluation process based on the total cost from the pricing submitted by each Proposer on the Attachment VII: Cost Proposal.

Each proposed region will be scored separately using the following methodology:

1. The lowest proposed cost will receive 100% of the available points for the cost component
2. Remaining proposals will receive points based on application of the following formula:

   Points for Cost Component = (Cost of Lowest Cost Proposal/Cost of Proposal Being Evaluated) X 20 (Points Available for the Cost Component)

6.6 Announcement of Contractor

The Evaluation Team will compile the scores and make a recommendation to the head of the OGB on the basis of the responsive and responsible Proposers with the highest score. OGB will award up to three (3) contracts for each region.

The OGB will notify the successful Proposer and proceed to negotiate terms for the final contract. Unsuccessful Proposers will be notified in writing accordingly.

After the "Notice of Intent to Award" letter has been issued, the OGB shall make available to all interested parties upon request, the proposals received (except for that information appropriately designated as confidential in accordance with La. R.S. 44:1 *et seq*.); evaluation of Proposers' strengths and weaknesses including the list of criteria used and the weight assigned each criterion; and scores for each considered Proposal. The "Notice of Intent to Award" letter is the notification of the award, contingent upon successful negotiation and execution of a written contract, approval by the Division of Administration, Office of State Procurement, and approval by the appropriate standing committees of the Louisiana legislature having jurisdiction over review of OGB rules as designated by La. R.S. 49:968(B)(21)(c).

Any Proposer aggrieved by the proposed award has the right to submit a protest in writing to the Chief Procurement Officer, copying the head of the OGB within 14 days after the award, in accordance with La. R.S. 39:1671. Should any person remain aggrieved after the protest decision, that person may appeal the protest decision to the Commissioner of Administration in accordance with La. R.S. 39:1683; and, if aggrieved by the Commissioner of Administration's decision, the aggrieved person may appeal the Commissioner of Administration's decision to the Nineteenth Judicial District Court in accordance with La. R.S. 39:1691 and 1692.

6.7 Commissioner's Statements

Statements, acts, and omissions made by or on behalf of the Commissioner of Administration regarding this RFP, any Proposer, and/or any subcontractor of a Proposer shall not be deemed a conflict of interest when the Commissioner is discharging her duties and responsibilities under law, including but not limited to, the Commissioner of Administration's authority in procurement matters.

6.8 Proposer's Cooperation

Any Proposer has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to the state when requested. This applies even if an eventual Contract is terminated and/or a lawsuit is filed. Specifically, the Proposer shall not withhold State owned documents or limit or impede the State's right to audit.

7 SUCCESSFUL CONTRACTOR REQUIREMENTS

7.1 Corporation Requirements

If the Contractor is a corporation not incorporated under the laws of the State of Louisiana, the Contractor shall have obtained a certificate of authority pursuant to La. R.S. 12:301-302 from the Secretary of State of Louisiana.

If the Contractor is a for-profit corporation whose stock is not publicly traded, the Contractor shall ensure that a Disclosure of Ownership form has been properly filed with the Secretary of State of Louisiana.

7.2 Billing and Payment

In consideration of the services required by this Contract, OGB hereby agrees to pay to Contractor a maximum fee of $[TO BE INSERTED] for the Term of the Contract. The Contractor will submit proposed rates for each 12 month renewal option period no later than September 1st of the preceding year. Note: Premium rates proposed for each 12 month renewal option period must be approved by the Centers for Medicare and Medicaid services (CMS).

Payments are predicated upon successful completion and written approval by the OGB of the described services and deliverables as provided in the RFP, Attachment II: Scope of Services. Contractor will not be paid more than the maximum amount of the Contract.

With respect to insureds who select a Louisiana HMO for their coverage, OGB shall impose no extraordinary restrictions on their plan participation due to the selection of the Louisiana HMO. Insureds selecting the Louisiana HMO option shall receive the same employer contributions provided under La. R.S. 42:851, and the regulations issued thereunder, as participants who choose other options under the OGB plan of benefits.

The Contractor will invoice OGB on the 1st of each month for payment of insurance premiums for services provided pursuant to the resulting Contract. The invoice should include, at a minimum, plan description/name, time period covered, total billed amount detailed by class of coverage, and total number of plan participants. Payments will be made to the Contractor after written acceptance by the State and approval of the invoice. State will apply every reasonable effort to make payment within fifteen (15) calendar days of invoice approval under a valid contract. Payment will be only made upon approval of OGB's Chief Executive Officer, or designee.

7.3 Performance Guarantees

Contractor agrees to provide its operational performance guarantees on a client-specific basis and report OGB's results on a quarterly basis. OGB shall have the ability to modify the performance guarantees each contract year; however, twenty-five (25%) percent of Contractor's fees will remain at risk. All guarantees must be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of the calendar year.

Performance Guarantees: The Contractor will be subject to negotiated performance standards subject to a maximum penalty of twenty-five (25%) percent of the total contracted cost.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit.

Measurement Periods: The first period to be measured shall be January 1, 2016 through December 31, 2016. The second period, subject to the renewable option, will be for calendar year 2017, and third period, subject to the renewable option, will be for calendar year 2018.

7.3.1 Performance Bond

The amount of the performance (surety) bond will be established following the annual open enrollment period in October 2015, and will be based on the premium payable for Plan Participants effective January 1, 2016. In the event that the parties agree to renew the Contract for two (2) additional one year terms, the amount of the bond for the renewal term will be adjusted following each annual open enrollment and will be based upon the premiums payable for plan participants effective at the commencement of the term.

The performance bond shall be written by a surety or insurance company currently on the U.S. Department of the Treasury Financial Management Services list of approved companies which is published annually in the Federal Register, or by a Louisiana domiciled insurance company with at least an A-rating to write individual bonds up to 10 percent of policyholders' surplus as shown in the latest printing of the A.M. Best's Key Rating Guide. In addition, the furnished performance bond shall be written by a surety or insurance company that is currently licensed to do business in the state of Louisiana.

No surety or insurance company shall write a performance bond which is in excess of the amount indicated as approved by the U.S. Department of the Treasury Financial Management Service list or in excess of the limit rated for a Louisiana domiciled insurance company with an A-rating by A.M. Best. Further, companies authorized by this Paragraph who are not on the treasury list shall not write a performance bond when the penalty exceeds 15 percent of its capital and surplus, such capital and surplus being the amount by which the company's assets exceed its liabilities as reflected by the most recent financial statements filed by the company with the Department of Insurance.

The performance bond is to be provided within 10 working days from request. Failure to provide within the time specified may cause the Contract to be cancelled.

7.4 Confidentiality

All financial, statistical, personal, technical and other data and information relating to the State's operation which are made available or which become available to the Contractor in carrying out this contract, are designated confidential and shall be protected by the Contractor from

unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the OGB. The Contractor shall not be required under the provisions of the paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Contractor's possession, is independently developed by the Contractor outside the scope of the contract, or is rightfully obtained from third parties.

Under no circumstance shall the Contractor discuss and/or release information to the media concerning this project without prior express written approval of the Office of Group Benefits.

Contractor 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 (50) United States of America. As used in this paragraph, PHI refers to protected health information as defined by the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder by the U.S. Department of Health and Human Services, as amended from time to time.

7.5 Business Associate Addendum

A Business Associate Addendum shall be executed between the parties to this Contract to protect the privacy and provide security of Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and regulations promulgated thereunder, as amended from time to time. See Attachment X.

ATTACHMENT I: HMO PLAN DESIGN

Office visit copay	
PCP	$5 copay
SCP	$20 copay
Preventive care	
Routine physical exam Well Woman Care Immunizations	$0 $0 $0
Inpatient hospital	
Semi-private room, ancillary services and physician visits	100% after $50 copay per day for first ten days
Pre-admission testing	100%
Outpatient hospital care	100%
Emergency room	100% after $50 copay
Ambulatory surgical care center	100%
Physical therapy, respiratory, occupational or speech	100%
Home health care	100% per date of service
Durable Medical Equipment	100% after 5% coinsurance
Skilled nursing	100% for days 1-20 100% after $25 copay per day (days 21-100)
Ambulance	100% after $50 copay
Immediate Care	100% after $10 copay
Mental Health	
Inpatient	100% after $25 copay per day for first five days
Outpatient	100% after $10 copay
Partial hospitalization	100% after $20 copay per day
Alcohol/Substance Abuse	
Inpatient	100% after $25 copay per day for first five days
Outpatient	100% after $20 copay
Prescription Drug	
Retail (30 days)	
Level One	$ 5 (low cost generic)
Level Two	$10 (higher cost generic)
Level Three	$25 (low cost brand)
Level Four	$50 (higher cost brand)
Level Five	20% (specialty)
Mail Order (90 days)	
Level One	$0
Level Two	$0
Level Three	$50
Level Four	$100
Level Five	20%

ATTACHMENT II: SCOPE OF SERVICES

Overview

Contractor shall provide Medicare Advantage Health Maintenance Organization Plan coverage on a parish basis for Medicare eligible OGB retirees. This plan offering will be available to all eligible retirees who wish to choose such means of acquiring health care services. However, eligible retirees who enroll in the Plan are members of the OGB.

The OGB will determine eligibility of plan participants and manage benefit enrollment information using its online system. All enrollment documents, changes, and/or terminations will be processed by OGB including data entry into the billing and eligibility system and transferred to Contractor daily in the form of an electronic eligibility data file. The Contractor must accept, efficiently process, and report any errors or omissions back to OGB in a timely manner.

Contractor must agree to maintain identical eligibility requirements and continued coverage provisions as the OGB, as the OGB may amend from time to time. It is anticipated that the open enrollment period will be conducted annually during the month of October or as required by the Affordable Care Act with an effective date of January 1 to allow Medicare eligible OGB retirees to join a plan or change coverage.

Upon request, selected Contractor(s) will need to work with one another, the appointed OGB actuary, employees from the Division of Administration, and the Office of Group Benefits, which is responsible for managing the program.

Below is a list of minimum services the successful Proposer will be responsible for providing under the contract resulting from this RFP.

- Provide a Health Maintenance Organization (HMO) Physician and Hospital Provider Network to OGB Plan Participants, including but not limited to inpatient and outpatient hospital services (including hospital based ancillary services), ambulatory surgical services (including ASC based ancillary services), physician services, mental/behavioral health, substance abuse services, prescription drugs, utilization management, medical management, and disease management (Asthma, Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease and Chronic Heart Failure).
- Provide at least 45 days advance written notification to OGB and its participants of any change in provider networks that will effect a 1% or greater change in the number of providers in the network or a disruption that would impact 3% or greater of participants.
- Provide a network of primary, specialty, and ancillary care providers within sixty (60) miles of a participant's address.
- Process premium refunds to Low Income Subsidy (LIS) members enrolled in Medicare Advantage Part D plans on behalf of OGB.
- Consult with OGB with regard to benefits provided under the Plan. No changes to said plan shall be made during the term of the resulting Contract without the consent of OGB.
- Accept enrollment information daily from OGB in electronic format and enroll plan participants to receive benefits in accordance with plan provisions.
- Staff and maintain a dedicated customer service unit and phone line to assist plan participants with questions on claims, benefits, and networks. Furnish a toll-free

telephone number for incoming customer service calls, including telephone technology for the hearing impaired. The customer service unit must be available for annual open enrollment.

- Provide knowledgeable staff to attend state-wide annual open enrollment meetings and informational meetings within the proposed parishes for which the Contractor is authorized to provide coverage as scheduled by OGB.
- Design, update, print, and/or mail all plan participant communication materials (i.e., provider directories, summary plan documents, plan participant education materials, etc.), advertisements and marketing materials. All such materials will be subject to OGB's approval prior to distribution. The cost of preparation and distribution of any and all plan participant communications or promotional materials must be included in the quoted premium.
- Facilitate management of the health care services afforded OGB's plan participants under the plan, including but not limited to authorization services, discharge planning, verification of provided services, utilization management and quality assurance.
- Maintain website for participant access to their claims information, benefits, order replacement ID cards, provider directories, self-care information, and other program information necessary to manage their healthcare needs.
- Designate one key person and at least one back-up staff member as the contacts to OGB for all daily operational questions related to operations.
- Provide 24/7 access to online portal for plan participants and plan sponsor for activities such as claim submission, account monitoring, reporting, communications requested and approved by OGB, etc. All outages in excess of one (1) hour must be reported to the OGB Contract Supervisor.
- Provide file data in a layout format designated by OGB to include, but not limited to, Wellness Participation, Medical Claims File, Provider Files, Code Files, and Adjusted Claims File. Contractor will need to accept OGB's standard file layout in Attachment XI, File Layout and Specifications.
- Medical Claims Administration to include, but not limited to: process claims and remit timely payment to providers; furnish to any claimant notices of payment, explanation of benefits, and/or denials for claims; provide review of plan participants' appeals and grievances; maintain medical and carved out pharmacy claims for integrated Medical/Rx out of pocket maximum accumulation; and adjudicate and process all claims with service dates prior to termination date, if requested by OGB.
- Submit standardized reports and/or data to OGB for the purpose of evaluating plan participant demographics, financial experience, and other aspects of the Contractor's performance. Format and layout must be approved by OGB.
- Distribute required membership materials to each new enrollee within thirty (30) days of receipt of confirmation from OGB as to the validity of the enrollment application:

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

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

3. One identification card to each plan participant for individual coverage or two cards for all other classes of coverage. Replacement cards shall be provided upon request at no additional charge to OGB or the plan participant.

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

- Provide a Wellness Program that includes the following components:
  - 24/7 online program for plan participants and administration
  - Preventive care tracking
  - Biometric data collection – onsite and PCP
  - Health coaching capabilities
  - Incentive tracking capabilities

Deliverables

The deliverables listed in this section are the minimum required from Contractor.

- Within fifteen (15) business days after the first of each month, Contractor shall submit reports which demonstrate plan participant demographics, financial experience, and other aspects of the Contractor's performance identified by OGB to include, but not limited to:
  - **Financial Experience:** Premium Income and Claims Utilization Experience.
  - **Average Speed to Answer:** Average lag time to answer by live voice percentage of plan participants who wait over 45 seconds to speak with a live customer service rep.
  - **Abandon Call Rate:** Percentage of calls where the caller hangs up before speaking to a live voice.
  - **Inquiry Timeliness**: Percentage of inquiries answered within seven calendar days.
  - **Claims Financial Accuracy:** Percentage of claims paid correctly – dollar amount only.
  - **Claims Accuracy:** Percentage of claims paid correctly the first time.
  - **Claims Process Time:** Percentage of electronic claims paid within 10 days of receipt and percentage of non-electronic claims paid within 15 days of receipt.
  - **Eligibility Posting Timeliness**: Percentage of membership files updated within 2 business days of the receipt of the OGB enrollment file.
  - **ID Card Timeliness**: Percentage of new plan participants who have ID cards issued prior to their effective date of coverage.
  - **PCP Turnover Rate**: Percentage of PCPs leaving the network voluntarily or involuntarily during the month.
  - **Open PCP/Participant Ratio:** Ratio of open PCPs accepting new plan participants to actual plan participants.

- **Grievance Log:** Number of appeals and grievances filed during the month. A detailed report is required listing all appeals and grievances and the current status of each.

- Submit annual Service Organization Control (SOC 1), Type II report resulting from SSAE 16 engagement no later than September 30 of each contract year and/or other independent assurances approved by OGB.

- Submit quarterly report that captures operational performance guarantees on a client-specific basis and report OGB's data within forty-five (45) calendar days after close of the quarter reporting. All performance guarantees will be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of the calendar year.

- Provide client-specific ad hoc reports within thirty (30) days of OGB request that will include data related to Contractor's operating performance and health outcomes of OGB's plan participants.

Performance Guarantees

The following performance guarantees are the minimum acceptable standards for the resulting contract. These metrics shall be reported quarterly and reconciled on an annual basis unless another time period is agreed to between OGB and Contractor.

Service Level	Fees at Risk Per Calendar Year
Annual Enrollment Meetings: 100% attendance of state-wide annual open enrollment meetings within the proposed parishes for which the Contractor is authorized to provide coverage.	$1,000 per annual enrollment meeting missed
Average Speed to Answer: Forty-five (45) seconds or less. The Average Speed to Answer means the average speed for answering of the customer service telephone line by a "live" representative each plan quarter.	6.25%
Abandon Call Rate: 2.5% or less of all incoming calls received will be abandoned. Abandon Call Rate means the number of incoming telephone calls received by the customer service telephone line during a which are abandoned by the caller after a selection is made either to the Interactive Voice Response Unit or Call Representative divided by the total number of incoming calls received by the customer service telephone line during such plan quarter.	6.25%
Eligibility Posting Timeliness: 100% of electronically transmitted eligibility updates shall be posted to the vendor's system within two (2) business days of receipt.	6.25%

Service Level	Fees at Risk Per Calendar Year
Required Membership Materials Distribution: Required membership materials shall be distributed by Contractor to each new enrollee within thirty (30) days of receipt of confirmation from OGB as to the validity of the enrollment application.	6.25%

ATTACHMENT III: REGIONS BY CITY AND ZIP CODE

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

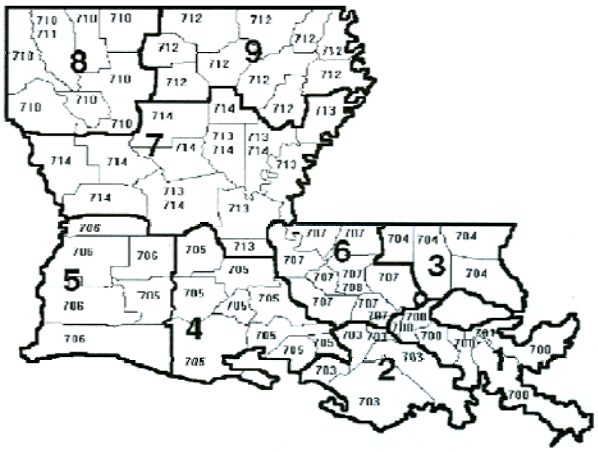
REGION 6
- Addis
- Baker
- Baton Rouge
- Brusly
- Clinton
- Denham Springs
- Gonzales
- Livingston
- Livonia
- Maringouin
- New Roads
- Plaquemine
- Port Allen
- Prairieville
- St. Francisville
- St. Gabriel
- Sunshine
- White Castle
- Zachary

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.

ATTACHMENT IV: ENROLLMENT INFORMATION BY PLAN

MEMBERS WITH MEDICARE A & B			
	MEMBER COUNTS		
Plan Description	**Employee**	**Spouse**	**Total**
Blue Cross – Magnolia Local	76	16	92
Blue Cross – Magnolia Open Access	17874	5571	23445
Blue Cross – Magnolia Plus	10939	3896	14835
Blue Cross – Pelican HRA	408	160	568
Peoples Health – Medicare Advantage	1612	485	2097
Vantage – Medicare Advantage	1369	351	1720
Vantage – Medicare Advantage- Zero Prem	184	54	238
Vantage – Medical Home HMO	150	59	209
LSU System Health Plan – ASO – Opt 1	1421	631	2052
LSU System Health Plan – ASO – Opt 2	50	21	71
One Exchange – HRA Account	425	138	563

*Enrollment information by plan as of May 1, 2015

ATTACHMENT V: ENROLLMENT INFORMATION BY REGION

MEMBERS WITH MEDICARE A & B – BY REGION			
	MEMBER COUNTS		
Member Region	**Retiree**	**Spouse**	**Total**
ALEXANDRIA	5420	1850	7270
BATON ROUGE	6930	2182	9112
HAMMOND	3208	1186	4394
HOUMA/THIBODAUX	947	383	1330
LAFAYETTE	3445	1225	4670
LAKE CHARLES	1342	489	1831
MONROE	3843	1353	5196
NEW ORLEANS	3882	1057	4939
OUT OF STATE	3072	963	4035
SHREVEPORT	2398	712	3110
UNKNOWN	2	1	3

*Enrollment information by region as of May 1, 2015

ATTACHMENT VI: TECHNICAL QUESTIONNAIRE

Provide a response to each of the following questions.

A. Organizational Background

1. Provide your company's latest financial rating. If not rated indicate N/R.

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

2. How long has your organization offered a Medicare Advantage Plan?

3. Please provide a statement and/or business plan discussing your organization's commitment to Medicare Advantage Plans.

4. Has your organization been sanctioned by the Centers for Medicare and Medicaid Services in the past five (5) years? If yes, explain.

5. How does your organization view the future stability of premiums for the Medicare Advantage Plans?

6. Identify the number of current members enrolled in Medicare Advantage Plans with your organization:

Product	Number of Members
Medicare Advantage HMO	

7. List the parishes for which you have CMS approval to offer your Medicare Advantage Plan.

B. Account Management

1. Provide the location of the office that will manage the account.

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

3. Provide name, title, and immediate superior of the Account Executive that will be assigned to OGB and indicate how the company evaluates the performance of this individual when considering compensation for the relevant period.

C. Customer Service

For the following questions, responses must be specific to the customer service location that is being proposed for OGB services.

1. What facility will handle customer service for OGB's plan participants and where will it be located?

2. Will staff be dedicated/designated to OGB? Define dedicated/designated.

3. What are the hours of operation for customer service provided to OGB's plan participants? How is customer service handled after hours of operation?

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

	Standard	2013 Actual	2014 Actual	2015 Goal
Telephone average speed of answer				
Percentage of calls abandoned				
Average waiting time				
Average call time				
Average time for problem resolution from initial notification				
Telephone quality				
Percentage of problems resolved during first call/contact (member does not need to call back)				

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

6. How are calls segmented (i.e., routing of inquiries by plan, inquiries about claims, requests to identify network providers, generalized member services questions, etc.)?

7. What methodologies (i.e., silent call monitoring) are employed to monitor and control the quality of service provided?

8. Are all customer calls recorded and if not, what percentage are? How long are the recordings kept?

9. Provide a sample of the specific management reports of telephone inquiry performance.

D. Claims Processing/Administration

1. Provide the name of the facility that will handle claims processing and where will it be located.

2. Provide claim adjudication statistics for the proposed claims office in the table below.

	Standard	2013 Actual	2014 Actual	2015 Goal
Financial accuracy (percentage of dollars paid correctly)				
Overall accuracy				
Turnaround time in 14 calendar days				
Turnaround time in 28 calendar days				

3. What percentage of overall claims is auto-adjudicated?

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

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

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

E. Web Tools

1. Which of the following services are currently or will be available through your website by January 1, 2016? (Please √ *Yes* or *No*.)

	Current		**01/01/2016**	
Member Self-Service – Can plan participants:	**Yes**	**No**	**Yes**	**No**
a. access provider information				
b. access provider directories				
c. access provider directories with driving instructions				

	Current		01/01/2016	
Member Self-Service – Can plan participants:	**Yes**	**No**	**Yes**	**No**
d. participate in community forums				
▪ If no, does your website link to this type of site				
e. access benefit plan summaries				
f. enroll on-line				
g. check eligibility				
h. order replacement ID cards				
i. participate in telemedicine				
j. file a claim				
k. download printable versions of claim forms				
l. check claim status				
m. submit appeals				
n. submit inquiries to customer service via email				
o. determine whether hospital-based doctors are in-network at each in-network facility				
Provider Support - Can providers:	**Yes**	**No**	**Yes**	**No**
p. verify in “real-time” the eligibility status of members				
q. create virtual medical records for their patients				
r. access drug and medical history for their patients				
s. access lab values or other encounter data				
t. submit claims				
u. submit precertification information/extended LOS information				

	Current		01/01/2016	
Health Management – Can plan participants:	**Yes**	**No**	**Yes**	**No**
v. access disease management program information				
w. access educational information				
x. complete a health risk assessment				
y. develop and save a health profile				
Plan Sponsor/Employer Support	**Yes**	**No**	**Yes**	**No**
z. Can plan sponsors check members online				
aa. Can plan sponsors update eligibility online				

2. Describe any planned upgrades to your reporting systems.

F. Health Management

1. Provide brief descriptions for all of the health management programs (i.e., health promotion, health risk management, chronic disease management, high cost case management, care coordination, etc.) your organization offers for Medicare Advantage HMO plan participants that are included in the quoted premium.

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

3. Is your organization able to report population health risk status and changes to the client on a regular basis using claims data and/or information from another health risk assessment vendor? If so, describe.

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

5. Describe the outreach methods to those participants eligible to participate in a structured program.

G. Prescription Drugs

1. Provide a listing of your full formulary.

2. Describe any dosage or imposed dispensing limits.

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

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

5. How will transition of care issues be handled?

H. Overall Plan Mechanics

1. Describe the group enrollment process. Specifically address signature requirements and data requirements.

2. If a participant receives services from a member of your provider network, is this provider allowed to balance-bill the member?

3. Does your organization have the capabilities to offer direct billing services to retirees?

4. Is pre-enrollment support provided via the Web or toll-free number to answer potential members' questions?

5. Does your organization allow customization of ID cards to include a statement and or toll-free number directing physicians outside of your network to accept the card as they would a Medicare card?

I. Communications

1. Provide an overview and samples of any communication pieces used during the enrollment process, especially for Medicare Advantage plans.

2. What off-the-shelf products are you able to provide, free of charge?

3. Provide samples of any communication campaigns or monthly/quarterly newsletters sent to Medicare plan participants.

4. Are large print enrollment/communication materials offered?

ATTACHMENT VII: COST PROPOSAL

The Proposer shall provide a fixed monthly premium inclusive of all services per enrollee per month (PEPM) for the first year of the initial contract period of January 1 to December 31, 2016 for all proposed parishes included in each selected Region(s). The monthly premium shall be fully burdened and inclusive of all travel and project expenses. **All 705 zip codes are to be included in Region 4, except for 70532, 70546, 70549, 70581 & 70591**. See Attachment III for a description of the regions by city and zip code. If proposing rates for Jefferson Davis Parish, include Jefferson Davis Parish in Region 4. See Attachment IV for enrollment information by plan. For OGB's monthly premium rates effective July 1, 2015, reference:

https://www.groupbenefits.org/portal/page/portal30/SHARED/O/OGBWEB/OGB_PUBLICATIONS.

The **total** cost for each proposed region will be scored separately from the technical proposal using the methodology detailed in Section 6.5. Commissions or finder's fees are not payable under this Contract. The Contractor will submit proposed rates for each 12 month renewal option period no later than September 1st of the preceding year. **Note: Premium rates proposed for each 12 month renewal option period must be approved by the Centers for Medicare and Medicaid Services (CMS).**

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

Proposed Parishes Included in Region 1	**Fixed Monthly Premium, Per Enrollee Per Month**
Total Cost	

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

Proposed Parishes Included in Region 2	**Fixed Monthly Premium, Per Enrollee Per Month**
Total Cost	

Region 3 – Hammond Area (Zip Codes 70400-70499)

Proposed Parishes Included in Region 3	Fixed Monthly Premium, Per Enrollee Per Month
Total Cost	

Region 4 – Lafayette Area (Zip Codes 70500-70599)
***Excludes 70532, 70546, 70549, 70581 & 70591**

Proposed Parishes Included in Region 4	Fixed Monthly Premium, Per Enrollee Per Month
Total Cost	

Region 5 – Lake Charles Area (Zip Codes 70532, 70546, 70549, 70581, 70591 & 70600-70699)

Proposed Parishes Included in Region 5	Fixed Monthly Premium, Per Enrollee Per Month
Total Cost	

Region 6 – Baton Rouge Area (Zip Codes 70700 -70899)

Proposed Parishes Included in Region 6	Fixed Monthly Premium, Per Enrollee Per Month
Total Cost	

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

Proposed Parishes Included in Region 7	Fixed Monthly Premium, Per Enrollee Per Month
Total Cost	

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

Proposed Parishes Included in Region 8	Fixed Monthly Premium, Per Enrollee Per Month
Total Cost	

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

Proposed Parishes Included in Region 9	Fixed Monthly Premium, Per Enrollee Per Month
Total Cost	

ATTACHMENT VIII: CERTIFICATION STATEMENT

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT. The OGB requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Print Clearly)

Date _____ Official Contact Name: _____

A. E-mail Address: _____

B. Facsimile Number with area code: ( ) _____

C. US Mail Address: _____

Proposer certifies that the above information is true and grants permission to the OGB or Agencies to contact the above named person or otherwise verify the information provided.

By its submission of this proposal and authorized signature below, Proposer certifies that:

1. The information contained in its response to this RFP is accurate.
2. Proposer complies with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer's quote is valid for at least *90* days from the date of proposal's signature below.
5. Proposer understands that if selected as the successful Proposer, he/she will have either **20** business days to complete the contract negotiation period or **10** business days from the date of delivery of final contract in which to complete contract negotiations, if any, and execute the final contract document.
6. Proposer certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov .)

Authorized Signature: _____

Typed or Printed Name: _____

Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SIGNATURE of Proposer's Authorized Representative	DATE

ATTACHMENT IX: SAMPLE CONTRACT

On this _____ day of _____, 2015, the State of Louisiana, Office of Group Benefits, 1201 N. 3rd Street, Suite G-159, Baton Rouge, LA 70802, hereinafter sometimes referred to as the "OGB", and (Contractor Name), (Address), hereinafter sometimes referred to as the "Contractor," do hereby enter into a Contract under the following terms and conditions.

1 SCOPE OF SERVICES

1.1 CONCISE DESCRIPTION OF SERVICES

(Contractor Name) shall offer a Medicare Advantage Plan for Medicare eligible OGB retired plan members in parishes approved by the Centers for Medicare and Medicaid Services (CMS) in the state of Louisiana. These services shall include, at a minimum, all services specified in the RFP, Attachment II: Scope of Services and/or any subsequent addendum.

1.2 STATEMENT OF WORK

The Statement of Work is detailed in the RFP, Attachment II: Scope of Services and/or any subsequent addendum.

1.3 GOALS AND OBJECTIVES

1. 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.

2. Provide quality, cost-effective hospital and health care services to Plan participants.

1.4 PERFORMANCE MEASURES

The performance of the Contract will be measured by the OGB Contract Supervisor. RFP Attachment II and/or any subsequent addendum include performance criteria and corresponding monetary penalties for Contractor's failure to comply with the identified criteria. The OGB Contract Supervisor is authorized to evaluate the Contractor's performance against these criteria.

1.5 MONITORING PLAN

The *OGB Medical and Pharmacy Administrator* is the OGB Contract Supervisor who will monitor the services provided by the Contractor and the expenditure of funds under this Contract. *The OGB Medical and Pharmacy Administrator* will be primarily responsible for the day-to-day contact with the Contractor and day-to-day monitoring of the Contractor's performance.

The Contractor shall develop a monitoring plan to provide for the following:

Account Executive. Contractor shall provide an Account Executive to provide day-to-day management of project tasks and activities, and coordination of Contractor employees. The Account Executive shall possess the technical and functional skill and knowledge to direct all aspects of the project and must be experienced in working with large public sector accounts.

The Account Executive will have at least one (1) back-up staff member to handle the overall responsibility of the OGB program. The Account Executive shall be supported by an Account management team, including but not limited to, an Implementation Manager, Account Manager, Accounting Specialist, Senior Operations Specialist, and Compliance Analyst. The Account Executive will be subject to OGB review and approval. Contractor will give OGB a minimum of sixty (60) days advance notice of any changes in the Account Executive, a description of training requirements for new team members, and a right to refuse any proposed Account Executive changes. Reasonable exceptions would apply in situations beyond the Contractor's control (e.g. resignation/termination with less than 60 days' notice.)

1.6 DELIVERABLES

The Contract will be considered complete when Contractor has delivered and State has accepted all deliverables specified in the RFP, Attachment II: Scope of Services and/or any subsequent addendum.

1.7 SUBSTITUTION OF KEY PERSONNEL

In the event that any OGB or Contractor personnel become unavailable due to resignation, illness, or other factors, excluding assignment to projects outside this Contract, outside of the OGB's or Contractor's reasonable control, as the case may be, the OGB or the Contractor shall be responsible for providing an equally qualified replacement in time to avoid delays in providing services. The Contractor will make every reasonable attempt to assign the personnel listed in the proposal.

1.8 Veteran-Owned and Service-Connected Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) Programs Reporting Requirements

During the term of the contract and at expiration, the Contractor will be required to report Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship subcontractor or distributor participation and the dollar amount of each.

2 ADMINISTRATIVE REQUIREMENTS

2.1 TERM OF CONTRACT

This Contract shall become effective on January 1, 2016 and shall end on December 31, 2016. OGB has the right to contract for up to a total of three (3) years with the concurrence of the Contractor and all appropriate approvals.

Notwithstanding any other provision of this Contract, this Contract and any amendments thereof shall not become effective until approved as required by statutes and regulations of the State of Louisiana.

2.2 OGB FURNISHED RESOURCES

OGB's Medical and Pharmacy Administrator will monitor the services provided by the Contractor. This person shall be the principal point of contact on behalf of the OGB and will be the principal point of contact for Contractor concerning Contractor's performance under this Contract. The items OGB agrees to provide and be responsible for are specified in the

RFP, Attachment I: Scope of Services and RFP, Attachment XI: File Layout and Specifications and/or any subsequent addendum.

2.3 TAXES

Contractor is responsible for payment of all applicable taxes from the funds to be received under this Contract. Contractor's federal tax identification number is _____.

2.4 PAYMENT TERMS

In consideration of the services required by this Contract, OGB hereby agrees to pay to Contractor a maximum fee of $[TO BE INSERTED] for the Term of the Contract. The Contractor will submit proposed rates for each 12 month renewal option period no later than September 1st of the preceding year. Note: Premium rates proposed for each 12 month renewal option period must be approved by the Centers for Medicare and Medicaid services (CMS).

Payments are predicated upon successful completion and written approval by the OGB of the described services and deliverables as provided in the RFP, Attachment II: Scope of Services. Contractor will not be paid more than the maximum amount of the Contract.

With respect to insureds who select a Louisiana HMO for their coverage, OGB shall impose no extraordinary restrictions on their plan participation due to the selection of the Louisiana HMO. Insureds selecting the Louisiana HMO option shall receive the same employer contributions provided under La. R.S. 42:851, and the regulations issued thereunder, as participants who choose other options under the OGB plan of benefits.

The Contractor will invoice OGB on the 1st of each month for payment of insurance premiums for services provided pursuant to the resulting Contract. The invoice should include, at a minimum, plan description/name, time period covered, total billed amount detailed by class of coverage, and total number of plan participants. Payments will be made to the Contractor after written acceptance by the State and approval of the invoice. State will apply every reasonable effort to make payment within fifteen (15) calendar days of invoice approval under a valid contract. Payment will be only made upon approval of OGB's Chief Executive Officer, or designee.

2.5 PERFORMANCE GUARANTEES

Contractor agrees to provide its operational performance guarantees on a client-specific basis and report OGB's results on a quarterly basis. OGB shall have the ability to modify the performance guarantees each contract year; however, twenty-five (25%) percent of Contractor's fees will remain at risk. All guarantees must be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of the calendar year.

Performance Guarantees: The Contractor will be subject to negotiated performance standards subject to a maximum penalty of twenty-five (25%) percent of the total contracted cost.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit.

Measurement Periods: The first period to be measured shall be January 1, 2016 through December 31, 2016. The second period, subject to the renewable option, will be for calendar year 2017, and third period, subject to the renewable option, will be for calendar year 2018.

2.6 PERFORMANCE BOND

The amount of the performance (surety) bond will be established following the annual open enrollment period in October 2015, and will be based on the premium payable for Plan Participants effective January 1, 2016. In the event that the parties agree to renew the Contract for two (2) additional one year terms, the amount of the bond for the renewal term will be adjusted following each annual open enrollment and will be based upon the premiums payable for plan participants effective at the commencement of the term.

The performance bond shall be written by a surety or insurance company currently on the U.S. Department of the Treasury Financial Management Services list of approved companies which is published annually in the Federal Register, or by a Louisiana domiciled insurance company with at least an A-rating to write individual bonds up to 10 percent of policyholders' surplus as shown in the in the latest printing of the A.M. Best's Key Rating Guide. In addition, the performance bond shall be written by a surety or insurance company that is currently licensed to do business in the state of Louisiana.

No surety or insurance company shall write a performance bond which is in excess of the amount indicated as approved by the U.S. Department of the Treasury Financial Management Service list or in excess of the limit rated for a Louisiana domiciled insurance company with an A-rating by A.M. Best. Further, companies authorized by this Paragraph who are not on the Treasury list shall not write a performance bond when the penalty exceeds 15 percent of its capital and surplus, such capital and surplus being the amount by which the company's assets exceed its liabilities as reflected by the most recent financial statements filed by the company with the Department of Insurance.

The performance bond is to be provided within 10 working days from request. Failure to provide within the time specified may cause this Contract to be cancelled.

3 TERMINATION

3.1 TERMINATION FOR CAUSE

OGB may terminate this Contract for cause based upon the failure of Contractor to comply with the terms and/or conditions of the Contract; provided that the 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 the OGB may, at its option, place the Contractor in default and the Contract shall terminate on the date specified in such notice. Failure to perform within the time agreed upon in the Contract or failure to comply with the statutory obligations Section 12 (Compliance with Civil Rights Laws) may constitute default and may cause cancellation of the Contract.

Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the OGB to comply with the terms and conditions of this Contract

provided that the Contractor shall give the OGB written notice specifying the OGB's failure and a reasonable opportunity for the OGB to cure the defect.

3.2 TERMINATION FOR CONVENIENCE

OGB may terminate the Contract at any time without penalty by giving thirty (30) days' written notice to the Contractor of such termination or negotiating with the Contractor an effective date. Contractor shall be entitled to payment for deliverables in progress to the extent work has been performed satisfactorily.

3.3 TERMINATION FOR NON-APPROPRIATION OF FUNDS

The continuation of this Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of the Contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act of Title 39 of the Louisiana Revised Statutes of 1950 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 reduction is 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.

4 INDEMNIFICATION AND LIMITATION OF LIABILITY

Neither party shall be liable for any delay or failure in performance beyond its control resulting from acts of God or force majeure. The parties shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under Contract.

(a) Contractor shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully protect, defend, indemnify, save, and hold harmless the OGB, its officers, trustees, employees, servants, subcontractors, agents, and volunteers from any and all losses, claims, demands, liabilities, suits, actions, damages, costs, fines, penalties, judgments, forfeitures, assessments, expenses, obligations (including attorney's fees), and other liabilities of every name and description relating to personal injury, violation of or failure to comply with any state or federal law, regulation, or other legal mandate, and damage to real or personal tangible property to the extent caused by Contractor, its agents, employees, partners or subcontractors; provided, however, that the Contractor shall not indemnify for that portion of any claim, loss or damage arising hereunder due solely to the negligent act or failure to act of the OGB.

(b) Specifically, Contractor shall fully protect, defend, indemnify, save, and hold harmless the OGB, its officers, trustees, employees, servants, subcontractors, agents, and volunteers from and against all adverse federal and state tax consequences, loss, liability, damage, expense, attorney's fees or other obligations resulting from, or arising out of, any act or omission by Contractor in connection with or other obligations resulting from or arising out of any premium charge, tax, or similar assessment by federal and state, for which the Contractor is liable.

(c) If applicable, Contractor will protect, defend, indemnify, save, and hold harmless, the OGB, its officers, trustees, employees, servants, subcontractors, agents, and volunteers,

from and against all losses, claims, demands, liabilities, suits, actions, damages, costs, fines, penalties, judgments, forfeitures, assessments, expenses, obligations (including attorney's fees), and other liabilities of every name and description which may be finally assessed against the OGB, its officers, trustees, employees, servants, subcontractors, agents, and volunteers in any action for infringement of a United States Letter Patent with respect to the Products furnished, or of any copyright, trademark, trade secret or intellectual property right, provided that the OGB shall give the Contractor: (i) prompt written notice of any action, claim or threat of infringement suit, or other suit; (ii) the opportunity to take over, settle or defend such action, claim or suit at Contractor's sole expense; and (iii) assistance in the defense of any such action at the expense of Contractor. Where a dispute or claim arises relative to a real or anticipated infringement, the OGB, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers, may require Contractor, at its sole expense, to submit such information and documentation, including formal patent attorney opinions, as the Commissioner of Administration shall require.

(d) The Contractor shall not be obligated to indemnify that portion of a claim or dispute based upon: i) the unauthorized modification or alteration of a product, material or service by the OGB, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers; ii) the use by the OGB, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers of the product, material, or services in combination with other products not furnished by Contractor; or, iii) the use of the product, material, or service in other than the specified operating conditions and environment by the OGB, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers.

(e) In addition to the foregoing, if the use of the product, material, or service or part(s) thereof shall be enjoined for any reason or if Contractor believes that it may be enjoined, Contractor shall have the right, at its own expense and sole discretion as the exclusive remedy of the OGB, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers, to take action in the following order of precedence: (i) to procure for the OGB the right to continue using such the product, material, or service or part(s) thereof, as applicable; (ii) to modify the product, material, or service so that it becomes a non-infringing product, material, or service of at least equal quality and performance; (iii) to replace the product, material, or service or part(s) thereof, as applicable, with non-infringing components of at least equal quality and performance; or (iv) if none of the foregoing is commercially reasonable, then provide monetary compensation to the OGB up to the dollar amount of the Contract.

(f) The OGB may, in addition to other remedies available to the OGB, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers at law or equity and upon notice to the Contractor, retain such monies from amounts due Contractor as may be necessary to satisfy any claim for damages, fines, penalties, judgments, assessments, expenses, obligations (including attorney's fees), and other liabilities asserted by or against the OGB, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers.

5 CONTRACT CONTROVERSIES

Any claim or controversy arising out of the Contract shall be resolved by the provisions of Louisiana Revised Statutes 39:1671-1672.4.

6 FUND USE

Contractor agrees not to use Contract proceeds 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.

7 ASSIGNMENT

Neither party shall assign any interest in this Contract by assignment, transfer, or novation, without prior written consent of the other. This provision shall not be construed to prohibit the Contractor from assigning to a bank, trust company, or other financial institution any money due or to become due from approved contracts without such prior written consent. Notice of any such assignment or transfer shall be furnished promptly to the OGB.

8 RIGHT TO AUDIT

The State Legislative auditor, federal auditors, and internal auditors of the Division of Administration or others so designated by the DOA, shall have the right to audit all accounts directly pertaining to the Contract as required by applicable State and Federal Law up to a period of five (5) years from the date of the last payment made under the contract. Records shall be made available during normal business hours for this purpose.

If OGB deems it necessary to review claims processing and payment procedures, the Contractor must allow the OGB the right to hire an independent third party auditor and must provide information system access, space access, and access to all files, upon request of the OGB for the party selected to perform the indicated audit.

8.1 RECORD OWNERSHIP

All records, reports, documents, or other material related to this Contract, delivered or transmitted to the Contractor by the State and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of the OGB and may be referred to as “Records.”

Contractor agrees to retain all Records in accordance with all Louisiana and federal laws and regulations. Further, Contractor agrees to retain all Records in accordance with OGB’s official retention schedules (the “Schedules”), until such time as the Records are returned to OGB. In the event the applicable law and the Schedules contain different retention periods, the records shall be kept for the longer period. The records shall be in a format and media as required by law or as agreed upon by the parties in writing if allowed by law. The Schedules in place as of the effective date of this Contract are contained in RFP Attachment XII,

Record Retention Schedule, and may be amended from time to time as deemed necessary by the OGB. To further ensure compliance with the Schedules and Louisiana retention laws and rules, Contractor agrees to abide by the processes outlined in RFP Attachment XIII, Imaging System Survey Compliance. Contractor shall return the Records to the OGB, at Contractor's expense, upon request or within 60 days after the termination or expiration of this Contract, and shall retain no copies of the Records unless required by law.

8.2 CONTRACTOR'S COOPERATION

The Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to the state when requested. This applies even if this Contract is terminated and/or a lawsuit is filed. Specifically, the Contractor shall not limit or impede the State's right to audit, or withhold State owed documents.

9 CONTRACT MODIFICATION

No amendment or variation of the terms of this Contract shall be valid unless made in writing, signed by the parties and approved as required by law. No oral understanding or agreement not incorporated in the Contract is binding on any of the parties.

10 CONFIDENTIALITY OF DATA

All financial, statistical, personal, technical and other data and information relating to the OGB's operations which are made available or become available to the Contractor in order to carry out this Contract are designated confidential and shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the OGB. The Contractor shall not be required under the provisions of the paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Contractor's possession, is independently developed by the Contractor outside the scope of the Contract, or is rightfully obtained from third parties.

Under no circumstance shall the Contractor discuss and/or release information to the media concerning this project without prior express written approval of the Office of Group Benefits.

Contractor 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 (50) United States of America. As used in this paragraph, PHI refers to protected health information as defined by the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated by the U.S. Department of Health and Human Services, as amended from time to time.

11 SUBCONTRACTORS

The Contractor may enter into subcontracts with third parties for the performance of any part of the Contractor's duties and obligations, with the express written approval of the OGB. In no event shall the existence of a subcontract operate to release or reduce the liability of the Contractor to the OGB for any breach in the performance of the Contractor's duties. The Contractor will be the single point of contact for all subcontractor work. The Contractor shall require subcontractors who are performing any key internal control to undergo independent assurance project/program review.

12 COMPLIANCE WITH CIVIL RIGHTS LAWS

The Contractor agrees to abide by the requirements of the following as applicable: Title VI and Title 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 1975, and Contractor agrees to abide by the requirements of the Americans with Disabilities Act of 1990.

Contractor agrees not to discriminate in its employment practices, and will render services under this Contract without regard to race, color, religion, sex, national origin, veteran status, political affiliation, or disabilities. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this Contract.

13 INSURANCE

Insurance shall be placed with insurers with an A.M. Best's rating of no less than A-: VI.

This rating requirement shall be waived for Worker's Compensation coverage only.

Contractor's Insurance: The Contractor shall not commence work under this Contract until he has obtained all insurance required herein. Certificates of Insurance, fully executed by officers of the Insurance Company, shall be filed with the OGB for approval. If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval of the OGB before work is commenced. Said policies shall not hereafter be canceled, permitted to expire, or be reduced without thirty (30) days' notice in advance to the OGB and consented to by the OGB in writing.

Compensation Insurance: The Contractor shall maintain during the life of the Contract, Workers' Compensation Insurance for all of the Contractor's employees. In case any class of employees engaged in work under the Contract is not protected under the Workers' Compensation Statute, the Contractor shall provide for any such employees, and shall further provide or cause any and all subcontractors to provide Employer's Liability Insurance for the protection of such employees.

Commercial General Liability Insurance: The Contractor shall maintain during the life of the Contract such Commercial General Liability Insurance which shall protect it, and the OGB, its officers, trustees, employees, servants, and/or agents, from losses, claims, demands, liabilities, suits, actions, damages, costs, fines, penalties, judgments, forfeitures, assessments, expenses, obligations (including attorney's fees), and other liabilities relating to personal injury, violation of or failure to comply with any state or federal law, regulation, or other legal mandate, and damage to real or personal tangible property to the extent caused by Contractor, its agents, employees, partners or subcontractors, and which may arise from operations under the Contract, whether such operations be by the Contractor or by a subcontractor, or by anyone directly or indirectly employed by either of them, or in such manner as to impose liability on the OGB, its officers, trustees, employees, servants, and/or agents. Such insurance shall name the OGB, its officers, trustees, employees, servants, and/or agents as additional insureds. The amount of coverage shall be as follows: Commercial General Liability insurance with policy limits of not less than $1,000,000 per occurrence and

in the aggregate, and Umbrella Liability insurance with policy limits of not less than $5,000,000 per occurrence and in the aggregate. Further, Contractor shall maintain professional and cyber liability insurance with policy limits of not less than $1,000,000 per occurrence and a minimum aggregate of $2,000,000 for the purpose of providing coverage for claims arising out of the performance of its services under this Contract.

Owned, Non-Owned and Hired Motor Vehicles: The Contractor shall maintain during the life of the Contract, Automobile Liability Insurance in an amount not less than combined single limits of $1,000,000 per occurrence for bodily injury/property damage. Such insurance shall cover the use of any owned, non-owned, and hired motor vehicles engaged in operations within the terms of the Contract, unless such coverage is included in insurance elsewhere specified.

14 APPLICABLE LAW

This Contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana, including but not limited to La. R.S. 39:1551-1736; rules and regulations; executive orders; standard terms and conditions, special terms and conditions, and specifications listed in the RFP; and this Contract. After exhaustion of administrative remedies, venue of any action brought with regard to this Contract shall be in the Nineteenth Judicial District Court, Parish of East Baton Rouge, State of Louisiana.

15 CODE OF ETHICS

The Contractor acknowledges that Chapter 15 of Title 42 of the Louisiana Revised Statutes (R.S. 42:1101 *et. seq.*, Code of Governmental Ethics) applies to the contracting parties in the performance of services called for in this Contract. The Contractor agrees to immediately notify the OGB if potential violations of the Code of Governmental Ethics arise at any time during the term of this Contract.

16 SEVERABILITY

If any term or condition of this Contract or the application thereof is held invalid, such invalidity shall not affect other terms, conditions, or applications which can be given effect without the invalid term, condition, or application; to this end the terms and conditions of this Contract are declared severable.

17 INDEPENDENT ASSURANCES

The Contractor shall submit to, and cause its subcontractors to submit to, certain independent audits to ascertain that processes and controls related to the contracted service are operating properly if performing a key internal control. Independent assurances may be in the form of a Service Organization Control (SOC) 1, Type II and/or SOC 2, Type II report resulting from an independent annual SSAE 16 engagement of the operations. The SSAE 16 engagement will be performed annually by an audit firm that will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. The audit firm that will conduct the SSAE 16 engagement will submit a final report on controls placed in operation for the project and include a detailed description of the audit firm's tests of the operating effectiveness of controls. The Contractor shall supply the OGB with an exact copy

of the SOC report resulting from the SSAE 16 engagement within thirty (30) calendar days of completion.

As an alternative to a SSAE 16 engagement and resulting SOC I, Type II and/or SOC 2, Type II report, the Contractor may provide other assurances of financial and operational viability of the outsourced program including testing of the policies and procedures placed into operation, by submitting a quality control plan [such as third party Quality Assurance (QA), an Independent Verification and Validation (IV&V)]; or, any other financial and performance audits from outside companies.

The cost of such independent assurances will be borne by the Contractor. Such independent assurances shall be performed annually during the term of the Contract. Contractor may review any audit report before delivery to the OGB and include with the report a supplementary statement containing facts that Contractor considers pertinent to the audit or engagement. The Contractor shall implement recommendations as suggested by the program review, audit, and/or SSAE 16 engagement within three (3) months of report issuance and at no cost to the OGB.

18 NOTICE

Any notice required or permitted by this Contract, unless otherwise specifically provided for in this Contract, shall be in writing and shall be deemed given: (i) one (1) day following delivery to a nationally reputable overnight carrier or hand delivery to OGB; or, (ii) three (3) days after the date it is deposited in the United States Mail, postage pre-paid, registered or certified mail, and addressed as follows:

To (Contractor Name): Contact Name
Contact Address

To OGB: Ms. Susan T. West, CEO
Office of Group Benefits
Post Office Box 44036
Baton Rouge, LA 70804

or

Ms. Susan T. West, CEO
Office of Group Benefits
1201 N. 3rd Street, Suite G-159
Baton Rouge, LA 70802

At any time, either party may change its addressee and/or address for notification purposes by mailing a notice stating the change and setting forth the new address.

19 BUSINESS ASSOCIATE ADDENDUM

Notwithstanding any provision to the contrary, a Business Associate Addendum shall be executed between the parties to this Contract to protect the privacy and provide security of

Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and regulations promulgated thereunder, as amended from time to time.

20 COMMISSIONER'S STATEMENTS

Statements, acts and omissions made by or on behalf of the Commissioner of Administration regarding the RFP or RFP process, this Contract, any Contractor, and/or any subcontractor of the Contractor shall not be deemed a conflict of interest when the Commissioner is discharging her duties and responsibilities under law, including, but not limited to, the Commissioner of Administration's authority in procurement matters.

21 CONTRACTOR ELIGIBILITY

Contractor, and each tier of Subcontractors, shall certify that it is not on the List of Parties Excluded from Federal Procurement or Nonprocurement Programs promulgated in accordance with E.O.s 12549 and 12689, "Debarment and Suspension" as set forth in 24 CFR part 24. Contractor has a continuing obligation to disclose any suspensions or debarment by any government entity, including but not limited to General Services Administration (GSA). Failure to disclose may constitute grounds for suspension and/or termination of the Contract and debarment from future Contracts.

22 CLAIMS LIABILITY AND REIMBURSEMENT

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

23 EMPLOYER GROUP WAIVER PLAN CONTRACT CLAUSES

a. If OGB subsidizes all or part of a Plan Participant's premium, then OGB agrees that:

(1) OGB will only subsidize different amounts for different classes of Plan Participants if such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly).

(2) The premium for each individual within a given Plan Participant class will not vary.

(3) The Part D premium charged to a Plan Participant will not be greater than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any).

b. If a low income premium subsidy is allocated to a Plan Participant, then OGB and Contractor agree:

(1) If the low income premium subsidy amount is less than the portion of the Part D premium paid by the Part D Plan Participant, Contractor will use its best efforts to advise the Plan Participant of the consequences of enrolling in the OGB's plan compared to enrolling in another plan where the monthly premium is equal to or below the low income premium subsidy amount.

(2) That the low income premium subsidy will be used to reduce the Plan Participant's premium by offsetting the amount of the low income premium subsidy from the Plan Participant's monthly premium. Contractor agrees to administer any low income premium subsidy offsets that may be owed to Plan Participants. OGB agrees to provide Contractor with any information that Contractor may need to process low income premium subsidy offsets for Plan Participants.

(3) To allocate low income premium subsidies within 45 days of receiving such payments from CMS.

c. In the event OGB determines that a Plan Participant is no longer eligible for the Plan, or if the Contract is terminated, Contractor agrees to the following:

(1) Contractor will provide a Plan Participant with at least 21 days of advance notice prior to the effective date of the disenrollment or the termination of the Contract. The notice shall contain information on the following:

(i) Other plan options offered by OGB for the Plan Participant and how to request enrollment,

(ii) Options on how to select individual plans from Contractor or a different organization,

(iii) That failure to make a new election will result in a disenrollment action, which will result in the Plan Participant being automatically enrolled in Original Medicare without drug coverage, and that the Plan Participant may be subject to a late enrollment penalty.

24 ENTIRE AGREEMENT

This Contract, together with the RFP and addenda issued thereto by the OGB, the proposal submitted by the Contractor in response to the OGB's RFP, and any exhibits incorporated herein by reference, shall constitute the entire agreement ("Entire Agreement") between the parties with respect to the subject matter.

25 ORDER OF PRECEDENCE

In the event of any inconsistent or incompatible provisions, this signed Contract (excluding the RFP and the Contractor's proposal) shall take precedence, followed by the provisions of the RFP, and then by the terms of the Contractor's proposal.

(signature page follows)

THUS DONE AND SIGNED on the date(s) noted below:

STATE OF LOUISIANA, **DIVISION OF ADMINISTRATION** **OFFICE OF GROUP BENEFITS**	**CONTRACTOR**
BY:_____	**BY:**_____
NAME: Susan T. West	**NAME:**_____
TITLE: Chief Executive Officer	**TITLE:**_____
DATE:_____	**DATE:**_____

ATTACHMENT X: PROTECTED HEALTH INFORMATION ADDENDUM

State of Louisiana, Division of Administration

Office of Group Benefits

HIPAA Business Associate Addendum

THIS HIPAA BUSINESS ASSOCIATE ADDENDUM (the "Addendum") is entered into effective the _____ day of _____, 20_____ (the "Effective Date"), by and between _____, ("Business Associate") and the State of Louisiana, Division of Administration, Office of Group Benefits, on behalf of itself and its affiliates, if any (individually and collectively, the "Covered Entity") and adds to the Agreement dated _____, 20___, entered into between Covered Entity and Business Associate (the "Agreement").

WHEREAS, pursuant to the Agreement, Business Associate performs functions or activities on behalf of Covered Entity involving the use and/or disclosure of protected health information that Business Associate accesses, creates, receives, maintains or transmits on behalf of Covered Entity ("PHI"); and

WHEREAS, Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI in compliance with the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("HHS"), as amended from time to time including by the Health Information Technology for Economic and Clinical Health Act ("HITECH") (collectively "HIPAA").

Business Associate, therefore, agrees to the following terms and conditions set forth in this Addendum.

1. *Definitions*. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms are defined under HIPAA.

2. *Compliance with Applicable Law*. The parties acknowledge and agree that, beginning with the Effective Date, Business Associate shall comply with its obligations under this Addendum and with all obligations of a business associate under HIPAA and other applicable laws, regulations, and record retention policies, as they exist at the time this Addendum is executed and as they are amended, for so long as this Addendum is effective.

3. *Uses and Disclosures of PHI*. Except as otherwise limited in the Agreement or this Addendum, Business Associate shall not, and shall ensure that its directors, officers, employees, contractors, and agents do not, use or disclose PHI other than as follows:

(a) Business Associate may use Covered Entity's PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

(b) Business Associate may disclose Covered Entity's PHI for the proper management and administration, or to carry out the legal responsibilities, of the Business Associate, provided that disclosures are required by HIPAA, or Business Associate obtains reasonable written assurances from the person or entity 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 or entity, and the person or entity notifies the Business Associate of any instances of which it is aware or suspects in which the confidentiality of the PHI has been breached. In such case, Business Associate shall report such known or suspected breaches to Covered Entity as soon as possible and in accordance with timeframes set forth in this Addendum.

(c) Business Associate, upon written request by Covered Entity, may use Covered Entity's PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B). For purposes of this Section, Data Aggregation means, with respect to Covered Entity's PHI, the combining of such PHI by Business Associate with the PHI received by Business Associate in its capacity as a Business Associate of another Covered Entity to permit data analyses that relate to the health care operations of the respective Covered Entities.

(d) Business Associate may de-identify any and all PHI created or received by Business Associate under this Agreement; provided, however, that the de-identification conforms to the requirements of HIPAA and in accordance with any guidance issued by the Secretary. Such resulting de-identified information would not be subject to the terms of this Addendum.

(e) Business Associate may create a Limited Data Set, as defined in HIPAA, and use such Limited Data Set pursuant to a Data Use Agreement that meets the requirements of HIPAA.

4. *Required Safeguards To Protect PHI*. Business Associate shall implement appropriate safeguards in accordance with HIPAA to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of the Agreement. To the extent that Business Associate creates, receives, maintains, or transmits electronic PHI ("ePHI") on behalf of Covered Entity, Business Associate shall comply with the HIPAA Security Rule as of the relevant effective date and further, shall implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI.

5. *Reporting to Covered Entity*. Business Associate shall immediately report to Covered Entity any use or disclosure of PHI not provided for by this Addendum, including breaches of unsecured PHI in accordance with the Breach Notification Rule (45 CFR Subpart D), and any security incident of which it becomes aware. Business Associate shall cooperate with Covered Entity's investigation, analysis, notification and mitigation activities, and shall be responsible for all costs incurred by Covered Entity for those activities.

6. *Mitigation of Harmful Effects*. Business Associate agrees to mitigate, to the extent practicable, any harmful effect of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum, including, but not limited to, compliance with any state law or contractual data breach requirements.

7. *Agreements by Third Parties*. Business Associate shall enter into an agreement with any agent or subcontractor of Business Associate that will create, receive, maintain, or transmit PHI on behalf of Business Associate. Pursuant to such agreement, the agent or subcontractor shall agree to be bound by the same restrictions, terms, and conditions that apply to Business Associate under this Addendum with respect to such PHI.

8. *Access to Information*. Within ten (10) days of a request by Covered Entity for access to PHI about an individual contained in a Designated Record Set, Business Associate shall make available to Covered Entity such PHI for so long as such information is maintained by Business Associate in the Designated Record Set, as required by 45 C.F.R. § 164.524. In the event any individual delivers directly to Business Associate a request for access to PHI, Business Associate shall within five (5) days forward such request to Covered Entity.

9. *Availability of PHI for Amendment*. Within ten (10) days of receipt of a request from Covered Entity for the amendment of an individual's PHI or a record regarding an individual contained in a Designated Record Set (for so long as the PHI is maintained in the Designated Record Set), Business Associate shall provide such information to Covered Entity for amendment and incorporate any such amendments in the PHI as required by 45 C.F.R. § 164.526.

10. *Documentation of Disclosures*. Business Associate agrees to document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. At a minimum, Business Associate shall provide Covered Entity with the following information: (i) the date of the disclosure; (ii) the name of the entity or person who received the PHI, and if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

11. *Accounting of Disclosures*. Within ten (10) days of notice by Covered Entity to Business Associate that it has received a request for an accounting of disclosures of PHI regarding an individual, Business Associate shall make available to Covered Entity information collected in accordance with Section 10 of this Addendum, to permit Covered Entity to respond to the request for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. In the event the request for an accounting is delivered directly to Business Associate, Business Associate shall within five (5) days forward such request to Covered Entity. Business Associate hereby agrees to implement an appropriate record keeping process to enable it to comply with the requirements of this Section.

12. *Other Obligations*. To the extent that Business Associate is to carry out Covered Entity's obligation under HIPAA, Business Associate shall comply with the requirements of HIPAA that apply to the Covered Entity in the performance of such obligation.

13. *Availability of Books and Records*. Business Associate hereby 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, Covered Entity available to the Secretary for purposes of determining Covered Entity's compliance with HIPAA.

14. *Effect of Termination of Agreement*. Upon the termination of the Agreement or this Addendum for any reason, Business Associate shall return to Covered Entity, at its expense and

within sixty (60) days of the termination, all PHI owned by or belonging to Covered Entity as provided in the Agreement, and shall retain no copies of the PHI unless required by law. In the event that the law requires Business Associate to retain copies of PHI, Business Associate shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes required by law, for so long as Business Associate maintains such PHI. This provision includes, but is not limited to, PHI: (a) received from Covered Entity; (b) created or received by Business Associate on behalf of Covered Entity; and, (c) in the possession of subcontractors or agents of Business Associate. This provision includes PHI in any form, recorded on any medium, or stored in any storage system. In addition, the Business Associate shall return any books, records, or other documents required by the Agreement.

15. *Breach of Contract by Business Associate*. In addition to any other rights Covered Entity may have in the Agreement, this Addendum or by operation of law or in equity, Covered Entity may (i) immediately terminate the Agreement if Covered Entity determines that Business Associate has violated a material term of this Addendum, or (ii) at Covered Entity's option, permit Business Associate to cure or end any such violation within the time specified by Covered Entity. Covered Entity's exercise of its option to permit Business Associate to cure a breach of this Addendum shall not be construed as a waiver of any other rights Covered Entity has in the Agreement, this Addendum or by operation of law or in equity.

16. *Indemnification*. Business Associate shall defend, indemnify and hold harmless Covered Entity and its officers, trustees, employees, subcontractors and agents from and against any and all claims, penalties, fines, costs, liabilities or damages, including but not limited to reasonable attorney fees, incurred by Covered Entity arising from a violation by Business Associate or its subcontractors of Business Associate's obligations under this Addendum or HIPAA. This Section 16 of the Addendum shall survive the termination of the Agreement or this Addendum.

17. *Exclusion from Limitation of Liability*. To the extent that Business Associate has limited its liability under the terms of the Agreement, whether with a maximum recovery for direct damages or a disclaimer against any consequential, indirect or punitive damages, or other such limitations, all limitations shall exclude any damages to Covered Entity arising from Business Associate's breach of its obligations relating to the use and disclosure of PHI. This Section 17 of the Addendum shall survive the termination of the Agreement and this Addendum.

18. *Injunctive Relief*. Business Associate acknowledges and stipulates that the unauthorized use or disclosure of PHI by Business Associate or its subcontractors while performing services pursuant to the Agreement or this Addendum would cause irreparable harm to Covered Entity, and in such event, Covered Entity shall be entitled, if it so elects, to institute and prosecute proceedings in any court of competent jurisdiction, either in law or in equity, to obtain damages and injunctive relief, together with the right to recover from Business Associate costs, including reasonable attorneys' fees, for any such breach of the terms and conditions of the Agreement or this Addendum.

19. *Third Party Rights*. The terms of this Addendum are not intended, nor should they be construed, to grant any rights to any parties other than Business Associate and Covered Entity.

20. *Owner of PHI*. Under no circumstances shall Business Associate be deemed in any respect to be the owner of any PHI used or disclosed by or to Business Associate pursuant to the terms of the Agreement.

21. *Changes in the Law*. Covered Entity may amend either the Agreement or this Addendum, as appropriate, to conform to any new or revised federal or state legislation, rules, regulations, and records retention policies to which Covered Entity is subject now or in the future including, without limitation, HIPAA.

22. *Judicial and Administrative Proceedings*. In the event Business Associate receives a subpoena, court, or administrative order or other discovery request or mandate for release of PHI, Covered Entity shall have the right to control Business Associate's response to such request. Business Associate shall notify Covered Entity of the request as soon as reasonably practicable, but in any event within five (5) business days of receipt of such request.

23. *Conflicts*. If there is any direct conflict between the Agreement and this Addendum, the terms and conditions of this Addendum shall control.

IN WITNESS WHEREOF, the parties have executed this Addendum effective the day and year first above written.

BUSINESS ASSOCIATE:	COVERED ENTITY:
By: _____	By: _____
Signature	*Signature*
_____	_____
Printed Name	*Printed Name*
Title: _____	Title: _____
Date: _____	Date: _____

ATTACHMENT XI: FILE LAYOUT AND SPECIFICATIONS

Files to be received by the Contractor from OGB:

The Contractor shall receive the following two files from OGB. Files shall be constructed using the layout as described in Appendix A-5 through A-6. All files from OGB shall be sent electronically using FTP (File Transfer Protocol) and WILL be encrypted using PGP (Pretty Good Privacy).

1. **Eligibility File (Appendix A-5)**
   This file shall be received the evening of every work day by the Contractor and posted to the Contractor's system before the next day. It will contain the Contractor's entire membership plus any terminations inputted in the last two months.

2. **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 Contractor will pay for the OGB administrative fee. Contractor will pay OGB based on this file. The file will contain adjustments to prior month's billing resulting from retroactive terminations and enrollment.

Files to be sent by the Contractor to OGB:

Prior to any transmission of claims data from the Contractor to OGB, OGB must have an understanding of the Contractor's procedures for processing, paying and adjusting claims so that the financial and clinical care of OGB's plan participants can be accurately reflected in the OGB data warehouse. Information provided to OGB is also transmitted to the OGB Living Well Louisiana health management program for management of ongoing health conditions, including diabetes, coronary artery disease, chronic 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 OGB members. Claim transmissions will include detail for each charge or service line on the patient's bill. All coding in each line will adhere to standard medical coding procedures.

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

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

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

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

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

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

2. **Provider File (Appendix A-2) -** This is a file of medical service providers for which checks and EOBs were issued in (1) above. This will include, for example, physicians, hospitals, urgent care facilities, and physician groups. The file will contain separate records relevant to the entity paid.

3. **Code Files (Appendix A-3)** – These files will contain codes used in claim processing that are not standard, universally accepted values. Codes that fall into this category include but are not limited to provider specialty codes, denial reason codes, types of service codes and override codes. Codes are subject to change over the life of this contract, and if a code changes, dates associated with the code are required for its meaning before and after the change. If the Contractor 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.

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

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 OGB is 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/ELECTRO INPUT
7	*	SYSTEM ENTRY DATE	D	8	106-113	THE DATE THE CONTRACTOR FIRST ENTERED THE CLAIM INTO THE CLAIM PAYMENT SYSTEM **FORMAT- CCYYMMDD**
Field 8: For each action affecting the payment status or clinical information on a claim, the date that action was taken.						
8	*	ADJUDICATION DATE	D	8	114-121	THE DATE THE CONTRACTOR PROCESSED AN ORIGINAL CLAIM. FOR ADJUSTMENTS, THE DATE REPROCESSED **FORMAT- CCYYMMDD**
9	*	PAID DATE	D	8	122-129	THE DATE THE PROCESSED CLAIM WAS PAID OR ADJUSTED. FOR DENIED CLAIMS, THE DATE DENIED. **FORMAT- CCYYMMDD**
10	*	MEDICAL CLAIM DOC TYPE	A/N	10	130-139	THE TYPE OF DOCUMENT SUBMITTED, EITHER THE HCFA OR UB DESIGNATION.
11		SUBMITTED DRG	A/N	20	140-159	FOR INPATIENT CLAIMS, THE V25 DRG CODE THAT WAS SUBMITTED ON THE CLAIM

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

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

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.						
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.						

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
46	*	PRIMARY DIAGNOSIS CODE	A/N	10	678-687	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE PRIMARY DIAGNOSIS FOR THE SERVICE PROVIDED
47		DIAGNOSIS CODE 2	A/N	10	688-697	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SECOND DIAGNOSIS FOR THE SERVICE
48		DIAGNOSIS CODE 3	A/N	10	698-707	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE THIRD DIAGNOSIS FOR THE SERVICE
49		DIAGNOSIS CODE 4	A/N	10	708-717	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE FOURTH DIAGNOSIS FOR THE SERVICE
50		DIAGNOSIS CODE 5	A/N	10	718-727	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE FIFTH DIAGNOSIS FOR THE SERVICE
51		DIAGNOSIS CODE 6	A/N	10	728-737	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SIXTH DIAGNOSIS FOR THE SERVICE
52		DIAGNOSIS CODE 7	A/N	10	738-747	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SEVENTH DIAGNOSIS FOR THE SERVICE
53		DIAGNOSIS CODE 8	A/N	10	748-757	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE EIGHTH DIAGNOSIS FOR THE SERVICE
54		DIAGNOSIS CODE 9	A/N	10	758-767	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE NINTH DIAGNOSIS FOR THE SERVICE
55		ADMIT DIAGNOSIS CODE	A/N	10	768-777	FOR INPATIENT CLAIMS, THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE ADMIT DIAGNOSIS FOR THIS CLAIM
56	*	PROCEDURE CODE	A/N	10	778-787	THE ACTUAL PROCEDURE PERFORMED: - THE CPT PROCEDURE CODE ON HCFA FORMS - THE HCPCS PROCEDURE CODE ON UB92 FORMS - THE ADA PROCEDURE CODE ON DENTAL FORMS.
57		MODIFIER CODE 1	A/N	5	788-792	THE FIRST MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
58		MODIFIER CODE 2	A/N	5	793-797	THE SECOND MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
59		MODIFIER CODE 3	A/N	5	798-802	THE THIRD MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
60		ICD9 PROCEDURE CODE 1	A/N	10	803-812	THE PRIMARY ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
61		ICD9 PROCEDURE CODE 2	A/N	10	813-822	THE SECOND ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
62		ICD9 PROCEDURE CODE 3	A/N	10	823-832	THE THIRD ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)

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

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

Appendix A-2 Provider File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: To simplify references, a provider may have more than one entry in the provider file. Specifically, a provider must be identified by services performed but may be paid as a separate entity from its identity as a service provider. Multiple entries may be caused by different addresses, tax requirements, and/or contractual responsibility to a group. Service providers are referenced in Fields 67 and 68 of Appendix A-1, Medical Claims File. Pay-to providers are referenced in Fields 69 through 73 of Appendix A-1.						
1	*	PROVIDER INTERNAL ID	A/N	20	1-20	THE UNIQUE ID FOR SERVICE OR PAY-TO PROVIDER ASSIGNED BY CONTRACTOR IN CLAIMS PROCESSING
2	*	PROVIDER TAX ID	A/N	10	21-30	TAX ID OF THIS PROVIDER
3	*	NPI	A/N	10	31-40	THIS PROVIDER'S NATIONAL PROVIDER IDENTIFIER
4		PROVIDER DEA ID	A/N	10	41-50	THE FEDERAL DEA NUMBER OF THIS PROVIDER IF PROVIDER PRESCRIBES DRUGS.
Fields 5-8: A provider may refer to a physician, a facility, or another care provider. Either an office (Field 8) or a person (Fields 5-7) or both must be named in the following 4 fields.						
5		PROVIDER LAST NAME	A/N	40	51-90	THE LAST NAME FOR THIS PROVIDER
6		PROVIDER FIRST NAME	A/N	40	91-130	THE FIRST NAME FOR THIS PROVIDER
7		PROVIDER MIDDLE INITIAL	A/N	1	131	THE MIDDLE INITIAL FOR THIS PROVIDER
8		PROVIDER OFFICE NAME	A/N	40	132-171	THE OFFICE NAME, CORPORATION NAME, OR LOCATION NAME OF THE OFFICE THIS PROVIDER OFFERS SERVICES.
9	*	PROVIDER ADDRESS LINE1	A/N	40	172-211	LINE 1 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
10		PROVIDER ADDRESS LINE2	A/N	40	212-251	LINE 2 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
11	*	PROVIDER CITY	A/N	40	252-291	THE CITY PORTION OF THIS PROVIDER'S ADDRESS
12	*	PROVIDER STATE	A/N	2	292-293	THE STATE PORTION OF THIS PROVIDER'S ADDRESS
13	*	PROVIDER ZIP	A/N	9	294-302	THE ZIP-CODE OF THIS PROVIDER'S ADDRESS, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
14		PROVIDER UPIN	A/N	20	303-322	THE UNIVERSAL PROVIDER IDENTIFICATION NUMBER FOR THIS PROVIDER
15		PROVIDER MEDICARE ID	A/N	20	323-342	THE MEDICARE IDENTIFIER FOR THIS PROVIDER
Fields 16-19: The Contractor will send initially and keep current a file of specialty codes and descriptions used in their claims processing to OGB						
16	*	PROVIDER SPECIALTY	A/N	10	343-352	THE CODE FOR THE PROVIDER'S PRIMARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
17		PROVIDER SPECIALTY 2	A/N	10	353-362	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
18		PROVIDER SPECIALTY 3	A/N	10	363-372	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
19		PROVIDER SPECIALTY 4	A/N	10	373-382	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
20	*	PROVIDER TYPE	A/N	1	383	**"F" – FACILITY, "P" – PHYSICIAN, "O" – OTHER, "Y" – PAY-TO, "G" - GROUP**

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

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

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

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD IDENTIFIER	N	1	1-1	4=CLAIM RECORD
2	PROCESSOR NUMBER	N	10	2-11	THIS NUMBER IS ASSIGNED BY NCPDP TO IDENTIFY THE SOURCE OF THE TAPE, I.E. PHARMACY, WHOLESALER, HOSPITAL, SERVICE BUREAU, ETC.
3	BATCH NUMBER	N	5	12-16	THIS NUMBER IS ASSIGNED BY THE PROCESSOR. FORMAT=YYDDD YY=YEAR DDD=JULIAN DATE I.E. 92252=SEPT. 8, 1992
4	PHARMACY NUMBER	A/N	12	17-28	ID ASSIGNED TO A PHARMACY
5	PRESCRIPTION NUMBER	A/N	7	29-35	
6	DATE FILLED	A/N	8	36-43	DISPENSING DATE OF RX **7.5.1.1.1.1.0.1.1 FORMAT=CCYYMMDD**
7	NDC NUMBER	N	11	44-54	FOR LEGEND COMPOUNDS USE: 99999999999 SCHEDULE II: 99999999992 SCHEDULE III: 99999999993 SCHEDULE IV: 99999999994 SCHEDULE V: 99999999995 COMPOUNDS: 99999999996
8	DRUG DESCRIPTION	A/N	30	55-84	LABELNAME
9	NEW/REFILL CODE	N	2	85-86	00=NEW PRESCRIPTION 01-99=NUMBER OF REFILLS
10	METRIC QUANTITY	N	6	87-92	NUMBER OF METRIC UNITS OF MEDICATION DISPENSED (LEADING SIGN IF NEGATIVE)
11	DAYS SUPPLY	N	4	93-96	ESTIMATED NUMBER OF DAYS THE PRESCRIPTION WILL LAST
12	BASIS OF COST	A/N	2	97-98	00=NOT SPECIFIED

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
	DETERMINATION				01=AWP 02=LOCAL WHOLESALER 03=DIRECT 04=EAC 05=ACQUISITION 06=MAC 6X=BRAND MEDICALLY NECESSARY 07=USUAL AND CUSTOMARY 08=UNIT DOSE 09=OTHER USED ON TAPE AND DISKETTE ONLY
13	INGREDIENT COST	N	10	99-108	COST OF THE DRUG DISPENSED. FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
14	DISPENSING FEE SUBMITTED	N	10	109-118	FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
15	CO-PAY AMOUNT	N	10	119-128	CORRECT CO-PAY FOR PLAN BILLED FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example:

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
16	SALES TAX	N	10	129-138	SALES TAX FOR THE PRESCRIPTION DISPENSED FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
17	AMOUNT BILLED	N	10	139-148	FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
18	PATIENT FIRST NAME	A/N	12	149-160	FIRST NAME OF PATIENT
19	PATIENT LAST NAME	A/N	15	161-175	LAST NAME OF PATIENT
20	DATE OF BIRTH	A/N	8	176-183	DATE OF BIRTH OF PATIENT **FORMAT=CCYYMMDD**
21	SEX CODE	A/N	1	184-184	0=NOT SPECIFIED 1=MALE 2=FEMALE
23	EMPLOYEE SSN	A/N	9	185-193	
24	OGB Internal Id-	A/N	8	194-201	See Appendix E (Eligibility File) Field number-33
25	FILLER	A/N	1	202-202	
26	RELATIONSHIP CODE	A/N	1	203-203	1=CARDHOLDER 2=SPOUSE 3=CHILD 4=OTHER
27	GROUP NUMBER	A/N	15	204-218	ID ASSIGNED TO CARDHOLDER GROUP

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					OR EMPLOYER GROUP
28	PRESCRIBER ID	A/N	10	219-228	IDENTIFICATION ASSIGNED TO THE PRESCRIBER
29	DIAGNOSIS CODE	A/N	6	229-234	ICD-9 STANDARD DIAGNOSIS CODES
30	Document number	A/N	15	235-249	Document Number becomes relevant if the pharmacy made a mistake on the original script and instead of the original claim getting corrected, a new one was submitted
31	FILLER	A/N	12	250-261	
32	RESUBMISSION CYCLE COUNT	A/N	2	262-263	0 = ORIGINAL SUBMISSION 1 = FIRST RE-SUBMISSION 2 = SECOND RE-SUBMISSION
33	DATE PRESCRIPTION WRITTEN	A/N	8	264-271	DATE PRESCRIPTION WAS WRITTEN
34	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	A/N	1	272-272	0 = NO PRODUCT SELECTION INDICATED 1 = SUBSTITUTION NOT ALLOWED BY PRESCRIBER 2 = SUBSTITUTION ALLOWED - PATIENT REQUESTED PRODUCT DISPENSED 3 = SUBSTITUTION ALLOWED PHARMACIST SELECTED PRODUCT DISPENSED 4 = SUBSTITUTION ALLOWED - GENERIC DRUG NOT IN STOCK 5 = SUBSTITUTION ALLOWED - BRAND DRUG DISPENSED AS A GENERIC 6 = OVERRIDE 7 = SUBSTITUTION NOT ALLOWED - BRAND DRUG MANDATED BY LAW 8 = SUBSTITUTION ALLOWED - GENERIC DRUG NOT AVAILABLE IN MARKETPLACE 9 = OTHER

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
35	ELIGIBILITY CLARIFICATION CODE	A/N	1	273-273	CODE INDICATING THAT THE PHARMACY IS CLARIFYING ELIGIBILITY BASED ON DENIAL 0 = NOT SPECIFIED 1 = NOT OVERRIDE 2 = OVERRIDE 3 = FULL TIME STUDENT 4 = DISABLED DEPENDENT 5 = DEPENDENT PARENT
36	COMPOUND CODE	A/N	1	274-274	CODE INDICATING WHETHER OR NOT THE PRESCRIPTION IS A COMPOUND 0=NOT SPECIFIED 1=NOT A COMPOUND 2=COMPOUND
37	NUMBER OF REFILLS AUTHORIZED	N	2	275-276	NUMBER OF REFILLS AUTHORIZED BY PRESCRIBER
38	DRUG TYPE	A/N	1	277-277	CODE TO INDICATE THE TYPE OF DRUG DISPENSED 0=NOT SPECIFIED 1=SINGLE SOURCE BRAND 2=BRANDED GENERIC 3=GENERIC 4=O.T.C. (OVER THE COUNTER)
39	PRESCRIBER LAST NAME	A/N	15	278-292	PRESCRIBER LAST NAME
40	POSTAGE AMOUNT CLAIMED	N	4	293-296	DOLLAR AMOUNT OF POSTAGE CLAIMED FORMAT- Field should be 4 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 1.23 would be expressed as “01.23” -1.23 would be expressed as “-1.23”

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
41	UNIT DOSE INDICATOR	A/N	1	297-297	CODE INDICATING THE TYPE OF UNIT DOSE DISPENSING DONE 0=NOT SPECIFIED 1=NOT UNIT DOSE 2=MANUFACTURER UNIT DOSE 3=PHARMACY UNIT DOSE
42	OTHER PAYOR AMOUNT	N	6	298-303	DOLLAR AMOUNT OF PAYMENT KNOWN BY THE PHARMACY FROM OTHER SOURCES FORMAT=positive 123.56 negative -12.45
43	FILLER	A/N	35	304-338	RESERVED FOR FUTURE NCPDP CONTINGENCIES
44	CONTRACT SSN	A/N	9	339-347	(Contract Holder's SSN)- RxClaim map from 1st nine digits of member ID number
45	COVERED AMOUNT	N	10	348-357	FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "0000123.45" -123.45 would be expressed as "-000123.45"
46	PAID AMOUNT	N	10	358-367	FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "0000123.45" -123.45 would be expressed as "-000123.45"
47	PAID DATE	A/N	8	368-375	Date of payment FORMAT = CCYYMMDD
48	FILLER	A/N	2	376-377	Spaces
49	Prescribe First Name	A/N	15	378-392	
50	Prescribe Last Name	A/N	25	393-417	
51	Prescribe MI	A/N	1	418-418	
52	Prescribe Address-1	A/N	55	419-473	
53	Prescribe Address-2	A/N	55	474-528	
54	Prescribe City	A/N	20	529-548	

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
55	Prescribe State	A/N	2	549-550	
56	Prescribe Zip Code	A/N	10	551-560	
57	Medicare D Eligible Indicator	A/N	1	561-561	Y = Medicare D eligible N = NOT Medicare D eligible
58	Filler	A/N	147	562-708	Spaces

Appendix A-5 Eligibility File					
FIELD	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	CONTRACT HOLDER'S SSN	A/N	9	001-009	CONTRACT HOLDER'S SSN
2	MEMBER LAST NAME	A/N	20	010-029	MEMBER LAST NAME
3	MEMBER FIRST NAME	A/N	15	030-044	MEMBER FIRST NAME
4	MEMBER MIDDLE INITIAL	A/N	1	045-045	MEMBER MIDDLE INITIAL
5	ADDRESS 1	A/N	35	046-080	ADDRESS LINE 1
6	ADDRESS 2	A/N	35	081-115	ADDRESS LINE 2
7	CITY	A/N	30	116-145	CITY
8	STATE	A/N	2	146-147	STATE
9	ZIP CODE	A/N	13	148-160	ZIP CODE
10	BIRTH DATE	A/N	8	161-168	CCYYMMDD
11	PLAN EFFECTIVE DATE	A/N	8	169-176	CCYYMMDD- EARLIEST EFFECTIVE DATE OF UNINTERRUPTED COVERAGE WITHIN THE HEALTH PLAN/RATE TABLE/COVERAGE LEVEL COMBINATION.
12	TERMINATION DATE	A/N	8	177-184	CCYYMMDD- BLANK IF ACTIVE
13	CLIENT / AGENCY CODE	A/N	8	185-192	CODE CLIENT /AGENT
14	SUB CLIENT / SECTION OF AGENCY	A/N	4	193-196	SUB CLIENT OR SECTION AGENCY
15	TYPE OF COVERAGE	A/N	1	197-197	"E" – MEMBER ONLY "C" – MEMBER AND CHILD(REN) "S" – MEMBER AND SPOUSE "F" – FAMILY
16	MEDICARE A PRIMARY EFFECTIVE DATE	A/N	8	198-205	CCYYMMDD(CAN BE BLANK)
17	MEDICARE B PRIMARY EFFECTIVE DATE	A/N	8	206-213	CCYYMMDD(CAN BE BLANK)
18	SEX CODE	A/N	1	214-214	MALE OR FEMALE(M/F)
19	STUDENT DATE	A/N	8	215-222	CCYYMMDD(CAN BE BLANK)
20	RELATION CODE	A/N	2	223-224	01 – ENROLLEE 02 – SPOUSE 03 – CHILDREN OR OTHER DEPENDENTS
21	TRANSACTION DATE	A/N	8	225-232	CCYYMMDD
22	AGENCY EMPLOYMENT DATE	A/N	8	233-240	CCYYMMDD

23	PREEXISTING TERMINATION DATE	A/N	8	241-248	CCYYMMDD- PREEXISTING TERMINATION DATE(CAN BE BLANK)
24	CONTRACT HOLDER PHONE	A/N	12	249-260	
25	ENROLLEE STATUS FIELD	A/N	1	261-261	C - FOR THE WHOLE FAMILY IF THE SUBSCRIBER IS ON COBRA R- FOR THE SUBSCRIBER AND SPOUSE IF THE SUBSCRIBER IS RETIRE AND ACTIVE FOR THE CHILDREN A-FOR THE WHOLE FAMILY IF THE SUBSCRIBER IS ACTIVE
26	HANDICAPPED INDICATOR	A/N	1	262-262	"Y" = YES "N" = NO
27	MARRIAGE DATE	A/N	8	263-270	CCYYMMDD(CAN BE BLANK)
28	HIC NUMBER	A/N	12	271-282	MEDICARE CARD NUMBER.
29	COB DATE	A/N	8	283-290	CCYYMMDD- BEGINNING COVERAGE BY OTHER CARRIER NOT INCLUDING MEDICARE.
30	MEDICARE PRIMARY	A/N	1	291-291	"Y" = YES "N" = NO
31	MEMBER SSN	A/N	9	292-300	MEMBER SSN
32	RETIREE 100	A/N	1	301-301	SWITCH IS ALWAYS BLANK FOR DEPENDENTS Y/N
32	LAST CHANGE DATE	A/N	8	302-309	CCYYMMDD- DATE THE ENROLLMENT RECORD WAS LAST CHANGED
33	MEMBER RECORD ID	A/N	8	310-317	OGB INTERNAL ID
34	CLAIM PAYMENT STOP DATE	A/N	8	318-325	CCYYMMDD- DATE BEYOND WHICH CLAIMS SHOULD NOT BE PAID BECAUSE OF NON-PAYMENT OF PREMIUMS

35	RATE TABLE	A/N	2	326-327	AC – ACTIVE CB - COBRA CD - COBRA DISABILITY CP - COBRA PART-TIME CS – COBRA STATE SUBSIDIZED R1 - RETIRED MEDICARE 1 R2 - RETIRED MEDICARE 2 RN - RETIRED NO MEDICARE THIS FIELD IS ALWAYS BLANK FOR DEPENDENTS
36	PLAN	A/N	4	328-331	
37	DRUG ACCUM	N	10	342-351	9999999.99 LEADING SPACES: SUM OF DRUG CLAIMS PAID. INCLUDED IN LIFETIME ACCUM.

Appendix A-6 Administrative Fee Billing					
FIELD	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	*INVOICE DATE*	A/N	8	001-008	CCYYMMDD
2	ENROLLEE SSN	A/N	9	009-017	SOCIAL SECURITY NUMBER
3	ENROLLEE LAST NAME	A/N	20	018-037	LAST NAME
4	ENROLLEE FIRST NAME	A/N	20	038-057	FIRST NAME
5	ENROLLEE MIDDLE INITIAL	A/N	1	058-058	INITIAL
6	ENROLLEE COVERAGE TYPE	A/N	2	059-060	"EE" -EMPLOYEE ONLY "ES"-EMPLOYEE AND SPOUSE "EC"-EMPLOYEE AND CHILD(REN) "FM"-FAMILY
7	RATE TABLE CODE	A/N	2	061-062	"AC"- ACTIVE "CB"- COBRA "CD"- COBRA DISABILITY "CP"- COBRA PART-TIME "R1" - RETIRED MEDICARE 1 "R2"- RETIRED MEDICARE 2 "RN"- RETIRED NO MEDICARE
8	BILLING OR COVERAGE	A/N	8	063-070	CCYYMMDD
9	PREMIUM AMOUNT	N	7	071-80	FORMAT-SHOULD BE 7 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE EXAMPLE: 123.45 WOULD BE EXPRESSED AS "0000123.45" -123.45 WOULD BE EXPRESSED AS "-000123.45"

ATTACHMENT XII: RECORDS RETENTION SCHEDULE

SS ARC 932 (01/12) R2014-620

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Records Retention Schedule

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Agency No: 03-005
Agency / Division / Section: Division of Administration / Office of Group Benefits – Administration- HIPAA

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Unit Audit Reports (Information Accuracy Checks)	ACT + 1 CY		ACT + 1 CY	M	S	N	I	ACT = until end of CY in which administrative need ends
2	Health Insurance Portability and Accountability Act Privacy and Security Policies and Procedures	ACT + 6 CY		ACT + 6 CY	M	S	N	I	ACT = until end of CY in which revised or superseded and agency ceases to operate
3	Notice of Privacy Practices	ACT + 6 CY		ACT + 6 CY	M	S	N	V	ACT = until the end of the CY created or received
4	HIPAA Compliance Documentation	ACT + 6 CY		ACT + 6 CY	M	S	N	V	ACT = until the end of the CY created or received

Permitted Retention Period Abbreviations
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Security Status Codes
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Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations

Agency Approval

12-16-14
Date Signed

Secretary of State, State Archives & Records Services

12/23/14
Date Approved

Records Retention Schedule

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Agency No	Agency / Division / Section								
	Division of Administration / Office of Group Benefits – Administration- Executive								
Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Internal Audit records (audited documents, reports, work papers, legislative audit reports)	ACT + 2 CY	3 CY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the CY in which report issued/project closed
2	Board and Committee Minutes	PERM		PERM	M	R	N	V	
3	Strategic Plan	ACT+ 5 CY		ACT + 5 CY	P	S	N	I	ACT = until the end of the CY in which agency ceases to operate
4	Legal Files	ACT + 1 CY	9 CY	ACT + 10 CY	M	S	Y	V	ACT = until end of CY in which file is closed out.
5	Board Election Materials	ACT + 2 CY	3 CY	ACT + 5 CY	M	S	Y	V	ACT = until end of CY in which election results are certified.
6	Publications	ACT + 10 CY		ACT + 10 CY	M	S	N	I	ACT = until end of CY in which agency ceases to exist.
7	Records Management Files (Retention Schedules, Disposal Requests, Transmittals)	ACT + 10 CY		ACT + 10 CY	M	S	N	V	ACT = until end of CY in which agency ceases to exist.

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Agency Abbreviations

Agency Approval — 12-30-14 Date Signed — Secretary of State, State Archives & Records Services — 1/7/15 Date Approved

Records Retention Schedule

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Agency No	Agency / Division / Section
	Division of Administration / Office of Group Benefits – Administration - General

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Special order forms, Personnel Action Requests, Travel Requests/Expense reports, requisitions and related correspondence/memos.	ACT + 2 CY	1 CY	ACT + 3 CY	M	S	Y	I	ACT = until end of the CY in which created or received.
2	General Correspondence (not related to other record series)	ACT + 2 CY	1 CY	ACT + 3 CY	M	S	Y	I	ACT = until end of the CY in which created or received.
3	Supervisor Files	ACT + 1 CY	1 CY	ACT + 2 CY	M	S	Y	I	ACT = until end of CY in which supervision ends.
4	Visitor sign-in/Sign – Out Sheets	ACT + 2 CY	3CY	ACT + 5 CY	M	S	Y	U	ACT = until end of CY in which created or received.
5	Time and Attendance Reports/Vendor Reports, PES, PPR, Leave requests, Overtime documentation and related correspondence/memos	ACT + 2 CY	3 CY	ACT + 5 CY	M	S	Y	V	ACT = until end of CY in which created or received.
6	Mail, Fax ,Postage & Tracked Logs	ACT + 1 CY	2 CY	ACT + 3 CY	M	S	Y	I	ACT = until end of CY created or received.
7	Budget records	ACT + 5 CY		ACT + 5 CY	P	S	N	I	ACT = until the end of the CY created or received.
8	Contracts and agreements (including contract approval backup material)	ACT + 3 CY	7 CY	ACT + 10 CY	M	S	N	V	ACT = until end of CY in which contract or agreement expires or terminates.
9	Notice of Intent to Contract (NIC), Request for Proposals and Reports	ACT + 3 CY		ACT + 3 CY	M	S	N	V	ACT = until end of CY in which contract is awarded

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Agency Abbreviations
PES = Personnel Evaluation System
PPR = Personnel Performance Rating

Agency Approval

12-18-14
Date Signed

Carrie Martin, CRM
Secretary of State, State Archives & Records Services

12/8/14
Date Approved

Records Retention Schedule

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Agency No	Agency / Division / Section
	Division of Administration / Office of Group Benefits/ Customer Service

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Automatic Call Distribution Reports/Performance Indicator Reports	ACT + 10 CY		ACT + 10 CY	M	S	N	I	ACT = until end of CY in which agency ceases to operate
2	Filing Deadline Mail Records	ACT + 3 CY		ACT + 3 CY	M	S	N	V	ACT = until end of CY in which created or received
3	Live and Event Claim records	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until end of CY in which agency ceases to operate
4	Field and Audit Reports	ACT + 1 CY	4 CY	ACT + 5 CY	M	S	Y	I	ACT = until end of CY report is issued.

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Agency No	Agency / Division / Section
	Division of Administration / Office of Group Benefits/ Flexible Benefits and Imaging Services

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Health Claims (including supplemental claims)	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until end of CY in which agency ceases to operate.
2	Explanation of Benefits (EOBs)	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until end of CY in which agency ceases to operate.
3	Medical Records	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until end of CY in which agency ceases to operate.
4	Pre-determinations	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until end of CY in which agency ceases to operate.
5	Case Management	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until end of CY in which agency ceases to operate.
6	Medical Necessities	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until end of CY in which agency ceases to operate.
7	Paid-In Vouchers	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until end of CY in which agency ceases to operate.
8	Flexible Benefit Forms	ACT + 5 CY		ACT + 5 CY	C	S	N	V	ACT = until end of CY in which superseded, cancelled or revoked.
9	Flexible Benefit Master File	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until end of CY in which agency ceases to operate.

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Agency Abbreviations

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Carrie Martin CRM
Secretary of State, State Archives & Records Services

12/18/14
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Records Retention Schedule

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Agency No	Agency / Division / Section
	Division of Administration / Office of Group Benefits/ Eligibility, Quality Assurance and Compliance

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Eligibility Records for Life and Health Insurance	ACT + 3 CY	PERM	PERM	M	R	N	V	ACT = until end of CY created or received. Microfilm after 3 years.
2	Life Insurance Beneficiary Forms (OGB and Outside agencies held by OGB)	PERM		PERM	C	R	N	V	
3	Hospital Audits, Statistical Reports and Work papers	ACT + 10 CY		ACT + 10 CY	M	S	N	I	ACT = until end of CY in which agency ceases to operate.
4	Fraud and Abuse Case files and logs	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until end of CY in which agency ceases to operate.
5	Health Claim Audits and work papers (including over $500 plan member check audits)	ACT + 5 CY		ACT + 5 CY	C	S	N	I	ACT = until end of CY in which audit is completed.
6	Special Reports (Outlier, Check Cycle)	ACT + 5 CY		ACT + 5 CY	M	S	N	I	ACT = until end of CY in which report is run.
7	Reviews (Medical and Chiropractic)	ACT + 10 CY		ACT + 10 CY	C	S	N	I	ACT = until end of CY in which agency ceases to exist.

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R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations

Agency Approval

12-18-14
Date Signed

Carol Martin, CRM
Secretary of State, State Archives & Records Services

12/18/14
Date Approved

Records Retention Schedule

SS ARC 932 (01/12)

Louisiana Secretary of State, Division of Archives, Records Management and History
Post Office Box 94125, Baton Rouge, LA 70804
Http://www.sos.la.gov

Indicate Use of Form
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Agency No: Agency / Division / Section
Division of Administration / Office of Group Benefits/Plan and Provider Administration

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Preferred Provider Option/Exclusive Provider Option Contracts	ACT + 5 CY		ACT + 5 CY	M	S	N	V	ACT = until end of CY in which agency ceases to exist.
2	Logic Approvals	ACT + 3 CY	7 CY	ACT +10 CY	M	S	N	V	ACT = until the end of the CY in which plan expires.
3	Adjusted Batch Listings	ACT + 7 CY		ACT + 7 CY	M	S	N	I	ACT = until the end of the CY in which plan expires.

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week DY - Day(s)
PERM – Permanent

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
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Agency Abbreviations

Agency Approval — 12-18-14 Date Signed — Carol Martin, CEM Secretary of State, State Archives & Records Services — 12/18/14 Date Approved

Records Retention Schedule

SS ARC 932 (01/12)

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Indicate Use of Form
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Agency No	Agency / Division / Section
003.	Division of Administration / Office of Group Benefits – Administration- General

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Daily work papers (includes copies of printouts and non-essential notes with PHI or contact information used for customer service work).	ACT		ACT	M	S	N	U	ACT = until end of DY in which created or received

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week DY - Day(s)
PERM – Permanent

Security Status Codes
P – Public Record
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Archival Processing Codes
A – Transfer to State Archives
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State Records Center Use
Y – Yes
N - No

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Agency Abbreviations

Agency Approval — 12-30-14 Date Signed

Secretary of State, State Archives & Records Services — 1/7/15 Date Approved

ATTACHMENT XIII: IMAGING SYSTEM SURVEY COMPLIANCE AND RECORDS DESTRUCTION

Imaging System Survey Compliance and Records Destruction

In connection with OGB's electronic records retention requirements and within thirty (30) days of the Contract's effective date, Contractor shall complete a State Archives Imaging System Survey ("System Survey") and forward to Monique Fisher[1] (the "Records Officer") at Monique.Fisher@LA.GOV. According to LAC 4:XVII.1305(A), the System Survey must contain the following information:

1. A list of all OGB records series[2] maintained/managed by Contractor's system;
2. The hardware and software used including model number, version number and total storage capacity;
3. The type and density of media used by Contractor's system;
4. The type and resolution of images being produced (TIFF class 3 or 4 and dpi);
5. Contractor's quality control procedures for image production and maintenance;
6. Contractor's system's back up procedures including location of back-up (on or off-site) and number of existing images; and
7. Contractor's migration plan for purging images from the system that have met their retention period.

OGB shall review the System Survey to make an initial determination of conformity with LAC 4:XVII.1305(A). Once OGB determines that Contractor's System Survey contains the requisite information, OGB will forward the System Survey to the Secretary of State. As a continuing requirement, any system changes necessitating a revised System Survey response must be submitted to the Secretary of State within 90 days of the change. To ensure compliance with this rule, Contractor shall notify the Records Officer of these changes within 60 days so that he or she may forward the appropriate information to the Secretary of State.

Further, to ensure compliance with OGB's Schedules (RFP Attachment XII) and applicable laws, Contractor shall not destroy any OGB records unless records are converted to digital images and thereafter approved for destruction by the Secretary of State. Contractor shall request expedited authority to destroy converted records by email to disposals@sos.louisiana.gov with "EDR_I2014-009 OGB [Contractor name]" in the subject line, carbon copy to the Records Officer, and a description of the subject records per the OGB Schedules (such as "Health Claims, scanned and inspected, for the week/month of X") in the body. Upon receiving approval of the Secretary of State to destroy the requested records, Contractor shall commence destruction of said records. Contemporaneously therewith, Contractor shall complete a Certificate of Destruction (SSARC 933) form which shall be forwarded to the Records Officer. All SSARC forms can be found on the Louisiana Secretary of State's website http://www.sos.la.gov/HistoricalResources/ManagingRecords/GetForms/Pages/default.aspx

[1] Monique Fisher is OGB's designated Records Management Officer and may be reached at 225-342-9655. If OGB designates someone other than Ms. Fisher as Records Management Officer, OGB will notify Contractor of the change and provide updated contact information.

[2] A records series is a group of related or similar records that may be filed together as a unit, used in a similar manner, and typically evaluated as a unit for determining retention periods. LAC 4:XVII.301(A). The records series listed in Contractor's imaging survey should correspond to the records series listed on the OGB official retention schedules, RFP Attachment XII.