Amendment to Agreement Between

State of Louisiana
Division of Administration
Office of Group Benefits (OGB)

And

Louisiana Health Service & Indemnity Company d/b/a
Blue Cross and Blue Shield of Louisiana and its subsidiary HMO Louisiana, Inc.
5525 Reitz Avenue, Baton Rouge, LA 70809-3802

CHANGE FROM:

3.1 TERM OF CONTRACT

This contract shall become effective on January 1, 2016 and shall end on December 31, 2018. With all proper approvals and concurrence with the Contractor, OGB may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial Contract term. Subsequent to the extension of the Contract beyond the initial thirty-six (36) month term, all prior approvals as required by law shall be obtained. Written evidence of such approval shall be submitted, along with the Contract amendment to the appropriate state office to extend the Contract term beyond the initial three (3)-year term. The term of the Contract with any extensions shall not exceed five (5) years.

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.

CHANGE TO:

3.1 TERM OF CONTRACT

This contract's initial term shall become effective on January 1, 2016, and shall end on December 31, 2018. With all proper approvals and concurrence with the Contractor, OGB may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial Contract term, as previously amended. Subsequent to the extension of the Contract beyond the initial thirty-six (36) month term, all prior approvals as required by law shall be obtained. Written evidence of such approval shall be submitted, along with the Contract amendment to the appropriate state office to extend the Contract term beyond the initial three (3)-year term. The term of the Contract with any extensions shall not exceed five (5) years.

At this time, OGB is exercising a portion of its 24-month option, to extend the initial term of the Contract for twelve (12) months, through December 31, 2019, at the same rates, terms, and conditions as the initial Contract term, as previously amended, except as provided herein.

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.

CHANGE FROM:

3.4 PAYMENT TERMS

In consideration of the services required by this Contract, OGB hereby agrees to pay to Contractor a maximum fee of $3,000,000,000.00 (Three Billion Dollars). Payments are predicated upon successful completion and written approval by OGB of the described services and deliverables as provided in the Contract. Contractor will not be paid more than the maximum amount of the Contract. **No payments will be made by OGB on banking, State holidays.** Payments will be made via check or wire transfer after written approval of the invoice by OGB's Chief Executive Officer, or his/her designee. Contractor shall notify the Contract Supervisor in writing when seventy-five (75%) percent of the maximum Contract amount has been expended.

CHANGE TO:

3.4 PAYMENT TERMS

In consideration of the services required by this Contract, OGB hereby agrees to pay to Contractor a maximum fee of $3,970,000,000.00 (Three Billion, Nine Hundred Seventy Million Dollars). Payments are predicated upon successful completion and written approval by OGB of the described services and deliverables as provided in the Contract. Contractor will not be paid more than the maximum amount of the Contract. **No payments will be made by OGB on banking, State holidays.** Payments will be made via check or wire transfer after written approval of the invoice by OGB's Chief Executive Officer, or his/her designee. Contractor shall notify the Contract Supervisor in writing when seventy-five (75%) percent of the maximum Contract amount has been expended.

SUPPLEMENT THE CONTRACT WITH THE FOLLOWING NEW PARAGRAPH:

33 PROHIBITION OF DISCRIMINATORY BOYCOTTS OF ISRAEL

In accordance with Executive Order Number JBE 2018-15, effective May 22, 2018, for any Contract for $100,000 or more and for any Contractor with five or more employees, Contractor, or any subcontractor, shall certify it is not engaging in a boycott of Israel, and shall, for the duration of this Contract, refrain from a boycott of Israel.

The State reserves the right to terminate this Contract if the Contractor, or any subcontractor, engages in a boycott of Israel during the term of the Contract.

REPLACE ATTACHMENT I: SCOPE OF SERVICES with the attached REVISED ATTACHMENT I: SCOPE OF SERVICES.

Effective Date of Amendment: April 1, 2018

Justification for Amendment:

- To exercise option to extend Contract for twelve (12) of the twenty-four (24) additional months available under the Contract, at the same rates, terms, and conditions of the initial Contract term, as previously amended, except as provided in this Amendment.
- To increase maximum payable amount to $3,970,000,000.00 (Three Billion, Nine Hundred Seventy Million Dollars).
- To amend the Contractor nurse provisions in the Contract. The Contract requires Contractor to provide a minimum of two on-site nurses dedicated to OGB in Year 3 of the Contract. One nurse is currently located on-site at the Bienville Building, and the other is located on-site at the Claiborne Building. After reviewing participation and usage information and other metrics available, the parties have decided that effective April 1, 2018, Contractor will provide a Community Care Nurse in lieu of the Bienville Building on-site nurse. The Community Care Nurse will work collaboratively with high-risk Baton Rouge area OGB Plan Participants and their primary care providers to achieve better health care outcomes for the Plan Participants and potentially lower costs for OGB. The substitution of the Community Care Nurse in lieu of one on-site nurse is at no change in cost to OGB.
- To clarify the scope of services to provide for Contractor's readjudication of Claims and recoupment of amounts paid to network providers for Claims of Plan Participants beyond the coverage termination date within the twelve months immediately prior to notification of the coverage termination date from OGB, as stated in the revised scope of services, at no additional charge to OGB.
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- To supplement the Contract with the Prohibition of Discriminatory Boycotts of Israel paragraph in accordance with Executive Order Number JBE 2018-15.

No Amendment shall be valid until it has been executed by all parties and approved by the Office of State Procurement, Division of Administration.

All other provisions of the Contract shall remain in full force and effect. Any conflict between the Contract and this Amendment regarding the subject matters of this Amendment shall be resolved in favor of this Amendment.

This Amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this Amendment is signed and entered into on the date(s) included below.

LOUISIANA HEALTH SERVICES & INDEMNITY COMPANY d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA	**STATE OF LOUISIANA, DIVISION OF ADMINISTRATION, OFFICE OF GROUP BENEFITS**
BY:_____	**BY:**_____
NAME: I. Steven Udvarhelyi MD	**NAME:** Tommy Teague
TITLE: President and CEO	**TITLE:** Chief Executive Officer

DATE:_____ **DATE: _____**

ATTACHMENT I: SCOPE OF SERVICES (REVISED)

Overview

Contractor will partner with OGB to provide innovative solutions for medical program management including efficient Claims processing, network management, and population health management. The Contractor is expected to drive health risk improvement and mitigation of rising costs of health care in order for OGB to continue to provide the best value to its Plan Participants.

Below is a list of services the Contractor will be responsible for providing effective January 1, 2016, unless otherwise specified.

Regulatory

- Benefit Plan Document/Summary Plan Description. Prepare and print a document containing a description of the covered benefits provided by the Plan to be used by OGB as a Summary Plan Description. However, it will be OGB's responsibility to review the draft prepared by Contractor and approve the document in writing as correct in the description of the benefits and compliant with all applicable laws and regulations, before dissemination to its Primary Plan Participant(s). If any changes to the draft prepared by Contractor are needed, OGB will request such changes in writing. Contractor shall update the draft to include OGB's requested changes and submit the revised draft to OGB within five (5) business days. Contractor will have no liability for any non-compliance of the document with ERISA, as applicable, or any other standards, or any inaccuracies in regard to the benefit descriptions, statements, disclosures, or any other information contained in the document. If OGB fails to return the document to Contractor at least forty-five (45) days prior to the first day of the next Plan year, Contractor will have the right to consider the last Schedule of Benefits/Benefit Plan submitted to OGB as final and approved in regards to the benefit description for the purpose of rendering the services contracted under the Contract.

- Summary of Benefits and Coverage Document. Prepare a Summary of Benefits and Coverage ("SBC") Document to be used by OGB. Contractor will provide to OGB the SBC within ten (10) business days after it has received from OGB all the benefits information Contractor needs to draft the document. Contractor will not be held responsible for any delays in the distribution of SBCs to Primary Plan Participant(s), unless it has assumed responsibility for such distribution in writing and OGB has submitted the information timely. In any case, it will be OGB's responsibility to review the draft prepared by Contractor. If any changes to the draft prepared by Contractor are needed, OGB will request such changes in writing. Contractor shall update the draft to include OGB's requested changes and submit the revised draft to OGB within five (5) business days. If no changes are required, OGB will approve the document in writing as correct in the description of benefits and compliant with all applicable laws and regulations. Contractor will have no liability for any non-compliance of the document with the law, or any inaccuracies in regard to the benefit descriptions, statements, disclosures, or any other information contained in the document.

  The SBC will be prepared by Contractor in the English language. Contractor will not be responsible for any translations of the SBC or any other Plan documents into any other language.

- Dissemination of Summary of Benefits and Coverage to Primary Plan Participant(s). Distribute to Primary Plan Participant(s) a Summary of Benefits and Coverage ("SBC") at the beginning of the Contract, upon renewal of the Contract, or when changes made by OGB to the Plan would require the distribution of a new SBC to all Primary Plan Participant(s). Distribution of the SBCs shall be accomplished by Contractor placing electronic copies of the SBCs on Contractor's OGB designated website. Contractor will not be liable to OGB or to Primary Plan Participant(s) if SBCs are not

distributed within legally required timeframes due to OGB's failure to provide benefit descriptions or benefit changes on time under this Section.
Note: Taxes and fees including but not limited to the Transitional Reinsurance Program fees and the Patient Certified Outcome Research Institute (PCORI) fees are the responsibility of OGB and are not included in the Administrative Fees.

- Notices
  - Women's Health and Cancer Rights Act ("WHCRA") Notices. Contractor will provide a notice to Primary Plan Participant(s) under the Women's Health and Cancer Rights Act of 1998.
  - HIPAA Authorized Delegate Form. Contractor will provide a HIPAA Authorized Delegate Form to Primary Plan Participant(s).
  - HIPAA Privacy Notice. Contractor will provide each Primary Plan Participant(s) with Contractor's HIPAA privacy notice, in the event that Primary Plan Participant(s) need to contact Contractor's Privacy Department. OGB will prepare and Contractor will provide OGB's HIPAA privacy notice to Primary Plan Participant(s).
  - Balance Billing Disclosure Notice. Contractor will provide a Balance Billing Disclosure Notice to Primary Plan Participant(s).
  - Notices Required by Patient Protection Affordable Care Act ("PPACA") or Other Laws. Contractor will not prepare or distribute any Plan Participant notices required under the Patient Protection and Affordable Care Act or any other state or federal law, unless Contractor assumes responsibility thereof in writing or under the Contract. This includes, but is not limited to, Genetic Information Non-discrimination Act ("GINA") notices, Michelle's Law notices, or COBRA notices.

Medical Claims Administration

- Enrollment and Eligibility. Based upon OGB's determination and written communication to Contractor of a Plan Participant's eligibility for benefits provided under the Plan, Contractor will enroll Plan Participant to receive Plan benefits in accordance with Plan provisions and process any certificates of creditable coverage received by Contractor. Contractor will to the best of its ability, utilizing its current commercial process, make eligibility determinations for eligible over-age dependents. Contractor will accept OGB's standard file layout for the initial eligibility enrollment file. OGB's request for Contractor to enroll subsequent Plan Participants will be subject to Contractor's subsequent enrollment processes.

- Plan Participant Materials. Prepare and distribute to each new Primary Plan Participant(s) within thirty (30) days of receipt of confirmation from OGB as to the validity of the enrollment application and Plan Participant the following materials:

  1. A plan document, 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 network physicians, hospitals and specialty facilities. Hard copies of provider directories and certificates of coverage must be available upon request.

  3. Contractor will supply identification cards to Primary Plan Participant(s) of the Plan when necessary. New cards will be issued to all Primary Plan Participant(s) of the Plan when OGB is serviced by Contractor for the first time. Thereafter, new cards will only be

issued on an individual basis, when Primary Plan Participant(s) make changes to their coverage upon annual or any other special enrollment that require the issuance of a new card, whenever OGB adds new Primary Plan Participant(s) to the Plan during a plan year, or whenever a card duplicate is requested at no additional charge to OGB or the Primary Plan Participant(s). Additional cards for family Plan Participants shall also be provided upon request and at no additional charge to OGB or the Plan Participant.

4. Summary of Benefits and Coverage and Uniform Glossary, as required by the federal PPACA and/or state law and/or rules and regulations promulgated pursuant thereto. If requested by OGB, Contractor shall provide printed SBC documents to OGB for distribution to eligible employees who are not enrolled in a medical plan.

- Claims Processing and Payment. Process Claims and determine payment levels based on the appropriate allowable charge, pursuant to the terms of the Benefit Plan as construed by Contractor, incurred and timely submitted on or after the Effective Date.

    1) OGB has the full, final, binding and exclusive discretion to determine eligibility of benefits and to interpret the terms of the Benefit Plan as may be necessary in order to make Claim determinations. Should OGB decide to overturn a benefit determination made by Contractor, it shall notify Contractor in writing prior to payment of the Claim.

    2) Contractor shall make coverage determinations and decide, in accordance with the Plan, the eligibility for payment of Claims incurred and submitted to it during the term of the Contract.

    3) Claims will be processed in the order received by Contractor and will not be reprocessed due to out of sequence dates of services.

    4) Contractor will process Claims for covered services rendered prior to the termination of the Contract, but not yet paid and/or not submitted for payment to Contractor prior to the termination of the Contract.

    5) Based on the Benefit Plan's express terms or OGB's written authorization, and subject to the terms of the Contract, Contractor shall determine the extent of the benefits (if any) to which any Plan Participant is entitled.

        (i) In the event that OGB determines that Contractor has misinterpreted the Benefit Plan and so informs Contractor in writing of making such determination, Contractor shall begin processing and paying Claims in accordance with OGB's interpretation as set forth in such writing as soon as possible but no later than thirty (30) days after receipt of such notice. Upon OGB's request, in writing, Contractor shall reprocess Claims submitted prior to OGB's notification.

        (ii) Notwithstanding any determination made by OGB under this Section, Contractor shall have no liability to a Plan Participant or OGB (and OGB shall indemnify Contractor against any such liability) for: withholding payments as directed by OGB; alleged or actual misinterpretations of the Benefit Plan made; or Claims that were denied prior to OGB's determination and written notification to Contractor.

    6) If benefits are payable, but the provider does not participate in the provider network, Contractor may make payment to the Primary Plan Participant(s) or to the provider. No one may assign a Plan Participant's right to the payment of benefits without Contractor's express written consent.

7) Contractor will readjudicate Claims and recoup any amounts paid to network providers for Claims of Plan Participants beyond the coverage termination date relayed by OGB to Contractor. Such readjudication and recoupment of Claims amounts paid shall be in compliance with all applicable laws, including OGB rules as amended from time to time, provided such readjudication and recoupment time period shall not exceed twelve (12) months from date of Claim payment.

8) OGB shall provide Contractor (in a format mutually agreeable to OGB and Contractor) with the following Plan Participant information, where available, upon enrollment and when changes occur: current mailing address, first and last name, date of birth, coverage effective date and/or termination of coverage date, current home phone number, gender, race, date of hire, relationship (e.g., employee/retiree, spouse, child or other dependent), and social security number. OGB will notify Contractor as soon as practicable of a change in such information or a change in coverage status. Claims will be paid in accordance with the information that has been supplied by OGB and received by Contractor at the time the Claims are paid.

9) OGB shall ensure that any retroactive Plan Participant termination of coverage sent to Contractor for processing is in compliance with applicable state and/or federal law, specifically with any prohibition on rescissions. Contractor will assume that OGB's request for a retroactive termination of coverage is compliant with applicable law. Contractor will attempt to recoup payments to network providers and readjudicate claims of network providers for the specific terminated Participants identified by OGB and relayed to Contractor prior to August 1, 2018. Otherwise, for purposes of this Contract, a "retroactive" termination of coverage is one where the coverage termination effective date precedes the date on which Contractor receives the notification of termination of coverage by no more than thirty (30) days.

   When notified of a coverage termination or retroactive coverage termination, Contractor shall not pay subsequently received Claims for the period of non-coverage. Because Contractor is generally unable to stop payment from occurring on pending or in-process Claims, Contractor shall attempt to recoup and readjudicate those Claims. Contractor will, as soon as reasonably practicable, initiate attempts to recoup from providers any Claim amounts paid in the twelve (12) months prior to OGB's notification to Contractor of the Plan Participants whose coverage has been terminated for such periods, except for the following: (a) Claims amounts paid for pharmacy benefits by a pharmacy benefits manager; (b) Claims with a paid amount less than $50; (c) Claims amounts paid to out-of-network providers; (d) (ITS) Claims (Claims amounts paid to out-of-state Contractor network or out-of-network providers); or (e) Claim or benefit amounts paid directly to a Plan Participant. <u>If, despite reasonable diligence, Contractor is unsuccessful in its attempt to recoup or recover the paid Claims amounts, OGB remains responsible to fund the Claims. Claims dollars that are successfully recouped will listed on OGB's invoice as a Claims credit.</u>

   Contractor will perform the recoupment <u>process for a maximum of twelve (12) months unless notified by OGB to stop attempting recoupment. The recoupment process stated herein is at no additional cost to OGB. OGB will not receive a refund of any administrative fees paid by OGB pursuant to the Contract for any Plan Participant for any month prior to OGB's notification to Contractor of the retroactive termination of coverage of that Plan Participant.</u>

10) Should a provider dispute the attempt to recoup amounts paid for Claims related to retroactive terminations of coverage, and/or seek a more formal resolution to the dispute, including but not limited to arbitration, Contractor will notify OGB as soon as practicable. Contractor and OGB will discuss the provider opposition or dispute and decide on a course of action. If OGB wishes Contractor to continue recovery attempts, OGB shall be responsible thereafter for payment of all documented, reasonable future costs and attorney's fees directly associated with the recovery effort. Contractor will not initiate arbitration on behalf of OGB unless OGB and Contractor mutually agree upon the terms of such.

- Out of Pocket Maximum. Maintain medical and carved out pharmacy Claims for integrated Medical/Rx out of pocket maximum accumulation to ensure compliance with the PPACA.

- Forms. Furnish necessary forms to OGB for its Plan Participants' eligibility and Claims activities.

- Claim, Administrative Appeals and Clinical External Reviews. Provide assistance to OGB in complying with grievance and appeal procedures adopted by OGB and as outlined in the Benefit Plan or Summary Plan Document.

    1) If OGB's Plan is subject to the appeals requirements of PPACA, with respect to processes for internal Claims and appeals and external review, Contractor shall abide by the grievance and appeals procedures as stated in the annual Plan Document. Contractor shall:

        (i) For the first level of internal appeal, determine whether benefits are payable in accordance with the Benefit Plan as a result of an adverse benefit determination, within the timeframes required by law. Contractor will also issue timely decision notices of benefit determination in the appropriate format. If the Contractor receives first level internal appeals requiring eligibility determinations, Contractor will immediately notify and forward the appeal to OGB within five (5) business days of receipt.

        (ii) At the conclusion of the first level of internal appeal for benefit determination, Contractor will notify the Plan Participant of Contractor's disposition of the appeal including instructions on how to initiate any additional levels of appeal that may be available to the Plan Participant. The determination will include instructions on how the Plan Participant may initiate a second level benefit determination appeal to the Contractor. For the second level internal appeal for benefit determination, Contractor will determine whether benefits are payable in accordance with the Benefit Plan as a result of an adverse benefit determination, within the timeframes required by law and issue timely decision notices in the appropriate format. Additionally, Contractor will notify the Plan Participant in writing of any external review rights that may be available.

        (iii) Unless otherwise requested by OGB in writing, Contractor will facilitate OGB's external review procedures by randomly assigning an external review request sent by OGB to Contractor to one of Contractor's contracted independent review organizations ("IRO"). Contractor is responsible for complying with applicable laws regarding external review. OGB

acknowledges that OGB is responsible for ensuring that the Plan is administered consistently and in accordance with applicable laws; provided, however, Contractor will be responsible for ensuring Claims received by Contractor are processed in accordance with the ERISA Claims regulation. If OGB requests Contractor in writing not to facilitate the Plan's external review process, OGB will be solely responsible for complying with applicable laws regarding external review.

2) If OGB's Plan is not subject to the appeals requirements of PPACA, with respect to processes for internal Claims and appeals and external review, Contractor shall:

(i) For the first level of internal appeal for benefit determination, determine whether benefits are payable in accordance with the Benefit Plan, as a result of an adverse benefit determination, within the time frames required by law. Contractor will also issue decision notices in the appropriate format. For first level internal appeals requiring eligibility determinations Contractor will immediately notify and forward appeal to OGB within five (5) business days of receipt.

(ii) At the conclusion of the first level of internal appeal, Contractor will notify the Plan Participant of the outcome of the appeal, including instructions on how to initiate the second and final level of appeal to OGB.

In the event Contractor receives any final appeal or grievance requests made by a denied claimant, Contractor shall immediately forward the request to OGB within five (5) business days of receipt. OGB accepts full responsibility and liability for ensuring the appeal rights available to a denied claimant under applicable law or the Plan.

- Network Development and Management. Establish, arrange and maintain physician, allied health and hospital provider networks through contractual arrangements with participating hospitals, allied health providers and physicians and with other Blue Cross and Blue Shield Plans.

- PHS/EOB. Furnish to any Plan Participant the appropriate personal health statements ("PHS"), explanation of benefits ("EOB") notices and notices of any denials for Claims.

- Customer/Plan Participant Services. Handle inquiries related to Plan Participant, benefits, Claims payment and Claims payment denial. Contractor will furnish a toll-free telephone number for incoming customer service calls, including telephone technology for the hearing impaired and multi-lingual support. The call center for providers, Plan Participants, account management, and nurse line must be staffed and available to receive calls 8:00AM – 5:00PM CT, Monday through Friday, except on state holidays, including the day following Thanksgiving and the last workday preceding or following Christmas each year. Contractor may be required to extend Call center hours, as needed, during annual and special enrollment periods and other appropriate times as requested by OGB. The crisis line call center for behavioral health will be staffed and available to receive crisis calls 24 hours a day, 7 days a week.

- Financial Functions. Perform financial functions such as billing, cash disbursements and refund processing.

- Coordination of Benefits. Contractor will coordinate benefits on behalf of the Plan following Contractor's standard practices and procedures. This will include the determination of the primary, secondary and tertiary order of liability of the Plan and any other health benefits program under

which a Plan Participant may be eligible for benefits, and the payment of the Plan's share of its liability for a Claim. Coordination of benefit efforts will be based on information available to Contractor at the time of the adjudication of the Claim.

Except for the standard processes that Contractor has in place for questioning Plan Participants regarding other health coverage (which may be subject to change from time to time, but which currently includes sending out a questionnaire to the Plan Participant when Contractor deems appropriate), Contractor shall not be required to determine the existence of any other plan or amount of benefits payable under any such other plan. Following Contractor standard investigation process, if a Plan Participant fails to respond to Contractor's inquiry about the existence of any other coverage, Contractor will reject the Claim and will only process such Claim upon receipt of Plan Participant's response.

- CMS and Medicaid Demand Letters. Remit payments on behalf of OGB to the Centers for Medicare and Medicaid Services ("CMS") or to state Medicaid collection entities in response to Demand Letters for the recovery of Medicare or Medicaid payments. Unless requested by OGB in writing not to make such payments, OGB shall reimburse Contractor for any payments remitted by Contractor on behalf of OGB to CMS or Medicaid collection entities in response to Demand Letters for the recovery of Medicare or Medicaid payments.

- COBRA/USERRA. Assist OGB in meeting its responsibilities with respect to providing the continuation of health care coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). OGB is the Administrator for purposes of COBRA and shall remain responsible for meeting all COBRA and USERRA requirements applicable to the Plan. OGB shall also be responsible for promptly notifying Contractor of individuals who elect to continue Contractor coverage under COBRA or USERRA provisions. Contractor's responsibilities shall include, but not limited to: (1) answer inquiries from former Plan Participants that continue Plan coverage under COBRA or USERRA provisions; and (2) prepare reports for OGB on COBRA and USERRA cases.

- QMCSOs/MCSOs. OGB shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Orders ("QMCSO"), if required by law. Contractor will assist OGB in meeting its responsibilities with respect to the receipt of Medical Child Support Orders ("MCSO"). OGB shall be responsible for: all notification responsibilities with respect to MCSOs, the establishment of written procedures for determining whether such MCSOs are "qualified" and for the administration of benefits under such qualified orders. OGB shall also be responsible for promptly notifying Contractor of the receipt of a MCSO relating to the Plan, OGB's determination as to whether such MCSO is "qualified", the name and address of Alternate Recipients whom OGB has determined are eligible to receive benefits under the Plan and the name and address of any custodial parent or legal guardian designated to receive benefit payments on behalf of such Alternate Recipient. Contractor's responsibilities shall include, but are not limited to, the answering of inquiries from Alternate Recipients or designated guardians who receive benefit payments under the Plan.

- OGB's HIPAA Privacy Obligations/OGB's Access to Protected Health Information. Assist OGB in meeting its responsibilities with respect to administering individual rights and obligations, such as access, amendment and disclosure accounting rights, as required by the HIPAA and its implementing regulations issued by the U.S. Department of Health and Human Services (45 C.F.R. Parts 160-164) as described in Attachment III: HIPAA Business Associate Addendum. However, OGB shall remain responsible for meeting all HIPAA requirements applicable to the Plan, including but not limited to the preparation of and distribution of its privacy notice.

From time to time, OGB or business associates of OGB may require access to certain protected health information, as defined in HIPAA and its implementing regulations, in order to perform certain Plan administration functions on behalf of the Plan. Before Contractor will disclose any protected health information regarding a Plan Participant covered under the Plan, OGB must adhere to the administrative requirements as outlined in the Attachment III: HIPAA Business Associate Addendum.

- Administrative Fee Statements and Claim Reports. Generate monthly statements for administrative services fees and other charges and Claim reports.

- Data. Assist OGB in preparation of any return or report pertaining to the Plan as required by any Federal Government Agency, and furnish OGB an annual report of information available to Contractor which may be needed by OGB to satisfy ERISA or any other applicable state or federal requirements. Contractor shall not be responsible for determining when or whether government filings are required or completing or filing any report or return.

- Service Provider Information. If applicable, Contractor will provide to OGB certain information required to be reported related to compensation earned with regard to administration of the Plan. This information shall include all direct and indirect compensation paid by OGB to either Contractor or a third party subcontractor for providing services to the Plan under this Contract.

- Vendor Integration. Integrate with selected contractor(s) as defined by OGB for the administration of the Plan, including pharmacy benefits manager for the purpose of out of pocket maximum accumulation and COBRA administrator.

Care Management

Conduct utilization review, medical necessity determinations, benefit coverage determinations, population health services, and related functions affecting benefit activities. More specifically, such Care Management activities may include, but are not limited to:

- Utilization Management for medical and behavioral health conditions and substance abuse
  - Contractor will conduct prior authorization and concurrent review of inpatient and designated outpatient services to determine medical policy coverage status, medical necessity, and clinical appropriateness of the service(s) and level of care. The appropriate length of service or service units will be determined if the service(s) is deemed appropriate.

- High Tech Imaging ("HTI") Utilization Management Program
  - Contractor will conduct prior authorization for non-emergent services on selected high-tech radiology modalities. The goal of the HTI program is to ensure diagnostic and treatment plans are medically necessary and meet or exceed evidence-based guidelines. The program will identify quality, lower cost alternative sites of service for selected high-tech radiology modalities and will contact Plan Participants telephonically to share this information.

- Specialty Care Insight

- Contractor will provide data to specialist physicians to identify effective strategies to encourage high value, lower cost services through the assessment of quality-of-care metrics.

- Shared Decision Making Tools
  - Contractor may make available shared decision making tools, such as interactive videos, to appropriate Plan Participants regarding their treatment options.

- BlueCare Telehealth
  - A health platform that allows for Primary Care Physicians to have on-line visits for certain allowable non-emergent conditions.

- Value-Based Programs
  - Contractor may implement certain value based programs, such as Contractor's Quality Blue programs.

- Population Health - Common Chronic Conditions such as Chronic Obstructive Pulmonary Disease ("COPD"), Coronary Artery Disease ("CAD"), Congestive Heart Failure ("CHF"), Asthma and Diabetes
  - Contractor will provide Population Health services designed to improve health outcomes, promote and maintain optimal level of functioning, improve confidence in self-management of conditions, and maximize Contract benefits through cost-effective services and coordination of appropriate community resources.

- Population Health - Non-Chronic and Complex Conditions and Care

- Transplant Care Management
  - The program is designed to improve transplant outcomes and reduce hospitalizations and overall costs associated with the transplant process. Contractor will provide education, steering to Contractor's Centers of Excellence, coordinate early transplant evaluations that support effective planning, promote safe health behaviors, manage co-morbid conditions and provide support to Plan Participants on a wait list and during the transplant process.

- Care Coordination and Complex Non-Chronic Conditions (Claims >$50,000 for medical; frequent admits or emergency department visits or repeated self-harm for behavioral health and substance abuse)
  - Health Coach will contact Plan Participant and/or their provider if unable to reach the Plan Participant, or if the Plan Participant declines participation, when there are intervention opportunities identified. Health Coaches will work collaboratively with the Plan Participants and their providers in an effort to ensure an appropriate treatment plan.

- High Risk Maternity Management
  - Contractor will identify high risk pregnancies and engage expectant mothers to improve pregnancy outcomes, reduce neonatal hospitalizations.

- Children with Special Needs

- The primary caregivers of children with special health care needs will be contacted if data indicates gaps in care or lack of appropriate care coordination. The Contractor will seek to improve the system of care for children from birth to 17 years of age and work with caregivers to optimize available benefits.

- Rare Diseases
  - Nurses will work with Plan Participants who are diagnosed with rare diseases and with their providers to reduce emergency department visits and admissions by educating on necessary diagnostic tests, management of symptoms, medication side effects and adherence, and disease progression.

- Post Discharge Outreach Calls
  - Contractor will identify and reduce risks associated with unplanned hospital readmits. Health coaches will call Plan Participants who are discharged from the hospital with medical admits for:
    - Pancreas Disorders
    - Diabetes
    - Cardiovascular Disorders
    - Respiratory Disorders
    - Bladder/Urinary Disorders

- Medication Adherence
  - Contractor will develop an individualized plan to increase or maintain medication adherence which includes, but is not limited to, education on conditions, provider outreach for samples, medication changes, pharmacist consult, and referral to social services for community support for those that enroll in Population Health.

- On-site Nurse and Community Care Nurse
  - The on-site nurse will seek to enhance the success of Population Health services by creating a personal, face-to-face experience allowing Plan Participants to build a strong relationship and increase personal accountability. The on-site nurse will:
    - Target employees with certain defined chronic conditions for on-site face to face engagement;
    - Reduce gaps in care and increase medication adherence for program Plan Participants;
    - Leverage relationships with local physicians to help effectively coordinate care for Plan Participants;
    - Further develop and enhance telephonic coaching; and
    - Promote wellness activities.

  Key success metrics will be mutually agreed to by the Parties in advance for each Contract year. OGB will provide data in electronic format as required to identify the targeted Plan Participants and to analyze results for the Plan Participants, and reasonable access by nurse/s to the Plan Participants at OGB designated sites. OGB will provide office space and furniture, connectivity for computers and access to sites. Contractor will provide oversight, project management, nurse staff and computer equipment needed to fulfill responsibilities.

  - The Community Care Nurse will seek to achieve better health outcomes and costs for targeted Plan Participants at high risk for diseases such as Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), and Diabetes (DM), by working

collaboratively with Baton Rouge area providers and Plan Participants to meet the Plan Participants' needs. The Community Care Nurse will focus on Plan Participants who meet the following criteria:

- Newly diagnosed with potential for complications;
- Have complex, comorbid, behavioral health issues;
- High risk, high cost utilizers; and
- Newly discharged requiring complex discharge coordination.

The Community Care Nurse will function in the Baton Rouge community by working with Plan Participants and primary care providers, becoming a part of the provider office teams, hospital teams, and community providers to improve health outcomes and lower costs. Key success metrics for the Community Care Nurse will be mutually agreed to by the Parties in advance for each Contract year. Contractor will provide oversight, project management, nurse staff and computer equipment needed to fulfill responsibilities of the Community Care Nurse.

- Base Wellness Program.
  - ***Live Better Louisiana*** is an OGB Wellness Program supported by Contractor that will give Plan Participants resources to help them better monitor their health, understand their risk factors and make educated choices as to their health.
  - OGB and Contractor will partner to evolve wellness initiatives as needed based on OGB population demographics and claims information.

Contractor shall provide or contract with independent provider(s) of care management services to provide services in accordance with the Benefit Plan, pursuant to the terms of the Plan and this Contract. OGB and Contractor agree to partner to modify the Population Health and Utilization Review programs as needed based on OGB Plan Participants health needs. For new programs or initiatives beyond those described in this Contract, the role of the Contractor and scope of services will be mutually agreed to prior to implementation, with no additional administrative costs to either party.

Third Party Recovery

- Reimbursement, Subrogation and Other Third-Party Recovery. Contractor shall comply with Attachment VII: Blue Cross Blue Shield of Louisiana/State of Louisiana Office of Group Benefits Subrogation and Workers' Compensation Process and Procedures.
  - Unless otherwise agreed between the Contractor and OGB, in the event of termination of the Contract, Contractor will not continue to work as outlined in Attachment VII any subrogation or reimbursement cases within its possession and will forward all cases to OGB for handling. The Contractor will forward any additional subrogation cases identified by the Contractor with dates of service incurred prior to the date of termination to OGB for handling. These cases will be forwarded to OGB in a mutually agreeable format, at no additional cost to OGB.

- Class Action Claims. From time to time, medical plans are certified as class Plan Participants in class actions that involve payments made by the plans for health care services, medications or medical devices. Contractor must notify OGB within five (5) business days of receipt that it has received any class action notice and/or other lawsuits in which Contractor determines OGB could have an interest. Contractor is not authorized to file such Claims on behalf of OGB. Contractor will provide Claims data and reporting to use in filing for refunds and judgments at no additional cost.

General

- Advisory Services. Provide OGB with ongoing Medical/Rx compliance advisory services relating to state and federal legislative changes for self-funded plans.

- Reporting and Technology Services. Contractor shall provide OGB and its designated actuarial consultant with access to its standard reporting package, as well as any OGB specific dashboard reporting as developed and mutually agreed upon by both parties, specific security view allowing access to only database records for Plan Participants.

- Online Access. Provide 24/7 access, except for scheduled maintenance, to online portal for Plan Participants for activities such as Claim submission, account monitoring, reporting, communications requested and approved by OGB, and any other information required by state and federal laws. All outages in excess of one (1) hour should be promptly reported to the Contract Supervisor.

- Communication Materials. Design, update, print and/or email all Primary Plan Participant(s) communication materials (i.e., provider directories, summary plan documents, etc.), advertisements, marketing materials, and education materials for services such as disease management and wellness programs at the Contractor's expense. Only material specific to OGB will be subject to OGB's approval prior to distribution.

- Annual and Special Enrollment Support. Provide knowledgeable staff to attend state-wide annual and any other special enrollments and informational meetings as scheduled by OGB as well as prepare, print, and distribute communication materials, etc.

- Run-Out Services. Contractor will process Claims for OGB eligible Plan Participants that were incurred prior to but not processed as of the termination of the Contract and which are received by Contractor not more than one (1) year following Contract termination. However, at OGB's request, the handling of such Claims may be transitioned to a successor agent appointed by OGB prior to the end of the run off period, and Contractor shall reasonably cooperate in transitioning of such services to any successor agent appointed by OGB. Further, Contractor will continue to process all Claims and appeals for Claims incurred prior to the termination of the Contract during the one (1) year run off period following termination, unless otherwise transitioned to a successor agent appointed by OGB, at OGB's option.

- Account Satisfaction. Conduct annual Primary Plan Participant(s) and OGB satisfaction surveys and report results to OGB. The survey tools are subject to OGB's approval. At a minimum, OGB satisfaction will be measured in the following areas:
    1. Provides effective support in preparing for, and conducting open enrollment events/sessions.
    2. Provides OGB with timely notification of issues impacting Plan Participants.
    3. Responds to issues and questions in a timely, comprehensive manner.
    4. Develops, follows through on action plans; effective coordination to resolve open issues.
    5. Is accessible and attends scheduled meetings.
    6. Delivers agreed upon reports and communication of program results in a timely manner.

- File Layout and Specifications. Provide file data in a layout format designated by OGB to include, but not limited to, Check Register File, Population Health Participation, Wellness Participation, Medical Claims File, Provider Files, Code Files, Out of Pocket Maximum, and Adjusted Claims

File. Contractor will need to accept OGB's standard file layout. See Attachment IV: File Layout and Specifications.

- Disaster Recovery/Business Continuity Plan. Contractor shall continue the performance of critical functions, including the continuation of the HSA Plan Participant accounts through an appropriate and compliant banking institution, and provide essential services in the event of crisis or other disruption.

- Plan Offerings. Provide Health Reimbursement Account and Health Savings Account Services for respective plan offerings.

- Anti-Fraud Efforts. Contractor agrees to include the OGB in anti-fraud efforts undertaken by Contractor. If Contractor initiates legal proceedings pursuant to anti-fraud efforts that would include the Plan's interests, Contractor shall notify OGB within five (5) business days of such litigation and as to any costs that would be incurred by OGB should OGB decide to allow Contractor to pursue OGB's interest in such litigation. OGB shall notify Contractor if Contractor should pursue OGB's interests in such litigation within a reasonable time.

Deliverables

The deliverables listed in this Section are the standard set required from the Contractor.

Deliverable	Description	Frequency of Submission
Operational Reports		
Quarterly Strategic Report	Plan Dashboard to include data, such as financial experience, claims utilization, program performance, cost management strategies, population health and wellness initiatives and key findings and Plan strategies and opportunities.	Due April 30, July 30, October 30, and January 30 of each calendar year.
Financial Experience	Premium Income and Claims Utilization Experience.	Within fifteen (15) calendar days after end of each month.
Claims Turnaround Time	Percentage of electronic and non-electronic Claims paid within thirty (30) days of receipt.	Within fifteen (15) calendar days after end of each month.
Telephone Abandonment Rate	Percentage of calls where the caller hangs up before speaking to a live voice.	Within fifteen (15) calendar days after end of each month.
PCP Turnover Rate	Percentage of PCPs leaving the network voluntarily or involuntarily during the month.	Within fifteen (15) calendar days after end of each month.
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.	Within fifteen (15) calendar days after end of each month.

Deliverable	Description	Frequency of Submission
Plan Participant - Level Enrollment Accuracy	Percentage of Plan Participant updates within two (2) business days of receipt of a complete eligibility file submission.	Within fifteen (15) calendar days after end of each month and calendar year.
Claims Processing Accuracy	Percentage of Contractor audited Claims processed accurately the first time.	Within fifteen (15) calendar days after end of each month and calendar year.
Financial Payment Accuracy	Percentage of Contractor audited Claims dollars paid accurately.	Within fifteen (15) calendar days after end of each month and calendar year.
Abandoned Call Rate	Percentage of calls where the caller hangs up before speaking to a live voice, excluding those calls abandoned in the first 30 seconds and calls routed to an Interactive Voice Recognition ("IVR") system.	Within fifteen (15) calendar days after end of each month and calendar year.
Plan Participant Written Inquiry Timeliness	Percentage of Plan Participant written inquiries answered within seven (7) business days.	Within fifteen (15) calendar days after end of each month and calendar year.
Average Speed to Answer ("ASA")	Average lag time to answer by live voice; percentage of Plan Participants who wait over 60 seconds to speak with a live customer service representative.	Within fifteen (15) calendar days after end of each month and calendar year.
Primary Plan Participant(s) ID Card Timeliness	Number of Primary Plan Participant(s) issued identification card within 30 days of receipt of confirmation of enrollment eligibility.	Within fifteen (15) calendar days after end of each month and calendar year.
Data Reporting Timeliness	All required data denoted in Attachment IV must be submitted to OGB within 10 days of the following month.	Within ten (10) calendar days after end of each month being reported.
Subrogation	Reporting in accordance with Attachment VII: Blue Cross Blue Shield of Louisiana / State of Louisiana Office of Group Benefits Subrogation and Workers' Compensation Process and Procedures.	Per Attachment VII

Deliverable	Description	Frequency of Submission
Reports in Response to Audit Requests	Description will be provided at time of request.	Ad Hoc
Account Satisfaction		
Overall Primary Plan Participant(s) Satisfaction Survey	Conduct annual Primary Plan Participant(s) satisfaction survey and report results to OGB.	Within thirty (30) calendar days after end of each calendar year.
OGB Satisfaction Survey	Conduct annual OGB satisfaction survey and report results to OGB.	

Deliverable	Description	Frequency of Submission
Population Health Management		
Semi-Annual Chronic Condition Management Report	Number of Plan Participants that are eligible and enrolled versus those who are eligible and not enrolled in Chronic Condition Management.	Calendar Year 1: Two semi-annual reports as follows: Due June 30 to include data beginning January 1 through June 15 and due December 31 to include data beginning June 16 through December 15. Calendar Year 2: Two semi-annual reports as follows: Due June 30 to include data beginning December 16 through June 15 and due December 31 to include data beginning June 16 through December 15. Calendar Year 3: Two semi-annual reports as follows: Due June 30 to include data beginning December 16 through June 15 and due January 15, 2019 to include data beginning June 16 through December 31, 2018. Calendar Year 4: Two semi-annual reports as follows: Due June 30 to include data beginning December 16 through June 15 and due January 15, 2020 to include data beginning June 16 through December 31, 2019.
Claimants Cost Report	Plan Participants accumulating > $10,000 in paid claims during period and > $25,000 YTD. The report will include the number of Plan Participants, number new to report versus ongoing, average paid per Plan Participant, total paid amount, percent of total paid claims, distribution by diagnosis, and Plan Participant category (active, dependents, retirees with Medicare, and retirees without Medicare Plan Participants).	Calendar Year 1: Two semi-annual reports as follows: Due June 30 to include Claims data beginning January 1 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 2: Two semi-annual reports as follows: Due June 30 to include

Deliverable	Description	Frequency of Submission
		Claims data beginning December 16 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 3: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2019 to include Claims data beginning June 16 through December 31, 2018. Calendar Year 4: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2020 to include Claims data beginning June 16 through December 31, 2019.
Diabetes Adverse Events	Disease related inpatient admits and/or emergency room visits for Plan Participants ages 18-64 with Diabetes.	Calendar Year 1: Two semi-annual reports as follows: Due June 30 to include Claims data beginning January 1 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 2: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 3: Two semi-annual reports as follows: Due June 30 to include

Deliverable	Description	Frequency of Submission
		Claims data beginning December 16 through June 15 and due January 15, 2019 to include Claims data beginning June 16 through December 31, 2018. Calendar Year 4: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2020 to include Claims data beginning June 16 through December 31, 2019.
Coronary Artery Disease ("CAD") Adverse Events	Disease related inpatient admits and/or emergency room visits for Plan Participants ages 18-64 with CAD.	Calendar Year 1: Two semi-annual reports as follows: Due June 30 to include Claims data beginning January 1 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 2: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 3: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2019 to include Claims data beginning June 16 through December 31, 2018. Calendar Year 4: Two semi-annual reports as follows: Due June 30 to include

Deliverable	Description	Frequency of Submission
		Claims data beginning December 16 through June 15 and due January 15, 2020 to include Claims data beginning June 16 through December 31, 2019.

Deliverable	Description	Frequency of Submission
Congestive Heart Failure ("CHF") Adverse Events	Disease related inpatient admits and/or emergency room visits for Plan Participants ages 18-64 with CHF.	Calendar Year 1: Two semi-annual reports as follows: Due June 30 to include Claims data beginning January 1 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 2: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 3: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2019 to include Claims data beginning June 16 through December 31, 2018. Calendar Year 4: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2020 to include Claims data beginning June 16 through December 31, 2019.
Diabetes Prevention Program ("DPP") Performance	Aggregated weight loss outcomes of DPP participants for each participant group (i.e. starters and graduates), projected diabetes reduction to include cost avoidance, claims impact, and health status (i.e., BMI, weight, etc.).	Calendar Year 1: Two semi-annual reports as follows: Due June 30 to include Claims data beginning January 1 through June 15 and due December 31 to include Claims data beginning June 16 through December 15.

Deliverable	Description	Frequency of Submission
		Calendar Year 2: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 3: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2019 to include Claims data beginning June 16 through December 31, 2018. Calendar Year 4: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2020 to include Claims data beginning June 16 through December 31, 2019.
Mental Health - 30 day follow up	Percentage of Plan Participants who have a follow up evaluation and management visit within 30 days of discharge.	Within fifteen (15) calendar days after close of each month.
On-site Nurse	Number of newly identified Plan Participants with chronic conditions who engage. Number of Plan Participants engaging with on-site nurse in report period.	Within fifteen (15) calendar days after close of each quarter.
Population Health	Eligible, referred, enrolled engagement statistics, and associated clinical indicators.	Within fifteen (15) calendar days after close of each quarter.

Deliverable	Description	Frequency of Submission
Readmissions Rate	Readmissions rates for inpatient admits including diagnosis within 30 days, 90 days, and 120 days.	Within fifteen (15) calendar days after close of each quarter.
Inpatient Reviews	Number of inpatient admissions reviews, and number of inpatient concurrent reviews per month.	Within fifteen (15) calendar days after close of each quarter.
Clinical Trend Report	List of 25 most common inpatient diagnoses (charges and paid). List of outpatient diagnoses with charges and paid (include cost/Plan Participant, sorted by region of the state where service was provided and in the aggregate).	Within fifteen (15) calendar days after close of each quarter.
Preventive Care	Number of eligible Plan Participants and the number of participating Plan Participants with adherence to required preventive and maintenance screenings based on age and condition.	Within fifteen (15) calendar days after close of each calendar year.
Cost Savings Report	Cost savings information for care management, disease management, wellness, and any other programs implemented to improve health outcomes of Plan Participants.	Within fifteen (15) calendar days after close of each calendar year.
Disease Management Activity Report	Activity Report broken out by line of business ("LOB") to include, but not limited to, plan type and status.	Within fifteen (15) calendar days after close of each month.
Performance Guarantees Report		
Performance Guarantees	A detailed monthly report including metrics for the performance guarantees set forth in the Contract.	Within thirty (30) calendar days after close of each month and calendar year.
Over-Utilization Reports		
ALERT	Over-utilization or abuse by Plan Participant or provider, fraud, etc. with number of cases identified and disposition, and number of cases under review.	Within forty-five (45) calendar days after close of each quarter.
Fraud and Abuse	Financial impact of identified fraud and abuse.	Within forty-five (45) calendar days after close of each quarter.
Network Management Reports		

Deliverable	Description	Frequency of Submission
Overall Network Discounts	Report illustrating the overall discount received by specialty and by region of the state.	Within thirty (30) calendar days after the close of each month and calendar year.
Geo Access	Report for rural and urban, displayed for inpatient facility, partial, hospital, outpatient provider and MD.	Calendar Year 1: Two semi-annual reports as follows: Due June 30 to include Claims data beginning January 1 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 2: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 3: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2019 to include Claims data beginning June 16 through December 31, 2018. Calendar Year 4: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2020 to include Claims data beginning June 16 through December 31, 2019.
Other Coverage	Monthly report of Plan Participants who have other coverage (i.e. Medicare or other commercial coverage).	Within fifteen (15) calendar days after the close of each month.

Deliverable	Description	Frequency of Submission
50 Most Utilized Providers	List of 50 most utilized in-network providers in Louisiana by 1) specialty, 2) per region of the state, 3) by number of evaluation and management visits and by 4) total allowed charges.	Reports due: January 4, 2016, and thereafter on April 15, July 15, October 15 and January 15 of each calendar year.
25 Most Utilized Facilities	List of top 25 most utilized facilities by number of admissions, average length of stay, 30, 90, and 120 day readmission rate and 30 day outpatient follow-up rate.	Calendar Year 1: Two semi-annual reports as follows: Due June 30 to include Claims data beginning January 1 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 2: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due December 31 to include Claims data beginning June 16 through December 15. Calendar Year 3: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2019 to include Claims data beginning June 16 through December 31, 2018. Calendar Year 4: Two semi-annual reports as follows: Due June 30 to include Claims data beginning December 16 through June 15 and due January 15, 2020 to include Claims data beginning June 16 through December 31, 2019.
Network Providers	Detailed listing including the number of providers and facilities in network by type, facility and provider terminations during report	Within thirty (30) calendar days after close of each quarter.

Deliverable	Description	Frequency of Submission
	period by type, and new and re-contracted providers and facilities by type during the report period.	
In vs. Out of Network Analysis	In-network versus out of network analysis for each level of care (i.e., inpatient, outpatient, etc.).	Within forty-five (45) calendar days after close of each quarter.
Disruption Notification		
Network Disruption Notification	Provide at least sixty (60) days advance written notification to OGB and its Primary Plan Participant(s) of any change in provider networks. Primary Plan Participant(s) communications are subject to OGB's approval prior to distribution by the Contractor.	Within sixty (60) calendar days of any change to network.
Independent Assurances		
Independent Assurances	Contractor and its subcontractors performing key delegated functions shall each supply OGB with an exact copy of the SOC 1, Type II report and/or SOC 2, Type II report (as agreed by OGB) resulting from the SSAE 16 engagement or other assurances as described in Section 25 and for the period Jan 1- Dec 31 If a report is not available for that period, the latest report will be provided with an attestation from the subcontractor's management that the controls reported on have not significantly changed since the issuance of the report ("bridge letter").	Calendar Year 1: Due March 31, 2017 for the period of January 1 – December 31, 2016. Calendar Year 2: Due March 31, 2018 for the period of January 1 – December 31, 2017 Calendar Year 3: Due March 31, 2019 for the period of January 1 – December 31, 2018. Calendar Year 4: Due March 31, 2020 for the period of January 1 – December 31, 2019.
Unclaimed Property Report		
Unclaimed Property	Detailed listing in a mutually agreeable format of any unclaimed property of OGB Plan Participants held by Contractor.	No later than June 30 of each calendar year.

Performance Guarantees

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

Metric	Performance Standard	Penalty Percent at Risk Annually
Independent Assurances		
Independent Assurances	Contractor shall supply OGB with an exact copy of the SOC1, Type II and/or SOC 2, Type II report (as agreed by OGB) resulting from the SSAE 16 engagement or any other independent assurances as described in Section 25 and for the period of January 1 – December 31 beginning March 31 2017 and each calendar year thereafter.	$1,000 per day
Plan Participant and Billing		
Plan Participant-Level Enrollment Accuracy	98% of Plan Participant updates within two (2) business days of receipt of a complete eligibility file submission.	1.5%
Claims Operations		
Claims Processing Accuracy	97% or greater of audited Claims adjudicated accurately in accordance with the Plan.	1.5%
Financial Accuracy	96% or greater of audited Claims accurately paid in accordance with the contracted provider rate.	1.5%
Customer Service		
First Call Resolution	80% of Plan Participant calls resolved on first call. **Measurement:** The number of calls that are completed without the need for referral or follow up actions divided by the total number of calls (excludes calls routed to IVR).	1.5%

Metric	Performance Standard	Penalty Percent at Risk Annually
Abandoned Call Rate	Less than or equal to 5% abandonment rate as a percent of all calls disconnected before a Customer Service Representative gets on the line. (Excludes calls abandoned within the first 30 seconds and calls routed to IVR).	1.5%
Plan Participant Written Inquiry Timeliness	95% of all written inquiries will be answered within 7 business days.	1.5%
Average Speed to Answer	The average elapsed time between call accepted into Contractor's system and a customer service representative gets on the line will be less than or equal to 60 seconds.	1.5%
Account Satisfaction		
Overall Primary Plan Participant Satisfaction Survey	Satisfaction Rate must be 85% or greater.	2%
OGB Satisfaction Survey	Satisfaction Rate must be 85% or greater, using metrics mutually agreed upon by Contractor and OGB prior to January 1, 2016.	2%
Reporting and Analytics		
Overall Reporting Requirements	Contractor agrees to provide 90% of all reports listed in the Contract by the required timeframe stated in the Contract.	2.5%
Data Analytics	Refresh analytic tool data monthly by the 30th of the following month at minimum 91 percent of the time.	2.5%
Provider Contracting and Network		
Minimum Overall Network Discounts (all services)	Contractor will guarantee at least a 60% network discount for Louisiana in-network providers, excluding pharmacy. Contractor will provide a discount report illustrating the overall discount achieved.	Calendar Year 1 - 15% Calendar Year 2 – 13% Calendar Year 3 – 13% Calendar Year 4 – 13%
Population Health Management		

Metric	Performance Standard	Penalty Percent at Risk Annually
Diabetes Adverse Events	Adverse events defined as disease related inpatient admits and/or emergency room for Plan Participants ages 18-64 with Diabetes. The adverse events for each year will be measured against the prior Plan year's adverse events. The adverse events for each Plan year shall be equal to or less than the prior Plan year's adverse events, using a *difference in difference*** trend model.	2%
Coronary Artery Disease Adverse ("CAD") Events	Adverse events defined as disease related inpatient admits and/or emergency room for Plan Participants ages 18-64 with CAD. The adverse events for each year will be measured against the prior Plan year's adverse events. The adverse events for each Plan year shall be equal to or less than the prior Plan year's adverse events using a *difference in difference*** trend model.	2%
Congestive Heart Failure ("CHF") Adverse Events	Adverse events defined as disease related inpatient admits and/or emergency room for Plan Participant ages 18-64 with CHF. The adverse events for each year will be measured against the prior Plan year's adverse events. The adverse events for each Plan year shall be equal to or less than the prior Plan year's adverse events, using a *difference in difference*** trend model.	2%
Mental Health 30 day follow up visit after discharge	60% of Plan Participants discharged from an inpatient mental health facility will have a follow up visit within 30 days of discharge.	2%

Metric	Performance Standard	Penalty Percent at Risk Annually
On-site Nurse and Community Care Nurse	Calendar Year 1: Establish on-site nurse population health management with one (1) registered on-site nurse dedicated solely to OGB. Calendar Year 2: Expand the on-site nurse to include two (2) on-site nurses dedicated solely to OGB. Calendar Year 3 from January 1, 2018 through March 31, 2018: A minimum of two on-site nurses dedicated solely to OGB. Calendar Year 3 effective April 1, 2018: Two nurses dedicated solely to OGB. Calendar Year 4: Two nurses dedicated solely to OGB.	Calendar Year 1 – 0% Calendar Year 2 – 2% Calendar Year 3 – 2% Calendar Year 4 – 2%

****Difference in difference*** model will isolate changes compared to risk adjusted benchmark reference population