On this 6th day of September, 2018, 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" or "State", and Vantage Health Plan, Inc., 130 DeSiard Street, Suite 300, Monroe, LA 71201, 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 shall provide a fully-insured Health Maintenance Organization (HMO) Physician and Hospital Provider Network, including behavioral health and pharmacy benefits, and associated services, to OGB Plan Participants in all OGB regions (i.e., statewide) on a fully-insured basis. These services shall include, at a minimum, all services specified in Section 1.2 and the attachments referenced therein.

1.2 STATEMENT OF WORK

The Statement of Work consists of the following and/or any subsequent addendum:

Attachment I: Scope of Work/Services

Attachment II: Business Associate Addendum

Attachment III: Premium Rate Schedule

Attachment IV: Record Retention Schedule

Attachment V: Imaging System Survey Compliance and Records Destruction

Attachment VI: File Layout and Specifications

1.3 GOALS AND OBJECTIVES

1. To provide quality, cost-effective fully-insured HMO health care services to Plan Participants.
2. To establish a Contract with a fully-insured HMO Contractor.

1.4 PERFORMANCE MEASURES

The performance of the Contract, including but not limited to Attachment I: Scope of Work/Services, and/or any subsequent addendum including performance criteria and corresponding monetary penalties for Contractor's failure to comply with the identified criteria in Section 3.6, Performance Guarantees, will be measured by the OGB Contract Supervisor. The OGB Contract Supervisor is authorized to evaluate the Contractor's performance against these criteria.

1.5 MONITORING PLAN

The Contract Supervisor will be the OGB Medical and Pharmacy Group Benefits Administrator, who will monitor the services and performance provided by the Contractor and the expenditure of funds under this Contract. The monitoring plan is as follows:

1. The Contractor will submit various monthly, quarterly, and annual reports to the Contract Supervisor as specified in Attachment I: Scope of Work/Services.
2. The Contract Supervisor will work to ensure all deliverables are submitted timely and perform subsequent review and acceptance.
3. The Contract Supervisor will provide oversight of the implementation of the Scope of Work/Services to ensure quality, efficiency, and effectiveness in fulfilling the goals and objectives of OGB.

1.6 CONTRACTOR PROJECT MANAGEMENT

Contractor Project Management is as follows:

A. **Account Management Team.** Contractor will provide an account management team for the duration of the engagement, including a project manager and any other personnel considered key to the success of the Contract.

B. **Substitution of Key Personnel.** The Contractor's personnel assigned to this Contract shall not be replaced without the prior written consent of OGB/State. Such consent shall not be unreasonably withheld or delayed, provided an equally qualified replacement is offered. In the event that any Contractor personnel become unavailable due to resignation, illness, or other factors, excluding assignment to projects outside this Contract, outside of the Contractor's reasonable control, as the case may be, the Contractor shall be responsible for providing an equally qualified replacement in time to avoid delays in providing services. When possible, Contractor will give OGB a minimum of sixty (60) days' advance notice of any changes in OGB's account management team, and a description of the training requirements for new team members. Reasonable exceptions would apply in situations beyond Contractor's control (i.e., resignation/termination with less than 60 days' notice). OGB reserves the right to request changes to any of the assigned personnel based on unsatisfactory performance levels as determined by OGB. Additionally, OGB will be provided with the opportunity to interview any new team member(s).

C. **Account Management Team Support.** The account management team will provide support around account strategy, issue resolution, reports and other requested projects and deliverables.

D. **Coordination with other OGB Vendor(s).** Contractor will coordinate and cooperate with OGB's administrative services provider(s) for OGB's self-insured medical plans, pharmacy benefit manager, and other vendors as needed on integration of information to or from other service providers relative to the services addressed in this Contract.

1.7 DELIVERABLES

The Contract will be considered complete when the entire scope of work/services has been completed and Contractor has delivered and OGB has accepted all deliverables specified in the Contract.

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 DEFINITIONS

Contractor – Denotes the successful Proposer who is awarded a Contract and assumes full responsibility and liability for completion of the scope of work and deliverables.

COBRA- Denotes Consolidated Omnibus Budget Reconciliation Act.

HIPAA – Denotes Health Insurance Portability and Accountability Act.

Network Provider – Denotes a health care provider that participates in the Contractor's established network to provide health care services to Plan Participants.

Non-Network Provider – Denotes a health care provider that does not participate in the Contractor's established network to provide health care services to Plan Participants.

OGB CEO– Denotes the Office of Group Benefit's Chief Executive Officer.

OSP – Denotes Office of State Procurement.

Plan Participant(s) – Denotes individuals who are entitled to Covered Benefits through OGB under the fully-insured plan, as identified in the eligibility data file prepared, maintained and as determined by OGB, and delivered to the Contractor.

Primary Plan Participant(s) – Denotes the Plan Participant whose relationship with OGB governs the coverage under the Plan.

Proposal – Denotes a response to a RFP.

Proposer – Denotes an individual or organization submitting a proposal in response to a RFP.

RFP– Denotes a Request for Proposals.

Shall, Must, Will– Denotes a mandatory requirement.

Should, May, Can– Denotes an advisable or permissible action.

State - The State of Louisiana.

3 ADMINISTRATIVE REQUIREMENTS

3.1 TERM OF CONTRACT

The initial term of this Contract shall begin on or about January 1, 2019, and is anticipated to end on December 31, 2021. With all proper approvals and concurrence with the successful Contractor, OGB may also exercise an option to extend the Contract for up to twenty-four (24) additional months at the same administrative fee, terms and conditions of the initial Contract term. Prior to the extension of the contract beyond the initial thirty-six (36)-month term, prior

approval by the Joint Legislative Committee on the Budget (JLCB) and/or other approval authorized by law shall be obtained. Written evidence of JLCB approval shall be submitted, along with the contract amendment, to the Office of State Procurement (OSP) to extend contract terms beyond the initial 3-year term. The total Contract term, with extensions, shall not exceed five (5) years. The continuation of this Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

3.2 OGB FURNISHED RESOURCES

OGB shall appoint a Contract Supervisor for this Contract who will provide oversight of the activities conducted hereunder. The assigned Contract Supervisor shall be the principal point of contact on behalf of OGB and will be the principal point of contact for the Contractor concerning Contractor's performance under this Contract.

3.3 TAXES AND FEES

Contractor is responsible for payment of all taxes and fees on Contractor's income, property, and entity status (i.e., permits, licenses, etc.). Contractor's federal tax identification number is 72-1285173. Contractor's seven-digit Louisiana Department of Revenue account number is 8810368. In accordance with La. R.S. 39:1624(A)(10), the Louisiana Department of Revenue ("LDR") must determine that the Contractor is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the Department of Revenue prior to the approval of this Contract by the Office of State Procurement. The Contractor hereby attests to its current and/or prospective compliance, and agrees to provide its seven-digit LDR Account Number to the contracting agency so that the contractor's tax payment compliance status may be verified. The Contractor further acknowledges understanding that issuance of a tax clearance certificate by the Louisiana Department of Revenue is a necessary precondition to the approval and effectiveness of this Contract by the Office of State Procurement. The contracting agency reserves the right to withdraw its consent to this Contract without penalty and proceed with alternate arrangements should the Contractor fail to resolve any identified apparent outstanding tax compliance discrepancies with the Louisiana Department of Revenue within seven (7) days of notification of such discrepancies.

3.4 PAYMENT TERMS

In consideration of the services required by this Contract, OGB hereby agrees to pay to Contractor a maximum fee of $140,500,000.00 (One Hundred Forty Million, Five Hundred Thousand Dollars) for work performed during the term of this Contract. This fee is inclusive of travel and all Contract-related expenses. Payments are predicated upon successful completion by Contractor 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 or State holidays.

With respect to Plan Participants 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. OGB shall impose upon Contractor a monthly administrative fee of $20.00 for each HMO Primary Plan Participant. This administrative fee will be retained from the

successful Contractor's fixed monthly premium paid directly to OGB for each Plan Participant. Those Plan Participants selecting the Louisiana HMO option shall receive the same employer contributions provided under La. R.S. 42:851, and the regulations issued thereunder, as Plan Participants who choose other health coverage options offered by OGB.

The Contractor will invoice OGB on the 1st of each month for payment of Plan premiums and for services provided pursuant to this Contract. The invoice should include, at a minimum, the time period covered, total billed amount detailed by class of coverage, and assessed administrative fee based on total number of Primary Plan Participant. Payments will be made to the Contractor after written acceptance by the State and approval of invoice. Upon approval of each submitted invoice by OGB's Chief Executive Officer or designee under a valid Contract, OGB/State will render payment of undisputed amounts within thirty (30) days.

3.5 PERFORMANCE BOND

Unless issuance of such bond is against applicable law, Contractor shall provide a performance (surety) bond in an amount determined by OGB of no more than one hundred percent (100%) of the quarterly administrative cost and profit to ensure the successful performance under the terms and conditions of the Contract. The administrative cost and profit is fifteen percent of the per Primary Plan Participant per month premium. 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 ten percent (10%) of policyholders' surplus as shown in the latest A.M. Best's Key Rating Guide. In addition, any performance bond furnished shall be written by a surety or insurance company that is currently licensed to do business in the State of Louisiana.

The performance bond is to be provided at least thirty (30) working days prior to the effective date of the Contract. Failure to provide the bond within the time specified may cause the Contract to be cancelled.

3.6 PERFORMANCE GUARANTEES

Contractor agrees to provide its operational performance guarantees and report OGB's results on a client-specific basis 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 total contracted cost will remain at risk, and Contractor will be subject to per day and per occurrence fees for certain performance guarantees. 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. "Total contract cost", for purposes of this Section 3.6 and elsewhere in this Contract as used to measure performance guarantees, denotes the annual premium payable for Plan administration plus profit, which is designated and measured by OGB as fifteen (15%) percent of the total premium payable for the twelve (12)-month period effective January 1, 2019, and each subsequent calendar year of the Contract.

Performance Guarantees: The Contractor will be subject to negotiated performance standards subject to a penalty of twenty-five (25%) percent of the total contracted cost, plus per day and per occurrence fees for certain performance guarantees.

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, 2019, through December 31, 2019. The second period will be for calendar year 2020, and the third period will be for calendar year 2021. The fourth and fifth period to be measured, subject to any option approval required by law, are calendar year 2022 and 2023, respectively.

4 TERMINATION

4.1 TERMINATION FOR CAUSE

The State may terminate this Contract for cause based upon the failure of the Contractor to comply with the terms and/or conditions of the Contract; provided the State shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) calendar 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) calendar days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the State 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 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 State to comply with the terms and conditions of this Contract, provided that the Contractor shall give the State written notice specifying the State agency's failure and a reasonable opportunity for the State to cure the defect.

4.2 TERMINATION FOR CONVENIENCE

OGB/State may terminate the Contract at any time by giving at least thirty (30) days' written notice to Contractor of such termination or negotiating with Contractor an effective date. Contractor shall be entitled to payment for services completed prior to receipt of such notice and deliverables in progress, to the extent work has been performed satisfactorily.

4.3 TERMINATION FOR NON-APPROPRIATION OF FUNDS

The continuation of this Contract is contingent upon the appropriation of funds by the Louisiana Legislature to fulfill the requirements of the Contract, as applicable. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the Contract, or if such appropriation is reduced or eliminated 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.

5 INDEMNIFICATION AND DEFENSE

(a) Contractor shall be fully liable for its own actions and the actions of its agents, employees, partners and subcontractors/vendors and shall fully protect, defend, and indemnify all State departments, including OGB, Agencies, Boards, and Commissions (collectively, the "State"), its officers, trustees, employees, servants, subcontractors, agents, and volunteers from and against any and all losses, claims, demands, liabilities, suits, actions, damages, costs, fines, penalties, judgments, forfeitures, assessments, expenses, obligations (including attorneys' fees), and other liabilities of every name and description ("Claims/Costs") relating to personal injury or death to any person or damages, loss, or destruction of any real or tangible property which Claims/Costs may occur, or in any way arise out of, any act or omission of Contractor, its employees, agents, partners, contractors, or officers.

(b) Contractor shall indemnify and defend State from and against any Claims/Costs arising out of or related to any violation of or failure to comply with any state or federal law, or other legal or Contract requirement, to the extent caused by Contractor, its agents, employees, officers, partners or subcontractors; provided, however, that Contractor shall not be required to indemnify for that portion of any Claims/Costs arising hereunder due solely to the negligent or intentional act or failure to act of the State.

(c) Contractor shall fully protect, defend, and indemnify, the State, OGB, its officers, trustees, employees, servants, subcontractors, agents, and volunteers from and against all adverse federal and state tax consequences, loss, liability, damage, expense, attorneys' fees or other obligations resulting from, or arising out of, any act or omission by Contractor in connection with this Contract resulting from or arising out of any premium charge, tax, or similar assessment by federal, state, and local governmental authorities, for which Contractor is liable.

(d) If applicable, Contractor will protect, defend, and indemnify, the State, OGB, its officers, trustees, employees, servants, subcontractors, agents, and volunteers, from and against all Claims/Costs which may be assessed against the State, 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, in relation to this Contract, provided that the State/OGB shall give 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 Claims/Costs at Contractor's sole expense; and (iii) reasonable assistance in the defense of any such action at the expense of Contractor. Where a Claim/Cost arises relative to a real or anticipated infringement, the State, 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 to such infringement claim as OGB/the State deems necessary.

(e) In addition to the foregoing remedies for patent infringement Claims/Costs, if the use of the product, material, or service or part(s) thereof shall be enjoined for any reason or if Contractor believes that such use may be enjoined, Contractor shall have the right, at its own expense and sole discretion take action in the following order of precedence: (i) to

procure for the State/OGB the right to continue using such product, material, or service or part(s) thereof, as applicable, under the same terms and conditions as provided in this Contract; (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, in State's/OGB's sole opinion; (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, in State's/OGB's sole opinion; or (iv) if none of the foregoing is commercially reasonable, provide monetary compensation to State/OGB.

(f) Contractor agrees to indemnify and defend the State and OGB from all Claims/Costs relating to Contractor's or its subcontractors'/vendors' fault or negligence, including, but not limited to, any Claims/Costs relating to the failure of Contractor to provide services or fulfill obligations as specified in this Contract due to financial hardship or insolvency.

(g) Contractor agrees to investigate, handle, respond to, provide defense for and defend any Claims/Costs, even if the Claims/Costs are groundless, false or fraudulent.

(h) The State and OGB may, in addition to other remedies available to the State, OGB, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers at Law or equity and upon notice to Contractor, retain such monies from amounts due or that become due to Contractor as may be necessary to satisfy any Claims/Costs, and other liabilities asserted by or against the State, OGB, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers, for which Contractor owes indemnification and/or defense pursuant to this Section.

6 FORCE MAJEURE

Neither party shall be liable for any delay or failure in performance beyond its control resulting from acts of God or force majeure. Whether a delay or failure results from a force majeure is ultimately determined by the State based on a review of all facts and circumstances. The parties shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under Contract.

7 CONTRACT CONTROVERSIES

Any claim or controversy arising out of the Contract shall be resolved by the provisions of La. R.S. 39:1672.2-1672.4.

8 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.

9 ASSIGNMENT

Contractor shall not assign any interest in this Contract by assignment, transfer, novation, or otherwise without prior written consent of the OGB CEO or his/her delegee. This provision shall not be construed to prohibit 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, transfer, or novation shall be furnished promptly to the State Contract Supervisor and shall not be binding upon the State until actually received by the State.

10 RIGHT TO AUDIT

The State Legislative Auditor, federal auditors, internal auditors of the Division of Administration and its designated agents, the State, OGB, or others so designated by the State/OGB shall be entitled to audit all accounts, procedures, matters, and records of any Contractor or subcontractor under any negotiated Contract or subcontract directly pertaining to the Contract for a period of five (5) years after final payment under the Contract and for the subcontractor/vendor for a period of five (5) years from the date of final payment under the subcontract or such longer period as required by applicable state and federal law. Records, including direct read access to databases and all tables, shall be made available during normal business hours for this purpose.

The State has the right to hire an independent third-party auditor, if the State deems necessary, to review all accounts, procedures, matters, and records, and Contractor and/or subcontractor/vendor shall provide access to all files, information system access, and space access upon request of the State for the third-party auditor selected to perform the indicated audit.

In the event that an examination of records results in a determination that previously paid invoices included charges which were improper or beyond the scope of the Contract, Contractor agrees that the amounts paid to the Contractor shall be adjusted accordingly, and that the Contractor shall within thirty (30) days of notification of such finding issue a remittance to the State of any payments declared to be improper or beyond the scope of the Contract. In combination therewith, or alternatively, the State may offset the amounts deemed improper or beyond the scope of the Contract against Contractor's outstanding or subsequent invoices, if any.

10.1 RECORDS

All records, reports, documents, or other material related to this Contract, delivered or transmitted to the Contractor by the State or its employees, agents, or authorized vendors, and/or obtained or prepared by Contractor or its subcontractors/vendors in connection with the performance of the services under the Contract, shall become records of the State and are referred to herein 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"), Attachment IV, until such time as the Records are returned to the State or other disposition is agreed. In the event the applicable law and the Schedules contain different retention periods, the Records shall be kept for the longer period.

Records shall be in a format and media as required by law or as agreed upon by the parties in writing if allowed by applicable law. The Schedules in place as of the effective date of this Contract are contained in Attachment IV, Records Retention Schedule, and may be amended from time to time as deemed necessary by the State. To further ensure compliance with the Schedules and Louisiana retention laws, Contractor agrees to abide by the processes outlined in Attachment V, Imaging System Survey Compliance and Records Destruction. Contractor shall return the Records to the State, at Contractor's expense, within seven (7) days of request or in the specific instance of termination or expiration of the Contract, within sixty (60) days after the termination or expiration of this Contract, and shall retain no copies of the Records unless required by applicable law; provided, the confidentiality and security requirements of this Contract shall apply to such Records as long as retained by the Contractor. Additionally, all State data must be sanitized from Contractor's (and its vendors') systems in compliance with the most current revision of NIST SP 800-66.

10.2 CONTRACTOR'S COOPERATION

Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, or other such requested support to the State when requested. This applies even if the Contract is terminated and/or litigation ensues. Specifically, Contractor shall not limit or impede OGB's right to audit, or withhold Records.

11 CONTRACT MODIFICATIONS

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 shall be binding on any of the parties.

12 CONFIDENTIALITY OF DATA

All financial, statistical, personal, technical, and other data and information relating to the State's operation or the Contract which are made available to the Contractor in order to carry out this Contract, or which become available to the Contractor in carrying out this Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective security and procedural requirements as are applicable to OGB and the State. The Contractor shall not be required under the provisions of this paragraph to keep confidential any data or information (other than protected health information) which is or becomes publicly available through no fault of Contractor or its subcontractors, vendors, agents, or employees, 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 without breach of the Contract.

Under no circumstance shall the Contractor discuss and/or release information to the media concerning this Contract or any Plan Participant without prior express written approval of the OGB CEO or his/her delegee.

12.1 SECURITY/DUTIES TO MONITOR AND REPORT SECURITY EVENTS

The Contractor and its subcontractors/vendors shall maintain safeguards and take commercially reasonable technical, physical, and organizational/administrative precautions to

ensure that the State's data is protected from unauthorized access, use, and disclosure, in accordance with the State's current and published Information Security Policy found at http://www.doa.la.gov/OTS/InformationSecurity/InformationSecurityPolicy-LA-v.1.0.pdf. The Contractor shall implement and maintain safeguards and monitoring plans to detect unauthorized access to or use of confidential information and any attempts to gain unauthorized access to confidential information. The Contractor and its subcontractors/vendors shall provide the Contract Supervisor with immediate notification (not more than forty-eight (48) hours) of the Contractor's awareness of any Security Event, as defined in the Information Security Policy ("Security Event"), involving confidential information under this Contract and also report such Security Event to Louisiana's Information Security Team at 1.844.692.8019 (open 24 hours a day, 7 days a week) as soon as feasibly possible, not to exceed 48 hours following discovery of the Security Event. The reference to Security Event herein may include, but not be limited to, the following: attempts at gaining unauthorized access to confidential information or the unauthorized use of a system for the processing or storage of confidential information, or the unauthorized use or disclosure, whether intentional or otherwise, of confidential information.

In the event of a Security Event, the Contractor shall consult and cooperate fully with the State regarding the necessary steps to address the factors giving rise to the Security Event and to address the consequences of such Security Event. Contractor shall also provide assistance performing a risk assessment of any Security Event that occurs, if requested by the State.

Nothing in this Contract shall be deemed to affect or limit any rights an individual Plan Participant may have under any applicable state or federal law concerning privacy rights or the unauthorized access, use, or disclosure of protected health information.

12.2 THIRD PARTY REQUESTS FOR RELEASE OF INFORMATION

Should third parties request the Contractor to submit confidential information to them pursuant to an audit or other request not initiated by the Contractor, public records request, subpoena, summons, search warrant or governmental order, the Contractor will notify the State immediately upon receipt of such request. Notice shall be forwarded via e-mail to the Chief Executive Officer of OGB. The Contractor shall cooperate with the State with respect to defending against any such requested release of information or obtaining any necessary judicial protection against such release if, in the opinion of the State, the information contains confidential information which should be protected against such disclosure. The reasonable legal fees and related expenses incurred by the Contractor or its subcontractor in resisting the release of information under this provision shall constitute reimbursable expenses under this Contract.

Legal service fees of law firms engaged pursuant to this Section may not be "marked up" (i.e., invoiced cost-plus) by the Contractor.

13 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 prior written approval of the OGB CEO or his/her delegee. In no event shall the existence of a subcontract operate to release or reduce the liability of the Contractor to the State for any breach or deficiency 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/vendors who are performing any key internal control to undergo independent assurance project/program review through the methods stated in or approved pursuant to this Contract.

14 COMPLIANCE WITH LAWS

The Contractor must comply with all applicable laws while providing services under this Contract. Specifically, 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 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 its subcontractors, or failure to comply with these statutory obligations when applicable, shall be grounds for immediate termination of this Contract.

15 INSURANCE

Contractor's Insurance: The Contractor shall not commence work under the Contract until it has obtained all insurance required herein, and Contractor shall maintain the required insurance for the duration of the Contract or as further indicated herein. The date of the inception of the policy must be no later than the first date of anticipated work under the Contract. Certificates of Insurance shall be filed with the State for approval. If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval of the State before work is commenced. Contractor must provide the State thirty (30) days' prior written notice of any cancellation or reduction in coverage for any such insurance. Any such cancellation or reduction in coverage, if not approved in advance, may result in termination of the Contract.

Workers' Compensation Insurance: Before any work is commenced, Contractor must have in place and shall maintain during the life of the Contract, Workers' Compensation Insurance for all of Contractor's employees and other persons for whom Contractor is required to provide Workers' Compensation Insurance under applicable law. In case any work is sublet, Contractor shall require the subcontractor similarly to provide Workers' Compensation Insurance for all the latter's employees, unless such employees are covered by the protection afforded by the Contractor. Workers' Compensation Insurance shall be in compliance with the Workers' Compensation law of the state of the Contractor's headquarters.

Workers' Compensation Indemnity: In the event Contractor is not required to provide or elects not to provide workers' compensation coverage, the parties hereby agree that Contractor, its owners, agents, and employees will have no cause of action against, and will not assert a claim against, the State of Louisiana, its departments, agencies, agents and employees as an employer, whether pursuant to the Louisiana Workers' Compensation Act or otherwise, under

any circumstance. The parties also hereby agree that the State of Louisiana, its departments, agencies, agents and employees shall in no circumstance be, or considered as, the employer or statutory employer of Contractor, its owners, agents, and employees. The parties further agree that Contractor is a wholly-independent contractor and is exclusively responsible for its employees, owners, and agents. Contractor hereby agrees to protect, defend, and indemnify the State of Louisiana, its departments, agencies, agents, and employees from any such assertion or claim that may arise from the performance of this Contract.

Commercial General Liability Insurance: Contractor shall maintain during the life of the Contract such Commercial General Liability Insurance, including Personal and Advertising Injury Liability, which shall protect it, and the State, 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 attorneys' fees), and other liabilities relating to personal injury, general negligence, 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 employees, officers, agents, partners or subcontractors, and which may arise from operations or services under the Contract, whether such operations or services be by Contractor or by a subcontractor, or by anyone directly or indirectly employed or procured by either of them, or in such manner as to impose liability on the State, its officers, trustees, employees, servants, and/or agents. Such insurance shall name the State of Louisiana, its officers, trustees, employees, servants, and agents as additional insureds. The amount of coverage shall be as follows: Commercial General Liability insurance, including Personal and Advertising Injury Liability, 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.

The Insurance Services Office (ISO) Commercial General Liability occurrence coverage form CG 00 01 (or current form approved for use in Louisiana), or equivalent, is to be used in the policy. Claims-made form is unacceptable.

Cyber Liability Insurance: Contractor shall have in place before commencing work under the Contract and maintain during the life of the Contract and for the extended reporting period herein, cyber liability insurance, including first-party costs, for any electronic breach that compromises the State's confidential data with a minimum policy limit of $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. Claims-made coverage is acceptable. Such insurance shall name the State of Louisiana, its officers, trustees, employees, servants, and agents as additional insureds. Coverage shall be provided for the duration of this Contract and shall have an expiration date no earlier than thirty (30) days after the anticipated completion of the Contract. The policy shall provide an extended reporting period of not less than twenty-four (24) months from the expiration date of the policy, if the policy is not renewed. The policy shall not be cancelled for any reason, except non-payment of premiums.

Owned, Non-Owned and Hired Motor Vehicles: 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. ISO form number CA 00 01 (or current form approved for use in Louisiana), or equivalent, is to be used in the policy. Such insurance shall cover and include third-party bodily injury and property damage liability for 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.

Subcontractor's Insurance: Contractor shall include all subcontractors performing work required by this Contract as insureds under its policies OR shall be responsible for verifying and maintaining the Certificates of Insurance provided for any and all subcontractors, which are not protected under the Contractor's own insurance policies, of the same nature and in the same amounts as required of Contractor. Subcontractors shall be subject to all of the requirements stated herein. The State reserves the right to request copies of subcontractor's Certificates of Insurance at any time.

Deductibles and Self-Insured Retentions: Any deductibles or self-insured retentions must be declared to and accepted by the State. The Contractor shall be responsible for all deductibles and self-insured retentions.

Other Insurance Provisions: The policies are to contain, or be endorsed to contain, the following provisions:

1. General Liability and Automobile Liability Coverages

    a. The State, OGB, its officers, agents, employees, and volunteers shall be named as an additional insured as regards negligence by the Contractor. ISO Form CG 20 10 (or current form approved for use in Louisiana), or equivalent, is to be used when applicable. The coverage shall contain no special limitations on the scope of protection afforded to the State.

    b. The Contractor's insurance shall be primary as respects the State, OGB, its officers, agents, employees, and volunteers. Any insurance or self-insurance maintained by the State/OGB shall be excess and non-contributory of the Contractor's insurance.

    c. Any failure of the Contractor to comply with reporting provisions of the policy shall not affect coverage provided to the State/OGB, its officers, agents, employees, and volunteers.

    d. The Contractor's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the policy limits.

2. Workers' Compensation and Employer's Liability Coverage

The insurer shall agree to waive all rights of subrogation against the State/OGB, its officers, agents, employees, and volunteers for losses arising from work performed by the Contractor for the State/OGB under the Contract.

3. All Coverages

a. Coverage shall not be cancelled, suspended, or voided by either the Contractor or the insurer or reduced in coverage or in limits, except after 30 days' written notice has been given to the OGB/State. Ten-day written notice of cancellation is acceptable for non-payment of premium. Notifications shall comply with the standard cancellation provisions in the Contractor's policy.

b. Neither the acceptance of the completed work nor the payment thereof shall release the Contractor from the obligations of the insurance requirements or indemnification agreement.

c. The insurance companies issuing the policies shall have no recourse against the OGB/State for payment of premiums or for assessments under any form of the policies.

d. Any failure of the Contractor to comply with reporting provisions of the policy shall not affect coverage provided to the State/OGB, its officers, agents, employees, and volunteers.

Acceptability of Insurers: All required insurance shall be provided by a company or companies lawfully authorized to do business in the jurisdiction(s) in which the Project is performed. Insurance shall be placed with insurers with a A.M. Best's rating of A-:VI or higher. This rating requirement may be waived for worker's compensation coverage only.

If at any time an insurer issuing any such policy does not meet the minimum A.M. Best rating, the Contractor shall obtain a policy with an insurer that meets the A.M. Best rating and shall submit another Certificate of insurance as required in the Contract.

Verification of Coverage: Contractor shall furnish the OGB/State with Certificates of Insurance reflecting proof of required coverage. The Certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf. The Certificates are to be received and approved by the OGB/State before work commences and upon any Contract renewal thereafter.

The Certificate Holder shall be listed as follows:

State of Louisiana
Office of Group Benefits, Its Officers, Agents, Employees and Volunteers
1201 N. 3rd Street, Suite G-159, Baton Rouge, LA 70802

Fully-Insured HMO Plan

In addition to the Certificates, Contractor shall submit the declarations page and the cancellation provision endorsement for each insurance policy. The OGB/State reserves the right to request complete certified copies of all required insurance policies at any time.

Upon failure of the Contractor to furnish, deliver, or maintain such insurance as above provided, the Contract, at the election of the OGB/State, may be suspended, discontinued, or terminated. Failure of the Contractor to purchase and/or maintain any required insurance shall not relieve the Contractor from any liability or indemnification under the Contract.

16 APPLICABLE LAW

This Contract shall be governed by and enforced in accordance with the laws of the State of Louisiana, including but not limited to La. R.S. 39:1551-1736 (Louisiana Procurement Code, as applicable). After exhaustion of any available administrative remedies, the exclusive venue of any action brought with regard to this Contract shall be in the Nineteenth (19th) Judicial District Court, Parish of East Baton Rouge, State of Louisiana.

17 CODE OF ETHICS

Contractor acknowledges that Chapter 15 of Title 42 of the Louisiana Revised Statutes (La. 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. Contractor agrees to immediately notify the OGB's CEO if violations or potential violations of the Code of Governmental Ethics by or through Contractor or its subcontractors/vendors under this Contract arise at any time during the term of this Contract.

18 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.

19 INDEPENDENT ASSURANCES

Contractor shall submit, and cause its subcontractors who perform key internal controls to submit, to certain independent audits to ascertain that processes and controls related to the contracted service are operating properly. 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 18 engagement of the operations. The SSAE 18 engagement will be performed at least 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 18 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 State with an exact copy of the SOC report resulting from the SSAE 18 engagement within the specified timeframe.

As an alternative to a SSAE 18 engagement and resulting SOC 1, Type II and/or SOC 2, Type II report, if approved by OGB on or before January 15th of each calendar year of the Contract, Contractor (or its subcontractor, as applicable) may provide a quality control plan [such as third party Quality Assurance (QA), an Independent Verification and Validation (IV & V)]; or, any other independent Contractor project or performance review or independent internal audit report.

The cost of such independent assurances will be borne solely by Contractor. Such independent assurances shall be performed at least annually during the term of the Contract. Contractor may review any audit report before delivery to the State and include with the report a

supplementary statement containing facts that Contractor considers pertinent to the audit or engagement. Contractor, or its subcontractor as applicable, shall implement recommendations as suggested by the program review, audit, and/or SSAE 18 engagement within three (3) months of report issuance and at no cost to the State.

20 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 upon receipt following delivery by: (i) an overnight carrier or hand delivery to the State/OGB; or (ii) registered or certified mail return receipt requested, and addressed as follows:

To Vantage Health Plan, Inc.:

P. Gary Jones, MD, President
Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, LA 71201

To OGB:

Mr. Tommy Teague, CEO
Office of Group Benefits
Post Office Box 44036
Baton Rouge, LA 70804

or

Mr. Tommy Teague, CEO
Office of Group Benefits
1201 N. 3rd Street, Suite G-159
Baton Rouge, LA 70802

The U.S. Postal Service does not make deliveries to OGB's physical location.

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.

21 HEADINGS

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

22 ENTIRE AGREEMENT

This Contract, together with the RFP and addenda issued thereto by the State, the Proposal submitted by the Contractor in response to the applicable RFP, and any exhibits incorporated herein by reference, shall constitute the entire agreement between the parties with respect to the subject matter hereof.

23 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.

24 BUSINESS ASSOCIATE ADDENDUM

A Business Associate Addendum, Attachment III, 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.

OGB is a "Covered Entity" under HIPAA/HITECH. For the purposes of this Contract, Contractor is deemed to be a "Business Associate" of OGB as such term is defined by HIPAA and regulations promulgated thereunder, including in the Privacy Standard of the Federal Register, published on December 28, 2000, and the parties have executed a Business Associate Addendum attached to this Contract, and made a part of this Contract. The parties understand and agree that if additional agreements are required to be compliant as required under HIPAA and applicable law, the parties will execute such agreements in a timely manner. Contractor agrees that its processes, systems, and reporting will be in full compliance with federal and state requirements, including but not limited to HIPAA, throughout the term of the Contract. Any fines or penalties imposed on any party related to Contractor's or its subcontractors' non-compliance will be the sole responsibility of Contractor. Contractor shall require its subcontractors' and any other vendors' processes, systems, and reporting to be in full compliance with federal and state requirements, including but not limited to HIPAA. Further, Contractor agrees that its organization, and that it requires that its subcontractors/vendors, will comply with all HIPAA regulations throughout the term of the Contract with respect to any issue related to the OGB Contract, plans, or participants involving PHI, including but not limited to participant services, complaints, appeals determinations, notification of rights, and confidentiality. Contractor shall require that all agreements with subcontractors or other vendors providing services for this Contract include the provisions of this Section and any Attachments referenced herein. OGB shall be provided copies of such subcontractor/vendor agreements upon request.

Notwithstanding any provision to the contrary, major delegated functions involving PHI, including but not limited to claims processing, customer service, and any other services as provided by applicable law, shall not be sourced outside of the territorial and jurisdictional limits of the fifty (50) United States of America.

25 CONTRACTOR ELIGIBILITY

At the time of execution, Contractor, and each tier of subcontractors/vendors, certifies that it is not on the List of Parties Excluded from Federal Procurement or Non-procurement Programs promulgated in accordance with Executive Orders 12549 and 12689, "Debarment and Suspension" as set forth in 24 CFR Part 24. Contractor has a continuing obligation to disclose any suspensions, debarment, or investigations 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 contracting opportunities.

26 CONTINUING OBLIGATIONS

Notwithstanding any provisions to the contrary herein, upon the termination of this Contract for any reason, the provisions of this Contract which by their nature require some action or forbearance after such termination, including but not limited to confidentiality, PHI, reporting, indemnity, insurance, records retention, and performance guarantees, shall survive such termination and be binding until any actions, obligations, and/or rights provided therein have been satisfied or released.

27 TRANSITION OF SERVICES AND DATA

Contractor shall comply with the provisions of this Contract, and other requests of OGB/State, to accomplish a timely transition of services without interruption of services to Plan Participants. During any such transition, Contractor will provide all of the same Records and data in the same format as provided during the term of the Contract, to OGB/State or its designee. Contractor further agrees that no dispute or objection it may have regarding the propriety of any transition of services by OGB/State will relieve Contractor of these obligations.

28 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.

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

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS

BY: Tommy Teague

NAME: Tommy Teague

TITLE: Chief Executive Officer

DATE: 9/6/18

VANTAGE HEALTH PLAN, INC.

BY: _____

NAME: P. Gary Jones. M.D.

TITLE: CEO/President

DATE: 8/21/2018

ATTACHMENT I: SCOPE OF WORK/SERVICES

Overview

Contractor shall provide fully-insured HMO coverage in all OGB regions (i.e., on a statewide basis) for eligible active employees and retirees and their eligible dependents.

1.1 Tasks and Services

The Contractor must possess the knowledge, capabilities, and resourcefulness to effectively provide a fully-insured HMO Plan in accordance with all federal, state, and any other applicable laws, regulations, policies, and OGB requirements. The Contractor shall provide competent and qualified staff to perform the scope of work/services under the Contract. The plan of benefits and the eligibility and continuation of coverage requirements for the fully-insured HMO shall be identical to the plan of benefits of OGB's self-insured plan, the Magnolia Local Plus Plan.

If the Contractor cannot deliver all benefits and services required by OGB's coverage provisions through network providers, the Contractor shall arrange and pay for such services to be rendered by non-network providers. When the Contractor or one of its network providers arranges for services covered under the fully-insured HMO plan by a non-network provider, the Plan Participant's financial liability shall be limited to the amount the Plan Participant would have had to pay, if any, had the service been rendered by a network provider. Balance billing is prohibited in such instances.

The Contractor will be responsible for ensuring the accuracy, timeliness, and completion of all tasks assigned under the resulting Contract. OGB reserves the right to modify or delete the tasks and services listed and, if appropriate, add additional tasks and services prior to and during the term of the Contract, subject to the approval of the OGB CEO, Office of State Procurement, and any other approval required by law.

At a summary level, these tasks include:

1. Implementation
2. General Support Services
3. Fully-Insured HMO Plan Services

The Contractor shall perform the following tasks and services:

Task (1): Implementation

- Assign a dedicated implementation team to manage the implementation process.
- Provide file data in a layout format designated by OGB to include, but not limited to, Wellness Participation, Medical Claims File, Drug Claims File, Provider Files, Code Files, and Adjusted Claims File. Contractor must accept OGB's standard file layout for the Medical Claims File, Provider File, Code Files, and Drug Claims File. Contractor shall coordinate with OGB to develop mutually-agreeable file layout specifications for eligibility and administrative fee billing files.

- Upon OGB request, work with other OGB vendors, the appointed OGB actuary, employees from the Division of Administration, and the OGB for management of the program.
- Conduct project status implementation meetings with the Contract Supervisor.
- Perform comprehensive systems testing and quality assurance audits as often as required, with results reported to OGB prior to the "Go-Live" date, at no additional cost.
- Ensure successful and timely completion of all tasks necessary to begin performance of the Contract on January 1, 2019, 12:00 am CST.

Task (2): General Support Services

- Designate one key person, the Account Executive, and designate at least one back-up staff member as the contacts to OGB for all daily operational questions.
- Provide knowledgeable staff to attend all statewide annual/special enrollment meetings and any other informational meetings as requested by OGB. There are approximately 36 meetings per year.
- Meet with OGB staff on-site, or via teleconference, on at least a quarterly basis to review and evaluate program administration.
- Maintain identical eligibility requirements and continuation of coverage provisions as the OGB, as OGB may amend from time to time. 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.
- Provide COBRA coverage for eligible Plan Participants. OGB's third-party COBRA administrator provides COBRA administration services for OGB. Plan Participants remit COBRA payments to the third-party COBRA administrator, and the third-party COBRA administrator remits the COBRA payments to OGB. OGB issues COBRA payments to the fully-insured HMO Contractor at the contracted COBRA rate.
- Notify the applicable state authority (i.e., state treasurer, etc.) and escheat any unclaimed property upon the expiration of the statutory time period for escheatment.

Task (3): Fully-Insured HMO Plan Services

- 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 services, substance abuse services, prescription drugs, utilization management and medical management, wellness program, and disease management (including but not limited to the five chronic diseases of focus to OGB: 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 Plan Participants, or such greater time period as required by applicable law, 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 Plan Participants.
- Provide a network of primary, specialty, and ancillary care providers within sixty (60) miles of each Plan Participant's address.
- Consult with OGB with regard to benefits provided under the Plan. No changes to said plan of benefits shall be made during the term of the resulting Contract without the prior written consent of OGB.
- Accept enrollment information daily from OGB in electronic format and enroll Plan Participants, including COBRA Plan Participants, to receive benefits in accordance with OGB requirements and Plan provisions.
- Staff and maintain a dedicated toll-free customer service unit and phone line on Monday through Friday from 8AM to 8PM, to assist Plan Participants with questions on claims, benefits, and networks, in compliance with the federal Patient Protection Affordable Care Act ("PPACA") Section 1557 and any other applicable laws. Furnish a toll-free telephone number for incoming customer service calls, including telephone technology for the hearing impaired and multi-lingual support. The customer service unit must be available for extended hours, from 8AM to 8PM for seven (7) days a week for OGB Plan Participants and potential participants, for the annual/special enrollment period.
- Design, update, print, and/or mail all Plan Participant communication materials (i.e., provider directories, Plan documents, Plan Participant education materials, etc.), advertisements and marketing materials. All such materials will be subject to OGB's approval prior to distribution and shall be in compliance with all applicable laws, including but not limited to PPACA Section 1557. 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 Plan Participant access to their claims information, benefits, order replacement ID cards, provider directories, self-care information, and other program information necessary to manage their health care needs, in compliance with all applicable laws, including but not limited to PPACA Section 1557.
- Provide 24/7 access to online portal for Plan Participants and OGB for activities such as claim submission, account monitoring, reporting, communications requested and approved by OGB, etc., in compliance with PPACA Section 1557 and any other applicable laws. This portal must include adequate encryption to guarantee protection of the Plan Participant's privacy and confidential data (e.g., PHI, personal data, and banking information, as applicable). All outages in excess of one (1) hour must be reported to the OGB Contract Supervisor.

- Maintain a service disruption plan or procedure to continue customer service, portal access, and other business operations when existing service is temporarily unavailable because of scheduled or unforeseen events.
- Provide Medical Claims Administration to include, but not limited to, the following, in compliance with all applicable laws: 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; adjudicate and process all claims with service dates prior to termination date.
- Submit standardized reports and/or data to OGB for the purpose of evaluating Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor's performance, at frequencies specified in the Contract. Format and layout must be approved by OGB.
- Prepare and distribute, at a minimum, the following required materials to each new Plan Participant within thirty (30) days of receipt of confirmation from OGB as to the validity of the enrollment application:

  1. A Plan Participant handbook, which includes information on all covered services, including, but not limited to the following: benefits, limitations, exclusions, copayments, coinsurances and deductibles, policies and procedures for utilizing clinical and administrative services, conditions under which an individual's Plan participation 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. Additional cards for family Plan Participants or replacement cards shall be provided upon request and at no additional charge to OGB or the Plan Participant.

  4. Summary of Benefits and Coverage ("SBC") and Uniform Glossary, as required by PPACA and/or applicable state law and/or rules and regulations promulgated pursuant thereto, and including PPACA Section 1557. Provide printed SBC documents to OGB for distribution to eligible but not enrolled employees/retirees.

  5. The following notices and any other notices required by applicable laws:
     - Women's Health and Cancer Rights Act 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).

- Provide a Wellness Program that includes, at a minimum, the following components:
  - 24/7 online program for Plan Participants and OGB
  - Preventive care tracking
  - Biometric data collection – onsite and PCP
  - Health coaching capabilities
  - Incentive tracking capabilities

1.2 Deliverables

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

Within fifteen (15) business days after the first of each month, Contractor shall submit reports which demonstrate Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor's performance including, but not limited to, the following:

- **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 representative.
- **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 18 engagement and/or other independent assurances approved by OGB no later than September 30 of each Contract year, for Contractor, and for each subcontractor which performs one or more key internal control functions.
- 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 each quarter. 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.
- Within fifteen (15) business days after the first of each month, Contractor shall provide to OGB a report that shows, by month, premiums paid, incurred claims, paid claims, and Plan Participants enrolled.
- One hundred and twenty (120) days prior to January 1, 2020, and January 1, 2021 respectively, for the initial Contract period and 120 days prior to January 1, 2022, and January 1, 2023, respectively, for any renewal option period(s), the Contractor shall provide OGB with a renewal report that shows how any indicated rate adjustment for the renewal year was calculated. The renewal report shall include, at a minimum, the base period-incurred claims on which the renewal projection is based, the annual trend factors used to project claims costs, the administrative fees included in the renewal calculation, adjustments due to credibility, adjustments for stop-loss premium, premiums at current rates, and the indicated rate adjustment.

1.3 Performance Guarantees

The following performance guarantees are the minimum acceptable standards for the resulting Contract. These metrics shall be reported to OGB 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
Independent Assurance Reporting: Submit annual Service Organization Control (SOC) 1, Type II report resulting from SSAE 18 engagement and/or other independent assurances approved by OGB no later than September 30 of each Contract year.	$1,000 per day

Service Level	Fees at Risk Per Calendar Year
Annual Enrollment Meetings: 100% attendance of state-wide annual and special enrollment meetings and other meetings required by OGB within every region for which the Contractor is authorized to provide coverage.	$1,000 per annual enrollment meeting missed
Average Speed to Answer: The average speed for answering of the customer service telephone line by a "live" representative shall be forty-five (45) seconds or less.	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 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.	6.25%
Eligibility Posting Timeliness: 100% of electronically transmitted eligibility updates shall be posted to the Contractor's system within two (2) business days of receipt.	6.25%
Required Membership Materials: Required Plan participation materials set forth in the Contract shall be distributed by Contractor to each new Plan Participant within thirty (30) days of receipt of confirmation from OGB as to the validity of the enrollment application.	6.25%

ATTACHMENT II: PREMIUM RATE SCHEDULE

The monthly premiums listed below are fully burdened and inclusive of all Contract costs and expenses. Commissions or finder's fees are not payable under this Contract.

January 1, 2019 – December 31, 2019

Statewide	Fixed Monthly Premium
Active Employee	
SINGLE	$671.00
+1 (SPOUSE)	$1,425.12
+1 (CHILD)	$818.32
WITH CHILDREN	$818.32
FAMILY	$1,502.98
Retiree Without Medicare and Re-Employed Retiree	
SINGLE	$1,252.34
+1 (SPOUSE)	$2,211.30
+1 (CHILD)	$1,395.02
WITH CHILDREN	$1,395.02
FAMILY	$2,200.68
Retiree With One Medicare	
SINGLE	$414.30
+1 (SPOUSE)	$1,514.20
+1 (CHILD)	$712.70
WITH CHILDREN	$712.70
FAMILY	$2,015.48
Retiree With Two Medicare	
+1 (SPOUSE)	$742.66
FAMILY	$919.50
COBRA	
SINGLE	$684.42
+1 (SPOUSE)	$1,453.62
+1 (CHILD)	$834.68
WITH CHILDREN	$834.68

FAMILY			$1,533.04
DISABILITY COBRA			
SINGLE			$1,006.50
+1 (SPOUSE)			$2,137.68
+1 (CHILD)			$1,227.48
WITH CHILDREN			$1,227.48
FAMILY			$2,254.48

Premium rates proposed for each twelve (12)-month period must be approved by the OGB. The maximum percentage increase for each twelve (12)-month period during the initial Contract period and during any renewal option period is 20%. OGB reserves the right to negotiate lower premiums for each twelve (12)-month period during the initial Contract period and for each twelve (12)-month period during any renewal option period.

ATTACHMENT III: BUSINESS ASSOCIATE ADDENDUM

State of Louisiana, Office of Group Benefits

HIPAA Business Associate Addendum

THIS HIPAA BUSINESS ASSOCIATE ADDENDUM (the "Addendum") is entered into effective the 6th day of September, 2018 (the "Effective Date"), by and between Vantage Health Plan, Inc., ("Business Associate") and the State of Louisiana, Office of Group Benefits, on behalf of itself and its affiliates, if any (individually and collectively, the "Covered Entity"), and adds to the Agreement or Contract dated September 6, 2018, entered into between Covered Entity and Business Associate (the "Agreement").

WHEREAS, pursuant to the Agreement, Business Associate performs functions or activities or arranges for such 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 may, and shall ensure that its directors, officers, employees, contractors, subcontractors, vendors, and agents use or disclose PHI only as follows:

(a) Business Associate may use 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 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 PHI to provide Data Aggregation services to Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B). For purposes of this Section, Data Aggregation means, with respect to 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. It is not contemplated that Business Associate will perform Data Aggregation services with PHI received from Covered Entity without express prior written permission of Covered Entity.

(d) Business Associate may completely 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, provided Covered Entity agrees to such creation and use of a Limited Data Set.

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 with Third Parties*. Business Associate understands and agrees that any agent or subcontractor that may create, receive, maintain or transmit PHI on behalf of Business Associate

must comply with all applicable laws and regulations as are applicable to Covered Entity in regard to PHI. Business Associate shall enter into a written 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. Such agreements with Business Associates agents and subcontractors shall be provided to Covered Entity upon request and subject to audit hereunder.

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 CFR 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 CFR 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 CFR 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 CFR 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 Covered Entity and to

the Secretary for purposes of determining Covered Entity's compliance with HIPAA for the term of this Agreement and for five years following the final payment under the Agreement.

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, other than a standard medical records request/medical records subpoena, Business Associate shall notify Covered Entity of such within five business days by providing a copy of such and any applicable comments. Covered Entity shall have the right to control Business Associate's response to 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.

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS

By: Tommy Teague
Signature

Tommy Teague
Printed Name

Title: Chief Executive Officer

Date: 9/6/18

VANTAGE HEALTH PLAN, INC.

By: P. Gary Jones
Signature

P. Gary Jones. M.D.
Printed Name

Title: CEO/President

Date: 8/21/2018

ATTACHMENT IV: RECORDS RETENTION SCHEDULE

Records Retention Schedule

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

SS ARC 932 (8/12) R2014-620
Page 1 of 7

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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: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
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
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 - Days)
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 Archivist
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

Secretary of State, State Archives & Records Services

12/18/14
Date Approved

Records Retention Schedule

SS ARC 932 (01/12) R2014-636 C

Louisiana Secretary of State, Division of Archives, Records Management and History
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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.

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
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Archival Processing Codes
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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
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I = Important
U= Useful

Agency Abbreviations

Agency Approval — 12-30-14 Date Signed

Carrie Martin, CRM — 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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Archival Processing Codes
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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
PES = Personnel Evaluation System
PPR = Personnel Performance Rating

Agency Approval — 12-18-14 Date Signed

Carol Martin CRM — Secretary of State, State Archives & Records Services — 12/19/14 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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State Records Center Use
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Agency Abbreviations

Agency Approval — 12-18-14 Date Signed — Carrie Martin CRM Secretary of State, State Archives & Records Services — 12/15/14 Date Approved

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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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U= Useful

Agency Abbreviations

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

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.

Permitted Retention Period Abbreviations
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AY – Academic Year (Aug 1 – July 31)
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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, CRM
Secretary of State, State Archives & Records Services

12/18/14
Date Approved

Records Retention Schedule

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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
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
__ORIGINAL SUBMISSION
__RENEWAL
__REPLACEMENT PAGE
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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)
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Security Status Codes
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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 — 12-30-14 Date Signed — Secretary of State, State Archives & Records Services — 1/7/15 Date Approved

ATTACHMENT V: 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 OGB.Records@la.gov[1], or as otherwise directed by OGB. 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 ninety (90) days of the change. To ensure compliance with this rule, Contractor shall notify the Records Officer of these changes within sixty (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 (Attachment IV) and applicable laws, Contractor shall not destroy any OGB records unless records are converted to digital images and thereafter approved for destruction or other disposition by the Secretary of State. Contractor shall request expedited authority to destroy or otherwise dispose of converted records by email to disposals@sos.louisiana.gov with "EDR_I2014-009 OGB Vantage Health Plan, Inc." in the subject line, carbon copy to the Records Officer and OGB.Records@la.gov, and a description of the subject records per the OGB Schedules (such as "Documents, scanned and inspected, for the week/month of X") in the body. Upon receiving approval of the Secretary of State to destroy or otherwise dispose of the requested records, Contractor shall commence destruction or other approved disposition 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] If OGB makes a different designation, 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 Record Retention Schedule, Attachment IV.

ATTACHMENT VI: FILE LAYOUT AND SPECIFICATIONS

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 utilized by OGB for management of population health and ongoing health conditions, including, but not limited to, diabetes, coronary heart disease, chronic heart failure, asthma, and chronic obstructive pulmonary disease (COPD). To facilitate OGB needs and clarify the expectations of the file layout, 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 by providers for OGB Plan Participants. 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, for changes related to services provided, or otherwise, 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 this information 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 Social Security Numbers (SSNs), ICD-10 codes, phone numbers, National Drug Codes (NDCs) and zip codes will be left-justified, with no dashes, commas, decimals or other formatting.

Files are to be transmitted by the Contractor to OGB on a monthly basis, 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 must be sent electronically to the OTS MOVEit DMZ Secure FTP server utilizing a security file transport protocol; the preference is FTPS. All files must be encrypted using Public Key Infrastructure (PKI) with a prior exchange of Public Key(s), commonly referred to as PGP encryption. The encrypted file(s) must have an extension of "pgp". The encryption key must have an expiration of no longer than 5 years from the creation date and be approved by the OTS InfoSec Team. All files must be encoded as an ASCII text file prior to encryption.**

1. **Medical Claims File (Appendix A-1)** – The Contractor shall send OGB all claims for which Explanations of Benefits (EOBs) 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 to be submitted to OGB 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 consistent with this format, if appropriate.

4. **Drug Claims File (Appendix A-4)** - This file contains all drugs for which prescriptions were filled by OGB Plan Participants 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/ELECTRONIC INPUT
7	*	SYSTEM ENTRY DATE	D	8	106-113	THE DATE THE CONTRACTOR FIRST ENTERED THE CLAIM INTO THE CLAIM PAYMENT SYSTEM **FORMAT- CCYYMMDD**

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 8: For each action affecting the payment status or clinical information on a claim, the date that action was taken.						
8	*	ADJUDICATION DATE	D	8	114-121	THE DATE THE CONTRACTOR PROCESSED AN ORIGINAL CLAIM. FOR ADJUSTMENTS, THE DATE REPROCESSED **FORMAT- CCYYMMDD**
9	*	PAID DATE	D	8	122-129	THE DATE THE PROCESSED CLAIM WAS PAID OR ADJUSTED. FOR DENIED CLAIMS, THE DATE DENIED. **FORMAT- CCYYMMDD**
10	*	MEDICAL CLAIM DOC TYPE	A/N	10	130-139	THE TYPE OF DOCUMENT SUBMITTED, EITHER THE HCFA OR UB DESIGNATION.
11		SUBMITTED DRG	A/N	20	140-159	FOR INPATIENT CLAIMS, THE V25 DRG CODE THAT WAS SUBMITTED ON THE CLAIM
Field 12: Revenue code is required for UB-92 claims. OGB will calculate the patient's length of stay for our data warehouse reports based on revenue coding.						
12		REVENUE CODE	A/N	10	160-169	THE 3 CHARACTER REVENUE CODE USED ON UB92 CLAIM FORMS.
Field 13: The original billed charge for each claim line will be provided on all activity affecting the claim or claim line.						
13	*	CHARGE AMOUNT	N	15	170-184	THE DOLLARS BILLED/CHARGED BY THE PROVIDER FOR THIS CLAIM LINE.
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.						

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

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
27	*	PLACE OF SERVICE	A/N	20	403-422	THE HCFA STANDARD PLACE OF SERVICE CODE
28	*	TYPE OF SERVICE	A/N	20	423-442	THE HCFA STANDARD TYPE OF SERVICE CODE ON THE CLAIM.
29	*	SERVICE UNITS COUNT	N	11	443-453	THE NUMBER OF UNITS OF SERVICE DESCRIBED BY THE PROCEDURE REFERENCED ON THIS CLAIM LINE.
30		ANESTHESIA MINUTES	N	11	454-464	WHEN APPROPRIATE, THIS CLAIM LINE LISTS THE NUMBER OF MINUTES OF ANESTHESIA THAT WAS RENDERED.
Fields 31-36: Employee refers to the contract holder (subscriber), identified as relation = '01' in the State of Louisiana's eligibility file provided to the Contractor in a daily transmission.						
31	*	EMPLOYEE SSN	A/N	11	465-475	THE CONTRACT HOLDER'S SOCIAL SECURITY NUMBER - LEFT JUSTIFIED AND FILLED WITH SPACES TO THE RIGHT. NO DASHES. THE FOREIGN WORKER NUMBER, WHEN APPROPRIATE.
32	*	EMPLOYEE ID QUALIFIER	A/N	1	476	INDICATES THE TYPE/ORIGIN OF THE IDENTIFYING NUMBER FROM THE BILL USED TO DETERMINE ELIGIBILITY: 'S'=SSN; 'P'=MEMBER ID OF THE CONTRACT HOLDER
33	*	EMPLOYEE LAST NAME	A/N	40	477-516	THE LAST NAME OF THE CONTRACT HOLDER.
34	*	EMPLOYEE SEX	A/N	1	517	THE GENDER OF THE CONTRACT HOLDER. 'F' = FEMALE; 'M' = MALE; 'U' = UNKNOWN
35	*	EMPLOYEE DATE OF BIRTH	D	8	518-525	THE CONTRACT HOLDER'S DATE OF BIRTH **FORMAT- CCYYMMDD**

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
36	*	EMPLOYEE ZIP CODE	A/N	9	526-534	THE CONTRACT HOLDER'S FULL ZIP CODE, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
Fields 37-43: 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.						
37	*	UNIQUE MEMBER ID	A/N	8	535-542	THE MEMBER'S UNIQUE IDENTIFIER FROM THE STATE OF LOUISIANA'S ELGIBILITY FEED.
38		MEMBER SSN	A/N	11	543-553	THE MEMBER'S SOCIAL SECURITY NUMBER - LEFT JUSTIFIED AND FILLED WITH SPACES TO THE RIGHT. NO DASHES. THE FOREIGN WORKER NUMBER, WHEN APPROPRIATE.
39	*	MEMBER FIRST NAME	A/N	40	554-593	THE FIRST NAME OF THE MEMBER (PATIENT)
40	*	MEMBER LAST NAME	A/N	40	594-633	THE LAST NAME OF THE MEMBER (PATIENT)
41	*	MEMBER SEX	A/N	1	634	THE GENDER OF THE MEMBER. 'F' = FEMALE; 'M' = MALE; 'U' = UNKNOWN
42	*	MEMBER DATE OF BIRTH	D	8	635-642	THE MEMBER'S DATE OF BIRTH. **FORMAT- CCYYMMDD**
43	*	MEMBER ZIP CODE	A/N	9	643-651	THE MEMBER'S FULL ZIP CODE, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
Field 44: The relationship code will be consistent with that provided to the Contractor in the daily eligibility transmission.						
44	*	RELATIONSHIP TO EMPLOYEE	A/N	2	652-653	THE RELATIONSHIP THIS MEMBER HAS TO THE CONTRACT HOLDER. '01 = EMPLOYEE/CONTRACT HOLDER '02' = SPOUSE '03' AND ABOVE= OTHER DEPENDENTS
Fields 45-46: The following should relate directly to a check written to a member in the check register transmitted along with the month's claim file.						

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
45		MEMBER CHECK NUMBER	A/N	10	654-663	FOR PAID CLAIMS, THE NUMBER OF THE CHECK USED TO PAY THE MEMBER
46		MEMBER CHECK AMOUNT	N	15	664-678	THE AMOUNT ON THE MEMBER'S CHECK
FIELDS 47-57 AND 61-66: DIAGNOSIS AND PROCEDURE CODING WILL ADHERE TO ICD-10 STANDARD CODING.						
47	*	PRIMARY DIAGNOSIS CODE	A/N	10	679-688	THE ICD-10-CM DIAGNOSIS CODE THAT IDENTIFIES THE PRIMARY DIAGNOSIS FOR THE SERVICE PROVIDED
48		DIAGNOSIS CODE 2	A/N	10	689-698	THE ICD-10-CM DIAGNOSIS CODE THAT IDENTIFIES THE SECOND DIAGNOSIS FOR THE SERVICE
49		DIAGNOSIS CODE 3	A/N	10	699-708	THE ICD-10-CM DIAGNOSIS CODE THAT IDENTIFIES THE THIRD DIAGNOSIS FOR THE SERVICE
50		DIAGNOSIS CODE 4	A/N	10	709-718	THE ICD-10-CM DIAGNOSIS CODE THAT IDENTIFIES THE FOURTH DIAGNOSIS FOR THE SERVICE
51		DIAGNOSIS CODE 5	A/N	10	719-728	THE ICD-10-CM DIAGNOSIS CODE THAT IDENTIFIES THE FIFTH DIAGNOSIS FOR THE SERVICE
52		DIAGNOSIS CODE 6	A/N	10	729-738	THE ICD-10-CM DIAGNOSIS CODE THAT IDENTIFIES THE SIXTH DIAGNOSIS FOR THE SERVICE
53		DIAGNOSIS CODE 7	A/N	10	739-748	THE ICD-10-CM DIAGNOSIS CODE THAT IDENTIFIES THE SEVENTH DIAGNOSIS FOR THE SERVICE

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
54		DIAGNOSIS CODE 8	A/N	10	749-758	THE ICD-10-CM DIAGNOSIS CODE THAT IDENTIFIES THE EIGHTH DIAGNOSIS FOR THE SERVICE
55		DIAGNOSIS CODE 9	A/N	10	759-768	THE ICD-10-CM DIAGNOSIS CODE THAT IDENTIFIES THE NINTH DIAGNOSIS FOR THE SERVICE
56		ADMIT DIAGNOSIS CODE	A/N	10	769-778	FOR INPATIENT CLAIMS, THE ICD-10-CM DIAGNOSIS CODE THAT IDENTIFIES THE ADMIT DIAGNOSIS FOR THIS CLAIM
57	*	PROCEDURE CODE	A/N	10	779-788	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.
58		MODIFIER CODE 1	A/N	5	789-793	THE FIRST MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
59		MODIFIER CODE 2	A/N	5	794-798	THE SECOND MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
60		MODIFIER CODE 3	A/N	5	799-803	THE THIRD MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
61		ICD-10 PROCEDURE CODE 1	A/N	10	804-813	THE PRIMARY ICD-10 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
62		ICD-10 PROCEDURE CODE 2	A/N	10	814-823	THE SECOND ICD-10 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
63		ICD-10 PROCEDURE CODE 3	A/N	10	824-833	THE THIRD ICD-10 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
64		ICD-10 PROCEDURE CODE 4	A/N	10	834-843	THE FOURTH ICD-10 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
65		ICD-10 PROCEDURE CODE 5	A/N	10	844-853	THE FIFTH ICD-10 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
66		ICD-10 PROCEDURE CODE 6	A/N	10	854-863	THE SIXTH ICD-10 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
67		RX DRUG CODE	A/N	11	864-874	FOR DRUGS ADMINISTERED, THE PRESCRIPTION DRUG CODE (NDC) FOR THE CLAIM LINE, FORMATTED 542, NO DASHES
Fields 68-69: The service provider must exist in the provider file transmitted along with the month's claim file.						
68	*	SERVICE PROVIDER ID	A/N	20	875-894	THE UNIQUE ID OF THE SERVICE PROVIDER ASSIGNED IN THE CONTRACTOR'S CLAIMS PROCESSING SYSTEM.
69	*	NPI	A/N	10	895-904	THE SERVICE PROVIDER'S NPI
Fields 70-72: The pay-to provider must exist in the provider file transmitted along with the month's claim file.						

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
70		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.**
71		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.**
72		PAY-TO TAX ID	A/N	10	925-935	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.						
73		PROVIDER CHECK NUMBER	A/N	10	936-945	FOR PAID CLAIMS, THE NUMBER OF THE CHECK USED TO PAY THE PROVIDER
74		PROVIDER CHECK AMOUNT	N	15	946-960	THE AMOUNT ON THE PROVIDER'S CHECK
75		OVERRIDE CODE	A/N	3	961-963	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**
76		BENEFIT LEVEL CAUSE CODE	A/N	2	964-965	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
77		DISCHARGE STATUS CODE	A/N	2	966-967	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 70 through 74 of Appendix A-1.						
1	*	PROVIDER INTERNAL ID	A/N	20	1-20	THE UNIQUE ID FOR SERVICE OR PAY-TO PROVIDER ASSIGNED BY CONTRACTOR IN CLAIMS PROCESSING
2	*	PROVIDER TAX ID	A/N	10	21-30	TAX ID OF THIS PROVIDER
3	*	NPI	A/N	10	31-40	THIS PROVIDER'S NATIONAL PROVIDER IDENTIFIER
4		PROVIDER DEA ID	A/N	10	41-50	THE FEDERAL DEA NUMBER OF THIS PROVIDER IF PROVIDER PRESCRIBES DRUGS.
Fields 5-8: A provider may refer to a physician, a facility, or another care provider. Either an office (Field 8) or a person (Fields 5-7) or both must be named in the following 4 fields.						
5		PROVIDER LAST NAME	A/N	40	51-90	THE LAST NAME FOR THIS PROVIDER
6		PROVIDER FIRST NAME	A/N	40	91-130	THE FIRST NAME FOR THIS PROVIDER
7		PROVIDER MIDDLE INITIAL	A/N	1	131	THE MIDDLE INITIAL FOR THIS PROVIDER
8		PROVIDER OFFICE NAME	A/N	40	132-171	THE OFFICE NAME, CORPORATION NAME, OR LOCATION NAME OF THE OFFICE THIS PROVIDER OFFERS SERVICES.
9	*	PROVIDER ADDRESS LINE1	A/N	40	172-211	LINE 1 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
10		PROVIDER ADDRESS LINE2	A/N	40	212-251	LINE 2 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
11	*	PROVIDER CITY	A/N	40	252-291	THE CITY PORTION OF THIS PROVIDER'S ADDRESS
12	*	PROVIDER STATE	A/N	2	292-293	THE STATE PORTION OF THIS PROVIDER'S ADDRESS
13	*	PROVIDER ZIP	A/N	9	294-302	THE ZIPCODE OF THIS PROVIDER'S ADDRESS, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
14		PROVIDER UPIN	A/N	20	303-322	THE UNIVERSAL PROVIDER IDENTIFICATION NUMBER FOR THIS PROVIDER
15		PROVIDER MEDICARE ID	A/N	20	323-342	THE MEDICARE IDENTIFIER FOR THIS PROVIDER
Fields 16-19: The Contractor will send initially and keep current a file of specialty codes and descriptions used in their claims processing to OGB						
16	*	PROVIDER SPECIALTY	A/N	10	343-352	THE CODE FOR THE PROVIDER'S PRIMARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
17		PROVIDER SPECIALTY 2	A/N	10	353-362	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.

18		PROVIDER SPECIALTY 3	A/N	10	363-372	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
19		PROVIDER SPECIALTY 4	A/N	10	373-382	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
20	*	PROVIDER TYPE	A/N	1	383	**"F" – FACILITY, "P" – PHYSICIAN, "O" – OTHER, "Y" – PAY-TO, "G" - GROUP**

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 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	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	4=CLAIM RECORD
2	PROCESSOR NUMBER	N	10	2-11	THIS NUMBER IS ASSIGNED BY NCPDP TO IDENTIFY THE SOURCE OF THE TAPE, I.E. PHARMACY, WHOLESALER, HOSPITAL, SERVICE BUREAU, ETC.
3	BATCH NUMBER	N	5	12-16	THIS NUMBER IS ASSIGNED BY THE PROCESSOR. FORMAT=YYDDD YY=YEAR DDD=JULIAN DATE I.E. 92252=SEPT. 8, 1992
4	PHARMACY NUMBER	A/N	12	17-28	ID ASSIGNED TO A PHARMACY
5	PRESCRIPTION NUMBER	A/N	7	29-35	
6	DATE FILLED	A/N	8	36-43	DISPENSING DATE OF RX FORMAT=CCYYMMDD
7	NDC NUMBER	N	11	44-54	FOR LEGEND COMPOUNDS USE: 99999999999 SCHEDULE II: 99999999992 SCHEDULE III: 99999999993 SCHEDULE IV: 99999999994 SCHEDULE V: 99999999995 COMPOUNDS: 99999999996
8	DRUG DESCRIPTION	A/N	30	55-84	LABELNAME
9	NEW/REFILL CODE	N	2	85-86	00=NEW PRESCRIPTION 01-99=NUMBER OF REFILLS
10	METRIC QUANTITY	N	10	087-096	NUMBER OF METRIC UNITS OF MEDICATION DISPENSED (LEADING SIGN IF NEGATIVE)
11	DAYS SUPPLY	N	4	097-100	ESTIMATED NUMBER OF DAYS THE PRESCRIPTION WILL LAST
12	BASIS OF COST DETERMINATION	A/N	2	101-102	00=NOT SPECIFIED 01=AWP 02=LOCAL WHOLESALER 03=DIRECT 04=EAC 05=ACQUISITION 06=MAC 6X=BRAND MEDICALLY NECESSARY 07=USUAL AND CUSTOMARY 08=UNIT DOSE 09=OTHER USED ON TAPE AND DISKETTE ONLY
13	INGREDIENT COST	N	15	103-117	COST OF THE DRUG DISPENSED. Format-All financial fields should be 15 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "000000000123.45"

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					-123.45 would be expressed as "-00000000123.45"
14	DISPENSING FEE SUBMITTED	N	15	118-132	Format-All financial fields should be 15 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "000000000123.45" -123.45 would be expressed as "-00000000123.45"
15	CO-PAY AMOUNT	N	15	133-147	CORRECT CO-PAY FOR PLAN BILLED Format-All financial fields should be 15 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "000000000123.45" -123.45 would be expressed as "-00000000123.45"
16	SALES TAX	N	15	148-162	SALES TAX FOR THE PRESCRIPTION DISPENSED Format-All financial fields should be 15 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "000000000123.45" -123.45 would be expressed as "-00000000123.45"
17	AMOUNT BILLED	N	15	163-177	THE PROVIDER's USUAL AND CUSTOMARY AMT Format-All financial fields should be 15 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "000000000123.45" -123.45 would be expressed as "-00000000123.45"
18	PATIENT FIRST NAME	A/N	12	178-189	FIRST NAME OF PATIENT
19	PATIENT LAST NAME	A/N	15	190-204	LAST NAME OF PATIENT
20	DATE OF BIRTH	A/N	8	205-212	DATE OF BIRTH OF PATIENT FORMAT=CCYYMMDD
21	SEX CODE	A/N	1	213-213	0=NOT SPECIFIED 1=MALE 2=FEMALE
22	EMPLOYEE SSN	A/N	9	214-222	
23	OGB Internal Id-	A/N	8	223-230	See Appendix E (Eligibility File) Field number-33
24	FILLER	A/N	10	231-240	Space
25	RELATIONSHIP CODE	A/N	1	241-241	1=CARDHOLDER 2=SPOUSE 3=CHILD 4=OTHER
26	GROUP NUMBER	A/N	15	242-256	ID ASSIGNED TO CARDHOLDER GROUP OR EMPLOYER GROUP
27	PRESCRIBER ID	A/N	10	257-266	IDENTIFICATION ASSIGNED TO THE PRESCRIBER

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
28	DIAGNOSIS CODE	A/N	6	267-272	ICD-10 STANDARD DIAGNOSIS CODES
29	DOCUMENT NUMBER	A/N	15	273-287	Document Number becomes relevant if the pharmacy made a mistake on the original script and instead of the original claim getting corrected, a new one was submitted
30	FILLER	A/N	12	288-299	
31	RESUBMISSION CYCLE COUNT	A/N	2	300-301	0 = ORIGINAL SUBMISSION 1 = FIRST RE-SUBMISSION 2 = SECOND RE-SUBMISSION
32	DATE PRESCRIPTION WRITTEN	A/N	8	302-309	DATE PRESCRIPTION WAS WRITTEN
33	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	A/N	1	310-310	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
34	ELIGIBILITY CLARIFICATION CODE	A/N	1	311-311	CODE INDICATING THAT THE PHARMACY IS CLARIFYING ELIGIBILITY BASED ON DENIAL 0 = NOT SPECIFIED 1 = NOT OVERRIDE 2 = OVERRIDE 3 = FULL TIME STUDENT 4 = DISABLED DEPENDENT 5 = DEPENDENT PARENT
35	COMPOUND CODE	A/N	1	312-312	CODE INDICATING WHETHER OR NOT THE PRESCRIPTION IS A COMPOUND 0=NOT SPECIFIED 1=NOT A COMPOUND 2=COMPOUND
36	NUMBER OF REFILLS AUTHORIZED	N	2	313-314	NUMBER OF REFILLS AUTHORIZED BY PRESCRIBER
37	DRUG TYPE	A/N	1	315-315	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)

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
38	PRESCRIBER LAST NAME	A/N	15	316-330	PRESCRIBER LAST NAME
39	POSTAGE AMOUNT CLAIMED	N	4	331-334	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"
40	UNIT DOSE INDICATOR	A/N	1	335-335	CODE INDICATING THE TYPE OF UNIT DOSE DISPENSING DONE 0=NOT SPECIFIED 1=NOT UNIT DOSE 2=MANUFACTURER UNIT DOSE 3=PHARMACY UNIT DOSE
41	OTHER PAYOR AMOUNT	N	15	336-350	DOLLAR AMOUNT OF PAYMENT KNOWN BY THE PHARMACY FROM OTHER SOURCES FORMAT=positive 123.56 negative -12.45
42	ACCOUNT NAME	A/N	15	351-365	Plan Code
43	CLAIM STATUS	A/N	20	366-385	APPROVED DENIED DUP_CLM=Duplicate Claim RDA= Reversal Approved RLA=Reversal Paid RLP=Reversed Approved RDP=Reversed Paid
44	CONTRACT SSN	A/N	9	386-394	(Contract Holder's SSN)- RxClaim map from 1st nine digits of member ID number
45	COVERED AMOUNT	N	15	395-409	Format-All financial fields should be 15 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "000000000123.45" -123.45 would be expressed as "-00000000123.45"
46	PAID AMOUNT	N	15	410-424	Format-All financial fields should be 15 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "000000000123.45" -123.45 would be expressed as "-00000000123.45"
47	PAID DATE	A/N	8	425-432	Date of payment FORMAT = CCYYMMDD
48	FILLER	A/N	2	433-434	Spaces
49	PRESCRIBER FIRST NAME	A/N	15	435-449	First Name of Prescribing Physician
50	PRESCRIBER LAST NAME	A/N	25	450-474	Last Name of Prescribing Physician
51	PRESCRIBER MI	A/N	1	475-475	Middle Initial of Prescribing Physician
52	PRESCRIBER ADDRESS-1	A/N	55	476-530	Address Line 1 of Prescribing Physician
53	PRESCRIBER ADDRESS-2	A/N	55	531-585	Address Line 2 of Prescribing Physician

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
54	PRESCRIBER CITY	A/N	20	586-605	City of Prescribing Physician
55	PRESCRIBER STATE	A/N	2	606-607	State of Prescribing Physician
56	PRESCRIBER ZIP CODE	A/N	10	608-617	Zip code of Prescribing Physician
57	GPI NUMBER	N	14	618-631	14-character Generic Product Identifier of prescribed drug
58	FILLER	A/N	6	632-637	Spaces
59	FILLER	A/N	10	638-647	Spaces
60	FILLER	N	7	648-654	Spaces
61	FILLER	N	7	655-661	Spaces
62	FAMILY ID	A/N	20	662-681	
63	ALTERNATE INSURANCE ID	A/N	10	682-691	
64	FILLER	N	1	692-692	Space
65	FILLER	A/N	11	693-703	Spaces
66	FILLER	A/N	11	704-714	Spaces
67	FILLER	A/N	2	715-716	Spaces
68	THERAPEUTIC CLASS CODE	N	6	717-722	Therapeutic Class Code for drug
69	THERAPEUTIC CLASS NAME	A/N	25	723-747	Therapeutic Class Name for drug
70	RX CLAIM NUMBER	N	15	748-762	
71	CLAIM SEQUENCE NUMBER	N	3	763-765	
72	MEDICARE D ELIGIBLE INDICATOR	A/N	1	766-766	Y = Medicare D eligible N = NOT Medicare D eligible
73	DATE PROCESSED	N	8	767-774	Format YYYYMMDD
74	TIME PROCESSED	N	6	775-780	Format HHMMSS
75	FILLER	A/N	1	781-781	Space
76	MAIL ORDER INDICATOR	A/N	1	782-782	Y=Mail Order N=Not Mail Order
77	BRAND/GENERIC INDICATOR	A/N	1	783-783	0= Non-drug Item 1=Generic 2=Brand Blank=Not Specified
78	BRAND/GENERIC OVERRIDE	A/N	1	784-784	Blank
79	CLAIM ORIGIN	A/N	1	785-785	T=Electronic B=Batch M=Manual (Paper)
80	FILLER	A/N	1	786-786	Space
81	FILLER	A/N	1	787-787	Space
82	FILLER	A/N	1	788-788	Space
83	FILLER	A/N	1	789-789	Space
84	DECIMAL QTY	N	15	790-804	Format -999999999.999 (ex. 000000030.000)
85	COST TYPE UNIT COST	N	15	805-819	Format 999999.999999999
86	COST BASIS	N	10	820-829	Values: SD=Submitted Drug Cost SM=Submitted Amount Due U=Usual and Customary AWP=Average Wholesale Price HCFA=HCFA MAC MAC=Company RX MAC Pricing

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
87	AVG WHOLESALE PRICE UNIT	N	15	830-844	Format 9.9999
88	DMR METHOD/CUST LOCATION	A/N	2	845-846	If DMR pricing is used values include: 91 indicated DMR is submitted value less copay 93 indicates pass- through rate less copay 94 indicates adjustment Else Blank
89	PRESCRIPTION NUMBER (12-BYTE)	A/N	12	847-858	12-byte prescription number