JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO.: 651,069 SECTION: 22
versus	:	19TH JUDICIAL DISTRICT COURT
TERRY S. SHILLING, GEORGE G. CROMER, WARNER L. THOMAS, IV, WILLIAM A. OLIVER, CHARLES D. CALVI, PATRICK C. POWERS, CGI TECHNOLOGIES AND SOLUTIONS, INC., GROUP RESOURCES INCORPORATED, BEAM PARTNERS, LLC, AND TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA	:	PARISH OF EAST BATON ROUGE
	:	STATE OF LOUISIANA

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OCT 25 2017
BY _____ DY CLERK OF COURT

MOTION FOR LEAVE TO FILE PLAINTIFF'S SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION FOR DAMAGES

NOW INTO COURT, through undersigned counsel, comes Plaintiff, James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc. ("LAHC"), through his duly appointed Receiver, Billy Bostick ("Plaintiff" or the "Commissioner"), who respectfully moves this Honorable Court for leave to file the attached Second Supplemental, Amending and Restated Petition for Damages ("Second Amended Petition"), pursuant to Louisiana Code of Civil Procedure article 1151 and Local Rule 9.9(g)(4), for the reasons set forth below:

Plaintiff filed his Original Petition for Damages on August 31, 2016, naming as defendants Terry S. Shilling; George G. Cromer; Warner L. Thomas, IV; William A. Oliver; Charles D. Calvi; Patrick C. Powers (collectively the "D&O Defendants"); as well as CGI Technologies and Solutions, Inc. ("CGI"); Group Resources Incorporated ("GRI"); Beam Partners, LLC ("Beam"); and Travelers Casualty and Surety Company of America ("Travelers"). Prior to any defendant filing responsive pleadings, Plaintiff filed his First Supplemental, Amending and Restated Petition for Damages on November 29, 2016, adding two defendants: Milliman, Inc. ("Milliman"); and Buck Consultants, LLC ("Buck").

In response, the D&O Defendants (joined by Travelers) filed various exceptions, as did GRI, Beam, Milliman, and Buck. CGI filed a Motion for Summary Judgment.[1] All of the

EXHIBIT A

[1] As of this filing, only GRI and CGI have answered the original and First Amended Petitions.

REC'D C.P.
OCT 27 2017

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defendants' exceptions and dispositive motions have been denied or rendered by moot by settlement.

Plaintiff now seeks leave to file his Second Amended Petition, a copy of which is attached hereto as Exhibit "A," to add certain excess insurers and related nominal defendants. Specifically, Plaintiff has reached a *Gasquet* settlement with the D&O Defendants. Pursuant to the terms of the parties' settlement agreement, the D&O Defendants and Other Insured Persons[2] may be named as nominal defendants to the extent Plaintiff elects to pursue his rights against any excess insurer of the D&O Defendants or Other Insured Persons by naming such insurers in this suit (other than Travelers). In accordance with this settlement agreement, Plaintiff now seeks leave to amend his petition to name the following excess insurers: Allied World Specialty Insurance Company a/k/a Darwin National Assurance Company; Atlantic Specialty Insurance Company; Evanston Insurance Company; RSUI Indemnity Company; and Zurich American Insurance Company. Likewise, Plaintiff seeks leave to amend his petition and name the following as nominal defendants: Michael Hulefeld; Peter November; Pat Quinlan; Scott Posecai; William Oliver (previously named but now specifically named as a nominal defendant); and Warner Thomas (same).

In addition, Plaintiff seeks leave to file a Second Amended Petition incorporating additional factual details and clarification regarding CGI's work. The Second Amended Petition clarifies the obligations assumed by CGI in the Letter Agreement dated June 19, 2014, wherein LAHC and CGI purportedly terminated the original CGI Agreement; the work performed by CGI during the transitional period after the alleged termination date of April 30, 2014; and the various ways in which CGI failed to perform and breached its warranties and obligations in both the Original Agreement and the subsequent Letter Agreement.

Finally, the Second Amended Petition adds the newly discovered allegation that GRI failed to submit correct Taxpayer Identification Numbers associated with 1099s, resulting in IRS penalties and fines of at least $37,700. Notice of the penalty proposed for the infractions associated with LAHC's 2015 returns was provided to Plaintiff in August 2017.

The filing of this Second Amended Petition will not delay this case or cause any undue hardship on the defendants. Discovery is in the initial stages. Plaintiff recently filed a Motion to

[2] As used in the parties' Settlement Agreement, the term "Other Insured Persons" shall mean all persons, other than the D&O Defendants, who qualify as an Insured Person, as that term is defined in either of the applicable Travelers Policies. The definition of "Insured Person" in the Travelers policies includes an employee or member of the board of directors of LAHC.

Adopt a Case Management Schedule, which is currently pending. The proposed deadlines and scheduling dates set forth the Case Management Schedule are all in 2018, including the deadline to amend pleadings (April 16, 2018). No trial date has been set, and the Case Management Schedule submitted by the Plaintiff proposes that trial be set in the late summer or fall of 2019.

WHEREFORE, Plaintiff prays that this Motion for Leave be granted, and that his Second Supplemental, Amending and Restated Petition for Damages be filed without delay.

Respectfully submitted,

J. E. Cullens, Jr., T.A., La. Bar #23011
Edward J. Walters, Jr., La. Bar #13214
Darrel J. Papillion, La. Bar #23243
David Abboud Thomas, La. Bar #22701
Jennifer Wise Moroux, La. Bar #31368
WALTERS, PAPILLION, THOMAS, CULLENS, LLC
12345 Perkins Road, Bldg One
Baton Rouge, LA 70810
Phone: (225) 236-3636

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing has been furnished via U.S. Mail, postage prepaid, and via e-mail to all counsel of record as follows:

Harry (Skip) J. Philips, Jr.
Taylor Porter
Post Office Box 2471
Baton Rouge, LA 70821

James A. Brown
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Adams and Reese, LLP
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Baton Rouge, LA 70801

Frederic Theodore 'Ted' Le Clercq
Deutsch Kerrigan, LLP
755 Magazine Street
New Orleans, LA 70130

Baton Rouge, Louisiana this 25th day of October, 2017.

J. E. Cullens, Jr.

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JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO.: 651,069 SECTION: 22
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	:	STATE OF LOUISIANA

ORDER

Considering Plaintiff's Motion for Leave to File Second Supplemental, Amending and Restated Petition for Damages (with Incorporated Memorandum):

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that the Motion for Leave is **GRANTED**, and the Plaintiff's Second Supplemental, Amending and Restated Petition for Damages be deemed filed.

SIGNED this 26 day of Oct, 2017, at Baton Rouge, Louisiana.

HON. JUDGE TIMOTHY KELLEY, 19th JDC

PLEASE PROVIDE NOTICE
PURSUANT TO LSA–CCP ART. 1913

JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO.: 651,069 SECTION: 22
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SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION FOR DAMAGES AND REQUEST FOR JURY TRIAL

NOW INTO COURT, through undersigned counsel, comes James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc., through his duly appointed Receiver, Billy Bostick, who respectfully requests that this SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION FOR DAMAGES AND REQUEST FOR JURY TRIAL be filed herein and served upon all named Defendants; and respectfully represents:

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1.

That the caption of this matter be amended to read as follows:

JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO.: 651,069 SECTION: 22
versus	:	
	:	PARISH OF EAST BATON ROUGE
CGI TECHNOLOGIES AND SOLUTIONS, INC., GROUP RESOURCES INCORPORATED, BEAM PARTNERS, LLC, MILLIMAN, INC., BUCK CONSULTANTS, LLC. WARNER L. THOMAS, IV, WILLIAM A. OLIVER, SCOTT POSECAI, PAT QUIINLAN, PETER NOVEMBER, MICHAEL HULEFELD, ALLIED WORLD SPECIALTY INSURANCE COMPANY a/k/a DARWIN NATIONAL ASSURANCE COMPANY, ATLANTIC SPECIALTY INSURANCE COMPANY, EVANSTON INSURANCE COMPANY, RSUI INDEMNITY COMPANY AND ZURICH AMERICAN INSURANCE COMPANY	:	19TH JUDICIAL DISTRICT COURT
	:	STATE OF LOUISIANA

JURISDICTION AND VENUE

2.

This Court has jurisdiction over this dispute involving Louisiana Health Cooperative, Inc., ("LAHC") a Louisiana Nonprofit Corporation that holds a health maintenance organization ("HMO") license from the Louisiana Department of Insurance, is domiciled, organized and doing business in the State of Louisiana, and maintains its home office in Louisiana.

3.

This Court has jurisdiction over all of the named Defendants because each of them has transacted business or provided services in Louisiana, has caused damages in Louisiana, and because each of them is obligated to or holding assets of Louisiana Health Cooperative, Inc.

4.

Venue is proper in this Court pursuant to the provision of the Louisiana Insurance Code, including La. R.S. 22:257, which dictates that the Nineteenth Judicial District Court has exclusive jurisdiction over this proceeding and La. R.S. 22:2004, which provides for venue in this Court and Parish, as well as other provisions of Louisiana law.

PARTIES

5.

Plaintiff

The Plaintiff herein is James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc., through his duly appointed Receiver, Billy Bostick ("Plaintiff").

6.

Louisiana Health Cooperative, Inc. ("LAHC") is a Nonprofit Corporation incorporated in Louisiana on or about September 12, 2011. LAHC was organized in 2011 as a qualified nonprofit health insurer under Section 501(c)(29) of the Internal Revenue Code, Section 1322 of the Patient Protection and Affordable Care Act of 2010, the Louisiana Nonprofit Corporation Law, and Louisiana Insurance Law.

7.

A Petition for Rehabilitation of LAHC was filed in the 19th JDC, Parish of East Baton Rouge, on September 1, 2015; on September 1, 2015, an Order of Rehabilitation was entered, and on September 21, 2015, this Order of Rehabilitation was made permanent and placed LAHC into rehabilitation and under the direction and control of the Commissioner of Insurance for the State of Louisiana as Rehabilitator, and Billy Bostick as the duly appointed Receiver of LAHC.

8.

Plaintiff has the authority and power to take action as deemed necessary to rehabilitate LAHC. Plaintiff may pursue all legal remedies available to LAHC, where tortious conduct or breach of any contractual or fiduciary obligation detrimental to LAHC by any person or entity has been discovered, that caused damages to LAHC, its members, policyholders, claimants, and/or creditors.

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9.

Defendants

Named Defendants herein are the following:

10.

D&O Defendants

Each of the D&O Defendants listed below are named only as Nominal Defendants in this matter, to the extent that insurance coverage, other than the Travelers Casualty and Surety Company of America policy, may apply to the claims asserted against them herein:

a. **WARNER L. THOMAS, IV ("Thomas"),** an individual of the full age of majority domiciled in the State of Louisiana. Thomas was a Director of LAHC from 2011 until approximately January 2014. Thomas was Ochsner Health System's Chief Operating Officer from 1998 until September 1, 2012; Ochsner's President from 1998 until present; and Ochsner's Chief Executive Officer from September 1, 2012, until present. Thomas is a Nominal Defendant only.

b. **WILLIAM A. OLIVER ("Oliver"),** an individual of the full age of majority domiciled in the State of Louisiana. Oliver was a Director of LAHC from 2011 through 2015. Upon information and belief, Oliver was a director and/or officer of Ochsner Health Systems at pertinent times hereto. Oliver is a Nominal Defendant only.

c. **SCOTT POSECAI ("Posecai"),** an individual of the full age of majority domiciled in the State of Louisiana. Posecai was a Director of LAHC from 2011 until October 28, 2013, and Treasurer of LAHC from September 25, 2012, until October 28, 2013. Posecai has been Chief Financial Officer of the Ochsner Clinic Foundation since 2001 and CFO of the Ochsner Health System since 2006. Posecai is a Nominal Defendant only.

d. **PATRICK QUIINLAN ("Quinlan"),** an individual of the full age of majority domiciled in the State of Louisiana. Quinlan was a Director of LAHC from September 25, 2012, until approximately January 2013. Quinlan was Chief Executive Officer of Ochsner Health System from 2001 until September 2, 2012. Quinlan is a Nominal Defendant only.

e. **PETER NOVEMBER ("November"),** an individual of the full age of majority domiciled in the State of Louisiana. November was a Director of LAHC from May 23, 2013, until 2015, and Secretary commencing July 9, 2013. Upon joining Ochsner in 2012, November initially served as Senior Vice President, General Counsel, and Chief Compliance Officer for Ochsner

Health System, and he currently is Executive Vice President and Chief Administrative Officer of Ochsner Health System. November is a Nominal Defendant only.

f. **MICHAEL HULEFELD ("Hulefeld"),** an individual of the full age of majority domiciled in the State of Louisiana. Hulefeld was a Director of LAHC from May 23, 2013, until 2015. Hulefeld is Executive Vice President and Chief Operating Officer of Ochsner Health System, and he previously served as the Chief Executive Officer of Ochsner Medical Center. Hulefeld is a Nominal Defendant only.

11.

TPA Defendants

a. **CGI TECHNOLOGIES AND SOLUTIONS, INC. ("CGI"),** a foreign corporation believed to be domiciled in Delaware with its principal place of business in Virginia. From approximately March 2013 to approximately November 2014, CGI served as the Third Party Administrator of LAHC and/or worked for LAHC to transition its TPA work to GRI. CGI contracted with and did work for LAHC in Louisiana.

b. **GROUP RESOURCES INCORPORATED ("GRI"),** a foreign corporation believed to be domiciled in Georgia with its principal place of business in Georgia. From approximately May 2014 to approximately May 2016, GRI served as the Third Party Administrator of LAHC. GRI contracted with and did work for LAHC in Louisiana.

12.

Beam Partners, LLC

a. **BEAM PARTNERS, LLC ("Beam Partners"),** a foreign corporation believed to be domiciled in Georgia with its principal place of business in Georgia. From prior to LAHC's incorporation in 2011 through approximately mid-2014, Beam Partners developed and managed LAHC. Beam Partners contracted with and did work for LAHC in Louisiana.

13.

Actuary Defendants

a. **MILLIMAN, INC. ("Milliman"),** a foreign corporation believed to be domiciled in Washington with its principal place of business in Washington. From approximately August 2011 to March 2014, Milliman provided professional actuarial services to LAHC.

b. **BUCK CONSULTANTS, LLC ("Buck"),** a foreign corporation believed to be domiciled in Delaware with its principal place of business in New York. From approximately March 2014 through July 2015, Buck provided professional actuarial services to LAHC.

14.

Insurer Defendants

a. **ALLIED WORLD SPECIALTY INSURANCE COMPANY a/k/a DARWIN NATIONAL ASSURANCE COMPANY ("Allied/Darwin"),** a foreign insurer, doing business in the State of Louisiana and subject to the regulatory authority of the Louisiana Department of Insurance, who issued an applicable policy or policies to Ochsner Clinic Foundation that provide coverage for claims asserted herein.

b. **ATLANTIC SPECIALTY INSURANCE COMPANY ("Atlantic"),** a foreign insurer, doing business in the State of Louisiana and subject to the regulatory authority of the Louisiana Department of Insurance, who issued an applicable policy or policies to Ochsner Clinic Foundation that provide coverage for claims asserted herein.

c. **EVANSTON INSURANCE COMPANY ("Evanston"),** a foreign insurer, doing business in the State of Louisiana and subject to the regulatory authority of the Louisiana Department of Insurance, who issued an applicable policy or policies to Ochsner Clinic Foundation that provide coverage for claims asserted herein.

d. **RSUI INDEMNITY COMPANY ("RSUI Indemnity"),** a foreign insurer, doing business in the State of Louisiana and subject to the regulatory authority of the Louisiana Department of Insurance, who issued an applicable policy or policies to Ochsner Clinic Foundation that provide coverage for claims asserted herein.

e. **ZURICH AMERICAN INSURANCE COMPANY ("Zurich"),** a foreign insurer, doing business in the State of Louisiana and subject to the regulatory authority of the Louisiana Department of Insurance, who issued an applicable policy or policies to Ochsner Clinic Foundation that provide coverage for claims asserted herein.

DEFINED TERMS

15.

As used herein, the following terms are defined as follows:

1. "**D&O Defendants**" shall refer to and mean those directors and officers of LAHC named as either original Defendants and/or Nominal Defendants herein, specifically: Terry S.

Shilling, George G. Cromer, Warner L. Thomas, IV, William A. Oliver, Charles D. Calvi, and Patrick C. Powers; Scott Posecai; Pat Quinlan; Peter November; and Michael Hulefeld.

2. "**TPA Defendants**" shall refer to and mean those third party administrators hired by LAHC to oversee, manage, and otherwise operate LAHC named as Defendants herein, specifically: CGI Technologies and Solutions, Inc. and Group Resources Incorporated.

3. "**Insurer Defendant**" shall refer to and mean those insurance companies named herein which provide insurance coverage for any of the claims asserted herein by LAHC against any of the Defendants named herein, including: Allied/Darwin, Atlantic, Evanston, RSUI Indemnity, and Zurich.

4. **"Actuary Defendants"** shall refer to and mean those actuaries hired by LAHC to perform actuarial services for LAHC and named as Defendants herein, specifically: Milliman, Inc. ("Milliman") and Buck Consulting, Inc. ("Buck").

5. "**LDI**" shall refer to and mean the Louisiana Department of Insurance.

6. "**CMS**" shall refer to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

7. **"Nominal Defendants"** shall refer to and mean those D&O Defendants and Other Insured Persons (as defined in the underlying settlement agreements between Plaintiff and Travelers Casualty and Surety Company of America and others), including but not limited to Warner L. Thomas, IV; William A. Oliver; Scott Posecai; Pat Quinlan; Peter November; and Michael Hulefeld, who are named herein solely to effectuate Plaintiff's right to proceed against any insurance companies, other than Travelers Casualty and Surety Company of America, which provided coverage for Plaintiff's allegations herein; including but not limited to Allied World Specialty Insurance Company a/k/a Darwin National Assurance Company; Atlantic Specialty Insurance Company; Evanston Insurance Company; RSUI Indemnity Company; and Zurich American Insurance Company, all pursuant to Plaintiff's *Gasquet* release of the D&O Defendants, Other Insured Persons, and Travelers Casualty and Surety Company of America.

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FACTUAL BACKGROUND

16.

The Patient Protection and Affordable Care Act ("ACA") established health insurance exchanges (commonly called "marketplaces") to allow individuals and small businesses to shop for health insurance in all states across the nation. To expand the number of available health insurance plans available in the marketplaces, the ACA established the Consumer Operated and Oriented Plan ("CO-OP") program. The ACA further directed the Secretary of Health and Human Services to loan money to the CO-OP's created in each state. Beginning on January 1, 2014, each CO-OP was allowed to offer health insurance through the newly minted marketplaces for its respective state. A total of 23 CO-OP's were created and funded as of January 1, 2014. State regulators, like the Louisiana Department of Insurance ("LDI"), have the primary oversight of CO-OP's as health insurance issuers.

17.

In Louisiana, the CO-OP created and funded pursuant to the ACA was Louisiana Health Cooperative, Inc. ("LAHC"), a Louisiana Nonprofit Corporation that holds a health maintenance organization ("HMO") license from the LDI. Incorporated in 2011, LAHC eventually applied for and received loans from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") totaling more than $65 million. Specifically, according to the 2012 Loan Agreement with LAHC, the Louisiana CO-OP was awarded a Start-up Loan of $12,426,560, and a Solvency Loan of $52,614,100. Pursuant to the ACA, these loans were to be awarded only to entities that demonstrated a high probability of becoming financially viable. All CO-OP loans must be repaid with interest. LAHC's Start-up Loan must be repaid no later than five (5) years from disbursement; and LAHC's Solvency Loan must be repaid no later than fifteen (15) years from disbursement.

18.

From the start, because of the gross negligence of the Defendants named herein, LAHC failed miserably. Before ever offering a policy to the public, LAHC lost approximately $8 million in 2013. While projecting a modest loss of about $1.9 million in 2014 in its loan application to CMS, LAHC actually lost about $20 million in its first year in business. And although LAHC projected turning a modest profit of about $1.7 million in 2015, it actually lost more than $54 million by the end of that year.

19.

The actuaries hired by LAHC to determine the CO-OP's feasibility, assess its funding needs, and set the premium rates to be charged by LAHC in both 2014 and 2015, breached their respective duties owed to LAHC. The actuaries hired by LAHC grossly underestimated the level of expenses that LAHC would incur, made erroneous assumptions regarding LAHC's relative position in the marketplace, and grossly misunderstood or miscalculated how the risk adjustment component of the ACA would impact LAHC. Rather than LAHC either receiving a risk adjustment payment or LAHC not being assessed any such risk adjustment payment at all, as the actuaries erroneously predicted, in actuality, LAHC incurred significant risk adjustment payments in both 2014 and 2015. These failures of the actuaries who served LAHC were a significant factor in causing LAHC's ultimate collapse.

20.

Not only did LAHC lose a tremendous amount of money, but, from its inception, LAHC was unable to process and manage the eligibility, enrollment, and claims handling aspects of the HMO competently. Almost every aspect of LAHC's eligibility, enrollment, and claims handling process was deficient, resulting in numerous unpaid claims, untimely paid claims, and erroneously paid claims.

21.

By July 2015, only eighteen months after it started issuing policies, LAHC decided to stop doing business. The LDI placed LAHC in rehabilitation in September 2015, and a Receiver, Billy Bostick, was appointed by this Court to take control of the failed Louisiana CO-OP.

22.

The various parties who created, developed, managed, and worked for LAHC (i.e., the Defendants named herein) completely failed to meet their respective obligations to the subscribers, providers, and creditors of this Louisiana HMO. From the beginning of its existence, LAHC was completely ill-equipped to service the needs of its subscribers (i.e., its members / policyholders), the healthcare providers who provided medical services to its members, and the vendors who did business with LAHC. As described in detail herein, the conduct of the Defendants named herein went way beyond simple negligence. For instance, when the LDI took over the operations of LAHC, the CO-OP had a backlog of approximately 50,000 claims that had not been processed.

Because of Defendant's gross negligence, as of December 31, 2015, LAHC had lost more than $82 million.

23.

As set forth herein, Defendants are liable to Plaintiff for all compensatory damages caused by their actionable conduct.

CAUSES OF ACTION

Count One: Breach of Fiduciary Duty (Against the D&O Defendants and Insurer Defendants)

24.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

25.

The D&O Defendants owed LAHC, its members, and its creditors, fiduciary duties of loyalty, including the exercise of oversight as pleaded herein, due care, and the duty to act in good faith and in the best interest of LAHC. The D&O Defendants stand in a fiduciary relation to LAHC and its members and creditors and must discharge their fiduciary duties in good faith, and with that diligence, care, judgment and skill which the ordinarily prudent person would exercise under similar circumstances in like position.

26.

At all times when LAHC was insolvent and/or in the zone of insolvency, the D&O Defendants owed these fiduciary duties to the creditors of LAHC as well.

27.

The conduct of the D&O Defendants of LAHC, as pled herein, went beyond simple negligence. The conduct of the D&O Defendants constitutes gross negligence, and in some cases, willful misconduct. In other words, the D&O Defendants did not simply act negligently in the management and supervision of and their dealings with LAHC, but the D&O Defendants acted grossly negligently, incompetently in many instances, and deliberately, in other instances, all in a manner that damaged LAHC, its members, providers and creditors.

28.

The D&O Defendants knew or should have known that Beam Partners was unqualified and unsuited to develop and manage LAHC.

29.

The D&O Defendants knew or should have known that GRI was unqualified and unsuited to develop and manage LAHC.

30.

The failure of the D&O Defendants to select a competent TPA, negotiate an acceptable contract with GRI, and manage and oversee Beam Partners, CGI, and GRI's conduct, constitutes gross negligence on the part of the D&O Defendants that caused LAHC to hire other vendors and/or additional employees, in effect, to either do work and/or fix work that should have been competently done by Beam Partners, CGI, and/or GRI, resulting in tremendous additional and unnecessary expenses and inefficiencies to LAHC which played a significant role in LAHC's failure.

31.

The D&O Defendants breached their fiduciary obligations in the following, non-exclusive, ways:

a. Paying excessive salaries to LAHC executives in relation to the poor, inadequate, or non-existent services rendered by them to LAHC and/or on its behalf;

b. Paying excessive bonuses to LAHC executives in relation to the poor, inadequate, or non-existent services renders by them to LAHC and/or on its behalf;

c. Grossly inadequate oversight of LAHC operations;

d. Grossly inadequate oversight of contracts with outside vendors, including CGI and GRI;

e. Lack of regularly scheduled and meaningful meetings of the Board of Directors and management; the few board meetings that took place (one in 2012; four in 2013; six in 2014; and one in 2015), generally lasted about an hour;

f. Gross negligence in hiring key management and executives with limited or inadequate health insurance experience;

g. Gross failure to protect the personal health information of subscribers; unauthorized disclosure of subscribers' personal health information; for example, in February 2014, an incorrect setting within LAHC's document production system caused 154 member ID cards to be erroneously distributed;

h. Gross failure to issue ID cards to members accurately and timely;

i. Gross failure to pay claims timely (if at all);

j. Gross failure to bill premiums accurately and timely;

k. Gross failure to properly calculate member out-of-pocket responsibilities resulting in members being over-billed for their portion of services rendered by providers;

l. Gross failure to collect premium payments timely (if at all);

m. Gross failure to process and record the effective dates of policies accurately or consistently;

n. Gross failure to process and record the termination dates of policies accurately or consistently;

o. Gross failure to process invoices correctly and timely;

p. Gross failure to determine and report eligibility of members accurately;

q. Gross failure to have in place and/or to implement a financial policy or procedure to verify check register expenditures;

r. Gross failure to have in place and/or to implement a financial policy or procedure to verify credit card expenditures; for example, in or around October to November 2013, a VP of IT Operations at LAHC, Larry Butler, misused his LAHC credit card by incurring more than $35,000 in charges, the vast majority of which were personal expenses, on a corporate account with limits of $5,000;

s. Gross failure to have in place and/or to implement a financial policy or procedure to verify sponsor invoices;

t. Gross failure to have in place and/or to implement policies and procedures regarding operational, financial, and compliance areas (such as background checks, corrective action plans, procurement, contract management, and financial management) before engaging in meaningful work and offering insurance coverage to the public;

u. Gross failure to understand, implement, and enforce the applicable "grace period" pertaining to subscribers as per the ACA and Louisiana Law, La. R.S. 22:1260.31, *et. seq.*;

v. Gross failure to record and report LAHC's claims reserves (IBNR) accurately;

w. Gross failure to report and appoint agents and brokers;

x. Gross failure to record and report the level of care provided to LAHC members, enrollees, and subscribers accurately;

y. As of March 2014, LAHC described its own system to process enrollment, eligibility, and claims handling as a "broken" process;

z. Grossly negligent to choose GRI to replace CGI; went from the frying pan into the fire; GRI was unqualified, ill-equipped, and unable to service the needs of LAHC, its members, providers, and creditors;

aa. Erroneously terminating coverage for fully subsidized subscribers;

bb. Failing to provide notice to providers regarding member terminations and lapses due to non-payment of premiums;

cc. Failing to provide notice (delinquency letters) to subscribers prior to terminating coverage;

dd. Failing to maintain an Information Technology environment with adequate controls and risk mitigation to protect the data, processes, and integrity of LAHC data;

ee. Failing to collect binder payments on-time;

ff. Failing to terminate members when binder payments were not received;

gg. Failing to correct ambiguities in the GRI contract(s);

hh. Failing to select qualified vendors

ii. Failing to select qualified management;

jj. They knew or should have known, prior to the public rollout of LAHC in January 2014, that LAHC would not be a viable HMO, and yet they proceeded to offer policies and services to the public and members knowing that LAHC would fail;

kk. They caused and/or allowed LAHC to misrepresent the financial condition and viability of LAHC to the LDI, the federal government, its member, its creditors, and the public, thereby allowing LAHC to remain in operation much longer that they should and would otherwise have, adding additional members and incurring additional claims and debt;

ll. They knowingly paid excessive salaries, professional service fees, and consulting fees, as alleged herein, without receiving appropriate value to LAHC;

mm. They failed to implement internal controls that would have prevented the gross waste and damages sustained by LAHC as a result of their gross negligence;

nn. They concealed LAHC's true financial condition and insolvency and artificially prolonged LAHC's corporate life beyond insolvency all to the detriment of LAHC, its members, and its creditors;

oo. They grossly mismanaged LAHC's affairs;

pp. They grossly failed to exercise oversight or supervise LAHC's financial affairs;

qq. They failed to operate LAHC in a reasonably prudent manner;

rr. They failed in their duty to operate LAHC in compliance with the laws and regulations applicable to them; and

ss. Other acts of gross negligence as may be later discovered.

32.

The D&O Defendants also breached their fiduciary duty of loyalty, due care, and good faith by allowing, if not fostering, individuals with conflicts of interest to influence, if not control, LAHC, all to the detriment of LAHC, its members, providers, and creditors.

33.

Because of the grossly negligent conduct of the D&O Defendants, LAHC was woefully not prepared for its roll-out to the public on January 1, 2014.

34.

By approximately March 2014, just three (3) months after its ill-advised roll-out, the D&O Defendants compounded an already bad situation by deciding to replace CGI with GRI as TPA. At this point, the D&O Defendants should have either exercised appropriate oversight and management to reform CGI's grossly inadequate performance, or the D&O Defendants should have terminated the Agreement with CGI and found a suitable TPA, or the D&O Defendants

should have ceased operations altogether. Instead, the D&O Defendants made matters worse by hiring a TPA that was even less qualified and less prepared than CGI for the job: GRI.

35.

To further damage the struggling LAHC, in approximately mid-2014, the D&O Defendants decided to switch healthcare provider networks from Verity Healthnet, LLC ("Verity") to Primary Healthcare Systems ("PHCS"). Once again, the D&O Defendants' conduct constitutes gross negligence that further damaged LAHC, its members, providers, and creditors.

36.

The D&O Defendants, in breaching both their duty of loyalty and duty of care, showed a conscious disregard for the best interests of LAHC, its members, providers and creditors.

37.

As a direct and proximate result of the gross negligence and foregoing failures of the D&O Defendants to perform their fiduciary obligations, LAHC, its members, its providers and its creditors have sustained substantial, compensable damages for which the D&O Defendants and the Insurer Defendants are liable, and for which Plaintiff is entitled to recover in this action.

38.

The compensable damages caused by the D&O Defendants' grossly negligent conduct, if not willful conduct, include, but are not limited to:

a. damages in the form of all losses sustained by LAHC from its inception (i.e., they should have never started LAHC in the first place);

b. damages in the form of lost profits (i.e., the amount LAHC would have earned, if any, but for their conduct);

c. damages in the form of excessive losses (i.e., the difference between the amount LAHC would have lost, if any, and the amount LAHC did lose, because of their conduct);

d. damages in the form of deepening insolvency (i.e., the damages caused by their decision to prolong the corporate existence of LAHC beyond insolvency);

e. damages in the form of all legitimate debts owed to creditors of LAHC, including but not limited to those unpaid debts owed to health care providers who delivered services to members of LAHC, any debts owed to members of LAHC that were not paid, and the debt owed to CMS (both principal and interest) as a result of LAHC's gross negligence as pled herein;

f. disgorgement of all excessive salaries, bonuses, profits, benefits, and other compensation inappropriately obtained by them;

g. damages in the form of all excessive administrative, operational, and/or management expenses, including:

    i. Untimely payment of member and provider claims;

ii. Incorrect payment of member and provider claims;

iii. Increased interest expense due to incorrect and/or untimely claims payments:

iv. Increased expenses due to incorrect and/or untimely claims payments;

v. Incorrect and/or untimely payment of agent/broker commissions:

vi. Inaccurate and/or untimely collection of premium due for health coverage;

vii. Increased expenses for services from LAHC vendors other than the third party administrator;

viii. Increased expenses for provider networks and medical services;

ix. Loss of money due to LAHC from the Center for Medicare and Medicaid Services ("CMS") for risk adjustments;

x. Fines incurred for failure to have agents/brokers properly appointed; and

xi. Inability to repay the millions of dollars loaned to LAHC by the federal government.

h. all costs and disbursements of this action, including all compensable litigation expenses.

39.

Plaintiff recently reached a *Gasquet* settlement with the originally named D&O Defendants, specifically: Shilling, Cromer, Thomas, Oliver, Calvi, and Powers. Pursuant to the terms of the parties' settlement agreement, the D&O Defendants and Other Insured Persons (i.e., other employees or directors of LAHC) may be named as nominal defendants to the extent Plaintiff elects to pursue his rights against any excess insurer of the D&O Defendants or Other Insured Persons by naming such insurers in this suit (other than Travelers). In accordance with the settlement agreement, Plaintiff has named the Insurer Defendants as excess insurers, and he has named the following as nominal defendants herein: Thomas; Oliver; Posecai; Quinlan; November; and Hulefeld.

40.

The Insurer Defendants are liable to the Plaintiff jointly, severally and *in solido* with the D&O Defendants to the extent of the limits of its respective policies of insurance, for the following reasons:

a. Allied/Darwin issued a Directors and Officers Liability Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of $5,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff;

b. Allied/Darwin issued an Excess Insurance Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of $5,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff;

c. Atlantic issued a Follow Form Excess Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of $10,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff;

d. Evanston issued an Excess Management Liability Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of $5,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff;

e. RSUI Indemnity issued an Excess Liability Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of 10,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff;

f. Zurich issued a Zurich Excess Select Insurance Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of $10,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff.

41.

The Insurer Defendants provide coverage for the liability of executives or employees of Ochsner Clinic Foundation who act as director or officer of any non-for-profit entity, such as LAHC, at the request of Ochsner. The Nominal Defendants, Thomas, Oliver, Posecai, Quinlan, November, and Hulefeld, were all Ochsner executives and/or employees who also served as directors and/or officers of LAHC at the request of Ochsner.

Count Two: Breach of Contract
(Against the TPA Defendants and Beam Partners)

42.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

CGI

43.

On or about February 15, 2013, LAHC and CGI entered into an Administrative Services Agreement ("Agreement") whereby CGI agreed to perform certain administrative and management services to LAHC in exchange for certain monetary compensation as set forth in the Agreement. A true and correct copy of the Agreement and all exhibits was attached and incorporated by reference in the original Petition for Damages as "Exhibit 1."

44.

Under the terms of the Agreement, CGI represented and warranted, *inter alia,* that "CGI personnel who perform the services under the Agreement shall have the appropriate training, licensure and or certification to perform each task assigned to them" and that "CGI will make a good faith effort to maintain consistent staff performing the delegated functions" for LAHC.

45.

Under the terms of the Agreement, CGI was, among other things, obligated to:

a. Function as a Third Party Administrator for LAHC;

b. Accurately process and pay claims for covered services provided to LAHC's members by participating providers according to payment terms regarding timeliness and the rates and amounts set forth in LAHC's Participating Provider Agreements.

c. Accurately process and pay claims for covered services provided to LAHC's members by providers;

d. Competently perform all of those tasks set forth in the Agreement, including Exhibit 2 thereto, such as paying claims, adjudicating claims, determining covered services, identifying and processing clean and unclean claims, collecting and processing all encounter data, transmitting denial notifications to members and providers, transmitting all required notices, tracking and reporting its performance, tracking, reporting and reconciling all records regarding deductibles and benefit accumulators, monitoring all claims, submitting all claims, tracking, reporting, and paying all interest on late paid claims, coordinating the payment and processing of all claims and EOBs, and developing and implementing a functional coding system; and

e. Competently perform all of those tasks expected and required of a Third Party Administration, whether specified in the Agreement or not.

46.

CGI breached its obligations and warranties set forth in the Agreement in a grossly negligent manner, all in the following, non-exclusive ways:

a. Failed to pay claims at the proper contract rates and amounts, thus resulting in an overpayment of claims;

b. Failed to accurately and properly process enrollment segments and failed to timely reconcile enrollment segments;

c. Failed to provide proper notice to providers regarding member terminations and lapses due to non-payment of premiums;

d. Failed to issue appropriate identification cards to subscribers;

e. Failed to provide proper notice (delinquency letters) so subscribers prior to terminating coverage;

f. Failed to process claims properly;

g. Failed to enter, record, and process paper claims properly;

h. Failed to establish, manage, and run the call center for LAHC properly;

i. Failed to implement a billing system that would accurately calculate balance due;

j. Failed to appropriately establish an EDGE server and/or failed to appropriately or timely provide the Department of Health and Human Services with access to required data on the EDGE server; and

k. Other acts of gross negligence as may be later discovered.

47.

As of March 2014, just three (3) months after its roll-out, LAHC described the system designed and implemented by CGI to process enrollment, eligibility, and claims handling, as a "broken" process. Indeed, the conduct of CGI, as described herein in detail, goes well beyond simple negligence; almost every facet of the system designed and implemented by CGI as a third party administrator of LAHC was a failure. CGI's conduct, as described herein in detail, constitutes gross negligence.

48.

Subsequently, LAHC and CGI memorialized their agreement to terminate the CGI Agreement via Letter Agreement dated June 19, 2014 ("Letter Agreement") (Exhibit 3). Assuming that this purported release is applicable to Plaintiff's claims against CGI, which Plaintiff expressly denies, the express terms of this Letter Agreement make clear that LAHC did not release CGI for "obligations assumed" by this Letter Agreement.

49.

According to this Letter Agreement, although the Original Agreement allegedly terminated on April 30, 2014, CGI assumed numerous obligations, including:

- For "the six month wind-down period [from April 2011 through October 2011], CGI shall provide such wind-down services as the parties may agree in a wind-down plan, all in accordance with Sections 2.5 and 2.5.1 of the Original Agreement." (Exhibit 3, ¶ 1).
- "The general scope and structure of the wind down period is as specified in Attachment 1 to this Letter Agreement." (Exhibit 3, ¶ 2). Attachment 1 to the Letter Agreement further specifies that, during the wind down period, CGI was responsible for transferring "membership data," "enrollment data," "paid claim data," "pending and/or in-flight claim data," "file server records," and "other data transfer as the parties agree" to GRI. (Exhibit 3, Attachment 1).

- "During the wind-down period, CGI will make commercially reasonable efforts to perform the Delegated Functions in accordance with the Service Level Specifications set forth in Section 6 in Exhibit 1 to the Original Agreement." (Exhibit 3, ¶ 3).

50.

Further, as evidenced by correspondence from LAHC to CGI dated April 17, 2014, requesting that the Original Agreement between LAHC and CGI be terminated because of numerous specific failures of CGI to perform under the agreement and asserting that "CGI is in fundamental breach of the Agreement, CGI continued to provide services to LAHC during the transitional "wind down" period. Specifically, in addition to detailing the numerous failures of CGI to perform, according to this correspondence:

- "LAHC must transition the revoked Delegated Functions to other organization(s) while relying on CGI to cooperatively effect a smooth and orderly transition of those services as required by Article 3.13.6."
- "Consistent with the provisions of Article 3.13.6 of the Agreement, LAHC expects that CGI continue to provide services, including information and exchanges as reasonably requested by LAHC or its designee, until effective transition on or about October 1, 2014."

51.

The services performed by CGI after April 30, 2014 are "obligations assumed" by the Letter Agreement. CGI breached its obligations and warranties set forth in the Letter Agreement in a grossly negligent manner.

52.

CGI was paid a total of approximately $1,176,224.42 by LAHC over the course of their working relationship from approximately April 2013 to November 2014. Of this total amount, $539,139.59—or about 46%—was paid to CGI on or after April 30, 2014, the alleged termination date of the original agreement. CGI did substantial work for LAHC after April 30, 2014 during the transitional or "wind down" period as GRI assumed the role of third party administrator of LAHC. For example, both before and after April 30, 2014, CGI:

- failed to ensure that its personnel who performed services for LAHC were adequately and appropriately trained, licensed, and certified to perform the services and functions delegated by LAHC to CGI;
- failed to accurately process and pay claims on LAHC's behalf in a timely manner at the correct rates and amounts;

- failed to cause LAHC to accurately process and pay health insurance claims in a timely manner at the correct rates and amounts; and
- in general, failed to provide for a smooth and seamless transition of LAHC's ongoing business to GRI.

53.

CGI's breaches of its warranties and obligations in both the Original Agreement and the Letter Agreement have directly caused LAHC to incur substantial, compensatory damages which are recoverable by Plaintiff herein.

GRI

54.

GRI was not qualified to render the services as a third party administrator ("TPA") that LAHC needed to be successful. Rather than decline taking on a job that was outside of its capabilities, GRI wrongly agreed to replace CGI and serve as TPA for LAHC. GRI's decision to serve as LAHC's TPA constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors. But for GRI's gross negligence, most of LAHC's substantial, compensatory damages would have been avoided.

55.

In or about July 2014, LAHC and GRI entered into an Administrative Services Agreement whereby GRI agreed to perform certain administrative and management services to LAHC in exchange for certain monetary compensation as set forth in the Administrative Services Agreement. The Administrative Services Agreement had an effective date of July 1, 2014. The Administrative Services Agreement was amended both in September 2014 and December 2014. A true and correct copy of the Administrative Services Agreement and all amendments and exhibits are collectively referred to as the "Agreement" and were attached and incorporated by reference in the original Petition for Damages as "Exhibit 2." A true and correct copy of the Delegation Agreement between LAHC and GRI effective August 20, 2014, was attached and incorporated by reference in the First Supplemental, Amending and Restated Petition For Damages as "Exhibit 2A."

56.

Under the terms of the Agreement, CGI represented and warranted that "GRI personnel who perform or provide the Delegated Services specified services under this Agreement shall

possess the appropriate authorization, license, bond and certificates, and are full and appropriately trained, to properly perform the tasks assigned to them."

57.

Under the terms of the Agreement, GRI was, among other things, obligated to:

a. Accurately process and pay claims for covered services provided to LAHC's members by participating providers according to payment terms regarding timeliness and the rates and amounts set forth in LAHC's Participating Provider Agreements.

b. Accurately process and pay claims for covered services provided to LAHC's members by providers;

c. Competently perform all of those tasks set forth in the Agreement, including Exhibit A-1 to the agreement, such as paying claims, adjudicating claims, determining covered services, identifying and processing clean and unclean claims, collecting and processing all encounter data, transmitting denial notifications to members and providers, transmitting all required notices, tracking and reporting its performance, tracking, reporting and reconciling all records regarding deductibles and benefit accumulators, monitoring all claims, submitting all claims, tracking, reporting, and paying all interest on late paid claims, coordinating the payment and processing of all claims and EOBs, and developing and implementing a functional coding system; and

d. Competently perform all of those tasks expected and required of a Third Party Administration, whether specified in the Agreement or not.

58.

GRI breached its obligations and warranties set forth in the Agreement in a grossly negligent manner, all in the following, non-exclusive ways:

a. GRI failed to meet most, if not all, of the performance standards mandated by the Services Agreement of July 1, 2014;

b. GRI was unqualified, ill-equipped, and unable to service the needs of LAHC, its member, providers, and creditors;

c. GRI knew or should have known that it was unqualified to service the needs of LAHC;

d. Pursuant to GRI's Service Agreement, GRI was responsible for critical processes that are typically covered by such a health insurance administrative service provider contracts, including the receipt and processing of member premium payments, the calculation and payment of broker commissions, and the process of managing calls into LAHC;

e. GRI wholly failed to provide sufficient and adequately trained personnel to perform the services GRI agreed to perform under the Agreement;

f. Failed to process and pay claims on a timely basis, resulting in interest payment alone in excess of $600,000.00;

g. Failed to pay claims at the proper contract rates and amounts, thus resulting in an overpayment of claims;

h. Failed to accurately and properly process enrollment segments and failed to timely reconcile enrollment segments;

i. Erroneously terminated coverage for fully subsidized subscribers ($0 Invoices);

j. Failed to provide proper notice to providers regarding member terminations and lapses due to non-payment of premiums;

k. Failed to timely process enrollment interface (ANSI 834) from CMS;

l. Failed to accurately process enrollment interface (ANSI 834) from CMS;

m. Failed to pass CMS data edits for CMS Enrollment Reconciliation Process;

n. Submitted inaccurate data to the CMS Enrollment Reconciliation Process causing erroneous terminations;

o. Failed to pass CMS data edits for Enrollment Terminations & Cancellations Interface (ANSI 834) to CMS;

p. Failed to pass CMS data edits for Edge Server Enrollment Submissions to CMS;

q. Failed to use standard coding for illustrating non-effectuated members (using years 1915 and 1900 as termination year);

r. Failed to provide proper notice (delinquency letters) to subscribers prior to terminating coverage;

s. Failed to invoice subscribers accurately when APTC changed;

t. Failed to invoice subscribers for previously unpaid amounts (no balance forward);

u. Failed to cancel members for non-payment of binder payment;

v. Failed to cancel members after passive enrollment;

w. Failed to administer member benefits (maximum out-of-pockets exceeded);

x. Failed to pay interest on claims to providers;

y. Failed to pay claims within the contractual timeframes;

z. Failed to adjust claims after retroactive disenrollments;

aa. Failure to examine claims for potential subrogation

bb. Failed to maintain adequate customer service staffing and call center technology;

cc. Failed to process APTC changes from CMS within an appropriate timeframe;

dd. Failed to capture all claims diagnoses data from providers;

ee. Failed to pass CMS data edits for Edge Server claims submissions to CMS;

ff. Failed to load the 1,817 claims from the 4/29/16 and 5/2/16 check runs onto the EDGE Server;

gg. Incorrectly calculated claim adjustments, especially as it pertains to a subscriber's maximum out-of-pocket limit;

hh. Paid claims for members that never effectuated;

ii. Failed to protect the personal health information of subscribers;

jj. Failed to issue ID cards to members accurately and timely and without effective dates;

kk. Failed to have in place and/or to implement a financial policy or procedure to verify credit card expenditures;

ll. Failed to understand, implement, and enforce the applicable "grace period" pertaining to subscribers as per the ACA and Louisiana Law, La. R.S. 22:1260.31, *et. seq.*;

mm. Failed to record and report LAHC's claims reserves (IBNR) accurately;

nn. Failed to report and appoint agents and brokers appropriately;

oo. Failed to record and report the level of care provided to LAHC members, enrollees, and subscribers accurately; and

pp. Failed to maintain an Information Technology environment with adequate controls and risk mitigation to protect the data, processes, and integrity of LAHC data.

qq. Failed to maintain correct Taxpayer Identification Numbers for providers and submitted incorrect Taxpayer Identification Numbers on tax forms for approximately 135 providers, resulting in IRS penalties and fines of at least $37,700.

59.

According to the Agreement, GRI was obligated to pay claims within the time frame required by applicable law; and if claims were paid untimely because of GRI's conduct, GRI "shall be responsible for paying any required interest penalty to Providers." Because of GRI's gross negligence and non-performance of its contractual obligations owed to LAHC, numerous claims were paid late and significant interest penalties were incurred and paid by LAHC. GRI is obligated to pay all such interest penalties.

60.

GRI's gross negligence and breaches of its warranties and obligations in the Agreement have directly caused LAHC to incur substantial, compensatory damages which are recoverable by Plaintiff herein.

Beam Partners

61.

Beam Partners was not qualified to render the services as a manager and developer and/or third party administrator ("TPA") that the start-up, LAHC, needed to be successful. Rather than decline taking on a job that was outside of its capabilities, Beam Partners wrongly orchestrated and agreed to manage, develop, and serve as TPA for LAHC from its inception. Beam Partner's decision to manage, develop, and effectively serve as LAHC's TPA constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors.

But for Beam's gross negligence, all of LAHC's substantial, compensatory damages would have been avoided.

62.

Given that numerous individuals who either owned, managed and/or worked for Beam Partners, including Terry Shilling, Alan Bayham, Mark Gentry, Jim McHaney, Deborah Sidener, Jim Krainz, Jim Pittman, Michael Hartnett, Eric LeMarbre, Etosha McGee, Diana Pitchford, Darla Coates, were also involved with and managed LAHC from the beginning as officers, directors, and employees of LAHC, for all intents and purposes, Beam Partners was closely related to and acted as LAHC.

63.

From approximately September 2012 through May 2014, LAHC paid more than $3.7 million in the form of consulting fees, performance fees, and expenses to Beam Partners.

64.

LAHC and Beam Partners, LLC entered into a Management and Development Agreement whereby Beam Partners agreed to perform certain management, administrative, and developmental services for LAHC in exchange for certain monetary compensation as set forth in the Management and Development Agreement. Warner Thomas, as Chair of the Board of Directors of LAHC, signed this Management and Development Agreement on October 8, 2012; Terry Shilling signed the Management and Development Agreement on behalf of Beam Partners, LLC, with an effective date of August 28, 2012. At this time, Terry Shilling was simultaneously the Interim CEO of LAHC and a member and owner of Beam Partners. This Agreement was amended at least twice. A true and correct of the Management and Development Agreement, all Exhibits thereto (with the exception of Exhibit 2, "Performance Objectives for Services"; which is unavailable, Amendment 1, and Amendment 2), was attached and incorporated by reference om the original Petition for Damages as "Exhibit 3."

65.

According to the terms of the Agreement, Beam Partners agreed to provide "services essential to the formation of the Cooperative and its application for CO-OP program loans," including training all directors, securing the requisite licensure from LDI, developing a network of providers for LAHC, recruiting and vetting candidates for positions at LAHC, creating

processes, systems, and forms for the operation of LAHC, and identifying, negotiating and executing administrative services for the operation of LAHC.

66.

In short, Beam Partners agreed to transform the start-up LAHC into a well-organized, well-funded, and well-run HMO prior to January 1, 2014, the roll-out date of LAHC to the public. Beam Partners utterly failed to meet its contractual obligations owed to LAHC, and breached its obligations and warranties set forth in the Agreement in a grossly negligent manner, all in the following, non-exclusive ways:

a. Failing to identify, select, and retain qualified third party contractors for LAHC, including but not limited to CGI and/or GRI;

b. Failing to train all directors of LAHC regarding how to manage such an HMO;

c. Failing to develop a network of providers for LAHC;

d. Failing to recruit and adequately vet appropriate candidates for positions at LAHC;

e. Failing to create adequate and/or functioning processes, systems, and forms for the operation of LAHC;

f. Failing to to identify, negotiate, and execute adequate and/or functioning administrative services for the operation of LAHC;

g. Failing to report and provide LAHC with complete, accurate, and detailed records of its performance of all services provided to LAHC;

h. Failing to adequately disclose conflict of interests regarding Beam Partners and LAHC to any regulatory authority;

i. Failing to provide sufficient and adequately trained personnel to perform the services Beam Partners agreed to perform under the Agreement; and

j. In general, by completely failing to have LAHC ready and able to meet its obligations to the public, members, providers, and creditors on or before the roll-out date of January 1, 2014.

67.

The numerous failures of Beam Partners to perform its obligations owed to LAHC constitute gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors.

68.

To the extent that Beam Partners made the decision to keep using CGI as TPA until it was too late, Beam Partners is grossly negligent in that it knew or should have known that CGI was unqualified to serve as TPA.

69.

To the extent that Beam Partners made the decision to replace CGI with GRI as TPA, Beam Partners is grossly negligent in that it knew or should have known that GRI was unqualified to serve as TPA.

70.

To the extent that Beam Partners made the decision to terminate the Verity contract, Beam Partners is grossly negligent in that it knew or should have known that terminating the Verity contract would be a substantial factor in causing LAHC to incur additional, unnecessary expense and, ultimately, to collapse.

71.

Beam Partners' gross negligence and breaches of its warranties and obligations in the Agreement have directly caused LAHC to incur substantial, compensatory damages which are recoverable by Plaintiff herein.

Count Three: Gross Negligence and Negligence
(Against the TPA Defendants and Beam Partners)

72.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

73.

CGI, GRI, and Beam Partners each had a duty to ensure that its personnel who performed services for LAHC were adequately and appropriately trained, licensed, and certified to perform the services and functions delegated by LAHC to each of them.

74.

CGI, GRI, and Beam Partners each had a duty to accurately process and pay claims on LAHC's behalf in a timely manner at the correct rates and amounts.

75.

CGI, GRI, and Beam Partners each had a duty to perform their obligations in a reasonable, competent, and professional manner.

76.

CGI, GRI, and Beam Partners each breached their duties in that it negligently failed to cause LAHC to accurately process and pay health insurance claims in a timely manner at the correct rates and amounts.

77.

CGI, GRI, and Beam Partners each breached their duties in that they negligently and wholly failed to perform their obligations in a reasonable, competent, and professional manner.

78.

CGI, GRI, and Beam Partners each were grossly negligent in that they wantonly failed to provide a sufficient number of adequately trained personnel who had sufficient knowledge of the system program utilized by LAHC to process and pay health insurance claims at the correct rates and amounts in complete and reckless disregard of the rights of LAHC, its members, providers, and creditors.

79.

CGI, GRI, and Beam Partners each were grossly negligent in that they wantonly failed to cause LAHC to accurately process and pay health insurance claims in a timely manner at the correct health insurance rates and amounts in complete and reckless disregard of the rights of LAHC, its members, providers, and creditors.

80.

As a direct and proximate result of CGI's, GRI's, and Beam Partners' negligence or gross negligence, LAHC has incurred substantial, compensatory damages, which are recoverable herein by Plaintiff.

Count Four: Professional Negligence And Breach of Contract (Against the Actuary Defendants)

81.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

Milliman

82.

At all relevant times, Milliman held itself out as having expertise to provide actuarial services and advice to health insurers like LAHC.

83.

In or around August 2011, Milliman was engaged by Shilling on behalf of Beam Partners and/or LAHC to provide "actuarial support" for LAHC, including the production of a "feasibility study and loan application as directed by the Funding Opportunity Announcement (Funding

Opportunity Number: 00-COO-11-001, CFDA 93.545) released from the U.S. Department of Health Services ("HHS") on July 28, 2011." This engagement letter pre-dated LAHC's formal contract with Beam Partners by a year; the engagement letter dated August 4, 2011, was addressed to Shilling as "Owner/Partner" of "Beam Partners," and was signed by Shilling on August 15, 2011, on behalf of LAHC. Indeed, this engagement letter pre-dated the incorporation of LAHC by about a month or so (LAHC was first registered with the Louisiana Secretary of State's Office on or about September 12, 2011).

84.

In the feasibility study dated March 30, 2012, prepared by Milliman for LAHC to use in support of its loan application to CMS, Milliman concluded that, in general, LAHC "will be economically viable based upon our [Milliman's] base case and moderately adverse scenarios." According to Milliman's actuarial analysis, "the projections for the scenarios are conservative, and in each of the scenarios modeled, LAHC remains financially solvent and is able to pay back federal loans within the required time periods." Furthermore, Milliman estimated that "LAHC will be able to meet Louisiana's solvency and reserve requirements."

85.

The Milliman feasibility study was prepared using unrealistic assumption sets. None of the enrollment scenarios considered the possibility that LAHC would have trouble attracting an adequate level of enrollment (which is what actually happened in 2014 and 2015) and every economic scenario assumed that the loss ratio in nearly every modeled year would be 85% (an outlier loss ratio was never higher than 91%). These assumptions completely disregarded the very real possibility that there would be significant volatility in enrollment and/or the medical loss ratio. With all of the uncertainty within the ACA, a competent actuary would have understood that it was a very realistic possibility that LAHC would fail to be viable. Some of the modeled scenarios should have reflected this possibility. The Milliman feasibility study would imply that two "black swan" events occurred in 2014 and 2015 with low enrollment and very high medical costs. In actuality, these possibilities should have been anticipated by Milliman when they prepared the LAHC feasibility study.

86.

If CMS is considered to be a regulatory body, the actuary who prepared the feasibility study would be guided by Actuarial Standard of Practice (ASOP) No. 8 – Regulatory Filings for Health

Benefits, Accident & Health Insurance, and Entities Providing Health Benefits. The following paragraphs are applicable:

- Paragraph 3.4.2 of ASOP No. 8 states that the actuary "should consider the impact of future changes in the underlying covered population on the projected claims. These changes may include, but are not limited to, changes in demographics, risk profile, or family composition". In the context of this feasibility study, Milliman should have considered the possibility that LAHC would not be able to successfully attract the level of enrollment necessary for LAHC to remain viable as an entity.

- Paragraphs 3.4.3 and 3.4.6 of ASOP No. 8 deal with claim morbidity and health cost trends. Given the enormous level of uncertainty with respect to the claim morbidity of the population that would be covered under the ACA (including many individuals who were previously uninsurable due to known medical conditions), Milliman should have generated economic scenarios that considered the possibility that the loss ratio of LAHC would have exceed 91%. Established insurance entities with statistically credible claim experience will occasionally misprice their insurance products with resulting loss ratios exceeding 100%. Milliman should have recognized that high loss ratios were a very real possibility (given the known uncertainty of the covered population) for LAHC and illustrated such scenarios in the feasibility study.

87.

Milliman's failure to consider the possibility of these adverse enrollment and/or medical loss ratio scenarios resulted in a feasibility study where every single scenario illustrated that LAHC would be generating significant cash earnings over the mid to long term time period. The only question to the reader of the feasibility study was how much money would be earned by LAHC.

88.

Upon information and belief, Milliman conditioned payment for its preparation of LAHC's feasibility study upon LAHC being awarded a loan by CMS. That is, Milliman would only receive payment for its services if LAHC's efforts to secure a loan from CMS were successful. By conditioning payment upon a successful result, Milliman may have compromised its independence as an actuary and thereby breached its duty to LAHC.

89.

Based in large part on the work performed by Milliman and relied upon by LAHC, in September 2012, LAHC was awarded a loan to become a qualified nonprofit health insurance issuer under the Consumer-Operated and Oriented Plan (CO-OP) Program established by Section 1322 of the ACA and applicable regulations. In other words, based in large part on the work performed by Milliman and relied upon by LAHC, the federal government authorized a Start-up Loan of $12,426,560 to LAHC, and a Solvency Loan of $54,614,100 to LAHC.

90.

In or around November 2012, Milliman was engaged by Shilling on behalf of LAHC to "develop 2014 premium rates in Louisiana" for LAHC. This engagement letter dated November 13, 2012, was addressed to Shilling as "Chief Executive" of LAHC and was signed by Shilling on behalf of LAHC on November 14, 2012.

91.

In the "Three Year Pro Forma Reports" dated August 15, 2013, prepared by Milliman and relied upon by LAHC, Milliman concluded and projected that, in general, LAHC would be economically viable, able to remain financially solvent, able to pay back federal loans within the required time periods, and would be able to meet Louisiana's solvency and reserve requirements. In reliance upon Milliman's professional services and actuarial estimates and projections, LAHC set its premium rate for 2014.

92.

The actuarial work performed by Milliman for LAHC, including the feasibility study and pro forma reports, were unreliable, inaccurate, and not the result of careful, professional analysis.

93.

For instance, according to the actuarial work performed by Milliman and relied upon by LAHC and the federal government as part of the ACA process, Milliman estimated that LAHC would lose $1,892,000 in 2014 (i.e., that LAHC's net income in 2014 would be negative $1,892,000). In actuality, LAHC reported a statutory loss of more than $20 million in 2014 (i.e., LAHC's statutory net income in 2014 was actually negative $20 million+). Milliman and LAHC's projections for 2014 were off by a factor of more than 10. For 2015, Milliman's projections were even more inaccurate: although Milliman projected that LAHC would earn $1,662,000 in 2015 (i.e., LAHC's net income in 2015 would be positive $1,662,000), in actuality, LAHC reported a statutory loss of more than $54 million in 2015 (i.e., LAHC's statutory net income in 2015 was actually negative $54 million+). Milliman and LAHC's projections for 2015 were off by a factor of more than 32.

94.

Milliman owed a duty to LAHC to exercise reasonable care, and to act in accordance with the professional standards applicable to actuaries in providing its services to LAHC.

95.

Milliman's actuarial memorandums prepared as part of the 2014 rate filings for the individual and small group lines of business indicate that they assumed that LAHC would achieve provider discounts on their statewide PPO product that were equal to Blue Cross Blue Shield of Louisiana ("BCBSLA"). No support was provided for the basis of this assumption.

96.

Provider discounts are a key driver of the unit costs of medical (non-pharmacy) expenses that are incurred by LAHC members. Since providers (hospitals and physicians) typically provide the largest insurance carriers with the highest (compared to smaller carriers) discounts off billed charges, it was not reasonable for Milliman to assume that a start-up insurance entity with zero enrollment would be in a position to negotiate provider discounts as large as BCBSLA. Since LAHC was utilizing a rental network in 2014 (rather than building their own network), Milliman should have analyzed the level of discounts that would be present in the selected network (Verity Healthnet, LLC) and quantify the difference between these discounts and the BCBSLA discounts since a primary basis of the 2014 rate manual was the level of 2013 BCBSLA rates for their most popular individual and small group products.

97.

When developing estimates of the level of insured claims expense loads for 2014, Milliman would be guided by Actuarial Standard of Practice (ASOP) No. 5 – Incurred Health and Disability Claims. Paragraph 3.2.2 of ASOP No. 5 states that the actuary should consider economic influences that affect the level of incurred claims. ASOP No. 5 specifically says that should consider changes in managed care contracts and provider fee schedule changes when developing estimates of incurred claims.

98.

Based on a review of the LAHC actuarial memorandums for individual and small group, upon currently available information and belief, no support has been provided for the assumption that LAHC would achieve provider discounts equal to BCBSLA. This assumption was not reasonable; if Milliman assumed a lower level of provider discounts, the calculated premium rates would have been higher. As a result, LAHC's statutory losses in 2014 would have been lower.

99.

Milliman grossly underestimated the level of non-claim expenses in 2014. In Milliman's 2014 rate development, they assumed that the "per member per month" (PMPM) level of administrative expenses, taxes, and fees (non-claim expenses) would be $70.85 PMPM for the individual line of business. For the small group line of business, the level of non-claim expenses built into the rate development was $87.00 PMPM. Milliman projected total 2014 member months of 240,000 and 96,000 for the individual and small group lines of business respectively.

100.

The actual level of expenses in 2014 was significantly higher. On a composite basis, the PMPM level of non-claim expenses was $145.70. Total member months were 111,689 of which 98.9% were from the individual line of business. At least part of the pricing error was due to Milliman significantly over-estimating the level of 2014 enrollment. For the component of LAHC expenses that were fixed, the impact of this incorrect enrollment estimate would be that they would need to be spread over a fewer number of members. This would result in the significantly higher level of expenses on a per member basis.

101.

When developing expense loads for 2014, Milliman would be guided by Actuarial Standard of Practice (ASOP) No. 8 – Regulatory Filings for Health Benefits, Accident & Health Insurance, and Entities Providing Health Benefits. The following sections of ASOP No. 8 are relevant for LAHC:

- Paragraph 3.4.2 of ASOP No. 8 states that the actuary "should consider the impact of future changes in the underlying covered population on the projected claims. These changes may include, but are not limited to, changes in demographics, risk profile, or family composition."

- Paragraph 3.4.4 of ASOP No. 8 instructs the actuary to "use appropriate methods and assumptions for calculating the non-benefit expenses component of premium rates. Possible methods include, but are not limited to, the use of a target loss ratio or the estimation of expenses appropriately attributed to the health benefit on a percentage of premium or fixed-dollar basis. When estimating the latter amounts, the actuary should consider the health plan entity's own experience, reasonably anticipated internal or external future events, inflation, and business plans. The actuary may also consider relevant external studies. The actuary should consider the reasonableness of the non-benefit expense component of premium rates relative to projected expenses."

102.

While there clearly was uncertainty about the overall size of the overall ACA Marketplace, it was unreasonable for Milliman to assume that LAHC, as an unknown entity in the Louisiana health insurance market, would be able to enroll 28,000 members (20,000 individual and 8,000

small group) in the first year of operation. While assuming a lower level of enrollment would have resulted in higher premiums, Milliman was aware that a significant percentage of the individual enrollment would be receiving government subsidies and thus would have limited sensitivity to pricing differences between the various plans offered on the ACA exchange.

103.

Assuming 100% individual members, the impact of this expense miscalculation is 111,689 times ($145.70 - $70.85), or about $8.4 million.

104.

When developing their estimate of the level of Risk Adjustment ("RA") transfer payments to build into the 2014 premium rates, Milliman assumed that there would be no difference in coding intensity between LAHC and the other insurance carriers in the State of Louisiana. This assumption was not reasonable as Milliman should have known that a small start-up health insurance carrier would be in no position to code claims as efficiently as Blue Cross Blue Shield of Louisiana ("BCBSLA") and other established insurance carriers.

105.

Whatever difference that Milliman assumed as the true morbidity difference between the members that LAHC would enroll and the average state enrollment, it was not reasonable to assume that there would be no difference in claim coding intensity. If Milliman had assumed a lower level of coding intensity for LAHC, this would have resulted in a lower assumed average risk score for LAHC for 2014. As a result, the calculated premiums would have been higher.

106.

When developing estimates of average LAHC risk scores for 2014, Milliman would have been guided by Actuarial Standard of Practice (ASOP) No. 45 – The Use of Health Status Based Risk Adjustment Methodologies. The following sections of ASOP No. 45 are relevant for LAHC with respect to the estimation of relative coding intensity:

- Paragraph 3.2.3 states that "Because risk adjustment model results are affected by the accuracy and completeness of diagnosis codes or services coded, the actuary should consider the impact of differences in the accuracy and completeness of coding across organizations and time periods."

107.

There is no indication that any meaningful assessment of LAHC claim coding capabilities took place by Milliman which resulted in the unreasonable assumption that LAHC's coding efficacy would be the same as larger established health insurance carriers which have years of

experience paying claims optimizing the RA coding for some of those claims under other RA programs such as the long established RA program in the Medicare Advantage product.

108.

In their 2014 rating, Milliman assumed that LAHC would actually receive $3.20 PMPM for the individual line of business and $0.00 for the small group line of business. In actuality, the company was assessed a 2014 RA liability of $7,456,986 and $36,622 for the individual and small group lines of business respectively in June 2015 by the Center for Medicare and Medicaid Services (CMS). If Milliman had used a more reasonable assumption with respect to claim coding intensity, some of this liability would have been built into the 2014 premium rates.

109.

Milliman breached its duty by failing to discharge its duties to LAHC with reasonable care, and to act in accordance with the professional standards applicable to actuaries, by failing to produce a feasibility study that was accurate and reliable, by failing to set premium rates for LAHC that were accurate and reliable, and, in general, by failing to exercise the reasonable judgment expected of professional actuaries under like circumstances.

110.

Milliman's failure to exercise reasonable care, and its failure to act in accordance with the professional standards applicable to actuaries, and its breach of contract, was the legal cause of all of, or substantially all of, LAHC's damages as set forth herein.

Buck

111.

At all relevant times, Buck held itself out as having expertise to provide actuarial services and advice to health insurers like LAHC.

112.

In or around March 2014, Buck was engaged by LAHC to perform "certain actuarial and consulting services" for LAHC, including but not limited to: a review of the actuarial work previously performed by Milliman, "develop cost models to prepare 2015 rates for Public Exchange," "present target rates for review and revision," "review and price new plan designs," and "prepare and submit rate filings and assist" LAHC with "state rate filing" with LDI. Buck's engagement letter was signed by Powers on behalf of LAHC on April 4, 2014, and had an effective date of April 1, 2014. On or about December 1, 2014, this contract was amended, inter alia, to

extend the term of Buck's engagement through November 30, 2015, and provided for an additional fee of $380,000 to be paid to Buck for its actuarial services provided to LAHC.

113.

On or about April 2, 2015, Buck issued its "Statement of Actuarial Opinion" to LAHC which was relied upon by LAHC and used to support its periodic ACA reporting requirements to the federal government. In Buck's actuarial opinion, "the March 2015 pro forma financial report is a reasonable projection of LAHC's financial position, subject to the qualifications noted below." In effect, Buck vouched for LAHC's economic health and continuing viability. Buck's professional opinion was clearly inaccurate and unreliable. LAHC would close its doors about three (3) months after Buck issued its April report, and LAHC would ultimately lose more than approximately $54 million in 2015 alone.

114.

The actuarial work performed by Buck was unreliable, inaccurate, and not the result of careful, professional analysis. Furthermore, upon information and belief, Buck may have been unqualified, given its limited experience with insurers like LAHC, to provide actuarial services to LAHC.

115.

Buck owed a duty to LAHC to exercise reasonable care, and to act in accordance with the professional standards applicable to actuaries in providing its services to LAHC.

116.

When Buck developed individual and small group premium rates for 2015, they essentially disregarded the claim experience that had emerged from the start of LAHC operations on January 1, 2014 until the filing was finalized in August 2014. Buck's explanation for not utilizing the claim experience was that it was not statistically credible. Although the claim data was not fully credible, it was unreasonable for Buck to completely disregard LAHC's claim data and incurred claim estimates that were made for statutory financial reporting.

117.

When analyzing credibility of claim data, the actuary would be guided by Actuarial Standard of Practice (ASOP) No. 25 – Credibility Procedures. ASOP No. 25 discusses the concept of two types of experience:

- Subject experience - A specific set of data drawn from the experience under consideration for the purpose of predicting the parameter under study.

- Relevant Experience - Sets of data, that include data other than the subject experience, that, in the actuary's judgment, are predictive of the parameter under study (including but not limited to loss ratios, claims, mortality, payment patterns, persistency, or expenses). Relevant experience may include subject experience as a subset.

118.

For the 2015 pricing exercise, the Subject Experience would be the LAHC claims data and the Relevant Experience was the manual claim data (obtained from Optum) that Buck used to develop rates for 2015. Buck judgmentally applied, through a credibility procedure, 100% weight to the manual claim data (Relevant Experience) and 0% weight to the actual claim experience of LAHC.

119.

By the time the 2015 rate filing was submitted, LAHC would have already prepared their June 30, 2014 statutory financial statements that reported a level of incurred claims of $23.3 million gross of Cost Sharing Reductions (CSR). This level on claims, on a per capita level, implies that LAHC would need a rate increase in the range of at least 40%. The incurred claim estimate prepared for statutory reporting effectively amounts to a data set of "Subject Experience" that was ignored by Buck.

120.

ASOP No 25 provides the following guidance to actuaries:

- Paragraph 3.2 states that "The actuary should use an appropriate credibility procedure when determining if the subject experience has full credibility or when blending the subject experience with the relevant experience."

- Paragraph 3.4 states that "The actuary should use professional judgment when selecting, developing, or using a credibility procedure."

121.

Buck's professional judgement in this case was to completely disregard the LAHC data that was available because they concluded that it had no predictive value in their credibility procedure. They arrived at this conclusion even though the filed rate increase for 2015 was inconsistent with the necessary rate increase that was implied by the incurred claim estimates reported on the LAHC statutory financial statements.

122.

At the time the 2015 rate filing was submitted in August 2014, there were already claims incurred and paid in the period from 1/1/2014 to 6/30/2014 of $220 PMPM (paid through July 2014) gross of Cost Sharing Reduction subsidies ("CSR"). It was readily apparent that there were

very significant claim adjudication issues with LAHC's TPA and that the actual ultimate level of incurred claims would be significantly higher than $220 PMPM and much higher than Buck's estimate of the manual level of LAHC claims.

123.

Buck underestimated the level of non-claim expenses in 2015. In Buck's 2015 rate development, they assumed that the "per member per month" (PMPM) level of administrative expenses, taxes, and fees (non-claim expenses) would be $96.24 PMPM for the individual line of business. For the small group line of business, the level of non-claim expenses built into the rate development was $96.70 PMPM. Per Buck, the expense load was based on a May 2014 expense budget that was prepared by LAHC.

124.

When developing expense loads for 2015, Buck would be guided by Actuarial Standard of Practice (ASOP) No. 8 – Regulatory Filings for Health Benefits, Accident & Health Insurance, and Entities Providing Health Benefits. The following sections of ASOP No. 8 are relevant for LAHC:

- Paragraph 3.4.2 of ASOP No. 8 states that the actuary "should consider the impact of future changes in the underlying covered population on the projected claims. These changes may include, but are not limited to, changes in demographics, risk profile, or family composition".

- Paragraph 3.4.4 of ASOP No. 8 instructs the actuary to "use appropriate methods and assumptions for calculating the non-benefit expenses component of premium rates. Possible methods include, but are not limited to, the use of a target loss ratio or the estimation of expenses appropriately attributed to the health benefit on a percentage of premium or fixed-dollar basis. When estimating the latter amounts, the actuary should consider the health plan entity's own experience, reasonably anticipated internal or external future events, inflation, and business plans. The actuary may also consider relevant external studies. The actuary should consider the reasonableness of the non-benefit expense component of premium rates relative to projected expenses."

125.

The actual level of expenses in 2015 was moderately higher. On a composite basis, the PMPM level of non-claim expenses was $111.05. Total member months were 165,682 of which 99.4% were from the individual line of business.

126.

When developing their estimate of the level of Risk Adjustment ("RA") transfer payments to build into the 2015 premium rates, Buck assumed that there would be no difference in coding intensity between LAHC and the other insurance carriers in the State of Louisiana. This assumption was not reasonable as Buck should have known that a small start-up health insurance

carrier would be in no position to code claims as efficiently as BCBSLA and other established insurance carriers.

127.

Whatever difference that Buck assumed as the true morbidity difference between the members that LAHC would enroll and the average state enrollment, it was not reasonable to assume that there would be no difference in claim coding intensity. If Buck had assumed a lower level of coding intensity for LAHC, this would have resulted in lower assumed average risk score for LAHC for 2015. As a result, the calculated premiums would have been higher.

128.

In their rate filing, Buck also noted that the average age of the LAHC enrollees was lower than the State of Louisiana average. Since age is component of the risk score calculation, the younger than average population provided some evidence that the average risk score for the LAHC would be lower than the state average. It was not reasonable for Buck to ignore this known difference in member ages between LAHC and the state average.

129.

When developing estimates of average LAHC risk scores for 2014, Buck would be guided by Actuarial Standard of Practice (ASOP) No. 45 – The Use of Health Status Based Risk Adjustment Methodologies. The following sections of ASOP No. 45 is relevant for LAHC with respect to the estimation of relative coding intensity:

- Paragraph 3.2.3 states that "Because risk adjustment model results are affected by the accuracy and completeness of diagnosis codes or services coded, the actuary should consider the impact of differences in the accuracy and completeness of coding across organizations and time periods."

130.

There is no indication that any meaningful assessment of LAHC claim coding capabilities took place by Buck which resulted in the unreasonable assumption that LAHC's coding efficacy would be the same as larger established health insurance carriers which have years of experience paying claims optimizing the RA coding for some of those claims under other RA programs such as the long established RA program in the Medicare Advantage product.

131.

Data Quality is also relevant with respect to Buck ignoring the known demographic data when developing an estimate of the RA transfer payment that should be built into the 2015 rates. Paragraph 3.2 of ASOP No. 23 states "In undertaking an analysis, the actuary should consider

what data to use. The actuary should consider the scope of the assignment and the intended use of the analysis being performed in order to determine the nature of the data needed and the number of Alternative data sets or data sources, if any, to be considered." Because demographic data was available, Buck should have used it to build in some level of RA transfer payment just on that basis alone (without regard for the coding intensity issue).

132.

In their 2015 rating, Buck assumed that LAHC would have a $0 RA transfer payment. In actuality, the company was assessed a 2015 RA liability of $8,658,833 and $177,963 for the individual and small group lines of business respectively in June 2016 by the Center for Medicare and Medicaid Services (CMS). If Buck had incorporated the known demographic information and used a more reasonable assumption with respect to claim coding intensity, some of this liability would have been built into the 2015 premium rates.

133.

Buck breached its duty by failing to discharge its duties to LAHC with reasonable care, and to act in accordance with the professional standards applicable to actuaries, by failing to produce a feasibility study that was accurate and reliable, by failing to set premium rates for LAHC that were accurate and reliable, and, in general, by failing to exercise the reasonable judgment expected of professional actuaries under like circumstances.

134.

Buck's failure to exercise reasonable care, and its failure to act in accordance with the professional standards applicable to actuaries was the legal cause of all of, or substantially all of, LAHC's damages as set forth herein.

Count Five: Negligent Misrepresentation
(Against the Actuary Defendants)

135.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

Milliman

136.

At all relevant times, Milliman held itself out as having expertise to provide actuarial services and advice to health insurers like LAHC.

137.

At all relevant times, Milliman held a special position of confidence and trust with respect to LAHC.

138.

LAHC justifiably expected Milliman to communicate with care when advising LAHC concerning its funding needs and the appropriate premium for LAHC.

139.

Milliman's advice and/or reports to LAHC and/or LDI and/or CMS concerning LAHC's funding needs negligently misrepresented the actual funding needs and premium rates of LAHC.

140.

Milliman had a duty to provide accurate and up-to-date information to LAHC that Milliman knew or should have known LAHC would rely on in making its decision concerning the amount of premium to charge policyholders.

Buck

141.

At all relevant times, Buck held itself out as having expertise to provide actuarial services and advice to insurers such as LAHC.

142.

At all relevant times, Buck held a special position of confidence and trust with respect to LAHC.

143.

LAHC justifiably expected Buck to communicate with care when advising LAHC concerning its funding needs and the appropriate premium rates for LAHC.

144.

Buck's advice and/or reports to the LAHC and/or LDI and/or CMS concerning LAHC's funding needs negligently misrepresented the actual funding needs and premium rates of LAHC.

145.

Buck had a duty to provide accurate and up-to-date information to LAHC that Buck knew or should have known LAHC would rely on in making its decision concerning the amount of premium to charge policyholders.

PRESCRIPTION AND DISCOVERY OF TORTIOUS CONDUCT

146.

Plaintiff shows that LAHC was adversely dominated by the Defendants named herein, who effectively concealed the bases for the causes of action stated herein. Plaintiff did not discover the causes of action stated herein until well after the Receiver was appointed and these matters were investigated as part of the pending Receivership proceeding. Furthermore, Plaintiff had no ability to bring these actions prior to receiving authority as a result of the Receivership orders entered regarding LAHC. Further, none of the creditors, claimants, policyholders or members of LAHC knew or had any reason to know of any cause of action for the acts and omissions described in this Petition until after LAHC was placed into Receivership.

147.

Plaintiff further shows that the activities of the Defendants named herein constituted continuing torts which began in 2011 and continued unabated until shortly before LAHC was placed into Receivership, or at least in the case of GRI, continued until its services were terminated by LAHC in May 2016.

148.

Applicable statutes of limitations and prescriptive/peremptive periods did not commence as to Plaintiff until shortly before LAHC was placed into Receivership, at the earliest.

149.

Further, according to applicable Louisiana law, once the Commissioner of Insurance filed suit seeking an order of rehabilitation regarding LAHC on September 1, 2015, the running of prescription and preemption as to all claims in favor of LAHC was immediately suspended and tolled during the pendency of the LAHC Receivership proceeding; La.R.S. 22:2008(B).

JURY DEMAND

150.

Plaintiff is entitled to and hereby demands a trial by jury on all triable issues.

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PRAYER FOR RELIEF

WHEREFORE, Plaintiff, James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc., through his duly appointed Receiver, Billy Bostick, prays and demands that the following Defendants named herein, CGI Technologies and Solutions, Inc., Group Resources Incorporated, Beam Partners, LLC, Milliman, Inc., Buck Consultants, LLC, Allied World Specialty Insurance Company a/k/a Darwin National Assurance Company, Atlantic Specialty Insurance Company, Evanston Insurance Company, RSUI Indemnity Company, and Zurich American Insurance Company, be cited to appear and answer, and that upon a final hearing of the cause, judgment be entered against Defendants and in favor of Plaintiff for all compensable damages in an amount reasonable in the premises, including:

a. All compensatory damages allowed by applicable law caused by Defendants' actionable conduct;

b. the recovery from Defendants of all administrative costs incurred as a result of the necessary rehabilitation and/or liquidation proceedings;

c. all fees, expenses, and compensation of any kind paid by LAHC to the D&O Defendants, Beam Partners, CGI, GRI, Milliman, and Buck;

d. all recoverable costs and litigation expenses incurred herein;

e. all judicial interest;

f. any and all attorneys' fees recoverable pursuant to statute and/or contract;

g. any and all equitable relief to which Plaintiff may appear properly entitled; and

h. all further relief to which Plaintiff may appear entitled.

Respectfully submitted,

J. E. Cullens, Jr., T.A., La. Bar #23011
Edward J. Walters, Jr., La. Bar #13214
Darrel J. Papillion, La. Bar #23243
David Abboud Thomas, La. Bar #22701
Jennifer Wise Moroux, La. Bar #31368
WALTERS, PAPILLION, THOMAS, CULLENS, LLC
12345 Perkins Road, Bldg One
Baton Rouge, LA 70810
Phone: (225) 236-3636
Facsimile: (225) 236-3650

[SERVICE INFORMATION ON FOLLOWING PAGES]

PLEASE SERVE A COPY OF:

THE PETITION FOR DAMAGES AND JURY DEMAND
AND
THE FIRST SUPPLEMENTAL, AMENDING AND RESTATED PETITION
AND
THE SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION

UPON THE FOLLOWING DEFENDANTS:

ALLIED WORLD SPECIALTY INSURANCE COMPANY a/k/a DARWIN NATIONAL ASSURANCE COMPANY

ATLANTIC SPECIALTY INSURANCE COMPANY

EVANSTON INSURANCE COMPANY

RSUI INDEMNITY COMPANY

ZURICH AMERICAN INSURANCE COMPANY

All through their agent for service of process:

The Louisiana Secretary of State
8585 Archives Avenue
Baton Rouge, LA 70809

PLEASE SERVE A COPY OF:

THE SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION

UPON THE FOLLOWING DEFENDANTS:

CGI TECHNOLOGIES AND SOLUTIONS, INC.
VIA LONG ARM SERVICE
Through its agent for service of process:
Corporation Service Company
2711 Centerville Road
Suite 400
Wilmington, DE 19808

GROUP RESOURCES INCORPORATED
VIA LONG ARM SERVICE
Through its agent for service of process:
Philip H. Weener
5887 Glendridge Drive
Suite 275
Atlanta, GA 30328

BEAM PARTNERS, LLC
VIA LONG ARM SERVICE
Through its agent for service of process:
Terry Shilling
2451 Cumberland Parkway, #3170
Atlanta, GA 30339

MILLIMAN, INC.
VIA LONG ARM SERVICE
Through its agent for service of process:
CT Corporation System
505 Union Avenue SE
Suite 120
Olympia, WA 98501

BUCK CONSULTANTS, LLC
VIA LONG ARM SERVICE
Through its agent for service of process:
Corporation Service Company
2711 Centerville Road
Suite 400
Wilmington, DE 19808

CERTIFICATE OF SERVICE

In addition to requesting service on the previously named defendants as directed on the prior page, undersigned counsel hereby certifies that the following counsel of record have been served this date pursuant to La.C.C.P. art. 1313 by transmitting a copy of the SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION FOR DAMAGES AND REQUEST FOR JURY TRIAL by electronic means to the following defense counsel:

Harry (Skip) J. Philips, Jr.
Taylor Porter
Post Office Box 2471
Baton Rouge, LA 70821
Skip.philips@taylorporter.com

W. Brett Mason
Stone Pigman
301 Main Street, #1150
Baton Rouge, LA 70825
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701 Poydras Street, #5000
New Orleans, LA 70139
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V. Thomas Clark, Jr.
Adams and Reese, LLP
450 Laurel Street
Suite 1900
Baton Rouge, LA 70801
Tom.clark@arlaw.com

Frederic Theodore 'Ted' Le Clercq
Deutsch Kerrigan, LLP
755 Magazine Street
New Orleans, LA 70130
ted@deutschkerrigan.com

Baton Rouge, Louisiana this 25th day of October, 2017.

J. E. Cullens, Jr.

June 19, 2014

Greg Cromer
CEO
Louisiana Health Cooperative, Inc.
3445 N Causeway Blvd
Metairie, LA 70002

Re: Termination of Administrative Services Agreement

Dear Greg:

I am writing to memorialize our agreement regarding termination of the Administrative Services Agreement (the "Original Agreement") between the Louisiana Health Cooperative, Inc. ("LAHC") and CGI Technologies and Solutions Inc. ("CGI") dated February 15, 2013. Once executed by you in the space provided, this letter agreement (this "Letter Agreement") shall be effective on the date of such execution and shall constitute an amendment to the Original Agreement. In the event of conflict between the terms of this Letter Agreement and the Original Agreement, the terms of this Letter Agreement shall control.

1. For the convenience of LAHC, the Original Agreement shall terminate on April 30, 2014. CGI shall continue to perform the Delegated Functions through April 30, 2014, to be followed by a six month wind-down period as specified in Section 2.5 of the Original Agreement. For the six month wind-down period, CGI shall provide such wind-down services as the parties may agree in a wind-down plan, all in accordance with Sections 2.5 and 2.5.1 of the Original Agreement.

2. LAHC shall pay all CGI invoices issued to date. CGI shall also be compensated for performance of the Delegated Functions prior to termination of the Original Agreement in accordance with Exhibit 1 to the Original Agreement. The general scope and structure of the wind down period is as specified in Attachment 1 to this Letter Agreement. CGI's compensation for services during the wind-down period shall be a fixed price of $75,000 per month for May and $60,000 per month for June and at LAHC direction on a time-and-materials basis July through October. In addition to CGI's compensation for performing Delegated Services during the wind-down period, LAHC will continue to pay Healthation (Aldera) Access Fees and direct expenses in accordance with Exhibit 1 of the Original Agreement . CGI waives all deferred implementation fees specified in Section 1 of Exhibit 1 to the Original Agreement (i.e., those implementation fees payable on December 31 of 2014, 2015 and 2016). LAHC waives all interest on late paid claims specified in Section 1.6 of Exhibit 2 to the Original Agreement.

3. No Service Level Credits shall be assessed for failures to meet one or more Service Level Specifications effective March 1, 2014. During the wind-down period, CGI will make commercially reasonable efforts to perform the Delegated Functions in accordance with the Service Level Specifications set forth in Section 6 in Exhibit 1 to the Original Agreement, but no additional CGI personnel will be assigned to the LAHC account for purposes of improving CGI's performance.

4. Neither party hereto will make any statement to any third party that disparages the other party's performance under the Original Agreement, nor will either party make statement to any third party that disparages any person or persons involved in the performance of the Original Agreement. LAHC will also

provide to CGI a reasonably complimentary letter of reference that CGI may use at its discretion in future efforts to secure new business.

5. Except for obligations assumed herein, LAHC and CGI hereby release each other, and their respective directors, officers, agents, employees, representatives, insurers, parents and subsidiaries, from any and all claims that either may have against the other arising out of or relating to the Original Agreement. Greg, , if the foregoing accurately states our agreement to amend the Original Agreement, please sign below in the space provided (two signed originals enclosed) and return one fully executed original to me.

Sincerely,

David L. Henderson
Senior Vice President
CGI Technologies and Solutions Inc.

SO AGREED:

Greg Cromer
CEO
Louisiana Health Cooperative, Inc.

6/19/2014
Date

Attachment 1 – Wind Down Period Services

1. **May and June 2014**

From May 1 to June 30, CGI will perform the Delegated Services as well as the following in-scope transition services, which will be further defined and mutually agreed in the more detailed Transition Plan;

In Scope

- Membership data transfer to GRI as follows:
  - Aldera Member Extract file, delivered initially at 6/1 and finally at 7/1
- Enrollment data transfer to GRI as follows:
  - 834 EDI files received from FFM, files received between 6/1 and 7/1
  - Effectuation EDI files sent to FFM, files sent between 6/1 and 7/1
  - Spreadsheets received from LAHC reflecting Bswift off-exchange enrollments, files received between 6/1 and 7/1
- Paid claim data transfer to GRI as follows:
  - TBD
- Pended and/or in-flight claim data transfer to GRI as follows:
  - TBD
- Compilation and hand-over of all Aldera and CGI file server records back to 10/1/13 where retention is required by law or regulation and/or essential for GRI continued operation, as listed and agreed with LAHC, as of the record date that all CGI processing terminates; destruction of all other records not listed and agreed with LAHC as soon as all CGI processing terminates
- Other data transfer as the parties agree

Not in Scope

- Completion of delivery of any intended system or interworking functionality not already operational at 5/16, except as the parties agree in advance
- Provider data updates or contract price/fee schedule updates, except as CGI determines helpful or necessary for claims processing
- Processing of any claims received after 6/8, regardless of service date
- Processing of member billings and associated payments for enrollments or enrollment modifications with an effective date of 7/1 or later
- Mailing of ID cards or welcome kits to paid-thru members with an effective date of 7/1 or later; the final mailing to be no later than GRI's initial bulk mailing of new ID cards
- Health Risk Assessment processing after 5/31
- FFM or other 3rd party system data reconciliation beyond 6/30

2. July to October 2014

Beginning July 1, CGI will perform all services on a Time and Materials basis, at the request of LAHC, using the rates in the table below. LAHC will make requests in writing and CGI will provide an estimate for approval by LAHC before any work is performed.

Role	Rate per Hour
Data Analyst Sr.	120.00
Data Analyst Jr.	100.00
Claim Supervisor	60.00
Project Manager	120.00
Claim Examiner or Customer Service Rep	35.00
Expenses	As Agreed

COURT OF APPEAL, FIRST CIRCUIT

STATE OF LOUISIANA

NO.: 2017-CW-1483

JAMES J. DONELON, COMMISSIONER OF INSURANCE
FOR THE STATE OF LOUISIANA IN HIS CAPACITY AS REHABILITATOR
OF LOUISIANA HEALTH COOPERATIVE, INC.
Plaintiff/Respondent

VERSUS

TERRY S. SHILLING, GORGE G. CROMER, WARNER L. THOMAS, IV,
WILLIAM A. OLIVER, CHARLES D. CALVI, PATRICK C. POWERS, CGI
TECHNOLOGIES AND SOLUTIONS, INC., GROUP RESOURCES
INCORPORATED, BEAM PARTNERS, LLC, MILLIMAN, INC., BUCK
CONSULTANTS, LLC, AND TRAVELERS CASUALTY AND SURETY
COMPANY OF AMERICAN
Defendants/Relators

ON WRIT APPLICATION
FROM THE 19TH JUDICIAL DISTRICT COURT
PARISH OF EAST BATON ROUGE, STATE OF LOUISIANA
DOCKET NO. 651,069, HONORABLE JUDGE TIMOTHY KELLEY

RESPONSE ON BEHALF OF PLAINTIFF/RESPONDENT, JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC. TO THE SUPPLEMENTAL BRIEF OF BUCK CONSULTING, INC.

CIVIL PROCEEDING

Respectfully submitted:

J. E. Cullens, Jr., T.A., La. Bar #23011
Edward J. Walters, Jr., La. Bar #13214
Darrel J. Papillion, La. Bar #23243
David Abboud Thomas, La. Bar #22701
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EXHIBIT B

and Buck breached this duty by: conditioning payment upon a successful result, which may have compromised Milliman's independence as an actuary; performing actuarial work for LAHC, including the feasibility study, three year pro forma reports, and memoranda prepared as part of the 2014 rate filings, that was unreliable, inaccurate, and not the result of careful, professional analysis; failing to set premium rates that were accurate and reliable. App. Rec. at pp. 55-62 (First Supplemental, Amending and Restated Petition for Damages and Request for Jury Trial, ¶¶75-103). None of these allegations require any court to interpret or enforce the engagement letters to determine Milliman and Buck's obligations to LAHC. Again, the contracts between LAHC and Milliman and Buck ended prior to the takeover of LAHC. Like the superintendent in *Taylor*, the Commissioner's claims arise from his statutory powers and Milliman and Buck's failure to perform services for LAHC in accordance with applicable professional standards—standards they were independently required to observe, irrespective of any written engagement letter.

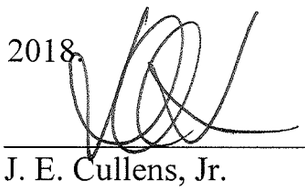
VIII. Enforcing Buck's forum-selection clause against the Commissioner would be "unreasonable and unjust" in this specific case

Regardless of whether this Honorable Court concludes that Buck's forum-selection clause violates the strong public policy embodies in the RLC, forcing the Commissioner to sever and litigate all claims against Buck in New York is both "unreasonable and unjust" given the specific facts involved in this case. This is not a simple, two-party, "garden variety" contract dispute between the Receiver and a third party like Buck or Milliman. Perhaps if it was, then enforcing Buck's forum-selection clause would not be "unreasonable and unjust." That, however, is different case. This case is a complex and massive litigation that arises out of the complete collapse of a Louisiana HMO that managed to lose more than $80 million in less than two years of operation. The Commissioner has sued seventeen (17) defendants whose tortious conduct allegedly contributed to LAHC's dramatic failure,

including: the directors and officers ("D&Os") of LAHC, three third party administrators ("TPAs") of LAHC (Beam Partners, GRI and CGI), two actuaries of LAHC (Buck and Milliman), and numerous insurance carriers for the respective defendants. Not surprisingly, the D&Os blame the TPAs and actuaries for LAHC's collapse; the TPAs blame the D&Os and the actuaries; the actuaries blame the TPAs and the D&Os. You get the picture. To force the Commissioner to sever and pursue all claims against Buck in New York state court (where there's no jurisdiction over any other defendant), would be "unreasonable and unjust" according to any fair and sensible analysis under *Rimkus*. Venue is proper in the 19th JDC against all seventeen defendants; reason and justice dictate that all of the Commissioner's many claims be litigated in a single Louisiana court before a common trier of fact. For this additional, and independent basis according to *Rimkus*, Buck's forum-selection clause is unenforceable here against the Commissioner.

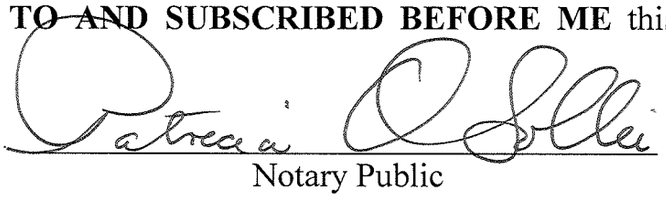
It is evident that an essential goal of the RLC, by providing in §2004(C) for venue in a single Louisiana court, and §257 that the 19th JDC "shall have exclusive jurisdiction over any suit arising from [the] takeover" of LAHC, is to promote consistent rulings in all matters that impact the rehabilitation of a failed insurance company. The strong language of the RLC is an unambiguous expression of the Louisiana Legislature's intention to achieve that goal by concentrating in a single forum, the 19th JDC, "any suit arising from [the] takeover" of a failed HMO. Considering the vesting of exclusive jurisdiction in the 19th JDC as per §257, and in "one [Louisiana] court where venue is proper" as per §2004(C), in conjunction with the broad authority to supervise all issues relating to a rehabilitation, provides a logical and reasonable means of attaining the RLC's purpose of achieving enhanced efficiency and economy of liquidation, through the consolidation of matters relating to the liquidation under the supervision of a single court so as to avoid divergent rulings by a multiplicity of judicial tribunals.

So certified this 7th day of May, 2018.



J. E. Cullens, Jr.

SWORN TO AND SUBSCRIBED BEFORE ME this 7th day of May, 2018.



Notary Public

Patricia O. Sollie, Notary Public
State of Louisiana
Notary Number 010497
My Commission Expires at Death

SUPREME COURT OF LOUISIANA

DOCKET NO.: 2019-C-515

JAMES J. DONELON, COMMISSIONER OF INSURANCE
FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF
LOUISIANA HEALTH COOPERATIVE, INC.

versus

TERRY S. SHILLING, GEORGE G. CROMER, WARNER L. THOMAS, IV, WILLIAM A. OLIVER, CHARLES D. CALVI, PATRICK C. POWERS, CGI TECHNOLOGIES AND SOLUTIONS, INC., GROUP RESOURCES INCORPORATED, BEAM PARTNERS, LLC, MILLIMAN, INC., BUCK CONSULTANTS, LLC, AND TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA

A CIVIL PROCEEDING

OPPOSITION TO APPLICATION OF BUCK CONSULTANTS, LLC FOR SUPERVISORY WRITS OF CERTIORARI, MANDAMUS AND REVIEW

OF THE DECISION OF THE LOUISIANA COURT OF APPEAL,
FIRST CIRCUIT, DOCKET NO. 2017-CW-1483
AND JUDGMENT FROM THE 19TH JUDICIAL DISTRICT COURT,
PARISH OF EAST BATON ROUGE, STATE OF LOUISIANA,
DOCKET NO. 651,069, SECTION 22 E
HONORABLE TIMOTHY E. KELLEY, JUDGE, PRESIDING

Respectfully submitted:

/s/ J. E. Cullens, Jr.

J. E. Cullens, Jr., T.A., La. Bar #23011
Darrel J. Papillion, La. Bar #23243
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EXHIBIT C

clause, combined with other facts and a strong policy favoring the plaintiff's domicile, enforcement should be avoided. "This is necessarily a fact-sensitive analysis, and while we agree that *Atlantic Marine* informs the analysis, we cannot conclude that it categorically requires a severance-and-transfer in all situations." *Rolls Royce,* 775 F.3d at 681.

D. The risk of depriving the Receiver of a remedy is a strong public policy concern that warrants non-enforcement of the forum-selection clause

The cases cited by Buck do not stand for the proposition that courts enforce forum-selection clauses that results in a unfair limitation on the plaintiff's rights to obtain damages. *Allianz Ins. Co. of Canada v. Cho Yang Shipping Co., Ltd.,* 131 F.Supp.2d 787 (E.D. Va. 2000), cited by Buck, supports the decision by the Appellate Court. The case involved international cargo shipping damages where the plaintiff insurer, as a subrogee of its insured, asserted claims against multiple parties. The insurer did not sign the shipping contract containing the invoked forum-selection clause. The *Allianz* Court did hold the insurer bound to the forum-selection clause because it was the signatory's subrogee and inherited its rights under the contract. But the *Allianz* Court did not enforce the forum-selection clause for all claims for similar reasons as expressed by the Appellate Court here. Recognizing that a "forum-selection clause will, however, be condemned as against public policy if the choice of law and choice of forum clauses operate 'in tandem as a prospective waiver of a party's right to pursue statutory remedies,"" the *Allianz* court refused to enforce the forum-selection clause with respect to an *in rem* claim because the forum selected would not recognize that claim under its law. *Allianz*, 131 F. Supp.2d at 793. ("[I]t would be unreasonable and unjust to enforce the forum-selection clause as to D.S.R. America, the *in rem* defendant, because an *in rem* action is unavailable under the forum law (Korea) and thereby reduces Allianz's rights….)." *Id.* at 794. Thus, contrary to Buck's argument here, *Allianz* actually supports the Appellate Court's decision.

Most of the other cases relied upon by Buck do not address the issue of whether enforcement of a forum-selection clause would unfairly limit a party's right to have his day in court. In *Rolls* Royce, the claims arose out of helicopter crash. There was no discussion of any risk of incoherent judgments. Unlike this case where enforcement of the clause could potentially deprive the Receiver from recovering from an at-fault party, in *Rolls Royce* there were no special interest factors that could not be handled by using common discovery and sequencing among the severed cases.

Buck mischaracterizes the Appellate Court's ruling by focusing on the "empty chairs" in this case. While an "empty chair" is an aspect of the Appellate Court's reasoning, it is not the harm caused by severing Buck from the other claims. What the Appellate Court found unreasonable is the risk that the Receiver will not have a remedy against Buck if a Louisiana jury finds it at fault, but a New York jury does not. That there are other settling defendants who will be "empty chairs" is irrelevant to this analysis. By agreeing to an out-of-court settlement, the Receiver has achieved a remedy from that settling party and accepts the possibility that the jury may allocate fault at trial to the "empty chair" caused by this settlement. Here, however, if the Receivers' claims against Buck are severed from the pending litigation in Baton Rouge and transferred to New York, if a Baton Rouge jury finds Buck at fault, but the New York jury does not, the Receiver will have achieved no remedy whatsoever from Buck. This is an inherently unreasonable and unjust result.

Buck's arguments are also not bolstered by *Royal Smit Transformers BV v. HC BEA-LUNA M/V*, 2017 WL 819243 (E.D. La. Mar. 2, 2017) which is similarly distinguishable on its facts. The U.S. Eastern District of Louisiana applied the *Rolls Royce* analysis as some of the parties to the lawsuit had not signed the forum-selection clause. Unlike the Receiver, the *Royal Smit* plaintiff signed the challenged forum section clause contract. The *Royal Smit* plaintiff relied on later-signed contracts not containing the same forum-selection clause as the grounds for not enforcing the one that it did sign. The Court rejected this argument because, unlike here, everyone was "aware at the time they entered into their contract that its performance would require …additional agreements." *Id.*, p. 7. Because the existence of future related contracts was part of the parties' legitimate expectations, the *Royal Smit* Court noted that the presence of non-signatories in suit was not an "extraordinary circumstance" warranting ignoring the forum-selection clause, but a manufactured effort to avoid it. Unlike the facts of *Royal Smit*, as required by applicable venue laws, the Receiver added to the suit all parties whose actions combined to cause the insolvency and failure of LAHC, satisfying his public duty to protect the interests of Louisiana citizens and policyholders by holding at-fault actors monetarily responsible.

Like an "empty chair", "duplicitous suits" are not inherently unfair as argued by a co-defendant in *Instrument and Valve Services Company v. Burt Group, Inc*, 2018 WL 1547340 (M.D. La. Mar. 29, 2018) ("*IVS*"). There, a construction project owner sued multiple parties in connection with faulty construction of the premises. One defendant, Burt Group, filed suit against

IV. CONCLUSION

Buck's expansive reading of the Appellate Court's ruling is misplaced. The Appellate Court's ruling did not "take forum-selection clauses off the table in potentially all multi-party cases in which any one of the litigants is not a party to the forum-selection agreement."[20] Pursuant to *Rimkus,* the Appellate Court correctly relied upon the unreasonable and unjust result of potentially having a New York jury find that Buck is not liable to the Receiver and a Louisiana jury found that it is, thereby placing the Receiver in the untenable position of proving Buck's liability but having no recovery rights against it. Buck wrongly complains that the Appellate Court considered judicial economy and other private factors when, in fact, the Appellate Court expressly disavowed these considerations.[21] Furthermore, the facts involved in *Rimkus, Bremen* and *Atlantic Marine* are not comparable to those presented here. Courts which have considered comparable facts, while recognizing the limitations set forth in *Bremen* and *Atlantic Marine*, view risking incoherent judgments in insolvency proceedings as the type of extraordinary circumstance that precludes the enforcement of pre-insolvency forum-selection clauses against an insurance Receiver. Buck cites no cases to the contrary. Standing alone, the risk of incoherent judgments potentially precluding recovery by the Receiver against Buck, even where a Louisiana jury finds it at-fault, is sufficient grounds to deny Buck's exception. Bolstered by the policy of Louisiana to favor plaintiff's claims in their domicile and the overwhelming public policy obligations of the Receiver to LAHC's policyholders and creditors, this is clearly an extraordinary case that presents narrow grounds to decline enforcement of forum-selection clauses in insurance insolvency cases. For all of the foregoing reasons, Buck's Writ Application should be denied.

Respectfully submitted:

/s/ J. E. Cullens, Jr.

J. E. Cullens, Jr., T.A., La. Bar #23011
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[20] Buck's Writ App., p. 23.
[21] Appendix C to Buck's Writ, p. 11 (Incoherent comparative fault judgments "are wholly unrelated to the convenience of the parties and judicial economy considerations....").

NINETEENTH JUDICIAL DISTRICT COURT

PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

DIVISION D, SECTION 21

.....

JAMES DONELON .

V. . SUIT NO.651,069

TERRY SHILLING .

.....

FRIDAY, NOVEMBER, 20, 2020

HEARING

THE HONORABLE TIMOTHY KELLEY, PRESIDING

APPEARANCES:

SEE NEXT PAGE FOR FULL LIST

REPORTED BY: MELISSA DAVID, CCR #2020005

EXHIBIT D

LISKOW & LEWIS
JAN 25 2021
RECEIVED

THIS MORNING IS ALL ABOUT. AND THE UNANIMOUS, IT'S VERY UNUSUAL IN LOUISIANA FOR AS EVERYBODY, FOR A UNANIMOUS LOUISIANA SUPREME COURT EVEN BEFORE THE ENACTMENT OF 2043.1 SAID THAT IS CATEGORICALLY IMPROPER. YOU CAN'T BUTTRESS, UNDERCUT, LIMIT, MODIFY DEFENDANT'S CONDUCT PRE-RECEIVERSHIP IN ANY WAY BY WHAT THE POLICE DID OR DID NOT DO, AND I'M SIMPLY ASKING YOUR HONOR AS THE CASE OF FIRST IMPRESSIONS TO MY KNOWLEDGE THERE SIMPLY NO REPORTED DECISION TO SIMPLY APPLY THE WILL OF THE LEGISLATURE AS ENACTED AND 2043.1B AND STRIKE DEFENSES RELATING TO REGULATOR FAULT. I THINK I WOULD RESPECTFULLY SUGGEST IT'S THE ONLY WAY TO PROCEED. WE WILL GET TO I'M SURE PROBABLY SOONER RATHER THAN LATER THE ISSUE OF DISCOVERY AND THAT'S COMING IN ALL LIKELIHOOD NEXT AND FOR ALL THOSE REASONS YOUR HONOR I WOULD RESPECTFULLY ASK YOUR HONOR'S TO GRANT BOTH OUR MOTION FOR PARTIAL SUMMARY JUDGMENT AS THERE IS NO MATERIAL ISSUE OF FACT THAT PRECLUDES THESE DEFENSES AND BECAUSE THERE IS NO ISSUE OF FACT OR LAW THERE IS NO NEED TO WAIT ANY LONGER AND STRIKE THESE DEFENSES AS A MATTER OF LAW.

THE COURT: THANK YOU. I'M GOING TO GRANT THE SUMMARY JUDGMENT. FIRST CONTRARY TO DEFENDANT'S ASSERTIONS, LOUISIANA CIVIL CODE ARTICLE 2323 DOES NOT CONTROL THIS CASE. LOUISIANA RS 22:2043.1 B DOES AND THE STATUTE IS VERY CLEAR AND UNAMBIGUOUS. NO ACTION OR INACTION BY THE INSURANCE REGULATORY AUTHORITIES MAY BE ASSERTED AS A DEFENSE TO A CLAIM BY THE RECEIVER. I DON'T KNOW HOW THEY CAN MAKE THAT CLEARER THAN THAT. SO, I'LL GRANT THE SUMMARY JUDGMENT.

19th JUDICIAL DISTRICT COURT

CERTIFICATE

THIS CERTIFICATE IS VALID ONLY FOR A TRANSCRIPT ACCOMPANIED BY MY ORIGINAL SIGNATURE AND REQUIRED SEAL ON THIS PAGE.

I, MELISSA DAVID, CERTIFIED COURT REPORTER IN AND FOR THE STATE OF LOUISIANA, EMPLOYED AS AN OFFICIAL COURT REPORTER BY THE 19TH JUDICIAL DISTRICT COURT FOR THE STATE OF LOUISIANA, AS THE OFFICER BEFORE WHOM THIS TESTIMONY TAKEN, DO HEREBY CERTIFY THAT THIS TESTIMONY WAS REPORTED BY ME IN THE STENOMASK REPORTING METHOD, WAS PREPARED AND TRANSCRIBED BY ME, AND IS A TRUE AND CORRECT TRANSCRIPT TO THE BEST OF MY ABILITY AND UNDERSTANDING; FURTHER, THAT THE TRANSCRIPT HAS BEEN PREPARED IN COMPLIANCE WITH TRANSCRIPT FORMAT GUIDELINES REQUIRED BY THE STATUTE OR BY RULES OF THE BOARD OR BY THE SUPREME COURT OF LOUISIANA, AND THAT I AM NOT RELATED TO COUNSEL OR THE THE PARTIES HEREIN, NOR AM I OTHERWISE INTERESTED IN THE OUTCOME OF THIS MATTER.

WITNESS MY HAND THIS 5TH DAY OF JANUARY, 2021

MELISSA DAVID, CCR
OFFICIAL COURT REPORTER
CCR #2020005

19th JUDICIAL DISTRICT COURT

ADMINISTRATIVE SERVICES AGREEMENT
By and between
CGI Technologies and Solutions Inc.
And
Louisiana Health Cooperative, Inc.

EXHIBIT
E

ADMINISTRATIVE SERVICES AGREEMENT
By and between
CGI Technologies and Solutions Inc.
And
Louisiana Health Cooperative, Inc.

This Administrative Services Agreement (this "Agreement") is entered into effective as of February 15, 2013 by and between the Louisiana Health Cooperative, Inc., a Louisiana not-for-profit corporation located at 3445 North Causeway, Suite 310, Metarie, LA 70070 ("LAHC") and CGI Technologies and Solutions Inc., a Delaware corporation having its principal place of business at 11325 Random Hills Road, Fairfax, Virginia 22030 ("CGI").

WHEREAS, LAHC has been organized to operate as a qualified nonprofit health insurance issuer within the meaning of Section 1322(c)(1) of the Affordable Care Act (Pub. L. 111-148) (the "CO-OP Program"), that once licensed, will offer health insurance plans that assist providers to deliver high quality health care to citizens of the State of Louisiana; and

WHEREAS, LAHC is a party to that certain Loan Agreement (the "Loan Agreement") with the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS"), dated September 27, 2012 pursuant to which LAHC is obligated to use funds provided to LAHC pursuant to the Loan Agreement to form a consumer-focused, member-governed health insurance company ("CO-OP") pursuant to the CO-OP Program; and

WHEREAS, CGI provides various administrative services in accordance with Applicable Law, Applicable Regulatory Agency, Accreditation Agency and LAHC standards; and

WHEREAS, LAHC and CGI desire to enter into this Agreement whereby CGI will perform certain administrative and management functions (the "Delegated Functions"); and

WHEREAS, nothing herein shall limit LAHC's responsibility or LAHC's ultimate authority with regard to Delegated Functions as required by Applicable Law.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

ARTICLE 1
DEFINED TERMS

All capitalized terms in this Agreement, unless otherwise defined herein, shall have the following meanings:

"Access" means, with respect to all Delegated Functions performed by CGI for LAHC –

Direct Access: direct, on site Access, during normal business hours, upon 2 Days prior written notice, to the site(s) where the Delegated Function is being performed unless an Applicable Regulatory Agency requires a shorter period.

Remote Access: real time read-only Access at LAHC's offices to all CGI Systems used to perform Delegated Functions, computer system inquiry capability including the ability to run reports and make inquiries and to pull historical information;

Personnel Access: Direct Access to, and reasonable cooperation from, all CGI staff performing the Delegated Functions; and

Records Access: electronic or paper copies of records relating to Delegated Functions when reasonably requested.

Unless Access is limited to one form of Access (e.g., Personnel Access), LAHC is entitled to all forms of Access. The Parties acknowledge that Access shall not include information related to individuals enrolled through other insurers.

"Accreditation Agency" means any non-governmental accreditation agency generally recognized in the health care industry which monitors, audits, accredits or performs other similar functions with respect to health care organizations and entities providing services to health care organizations, including without limitation the National Committee for Quality Assurance ("NCQA"), the Joint Commission on Accreditation of Health Care Organizations ("JCAHO") and the Utilization Review Accreditation Commission ("URAC").

"Affiliate" of a Party means any other entity that directly or indirectly controls, or is under common control with, or is controlled by, the Party. As used in this definition, "control" means actual or equitable ownership of a majority of the shares (or other securities, partnership interests or means of ownership, as the case may be) of an entity or management of the entity as a result of a management contract.

"Agreement" means this Administrative Services Agreement between LAHC and CGI, including all exhibits, appendices, and attachments hereto and listed in Article 8, as any of these may be amended, supplemented, or modified from time to time.

"Applicable Law" means (i) such federal, state and local laws, rules and administrative regulations and guidance, including manuals, guidelines, policy letters, court decisions, and CMS instructions to LAHC, that are adopted and/or published or sent to LAHC by CMS or any State agency or other federal, state or local governmental body, or agent thereof, with authority over LAHC, CGI, Providers or Payors (the "Applicable Regulatory Agencies"), and communicated in writing by LAHC to CGI, and (ii) applicable Accreditation Agency requirements and policies; and (iii) health insurance exchanges on which LAHC is approved to offer Benefit Plans. Without limiting the generality of the foregoing, "Applicable Law" shall include all federal and state insurance requirements, all federal and state privacy, security and confidentiality requirements, bonding requirements, licensure requirements, financial solvency requirements, prompt pay requirements, claims administration requirements and fraud and abuse requirements. Adherence to these laws, policies, regulations and guidance shall be a material requirement. It is understood by the Parties that the Applicable Laws are subject to change during the term of this Agreement, such that the Parties agree that any substantive change will require the parties to react promptly and in good faith by negotiating appropriate modifications or alterations to this Agreement.

"Benefit Plan" means a Member's health benefits program as described in the Member Materials and underwritten or administered by LAHC.

"Claims Administration" means the process of determining: whether a claim submitted for payment is entitled to be paid, the appropriate payment amount according to the terms of the Participating Provider agreement, and the Non-Participating Provider payment rules, as applicable, and issuing payment in accordance with claim payment requirements, including timeliness, of Applicable Law, tracking and reporting Provider claims, timely redirecting claims for Non-Covered Services, collection

and submission of encounter data, timely transmission of notification to Members and such other tasks as described in Exhibit 2.

"Clean Claim" means a request for reimbursement for Covered Services (i) that has no material defect or impropriety (including any lack of any reasonably required substantiating documentation) which materially prevents timely adjudication of the claim; or (ii) such other definition as may be required by Applicable Law.

"Client Group" means an insurer that LAHC or an Affiliate brings to CGI and/or that CGI accepts as a client and enters into an agreement to purchase Services substantially the same (including platform, scope, etc.) as those Services described herein. All volume-based pricing discounts shall include the combined business of all insurers participating in Client Group. The current list of insurers (including companies in the process of seeking licensure as insurers) is listed at Exhibit 11.

"CMS" means the federal Centers for Medicare and Medicaid Services.

"Cold Site" means a backup site that contains infrastructure, all of the server hardware and certain software components necessary for and configured for restoration of the Systems in the event of an emergency or disaster, but does not contain all of the software and data components necessary to do an immediate restore of all business functions. Upon an emergency or disaster the remaining software applications necessary for the restoration of the Systems will be obtained out of escrow and installed at the cold site.

"Confidential Information" means information belonging or relating to one Party the "Disclosing Party") that is non-public, confidential and/or proprietary in nature such as financial information, customer contacts, operating policies and business methods, but does not include information that the recipient (the "Receiving Party") demonstrates (i) is or becomes generally available to the public other than as a result of a disclosure by the Receiving Party or its representatives, (ii) was within Receiving Party's possession prior to its being furnished to Receiving Party or its representatives by the Disclosing Party or its representatives pursuant hereto, but only to the extent that the source of such information was not bound by a confidentiality agreement with, or other contractual, legal or fiduciary obligation of confidentiality to, the Disclosing Party or any other Party with respect to such information; (iii) is or becomes available to the Receiving Party from a source other than the Disclosing Party or any of the Disclosing Party's representatives, but only to the extent that such source is not bound by a confidentiality agreement with, or other contractual, legal or fiduciary obligation of confidentiality to, the Disclosing Party or any other Party with respect to such information; or (iv) is independently developed by the Receiving Party without reference to the Disclosing Party's Confidential Information.

"Covered Services" means those Medically Necessary health care services or supplies that a Member is eligible to receive according to the terms of his / her Benefit Plan.

"Day" means, with respect to any action to be taken under this Agreement, a calendar day; provided however, that when the date an action is to be taken falls on a Saturday, Sunday or federal holiday, then the day on which the action must be taken shall be the first business day following such day.

"Delegated Functions" means those administrative claims processing and payment functions relating to services provided to Members, including Member enrollment, responding to Member and Provider phone or other inquiries, creation and distribution of Member materials, Explanation of Benefits, Explanation of Payments and other communications which shall be performed by CGI on behalf of LAHC pursuant to the terms and conditions of this Agreement.

"Deposit Materials" means all CGI-developed or CGI-owned software source code related to application support for Delegated Functions, including administration of Benefit Plans, claims coding, claims processing, document management, claims adjudication and payment of claims for Covered Services, including System documentation, related compiler command files, build scripts, scripts relating to the operation and maintenance of such application, application programming interface(s), graphical user interface(s), object libraries, instructions on building the object code of the software, all documentation relating to the foregoing, and a list of all third party applications and tools required in the use and compilation of the software.

"Dispute" shall have the meaning given to such term in Article 7 the Agreement.

"Effective Date" with respect to each Delegated Function, has the meaning given to such term in Section 2.2.

"Escrow Agent" means the agent selected by CGI to hold the Deposit Materials.

"Hot Site" means a backup site for the Systems that is fully prepared to resume business operations immediately in the event of a disaster or emergency, including all the needed infrastructure, space and hardware, software and equipment necessary to immediately resume operation of the Systems.

"Joint Operations Committee" or "JOC" means the committee established between the Parties and Client Group to discuss issues of shared concern among the Client Group and ways to collaborate for increased performance and efficiency.

"Loan Agreement" has the meaning in the Recitals to this Agreement.

"Medically Necessary" or "Medical Necessity" has the meaning stated under the Member's Benefit Plan.

"Member" means any individual who is entitled to receive Covered Services as a result of an arrangement between LAHC and the Member or a person or entity on the Member's behalf and for whom LAHC has assigned CGI to perform the Delegated Functions.

"Member Month" means any calendar month or portion of a calendar month during which a Member is entitled to receive Covered Services. For example, if a person becomes a Member on January 15 and remains a Member through June 3, such person would be enrolled for six (6) Member Months.

"Non-Covered Services" means those health care services and supplies which are not covered under the Member's certificate of coverage and are, therefore, the financial responsibility of the patient, including those services provided to a patient who is determined ineligible for coverage at the time services were rendered (i.e., a retroactively disenrolled patient).

"Party" means either LAHC or CGI.

"Parties" means LAHC and CGI.

"Participating Provider" means a provider who has a participating provider agreement with LAHC or has a contract with a rental network with which LAHC has contracted.

"Non-Participating Provider" means a Provider who does not, directly or indirectly, have a Participating Provider agreement with LAHC.

"Payor" means an insurer, health maintenance organization, self-insured plan or other entity that has a contract or other arrangement with LAHC for the provision of Covered Services to its insureds.

"Person" means a natural person, partnership (general or limited), corporation, Limited Liability Company, trust, estate, association or other entity.

"Prepaid Rate" means the monthly amount paid to CGI for the Delegated Functions, as set forth in Exhibit 1.

"Protected Health Information" means individually identifiable health information that is transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium except individually identifiable health information and educational records described at 20 USC § 1232g(a)(4)(B)(iv) and employment records held by a covered entity in its role as an employer.

"Provider" means a person or organization who or which is certified, licensed or otherwise legally permitted to provide health care services or supplies.

"Quality Improvement" or "QI" means the continuous quality improvement program to monitor the quality and appropriateness of care and services provided to Members or the quality of the Delegated Functions rendered and their compliance with the terms of this Agreement..

"Risk Management" means that part of the Quality Improvement process involving the reduction and/or prevention of losses and injuries to Members, for identification, analysis, and evaluation of areas of potential loss, and for review of specific incidents (both reported and unreported).

"Systems" means the computer, management and administrative systems that CGI is using and will use to provide the Delegated Functions under the Agreement including, but not limited to Healthation software.

"Term" means the Initial Term and Renewal Terms, if any, as defined in Section 2.1.

ARTICLE 2
TERM AND TERMINATION

2.1. Duration of Agreement and Renewal. The Initial Term of this Agreement shall commence on the date set forth in the Preamble and extend until December 31, 2016 (the "Initial Term"). This Agreement shall thereafter be automatically renewed for consecutive one (1) year terms (each a "Renewal Term") if permitted by Applicable Law unless terminated in accordance with this Article 2.

2.2. Effective Date for Delegated Functions. The Effective Date for each Delegated Function to be performed hereunder shall be determined separately and upon written notification by LAHC to CGI. With respect to each Delegated Function, as outlined in the table below, the Effective Date shall be no earlier than the date on which CGI shall assume initial responsibility for performing the function and, as applicable: i) the Day that LAHC has completed its review, including all testing and determined that CGI has met the mutually agreed upon capability criteria in accordance with Section 3.2; and ii) the date an Applicable Regulatory Agency has provided any necessary approval for CGI to assume the Delegated Function. The Parties acknowledge that the Effective Date, with respect to each Delegated Function, must occur on or before January 1, 2014, or as listed in Table 1 below.

ADDENDA - Delegated Function/Date Due	
Delegated Function	**Function Start Date /**
Claims Processing	1/1/2014
Enrollment	10/1/2013
Printing and Fulfillment (New Member Kit Materials)	10/1/2013
Printing and Fulfillment (Member Communication Materials)	1/1/2014
Premium Billing On Exchange	10/1/2013
Premium Billing Off Exchange	12/1/2013
Member Provider Support Services (pre-1/1/2014)	10/1/2013
Member/Provider Support Services (Post 1/1/2014)	1/1/2014

Notwithstanding any Effective Date above or the effective date in the initial paragraph of this Agreement, this Agreement shall not become effective unless and until a second CO-OP joins the Client Group not later than ten (10) business Days following the date this Agreement is fully executed by LAHC and CGI.

2.3. Termination on Written Notice. Any Party may terminate this Agreement, in its entirety or with respect to one or more Delegated Functions, as of the end of the Initial Term or any Renewal Term by providing written notice of termination to the other Party no later than one hundred and eighty (180) Days prior to the end of such Initial Term or Renewal Term.

2.4. Termination for Cause. LAHC or CGI may terminate this Agreement, with prior written notice to the other upon one or more of the following, subject to the notice periods set forth below:

2.4.1. Effective immediately if the other Party files a petition in or for bankruptcy, reorganization or an arrangement with creditors, makes a general assignment for the benefit of creditors, is adjudged bankrupt, is unable to pay debts as they become due, has a trustee, receiver or other custodian appointed on its behalf, or has any other case or proceeding under any bankruptcy or insolvency law, or any dissolution or liquidation proceeding commenced against it.

2.4.2. Effective as of the date that termination of this Agreement is required by an Applicable Regulatory Agency pursuant to Applicable Law including, but not limited to, exclusion of a Party from participation in federal programs;

2.4.3. Effective as of the date of the other Party's loss of a license necessary to perform the obligations assumed under this Agreement, including CGI's loss of its license to perform one or more Delegated Functions;

2.4.4. Effective upon thirty (30) Days written notice if LAHC or CGI commits a material fraud with respect to its duties hereunder; or

2.4.5. Effective upon thirty (30) Days written notice for failure to cure a material breach identified by the non-breaching Party within thirty (30) Days of such identification.

2.5. Wind-Down. Upon termination, expiration, or non-renewal of this Agreement pursuant to this Article 2, or revocation of delegation of a Delegated Function pursuant to Article 3 or for any other reason, the Parties shall each work in good faith to cooperate and effect a smooth and orderly transition including, without limitation, the following, as determined by LAHC, in LAHC's sole discretion: (1) CGI shall perform one or more Delegated Functions for a period of up to six (6) months after the effective date of termination as requested by LAHC; and (2) LAHC may perform such Delegated Function or redelegate such Delegated Function to a third party. Notwithstanding the foregoing, CGI shall not be required to provide services beyond the effective date of termination in the event that CGI terminates the Agreement for cause in accordance with Section 2.4. Upon completion of any wind down services, CGI shall return all LAHC documents and data to LAHC and all Access shall terminate provided, however, that CGI will retain an archive of the Member data for a period of ninety (90) days or such longer period as the parties may agree in a wind-down plan.

2.5.1. CGI shall comply in good faith with any information requirements and exchanges reasonably requested by LAHC or any third party engaged by LAHC, in formats reasonably required by LAHC or the third party engaged, as necessary to orderly transfer the Delegated Functions, including complying with wind-down protocols reasonably established by LAHC or any third party engaged by LAHC. If some Member or claims records are retained by CGI, CGI shall: i) store said records in accordance with Section 5.1, and ii) provide LAHC and its engaged third parties, auditors, authorized agents, Payors and Applicable Regulatory Agencies with jurisdiction over LAHC with timely Access to said records. During any wind down, CGI shall provide LAHC and any third party engaged by LAHC reasonable Direct Access to CGI facilities, staff, Systems and other resources related to this Agreement or the performance hereunder for purposes of effectuating a smooth and orderly transition.

2.5.2. If the Agreement is terminated due to breach by CGI prior to successful completion of the implementation, or CGI's failure to timely implement the Delegated Functions, CGI shall only be paid for services properly performed through the point of termination, plus expenses to transition pursuant to this Agreement. In the event of any termination of the Agreement for any reason *other than* breach by CGI prior to successful completion of the implementation, or CGI's failure to timely implement the Delegated Functions, any deferred implementation fees pursuant to Exhibit 1 shall immediately become due and LAHC will pay its obligation within thirty (30) days of the effective date of termination. All services provided by CGI after the effective date of termination shall be paid in accordance with Section 2.5.3. CGI shall provide all services after the effective date of termination in the same manner as services were provided prior to the termination, unless otherwise specified by LAHC.

2.5.3. Fees for Wind Down Services. CGI agrees that it shall not be paid any amount for performing the Delegated Functions during a wind down period in addition to its monthly fees at the rates in effect prior to the non-renewal or termination, for a period of six months. Non-prepaid services will be paid in accordance with the rates outlined in Exhibit 1 for a period of six months. The Parties will negotiate in good faith for rates for Delegated Functions services beyond the six-month wind down period. Any services CGI provides that are outside the scope of the Delegated Functions shall be paid at CGI's then-current rates.

2.5.4.

2.6. Survival. Definition of Access, Sections 2.5, 2.6, 3.1, 3.2.3, 3.2.6, 3.3, 3.4.1 and 3.6 (but only to the extent necessary to cover claims arising during the term of this Agreement, any renewals thereof

and any wind-down period), 3.8, 3.9, 3.11, 3.17 through 3.19, 4.4, 4.5, 5.1, 6.3, 6.6, 6.7, 6.11, 6.16, 6.17 and Article 7 shall survive the termination of this Agreement for any reason."

ARTICLE 3
GENERAL PROVISIONS APPLICABLE TO ALL DELEGATED FUNCTIONS

3.1. Independent Contractors. LAHC and CGI are independent contractors and separate legal entities. The relationship between LAHC and CGI is reflected in this Agreement, and neither LAHC nor CGI or the employees, servants, agents or representatives of either of them, shall be considered the employee, servant, agent or representative of the other. No provision of this Agreement is intended to create or shall be construed to create any agency, partnership, joint venture or employer-employee relationship between or among LAHC and CGI, or any of their respective employees, servants, agents or representatives or between CGI and any Payor.

3.2. CGI Qualifications & Representations and Warranties.

3.2.1. Legal, Regulatory and Accreditation Compliance. CGI represents and warrants that all Delegated Functions performed hereunder will be in accordance with Applicable Law and Accreditation Agency standards, including without limitation those applicable to LAHC that are provided to CGI by LAHC, subject to Section 6.14.

3.2.2. Licensure. CGI represents and warrants to LAHC that CGI shall at all times during the term of this Agreement be appropriately licensed, bonded and certified, as applicable, and operating in material compliance with Applicable Law in each regional or product market. As required by Applicable Law or as consistent with Accreditation Agency standards, CGI shall obtain, and maintain in good standing all required licenses, bonds and certifications. CGI shall provide LAHC with a copy of its licenses, bonds and/or certifications prior to the Effective Date of any Delegated Function and upon the anniversary date of such Delegated Function thereafter. CGI shall notify LAHC within five (5) Days if any required license, certificate, bond or any other similar requirement is, voluntarily or involuntarily, found to be deficient, is in jeopardy, or is withdrawn.

3.2.3. CGI shall notify LAHC within five (5) Days of any action taken or sanction issued against CGI, and/or any of its employees or contractors, or by any Applicable Regulatory Agency related to its services performed including under this Agreement.

3.2.4. CGI shall submit the following financial information to LAHC upon request as proof of CGI's continued financial solvency:

3.2.4.1. Recent audited financial statements for CGI's parent company (balance sheet, statement of operations, statement of cash flows, and notes to the financial statements).

3.2.4.2. Unaudited financial statements for CGI with an attestation by the CFO on a basis no less frequently than annually. To the extent that CGI is required to provide financial statements for Louisiana TPA licensure or regulatory compliance, LAHC would request copies of said statements. All such financial statements shall be treated as Confidential Information in accordance with this Agreement.

3.2.5. CGI represents and warrants that the CGI personnel who perform the services under this Agreement shall have appropriate training, licensure, and or certification to perform each task assigned to them. CGI shall provide LAHC with a staffing plan outlining the key staff roles that will have primary interaction with LAHC staff. LAHC shall be notified immediately of any staffing

changes for key staff. LAHC reserves the right to request a change in designated CGI personnel as LAHC deems necessary, in LAHC's determination, which may negatively impact successful implementation of all facets of this Agreement. For continuity of service and to guard against loss in productivity, CGI will make a good faith effort to maintain consistent staff performing the delegated functions for LAHC. The key personnel at a minimum are defined as follows:

- Project/Implementation Manager (on site at LAHC through implementation)
- Compliance Officer
- Integration Lead, during implementation

3.2.6. CGI represents, warrants and covenants that (i) it has a valid, legal and non-exclusive license to use the Systems and that such Systems are sufficient to administer all aspects of the Delegated Functions; (ii) it is authorized to place the source codes into escrow pursuant to Section 3.23; (iii) it will retain complete authority and/or rights to use the Systems for the Term of this Agreement and any wind-down or transition period; (iv) it will provide or arrange for maintenance for the Systems so that such Systems remain operational during the term of this Agreement and any wind-down or transition period; (v) there are no other third party entities who have the right to claim control or ownership over the Systems; and (vi) it shall indemnify, defend, at its own expense, and hold LAHC harmless for any and all claims or actions of infringement of copyrights, patents, trademarks or other intellectual property rights that arise or are enforceable under the laws of the United States of America and CGI will pay all settlements, costs, damages and damages, or expenses (including reasonable attorney fees) finally awarded relating to CGI's or LAHC's use of the Systems. CGI agrees to provide LAHC with prompt notice of any claim specified in this section that is made against CGI, LAHC, or the Systems. If such a proceeding claiming infringement in accordance with (vi) above is brought or appears to CGI to be likely to be brought, CGI shall at CGI's expense and with prior written notice to LAHC either obtain the right for LAHC to continue to access the Systems or replace or modify the Systems to resolve such proceeding. If neither of these alternatives is reasonably available to CGI, CGI may be required to terminate LAHC's access, in which case CGI shall cooperate with LAHC's efforts to transition to another vendor and shall pay LAHC's reasonable costs to transition to another vendor. This section states CGI's entire obligation to LAHC and LAHC's exclusive remedy with respect to any claim of infringement. CGI is not responsible for any infringement claim or claimed breaches of the foregoing warranties caused by: (i) modifications made to the Systems by anyone other than CGI and its subcontractors working at CGI's direction; (ii) the combination, operation or use of any System component with other components or items CGI did not supply; (iii) LAHC's misuse of the Systems; or (iv) CGI's adherence to LAHC's specifications or instructions.

3.3. THE FOREGOING WARRANTIES ARE IN LIEU OF ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING ANY IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, INTEGRATION, PERFORMANCE AND ACCURACY, AND ANY IMPLIED WARRANTIES ARISING FROM STATUTE, COURSE OF DEALING, COURSE OF PERFORMANCE, OR USAGE OF TRADE. CGI DOES NOT WARRANT THAT THE SERVICES OR ACCESS TO THE CGI SYSTEM WILL BE UNINTERRUPTED OR THAT THE RESULTS OF THE SERVICES WILL BE ERROR-FREE. CGI DOES NOT GUARANTEE THE ACCURACY OF ANY ADVICE, REPORT, DATA, OR OTHER PRODUCT DELIVERED TO LAHC THAT IS PRODUCED WITH OR FROM DATA OR SOFTWARE PROVIDED BY LAHC.

3.4. Representations and Warranties of LAHC. LAHC represents and warrants to CGI that LAHC is, and at all times during the term of this Agreement shall operate, in material compliance with Applicable Law.

3.4.1 LAHC shall use all commercially reasonable efforts to ensure that Members' Notices of Privacy Practices inform them that an administrative services provider may handle their claims.

3.4.2 LAHC is responsible for the adequacy and accuracy of all data and information that LAHC furnishes to CGI and the results obtained therefrom. LAHC warrants that any LAHC-provided specifications or requirements around which services are configured will be in compliance with Applicable Laws.

3.4.3 LAHC warrants that it (i) will not disclose, download, decompile, or re-engineer any portion of the Systems (ii) will maintain the security of any user or identification codes and associated passwords assigned to LAHC by CGI to enable LAHC and its engaged third parties, auditors and authorized agents to Access the Systems. LAHC agrees that neither it nor its employees or agents will attempt to gain or allow access to any data, files or programs of CGI to which they are not entitled under the Agreement, and that if such access is obtained, LAHC will immediately report such access to CGI, cease all unauthorized access, return all CGI, third party, or CGI customer information obtained as a result of such unauthorized access, and safeguard any CGI, third party, or CGI customer information obtained as a result of unauthorized access to CGI Confidential Information. LAHC will be responsible for the actions of its employees, agents, and permitted contractors in connection with their access to and use or misuse of the Systems.

3.4.4 LAHC warrants that (i) any information, data, and any other materials placed by LAHC and/or Providers, Payors or Members and/or by CGI on the LAHC's behalf onto the Systems ("Content") does not and will not contain unlawful, discriminatory, libelous, harmful, obscene or otherwise objectionable material of any kind and does not and will not violate any right of privacy or publicity, (ii) the Content does not infringe any copyright, patent, trademark or other intellectual property right that arises or is enforceable under the laws of the United States of America, (iii) the Content transmitted during the term of this Agreement and the use of the Systems pursuant to the Agreement will not encourage conduct that could constitute a criminal offense, give rise to civil liability or otherwise violate any Applicable Laws, and (iv) LAHC shall not attempt to gain unauthorized access to other computer systems, any application/service for which LAHC has not paid fees to use, or data and information belonging to others that is also hosted on the Systems. LAHC warrants that it will use all commercially reasonable efforts, including industry-standard processes to avoid propagating computer worms, disabling codes or viruses, or use the Systems to make unauthorized entry into any other computer or machine.

3.5. LAHC's Standards for and Approval of Delegated Functions. LAHC and CGI agree that:

3.5.1 LAHC shall establish terms and standards for the Delegated Functions ("LAHC Standards") which, along with LAHC's interpretation of Applicable Law, Accreditation Agency standards and Payor standards, shall be the standards required for the performance of each Delegated Function described in this Agreement. CGI's performance of any Delegated Function shall not adversely affect the status of LAHC with any Accreditation Agency or Applicable Regulatory Agency. LAHC agrees to indemnify and hold harmless CGI and CGI's Affiliates, and their respective shareholders, directors, officers, employees, agents, and assigns (the "CGI Indemnified") from and against any claims, liability, obligation, costs, or expense, including reasonable attorneys' fees, filed against or incurred by any of the CGI Indemnifieds arising out of CGI's following LAHC Standards if and only if all of the following apply:

- 3.5.1.1 The LAHC Standard is a specific and unique standard developed by LAHC; and

- 3.5.1.2 CGI has raised concerns about the legality of LAHC Standard or its compliance with Applicable Law in writing in advance of the implementation; and

- 3.5.1.3 Despite receiving the written concern, LAHC has, in writing, required CGI to comply with the LAHC Standard.

3.5.2 CGI shall have written policies and procedures for all LAHC Delegated Functions. In accordance with the agreed upon implementation project plan, LAHC shall conduct an initial review of CGI's operations, policies and procedures regarding the Delegated Functions and its readiness to assume each Delegated Function in accordance with the terms of this Agreement. Within thirty (30) Days after the review, LAHC shall determine whether to approve CGI's policies and procedures as satisfying the requirements of Section 3.2.1 and issue a written decision. Notwithstanding the foregoing sentence, LAHC shall review such policies as quickly as possible. At all times this Agreement in effect, CGI shall provide LAHC with Records Access to its policies. If such policies are determined problematic for the efficient and secure operation or are not in compliance with Applicable Law with regard to the Delegated Functions, CGI will implement updated policies in a timely manner to remedy such issues.

3.5.3 As a condition of LAHC delegating one or more Delegated Functions, CGI shall provide a certification by CGI's manager in charge of the LAHC account, as provided in §3.5.2, of the readiness of CGI, including its Systems, to meet the requirements of the Applicable Law with respect to each Delegated Function.

3.5.4 Once reviewed and approved by LAHC, CGI shall maintain each Delegated Function as so approved, unless CGI provides LAHC with prior notice of, and receives approval for, any change to its approved process.

3.5.5 LAHC shall provide CGI with thirty (30) Days prior written notice of any changes to LAHC's delegation standards or other administrative requirements under this Agreement. If the Parties cannot agree on the proposed change within thirty (30) Days, the matter shall be submitted to dispute resolution in accordance with Article 7.

3.6. The Relationship between CGI and LAHC.

3.6.1. CGI shall appoint a manager whose responsibility it shall be to serve as the central contact point between CGI and LAHC. As necessary to meet the requirements of this Agreement, the manager shall devote his or her full time efforts to overseeing the Delegated Functions and serving as the liaison between the Parties. LAHC shall have the ability to review the credentials of the manager and approve the manager, including having input on CGI's periodic evaluations of the manager's performance. LAHC's approval shall not be unreasonably withheld.

3.6.2. CGI shall provide, at its own expense, a representative who will be dedicated to the LAHC implementation, and based at LAHC facilities, in order to provide real-time project management updates to the LAHC leadership during the implementation phase through either (i) the commencement of LAHC's commercial business process operations on 1/1/2014, or (ii) the Effective Date of all Delegated Functions, whichever comes first. The Manager referred to in Section 3.2.5 and the representative may be the same person, but shall have the necessary authority within CGI to perform under this Agreement. LAHC shall provide office space and equipment (tools, supplies, telephone lines and service, office support, etc.) for the use by such representative at no cost to CGI. Travel expenses related to the on-site services of such representative would be the responsibility of

CGI, while other travel expenses for necessary CGI personnel assisting with the successful implementation process for LAHC will be reimbursed by LAHC for expenses (i) approved in advance by LAHC's CEO or CFO, and (ii) which are subject to reimbursement under the terms and provisions of LAHC's travel policies. In a timely manner but not later than within thirty (30) days of execution of this Agreement, CGI will provide LAHC with a preliminary implementation plan and within ninety (90) days a mutually agreed upon detailed implementation plan, sufficient to ensure all tasks are completed in accordance with all of the requirements in this Agreement pertaining to the Delegated Functions. The final implementation plan will be incorporated as an Exhibit to this Agreement.

3.6.3. Delegated Functions that require access to Protected Health Information shall be performed by staff members located in the United States.

3.6.4. CGI shall notify LAHC if any lead development staff or individuals considered mission critical to this Agreement, whether employed or independent contractors, are terminated or discontinue work for any reason, and CGI shall inform LAHC of its arrangements to maintain the required performance standards for the Delegated Functions.

3.6.5. CGI shall provide all Delegated Functions acting as LAHC's delegate for respective Delegated Functions, including identifying itself in the manner indicated by LAHC when answering the telephone and corresponding or communicating with Members, Providers and any others on behalf of LAHC.

3.6.6. The Parties acknowledge that LAHC retains ultimate responsibility for the performance of the Delegated Functions and that LAHC may change the scope of the Delegated Functions, impose additional or different performance standards, and review CGI's performance from time to time during the term of this Agreement. LAHC and CGI shall cooperate to agree on the impact and implement any such changes as soon as reasonably possible. If, as a direct result of LAHC's changes to the scope of one or more Delegated Functions, CGI anticipates a net cost increase/decrease for the Delegated Functions performed under this Agreement, CGI shall promptly notify LAHC and LAHC and CGI shall negotiate a payment rate adjustment specific to the scope change according to Section 6.14.

3.6.7. The Parties shall cooperate in good faith to establish and comply with a process to determine, validate, and reconcile the Members that are subject to this Agreement in accordance with Exhibit 1.

3.7. CGI Insurance.

3.7.1. CGI, at its sole cost and expense, shall maintain:

3.7.1.1. comprehensive general liability policies including coverage against any claim or claims for damages arising by reason of personal injury or death occasioned directly or indirectly by CGI or its agents, servants or employees in connection with the performance of any Delegated Function or CGI's responsibilities hereunder, for CGI, its agents, servants and employees consistent with industry standards in the amount of at least five million ($5,000,000) dollars per occurrence and ten million ($10,000,000) dollars annual aggregate; and

3.7.1.2. professional liability policies including coverage for errors and omissions arising from professional services rendered in an amount of at least two million ($2,000,000) per claim and three million ($3,000,000) annual aggregate.

3.7.2. If such policies are "claims made" policies as distinguished from occurrence policies, prior to termination of such insurance, CGI shall procure and maintain continuing "tail coverage" or similar coverage in the same coverage amounts. CGI shall also maintain (i) workers' compensation insurance, and (ii) any other insurance coverage required to meet minimum requirements of Applicable Law.

3.7.3. CGI shall provide LAHC with evidence of coverage within thirty (30) days following the execution of this Agreement and then annually thereafter upon policy renewal, and shall give LAHC immediate notice of any material changes in insurance coverage, including any notice of cancellation, reduction or material modification.

3.8. Indemnification

3.8.1. CGI. CGI agrees to indemnify and hold harmless LAHC and LAHC's Affiliates, and their respective shareholders, directors, officers, employees, agents, and assigns (the "LAHC Indemnifieds") from and against any claim, liability, obligation, costs, or expense, including reasonable attorneys' fees, filed against or incurred by any of the LAHC Indemnifieds arising out of any grossly negligent act or omission or willful misconduct by CGI or any CGI Affiliate or their respective employees, directors, officers, agents, or contractors in connection with their responsibilities under this Agreement. CGI and its Affiliates agree to supply LAHC with information, including documents, contracts or other materials as LAHC reasonably deems necessary within thirty (30) Days of the request subject to more stringent timeline(s) set by the respective Applicable Regulatory Agency, to respond to inquiries by any Applicable Regulatory Agency, or court of competent jurisdiction concerning the matters under this Agreement and all attachments hereto.

3.8.2. LAHC. LAHC agrees to indemnify and hold harmless CGI and CGI's Affiliates, and their respective shareholders, directors, officers, employees, agents, and assigns (the "CGI Indemnifieds") from and against any claim, liability, obligation, costs, or expense, including reasonable attorneys' fees, filed against or incurred by any of the CGI Indemnifieds arising out of any (i) grossly negligent act or omission or willful misconduct by LAHC or any LAHC Affiliate or their respective employees, directors, officers, agents, or contractors in connection with their responsibilities under this Agreement or (ii) breach of Sections 3.4.3 or 3.4.4. LAHC and its Affiliates agree to supply CGI with information, including documents, contracts or other materials as CGI reasonably deems necessary within thirty (30) Days of the request subject to more stringent timeline(s) set by the respective Applicable Regulatory Agency, to respond to inquiries by any

Applicable Regulatory Agency, or court of competent jurisdiction concerning the matters under this Agreement and all attachments hereto.

3.8.3. Indemnification Procedures. A Party's indemnification obligations specified in this Agreement are conditioned upon the indemnified Party timely notifying the indemnifying Party in writing of the proceeding, providing the indemnifying Party a copy of all notices received by the indemnified Party with respect to the proceeding, cooperating with the indemnifying Party in defending or settling the proceeding, and allowing the indemnifying Party to control the defense and settlement of the proceeding, including the selection of attorneys. The indemnified Party may observe the proceeding and confer with the indemnifying Party at its own expense.

3.9. Liability.

3.9.1. Each Party to this Agreement may seek damages resulting from the other Party's breach of this Agreement.

3.9.2. Each Party explicitly waives any right to consequential, special, incidental, indirect, exemplary, or punitive damages (including, without limitation, lost profits, loss of business, loss of data, loss of use, lost savings) under this Agreement, even if a Party has been advised of the possibility of such damages.

3.9.3. If either Party shall become entitled to claim damages from the other Party for any reason (including without limitation, for breach of contract, breach of warranty, negligence or other tort claim), the Party that is liable (the "Party at Fault") shall be liable to the injured Party for an amount equal to the damages sustained by the injured Party; however, in no event shall the Party-at-Fault's total liability in the aggregate for all claims exceed Two Million Dollars ($2,000,000). The foregoing limitations do not apply to the payment of settlements, costs, damages, and legal fees with respect to any indemnification provided hereunder, or for unauthorized disclosure of Confidential Information due to a breach of Section 3.17. Notwithstanding the foregoing, if there has been a breach of CGI's obligation with respect to Exhibit 5, CGI's total liability to LAHC shall not exceed one hundred twenty-five percent (125%) of the amounts paid by LAHC to CGI under the Agreement. In addition, in the event LAHC in good faith makes any formal demand(s) of, or files any claim(s) against, CGI while this Agreement is in effect for an amount equal to or greater than 50% of the total liability limitation indicated above, then LAHC may, at its option, elect to transition the Delegated Functions to another vendor, and upon completion of such transition terminate this Agreement on notice of such to CGI, notwithstanding any other term or provision herein.

3.9.4 Governmental Sanction s. If any Party, in performing or arranging for the performance of its obligations and responsibilities as set forth in this Agreement, fails to comply with Applicable Law and as a result fines or monetary sanctions are imposed on the other Party, then the Party whose action or inaction failed to comply shall indemnify the Party on which such fine or sanction was imposed for the amount of such fines or sanctions, which shall be considered direct damages and subject to Section 3.9.3.

3.9.5 In no event will CGI be liable for: (i) any damages arising out of or related to the failure of LAHC or its affiliates or suppliers to perform their responsibilities; or (ii) any claims or demands of third parties (other than those third party claims for which CGI has indemnified LAHC).

3.9.6 The limitations of liability set forth in this Section 3.9 will survive and apply notwithstanding the failure of any limited or exclusive remedy for breach of warranty set forth in this

Agreement. The parties agree that the foregoing limitations will not be read so as to limit any liability to an extent that would not be permitted under Applicable Law.

3.10 Notification of Applicable Law. Each Party shall use reasonable efforts to notify the other Party if, in its opinion, any act or omission on the part of the other Party in administering the Delegated Functions or providing the services violates a provision of Applicable Law.

3.11 Audits and Access. CGI acknowledges and agrees that periodic audits are necessary to monitor the quality and effectiveness of CGI's programs and services to ensure that CGI is able to meet its continuing obligations hereunder. Problems identified by LAHC shall be resolved in accordance with Section 3.13.

3.11.1 Once any Delegated Function has been delegated, LAHC, the Payor(s), and all Applicable Regulatory Agencies shall be entitled to audit CGI (including, without limitation, using onsite visits and document requests) in order to verify performance of CGI's duties under this Agreement. LAHC shall use reasonable efforts to cause Payors to coordinate / combine audits and conduct audits in such a way as to minimize interference with CGI operations. Periodically, LAHC will review documentation pertinent to this Agreement, including without limitation, CGI's applicable policies and procedures (e.g., Claims Administration, Medical Management, Quality Improvement, data collection, clinical criteria, medical records) and other documents, records and information necessary to determine the adequacy of CGI's performance pursuant to this Agreement. LAHC may engage a third party to assist it in conducting the audit, provided that: (a) the third party agrees in writing to maintain Confidential Information, and (b) LAHC retains final authority with respect to such audits. If LAHC discovers deficiencies during the audit, it shall issue a corrective action request within thirty (30) Days of completing the audit, and provide guidance to CGI in connection with CGI's responsive corrective action plan. LAHC shall be permitted to re-audit CGI quarterly until the corrective action plan has been implemented. CGI shall provide LAHC, or any Applicable Regulatory Agencies with jurisdiction over LAHC or CGI, immediately upon request with copies of financial reports of CGI's parent company. If CGI provides documents to an Applicable Regulatory Agency, CGI shall contemporaneously provide copies of such documents to LAHC. CGI agrees to provide the right to audit CGI's records with respect to its performance of this Agreement to the Comptroller General and the U.S. Department of Health and Human Services or its designees for ten (10) years or for periods in excess of ten (10) years as necessary to complete an audit, provided, however, CGI has been notified prior to the end of the ten (10) year period of the need for such continued Access. Provided that CGI has complied with its obligations under Section 2.5, the foregoing shall not be interpreted to require CGI to retain LAHC documents and data or any Member data beyond the retention period specified in Section 2.5.

3.11.2 At all times that CGI is performing a Delegated Function, LAHC, all of LAHC's designees, all Payors and all Applicable Regulatory Agencies shall be permitted Direct and Records Access to CGI's operations, facilities, records, Systems, and staff performing the Delegated Function. LAHC shall provide CGI with advance notice of any on site visit unless prohibited by Applicable Law.

3.11.3 Subject to Section 6.14, the Parties shall comply with each others' reasonable recommendations regarding the performance of Delegated Functions and associated time frames to implement any recommendations arising from such audits, including corrective actions, as provided in Section 3.11. CGI shall cooperate with LAHC, Payors, and third party auditors.

3.11.4 Subject to Applicable Laws, CGI shall provide LAHC and any third party engaged by LAHC with Records Access to claims payment records, credentialing files, medical management and medical records, and any other documents pertaining to Members. CGI shall provide Direct and Records Access to Payors, Accreditation Agencies and all Applicable Regulatory Agencies during the term of this Agreement and for all periods afterwards as required by Applicable Law. The obligations of this Section shall survive termination of this Agreement for any reason whatsoever for so long as CGI is required to retain records hereunder.

3.11.5 Subject to Applicable Law and notwithstanding any other provision in this Agreement, the Parties will permit all Access contemplated by this Agreement for purposes of effectuating smooth and orderly transitions and wind-down.

3.11.6 Annually during the term of this Agreement, CGI will provide LAHC with an independent service auditor's report compliant with SSAE No. 16, describing whether Healthation's description of its System controls used by CGI to prevent, detect, and correct errors or omissions in the information reported to LAHC are fairly presented and whether the controls over that system were suitably designed. This service auditor's report shall be at no expense to LAHC.

3.11.7 Where applicable for the purpose of this section, LAHC's third party auditor must provide LAHC's written authorization to act as its external auditor and will then be deemed to be LAHC's representative. No proposed auditor will be a competitor of CGI. Any third party auditor will execute a non-disclosure agreement reasonably acceptable to CGI. All audit reports contemplated by this section and their content will be deemed Confidential Information and will be subject to the confidentiality provisions contained in this Agreement.

3.12 Compensation. LAHC shall compensate CGI in accordance with the provisions in Exhibit 1. Compensation for each Delegated Function will begin upon the Effective Date for each pursuant to Section 2.2.

3.13 Corrective Action Plan Procedure. If LAHC reasonably determines that CGI is not performing a Delegated Function in accordance with Section 3.2.1 or any other provision of this Agreement, the following procedures shall apply:

3.13.1 LAHC shall issue a corrective action request ("CAR") to CGI;

3.13.2 Upon receipt of such CAR, CGI must: (a) promptly respond to LAHC in writing disputing the determination; or (b) if CGI does not dispute the determination, then (i) if reasonable and possible, take immediate action if such is indicated in the CAR, and (ii) submit to LAHC a corrective action plan ("CAP") within thirty (30) Days of receipt of the CAR (unless otherwise specified in the CAR) that includes specific time frames for achieving compliance;

3.13.3 CGI shall immediately implement the CAP, provided that LAHC may reject (or amend) a CAP if LAHC reasonably determines that such CAP is inadequate. If LAHC rejects a CAP, LAHC and CGI shall work together to develop a mutually agreeable CAP. LAHC may audit CGI according to the Audit and Direct Access provisions of this Agreement to determine CGI's compliance with the CAP;

3.13.4 If the Parties cannot agree on a CAP or in the event of repeated noncompliance with any material provisions of a CAP or noncompliance in more than one regional or product market, then LAHC may, in addition to any other remedy provided hereunder, revoke delegation of

one or more Delegated Functions that are the subject of the CAR, identify a third party to perform such Delegated Function, or assume responsibility for performing the Delegated Function subject to the approval of any Applicable Regulatory Agency. If any such third party is engaged to perform one or more Delegated Functions, then CGI shall reimburse LAHC for the difference between (i) the compensation agreed upon between LAHC and CGI for the applicable Delegated Function, and (ii) the compensation paid to the third party and cost incurred by LAHC.

3.13.5 If CGI fails to comply with a CAP or notifies LAHC that it has determined that it is unable to comply with a CAP, then LAHC, in its sole discretion may take one or more of the following actions:

3.13.5.1 amend the time to comply with a CAP; or

3.13.5.2 increase the frequency of review and audits; or,provide CGI with LAHC's resources to perform; or

3.13.5.3 any combination of the above; or

3.13.5.4 revoke any or all Delegated Functions immediately upon written notice to CGI.

During any CAP process, LAHC may reduce payments to CGI for the Delegated Functions that are the subject of the CAP, in accordance with the Service Level credits outlined in Exhibit 1.

3.13.6 If a Delegated Function is revoked in accordance with this Section 3.13 and LAHC determines, in LAHC's sole discretion, that one or more Delegated Functions must be transitioned, the Parties shall each work in good faith to cooperate and effect a smooth and orderly transition including, without limitation, the following as determined by LAHC in LAHC's sole discretion: (1) CGI shall perform such Delegated Functions for the period of time requested by LAHC; and (2) LAHC may resume performing such Delegated Function or re-delegate such Delegated Function to a third party.

3.13.7 CGI shall comply, at LAHC's expense, in good faith, with any information requirements and exchanges reasonably requested by LAHC or any third party engaged by LAHC, in formats reasonably required by LAHC or the third party, as necessary for the orderly transfer of Delegated Functions, including complying with the transition protocols reasonably established by LAHC or the third party. If some Member or claims records are retained by CGI, CGI shall: i) store said records in accordance with Section 5.1, and ii) provide LAHC and its engaged third parties, auditors, authorized agents, Payors, and Applicable Regulatory Agencies with jurisdiction over LAHC with timely Records Access to said records. During any transition period, CGI shall provide LAHC and any third party engaged by LAHC reasonable Records, Direct or Personnel Access to CGI facilities, records, staff, Systems, and other resources related to this Agreement or the performance hereunder for purposes of effectuating an orderly and smooth transition.

3.13.8 Immediate Revocation of Delegated Functions. LAHC may revoke delegation of a Delegated Function immediately upon notice if:

3.13.8.1CGI, in performing the Delegated Function, threatens the health or safety of a Member, or fails to comply with Applicable Law, or may subject LAHC to

regulatory or legal actions from any Applicable Regulatory Agency, including CMS, or an Accreditation Agency; or

3.13.8.2CMS or any Applicable Regulatory Agency acts or threatens to act to issue an adverse finding against LAHC with respect to a Delegated Function, including revoking its license, terminating any contract; or imposing any sanction or fine; or

3.13.8.3two (2) consecutive CARs for the same or similar performance standard in Exhibit 1 fail to result in CGI achieving substantial compliance with the standards for the Delegated Function; or

3.13.8.4two (2) consecutive CARs fail to result in timely and complete submission by CGI of claims, encounter data, and any other data required to satisfy HEDIS (to the extent otherwise required under this Agreement), in formats specified herein.

3.14 Sub-Delegation & Location of Performance. CGI may not sub-delegate any Delegated Function or any task included as a portion of a Delegated Function without the prior written approval of LAHC and, as required, Applicable Regulatory Agencies, provided that LAHC acknowledges that CGI has subcontracted hosting of the Systems by Healthation. All services and Delegated Functions must be performed within the United States.

3.15 Participation In Meetings, Task Forces, and Committees. At any time multiple CO-OPs belong to the Client Group, the Parties and CO-OPs belonging to the Client Group shall form a Joint Operations Committee ("JOC") which shall be comprised of the following representatives from CGI: the manager, as provided in §3.5.2, representatives from each CO-OP in Client Group as determined by CO-OP, which may include an operations executive, plus leadership from claims, customer service and other areas as determined by the Client Group. The JOC shall discuss and review all activities related to or involving the delivery of the Delegated Functions. The JOC shall meet at least monthly and there shall be a standing list of agenda items for addressing issues related to the Delegated Functions.

3.16 NCQA Accreditation. CGI shall comply with Accreditation Agency standards with respect to its performance of each Delegated Function or portion thereof subject to Section 6.14, and shall actively support LAHC in activities related to NCQA accreditation with respect to performance of the Delegated Functions.

3.17 Protection of Confidential Information.

3.17.1 Confidential Information. LAHC and CGI agree that in the process of contracting and performing the services contemplated by this Agreement each is expected to disclose or exchange Confidential Information. This Confidential Information may have competitive value in the market. The Parties desire to preserve and protect the confidential nature of the Confidential Information and acknowledge that disclosure of the Confidential Information would cause the Party that owns the Confidential Information and is making the disclosure (the "Disclosing Party") substantial and irreparable harm. The Parties agree to receive and hold all such Confidential Information in confidence, whether relating to CGI or LAHC, whether presented in oral, electronic, or written form, and to use it only for the purpose of carrying out their respective obligations under this Agreement, irrespective of whether the information independently qualifies as entitled to legal protection.

3.17.2 Nondisclosure. Neither Party shall, without the prior written consent of the other, sell, market, or disclose (directly or indirectly, in whole or in part) Confidential Information to any third person, firm, corporation, entity, or association, or take any action or make any disclosure that permits any third person, firm, corporation, entity, or association to use or benefit from such Confidential Information. The Parties further agree that they will adhere to, and fully comply with, any additional restrictions or limitations as may be specifically indicated on the documents or information disclosed to them, or as may be otherwise communicated to them in writing by the Disclosing Party or its representative. Such additional restrictions or limitations, or the lack thereof, on any documents or information disclosed by either Party shall not negate in any way the general requirements of this Agreement.

3.17.3 Restrictions on Use of Confidential Information. The Parties will use the Confidential Information solely for the purposes of carrying out their responsibilities under the Agreement, and neither will use the information in any way, directly or indirectly, for any other purpose or in any way that may be detrimental to the other Party. Without prior written consent of the Disclosing Party, the Receiving Party will not disclose, discuss, or make known the Confidential Information to any third party or entity. Each Party will ensure that its employees, agents, and affiliates who receive such Confidential Information are made aware of the obligation to maintain the Confidential Information in confidence and will not disclose such Confidential Information to any third party. Each Party shall require that all of its employees, agents, and contractors who provide services pursuant to this Agreement execute an agreement with that Party ensuring that such individuals will protect all Confidential Information and Protected Health Information. This employee agreement can be a general agreement to maintain confidentiality and need not specifically reference this Agreement.

3.17.4 Subpoenas and Requests for Disclosure. If a Receiving Party is requested or required by legal process to disclose any Confidential Information, the Receiving Party shall promptly give notice of such request or requirement to the Disclosing Party, so that the Disclosing Party may, at its own cost and expense, seek an appropriate protective order, or in the alternative, waive compliance to the extent necessary to comply with the request or order. If a protective order is not obtained, or if a waiver is granted, the Receiving Party may disclose only so much of the Confidential Information as is required by the court order or permitted by the waiver.

3.17.5 Protected Health Information. The Parties further agree that to the extent Protected Health Information is disclosed by a Party hereto, the Receiving Party will adhere to the privacy and security standards of Applicable Law, including specifically, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") and as hereafter adopted or amended, as well as any and all applicable health information standards, rules, guidelines, regulations, and laws of the United States or of any states where the Parties conduct business, or of Accreditation Agencies. Such data, whether contained in claim or medical records, other written records, electronic records, facsimiles, electronic mail, or any other similar format, shall not be disclosed to any person, except (a) to any employee or agent of LAHC or CGI to the extent such employee or agent has an identifiable need, as determined by the Disclosing Party, for such information and such information is necessary to carry out the responsibilities set forth in this Agreement; (b) to the extent necessary under Applicable Law; or (c) upon the express consent of the Party. The Parties further incorporate by reference, as if fully stated herein, the Business Associate Agreement, attached hereto as Exhibit 5.

3.17.6 Remedies. Each Party hereby agrees that its breach or threatened breach of this Section 3.17 would cause serious and irreparable injury to the other Party and, therefore, each

non-breaching Party, in addition to any other remedies at law or in equity it may have, shall be entitled to equitable relief, including without limitation, injunctive relief and specific performance.

3.17.7 Termination of Agreement. The Parties agree that upon the termination of the Agreement for any reason, they will promptly return or destroy in accordance with the Disclosing Party's instructions (or as specifically indicated on the document or information itself), the original and all copies and extracts of any Confidential Information, and all copies of any analyses, compilations, studies or other documents prepared by them containing or reflecting any Confidential Information. The Parties further agree that the confidentiality obligations of this Agreement shall survive the termination of the Parties' contractual relationship and that, thereafter, neither Party will use, reveal or divulge any Confidential Information, except as specifically provided in this Agreement. Subject to the continuing confidentiality obligations hereunder the Receiving Party (i) shall not be obligated to erase the information contained in archived computer system backups in accordance with its security and/or disaster recovery procedures, and (ii) may maintain one copy of any of the information in the Receiving Party's records in accordance with the Receiving Party's usual, customary, and prudent business practices, including secure destruction of the records following the end of the Receiving Party's record retention period, as may be required by the Applicable Law.

3.17.8 No License. The disclosure of Confidential Information under this Agreement will create no license, right, interest, or ownership in any such Confidential Information in the Receiving Party. Each Party agrees that all Confidential Information is and shall remain the exclusive property of the Disclosing Party.

3.18 Member Communications. CGI shall not send any form or other communication to any Member unless such form has received prior approval by LAHC. CGI and LAHC shall cooperate to establish processes for CGI to submit Member communications and for LAHC to approve or to obtain approval for them, as required.

3.19 No Incentive to Reduce or Deny Medically Necessary Care or Interfere with Member Communications. CGI shall not provide incentives to deny, limit, or discontinue Medically Necessary services. Nothing contained in this Agreement is intended by LAHC to be a financial incentive or payment that directly or indirectly acts as an inducement for the CGI to limit Medically Necessary services.

3.20 Cooperation with LAHC Quality Improvement Activities. Notwithstanding CGI's assumption of responsibility for performing certain Quality Improvement (QI) activities in Article 4 of this Agreement, CGI acknowledges LAHC's obligation to conduct QI activities. CGI agrees to cooperate with LAHC's QI activities.

3.21 Screening for Individuals Excluded from Federal Programs. CGI agrees not to employ or contract with an individual or entity that is excluded from participation in Medicare, Medicaid, or another governmental program, or with an entity that employs or contracts with such an excluded individual or entity. CGI agrees to maintain a system consistent with industry standards for monitoring and periodically re-monitoring its employees and contractors to ensure compliance with this requirement.

3.22 Business Continuity. The Parties shall mutually agree on and CGI shall implement the business continuity plan, which shall be appended to this Agreement as Exhibit 4. Such plan shall address security, joint management oversight, power management, hazard protection, resilience, system

continuity, back-up, emergency preparedness, incident management, disaster recovery, testing, and quality assurance. As specified in the plan, CGI shall either (i) set up and maintain a Cold Site or (ii) contract to create and maintain a Hot Site.

3.23 Source Code Escrow. During the Term, CGI shall place into escrow, with Escrow Agent, all Deposit Materials. During the term of this Agreement, CGI shall update the Deposit Materials from time to time. Any and all fees and expenses associated with establishing and maintaining the aforesaid source code escrow shall be borne solely by CGI, and CGI will be solely responsible for establishing the source code escrow arrangement with the Escrow Agent. CGI shall certify to LAHC, no later than the earliest Effective Date, complete compliance with all conditions in this section of the Agreement.

If, during the Term of this Agreement, CGI becomes insolvent within the meaning of §2.4.1 or the Agreement is terminated by LAHC for CGI's breach as provided in Sections 2.4.2, 2.4.3, 2.4.4 or 2.4.5 or CGI ceases ongoing business operations, including temporarily for a period expected to last five Days or longer or loses key programming staff, rendering it incapable of performing the Delegated Functions, LAHC may instruct the Escrow Agent to release all Deposit Materials to LAHC, subject to the provisions of any escrow agreement that the Parties and the Escrow Agent may enter. For the avoidance of doubt, no breach of this Agreement other than those specifically stated in this paragraph will allow LAHC to instruct the Escrow Agent to release Deposit Materials to LAHC.

If the Deposit Materials are released to LAHC as aforesaid, CGI hereby grants LAHC an irrevocable, world-wide, paid-up, and royalty-free right and license to use the software, the Deposit Materials, and each manual, workbook, and any other materials made available to users during the Term in connection with the Access or use of the platform by users, and to use, modify, and create derivative works therefrom (including any source codes) for the sole purpose of supporting LAHC's use of the software for the purposes contemplated herein. Such right and license shall be limited in duration to the unexpired Term of the Agreement, plus any period needed to transition to another system or Vendor at LAHC's option. If the Deposit Materials are released to LAHC as aforesaid, LAHC shall be permitted to allow Access and use thereof by third-party vendors providing software support services for LAHC, provided that such third parties may use the Deposit Materials solely to provide services in connection with maintaining the functionality of the software, and not for their own benefit or for the benefit of any other third party, and each third-party vendor providing such services must enter into a written confidentiality agreement prior to gaining Access to the Deposit Materials agreeing not to use or disclose the Deposit Materials except as permitted in this paragraph.

ARTICLE 4
QUALITY IMPROVEMENT.

4.1. Responsibility for Quality Improvement. The Parties agree that CGI's obligation to conduct quality assessment and quality improvement activities pursuant to this Article 4 is in addition to any quality assessment or quality improvement activities of LAHC.

4.2. Quality Improvement Committee. CGI shall maintain a QI Committee to evaluate its performance of each Delegated Function performed under this Agreement and develop and implement ongoing recommendations to improve the processes and procedures for each Delegated Function undertaken under this Agreement. CGI shall supply LAHC with minutes and reports of its QI Committee.

4.3. Cooperation. CGI shall cooperate with and participate in QI related activities as set forth herein and shall assist and cooperate with any LAHC QI activities.

4.4. Investigations. CGI shall fully cooperate with any quality of care investigation initiated by LAHC as the result of Member or Provider complaints or grievances or an adverse event. CGI shall institute any reasonably recommended actions resulting from such investigation.

4.5. Quality Reporting. CGI shall maintain records of all activities of its QI Committee and shall report on its Quality Improvement Activities to LAHC and to Applicable Regulatory Agencies as required.

ARTICLE 5
DATA RETENTION, CREATION, COLLECTION AND PERFORMANCE REPORTING

5.1. Retention. CGI shall retain all records, documents, and information (i) as required by Applicable Law, and (ii) in accordance with LAHC's then current policies and procedures, whichever is more restrictive. CGI has provided LAHC with copies of CGI's current records retention policies and procedures. CGI shall periodically review and update, as necessary and appropriate, its retention policies so as to maintain its compliance with Applicable Law and this Agreement. Prior to the destruction of any records related to its performance under this Agreement, CGI shall give LAHC notice of the records scheduled to be destroyed and the opportunity to have those records retained at LAHC's own expense.

5.2. Performance Reports. For each Delegated Function, CGI shall collect data and monitor its performance according to the frequency and in the formats as mutually agreed by the deadlines contained in Exhibit 1. CGI's failure to meet a deadline shall subject CGI to the corrective action program set forth in Section 3.13.

5.3. Data Transmission. CGI shall furnish, at no expense to LAHC, any and all,: staffing and Systems necessary to receive from and transmit to LAHC or its designee data required to be exchanged hereunder, and will allow Access to and provide to LAHC or its designee all data required by Applicable Law, PPACA, LAHC, or Accreditation Agency standards including any documentation, records, files, or data necessary to perform the functions delegated under this Agreement.

5.4. HIPAA Standard Transaction Sets for Electronic Exchange.
CGI will additionally support electronic exchange of data for the purposes of loading the system, maintaining records of eligibility and benefits, supporting functions of CGI, and integrating with LAHC. CGI will support all of the following in the HIPAA standard format indicated, or in a proprietary format if required by LAHC or a Payor:

5.4.1. Health Care Eligibility Benefit Inquiry and Response ASC X12N 270/271
5.4.2. Health Care Claim Status Request and Response ASC X12N 276/277
5.4.3. Health Care Services Review-Request for Review and Response ASC X12N 278
5.4.4. Benefit Enrollment and Maintenance ASC X12N 834
5.4.5. Health Care Claim Payment/Remittance Advice ASC X12N 835
5.4.6. Health Care Claim: Professional/Institutional ASC X12N 837P/837I
5.4.7. Electronic Premium Payment/PPACA – 820 health care premium payment

5.5 Other Electronic Exchange
CGI will support all HIPAA standard transaction formats including those indicated, as well as other standardized formats in accordance with PPACA and as required by LAHC or any Applicable Regulatory Agency or Accreditation Agency. CGI will support electronic exchange, in proprietary format, as follows:

Benefits Accumulators

Employer Group Data
Benefit Plan Data
Claims Adjudication Logic
Provider Demographic, Credentialing and Provider Network Information

ARTICLE 6
GENERAL PROVISIONS

6.1. Entire Agreement; Modification. This Agreement, its Attachments and Appendices constitutes the entire understanding of the Parties and supersedes any and all prior written or oral agreements, representations, or understandings regarding the specific subject matter hereto. Except as otherwise set forth herein, no modifications, discharges, amendments, or alterations to this Agreement shall be effective unless signed by both Parties.

6.2. Invalid Provisions. It is understood that any provision of this Agreement which is determined to be in violation of any Applicable Law shall be null and void and that no such provision shall affect the validity or enforceability of any of the other provisions of this Agreement; provided, however, that if a provision of this Agreement which materially affects the financial terms and conditions of this Agreement is deemed null and void in accordance with this Section, the Parties shall negotiate in good faith modifications to such financial terms and conditions that are in compliance with Applicable Law. If the Parties cannot successfully renegotiate such financial terms and conditions of this Agreement within thirty (30) Days, the matter shall be submitted to arbitration pursuant to Article 7.

6.3. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Louisiana without giving effect to the principles of conflicts of law.

6.4. Compliance with Law. At all times during the Term of this Agreement and any renewal thereof, CGI and LAHC each agree to comply with Applicable Law. LAHC agrees to pay directly or reimburse CGI for any taxes arising out of the CGI's performance under the Agreement, excluding taxes on CGI's net income and all employer reporting and payment obligations with respect to its personnel.

6.5. No Waiver. No responsibility, condition, or undertaking contained in this Agreement may be waived except by the written agreement of the Parties. Forbearance or indulgence in any other form by either Party in regard to any responsibility, condition, or undertaking to be kept or performed by the other Party shall not constitute a waiver thereof, and until complete satisfaction or performance of all such responsibilities, conditions, and undertakings have been satisfied, the other Party shall be entitled to invoke any remedy available under this Agreement, despite any such forbearance or indulgence.

6.6. Notices. All notices, requests, demands, and other communications which are required or may be given under this Agreement shall be in writing and shall be deemed to have been duly given on the Day of delivery if personally delivered; the following Day if sent for next Day delivery by a recognized overnight delivery services as verified (e.g., Federal Express); and upon receipt, if sent by certified or registered mail, return receipt requested, to the address in the initial paragraph of this Agreement.

6.7. Ownership of Records. The Parties acknowledge and agree that each party's business records, including but not limited to those related to the Delegated Functions, including Member eligibility, benefits, policies and procedures, Benefit Plans, and Covered Services, shall remain the property of such Party, unless as otherwise required by Applicable Law. The Parties agree that, as between the Parties, all data relating to Delegated Functions are the property of LAHC.

6.8. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original; however, all shall constitute one and the same Agreement.

6.9. Headings. The Section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof. Any attachments, Exhibits, Appendices, tables, or schedules referred to herein and/or attached or to be attached hereto are incorporated herein to the same extent as if set forth in full herein.

6.10. Assignment and Delegation.

6.10.1. This Agreement, and the right to receive payment hereunder, may not be assigned by CGI, and none of the duties assumed by CGI under this Agreement may be delegated or subcontracted to any Person without the prior written approval of LAHC, which approval shall not be withheld unreasonably. CGI shall provide thirty (30) Days prior written notice to LAHC of a proposed assignment, subcontract, or delegation of any duty described hereunder to an Affiliate. Any attempt by CGI to assign this Agreement or any rights hereunder, or subcontract any duties hereunder without the prior written consent of LAHC, shall void the attempted assignment.

6.10.2. LAHC shall be permitted to assign this Agreement to any Affiliate or successor organization.

6.10.3. All provisions hereof shall be binding upon, inure to the benefit of, and be enforceable by and against the respective successors and permitted assigns of the Parties hereto.

6.11. No Third-Party Beneficiaries. This Agreement is not a third party beneficiary contract and shall not in any manner whatsoever confer any rights upon or increase the rights of any Member with respect to LAHC or the duties of LAHC to any Member.

6.12. Communications. Any public announcement of this Agreement shall be subject to the mutual approval of the Parties.

6.13. Non-Exclusive Arrangement. The Parties acknowledge that this is not an exclusive arrangement.

6.14. Change Orders.

6.14.1. Either Party may propose changes to the Delegated Functions under this Agreement. Requests for changes will be submitted to the other Party in writing for consideration of feasibility and the likely effect on the cost, schedule, and service levels for performance of the Delegated Functions. The parties will mutually agree upon any proposed changes, including resulting equitable adjustments to costs and schedules for the performance of the Delegated Functions. The agreed changes will be documented in an amendment to the Agreement ("Change Order").

6.14.2. Response and Addenda supplied by CGI. The order of precedence should be determined as follows: CGI will be entitled to an equitable adjustment in the schedule for performance, service levels, and/or the compensation otherwise payable to it under the Agreement if the net effect of all (i) changes in Applicable Law and actions and standard directed by Applicable Regulatory Agencies or Accreditation Agencies causes a material increase in CGI's cost of performing services under this Agreement; and (ii) action or inaction by LAHC prevents CGI from or delays CGI in performing its services (CGI should provide the policies and procedures to meet all requirements so as to not delay the service). In such event, the parties will mutually agree upon a Change Order documenting the adjustments.

6.14.3 Change Control Process: Modifications to existing processes or maintenance of processes. Following contract signing, the parties will document and mutually agree to a change control process that at a minimum addresses and outlines the following:

- Process Summary,
- Identification and Documentation of Change Request
- Impact Analysis
- Approval of Change Requests
- Implementation of Approved Change Requests
- Closing of Change Requests
- Change Request Monitoring
- Change Request Meetings

6.15 Priority of Documents. If any conflict exists between the provisions of this Agreement and any Applicable Law, Exhibit or any policy implemented after the effective date of this Agreement (collectively, the "Documents"), the Parties agree that the Documents shall be interpreted in the following order of priority:

1) Applicable Law shall govern all Documents, and all Documents shall be applied in a manner consistent therewith;
2) The Agreement shall supersede any conflicting provision in another Document;
3) The terms of any Exhibit shall supersede any conflicting provision in any policy or any other writing or oral agreement.

6.16 Internet Not Secure. Electronic transmissions over the Internet are not secure, and CGI does not warrant the security or privacy of any transmissions, messages, conduct or communications by LAHC or any third party. CGI shall monitor and disclose any conduct, content, or communications on the Systems to the extent necessary to protect the Systems, identify or resolve service problems, protect the rights and property of CGI and its customers, or as otherwise permitted or required by Applicable Law. Notwithstanding the foregoing, CGI does not have the practical ability to restrict conduct, content, or communications that might violate this Agreement before it occurs on the Systems, nor can CGI assume any liability for any action or inaction with respect to such conduct, content, or communications. The foregoing provisions do not affect or negate CGI's obligations to fulfill its security obligations with regard to the Systems as part of CGI's performance of any Delegated Functions.

6.17 Nonsolicitation. During the term of the Agreement and for twelve (12) months after its expiration or termination, neither Party will, either directly or indirectly, solicit for employment or employ (except as permitted below) by itself (or any of its affiliates) any employee of the other Party (or any of its Affiliates) who was involved in the performance of the Party's obligations under the Agreement, unless the hiring Party obtains the written consent of the other Party. The actual damages attributable to a breach of the provisions of this Section would be difficult to determine and prove. Accordingly, the parties agree that if either Party breaches this Section, the breaching Party will promptly pay the non-breaching Party liquidated damages in an amount equal to the employee's annual salary (including bonuses and incentive compensation) prior to the breach, such sum being a reasonable measure of the damages reasonably anticipated by the parties. The foregoing provision will not (i) prohibit a general solicitation of employment in the ordinary course of business or prevent a Party from employing any employee who contacts such Party as a result of such a general solicitation; or (ii) be read so as to limit employment opportunities to an extent that would not be permitted under Applicable Law.

6.18 Force Majeure. Neither Party shall be liable for any damages for delays or failure in performance under the Agreement caused by acts or conditions beyond its reasonable control, without its fault or negligence, which could not have reasonably foreseen or prevented by reasonable precautions. Such acts or conditions (each a "Force Majeure") shall include, but not be limited to: acts of God or of the public enemy; civil war; insurrections or riots; acts of war; acts of government; acts of terrorism; fires; floods; storms; explosions; earthquakes or accidents; unusually severe weather; epidemics or public health restrictions; strikes or labor troubles causing cessation, slowdown or interruption of work; and other similar events, or any event referred to above preventing a subcontractor from performing its obligations under a subcontract. In the event of a Force Majeure, (i) the Party experiencing the Force Majeure shall exercise due diligence in endeavoring to overcome any Force Majeure impediments to its performance and shall provide prompt notice to the other Party of the Force Majeure; and (ii) the time for performance shall be extended by a period equal to the delay caused by the Force Majeure and, if warranted, the fees payable to CGI shall be equitably adjusted.

ARTICLE 7
DISPUTE RESOLUTION

If any controversy, dispute, or claim ("Dispute") between the Parties arises out of or relates to this Agreement, which the Parties cannot settle by good faith negotiation between them during the time frames set forth herein, the Parties agree that the Dispute shall be resolved by mediation or arbitration. Financial issues that cannot be resolved between the Parties within thirty (30) Days of the identification of the issue by either Party shall proceed directly to arbitration. The Parties agree to take the following measures to resolve the Dispute:

7.1 Internal Dispute Resolution Process. The Parties shall work together in good faith to resolve all Disputes. Disputes shall include all operational matters regarding the implementation of this Agreement, and all issues over amounts due. Either Party may give the other notice of a Dispute. Notices shall be addressed as set forth in Section 6.6. If the Dispute is not resolved within fifteen (15) Days by the Parties directly involved (or their designees), it shall be forwarded to the CEOs (or their designees) of LAHC and CGI for resolution within fifteen (15) Days. If the Dispute is not resolved, each Party shall select a mediator. The two mediators shall select a third mediator who will resolve the Dispute. During any Internal Dispute Resolution Process described in this Section 7.1, the Parties agree to toll any time limits applicable to appeals or external remedies.

7.2 Alternate Dispute Resolution.

7.2.1 If the Dispute is not resolved within sixty (60) Days in accordance with Section 7.1, above, the Parties shall submit it to mediation, which shall be conducted in the State of Louisiana in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Mediation.

7.2.2 If the Dispute has not been resolved to the satisfaction of both Parties following conclusion of the mediation in Section 7.2.1, then the Dispute shall be submitted to arbitration in Louisiana in accordance with the arbitration rules of the American Health Lawyers Association (AHLA) Alternative Dispute Resolution Service, or such other dispute resolution service as the Parties may agree. The arbitration shall be commenced by either Party submitting a notice to the other of the intent to commence arbitration and by notifying the AHLA Alternative Dispute Resolution Service in Washington, D.C.

7.2.3 The Parties covenant and agree to be bound by the decision of the arbitrator or, if applicable, the decision of a majority of the arbitrators. The arbitrator(s) shall apply Applicable Law, and shall have the jurisdiction to decide all claims between the Parties. The arbitrators shall also have the power to decide procedural matters in accordance with the rules of the AHLA Alternative Dispute Resolution Process, and shall not be bound to state or federal evidentiary or procedural rules. The arbitrator(s) shall issue findings of fact and conclusion of law, and shall be bound by Applicable Law. Any court(s) having jurisdiction over the Parties may enter judgment upon the award rendered by the arbitrator(s). The Parties each agree to pay their own legal fees and expenses in connection with the arbitration and, in addition, to pay one-half of the cost of the arbitration, including fees charged by the arbitrator(s).

7.2.4 During any alternate dispute resolution procedure pursuant to this Section 7.2, the Agreement shall remain in full force and effect, provided that LAHC continues to meet its payment obligations to CGI during the pendency thereof. If amounts due to CGI or refunds to LAHC are the subject of the dispute, the Party that is claimed to owe the funds / refunds shall place the funds into escrow. All arbitration proceeding evidence and decisions shall be confidential.

7.3 Financial Issues. LAHC and CGI may, at their option, agree to submit disputes regarding any payment or compliance with financial terms hereunder to an independent third party auditor or actuary for purposes of resolving such dispute pursuant to mutually agreeable terms.

ARTICLE 8
EXHIBITS & APPENDICES

The following Exhibits and Appendices are attached to and incorporated into this Agreement by reference:

Exhibit 1	Payment Terms
Exhibit 2	Claims Administration Services
Exhibit 3	CGI Information Technology Security Plan
Exhibit 4	CGI Business Continuity Plan
Exhibit 5	Business Associate Agreement
Exhibit 6	Enrollment Services
Exhibit 7	Printing, Fulfillment, and Ancillary Services
Exhibit 8	Software Configuration and IT Related Services
Exhibit 9	Premium Billing and Collection Services
Exhibit 10	Member & Provider Support Services
Exhibit 11	Participants in Client Group
Exhibit 12	Project Implementation Plan

IN WITNESS WHEREOF, this Agreement has been duly executed by the authorized representatives of LAHC and CGI.

LOUISIANA HEALTH COOPERATIVE, INC.

BY: _____

Terry S. Shilling
ITS: Chief Executive Officer

DATE: 3/21/2013

CGI TECHNOLOGIES AND SOLUTIONS, INC.

BY: _____

[[NAME]] Jody K. Beasley
ITS: [[TITLE]] Vice President

DATE: March 21, 2013

EXHIBIT 1
Payment Terms

1. Implementation Fees. LAHC shall pay a total of $707,500.00 toward the cost of CGI's services implementing the Systems. The implementation fee shall be payable in the following increments:

Payable at contract execution	$175,000
Payable Dec 31, 2013	$133,500
Payable Dec 31, 2014	$133,000
Payable Dec 31, 2015	$133,000
Payable Dec 31, 2016	$133,000

Each new member joining the Client Group will have an implementation fee designed for the scope of services and the timeframe required, that will be separate and unique.

As the initial investment made by the LAHC and LAHC will enable additional members to leverage elements of the initial implementation, LAHC and LAHC will receive credits, equally shared between them, for each new member that joins the Client Group for a minimum of three years based on the date that the new member's contract is executed:

Date	Amount
Before March 31, 2013	$50,000.00
April 1 - December 31, 2013	$40,000.00
After December 31, 2013	$30,000.00

LAHC shall pay its portion of the implementation fee, net of any credit resulting from additional insurers in the Client Group as described above, within thirty (30) Days of receiving an invoice from CGI.

2. Monthly Fees. LAHC shall be responsible for paying monthly fees which shall include all Delegated Functions described in the Agreement and Exhibits unless a separate fee is contained in this Exhibit 1. Beginning October 1, 2013, the Client Group shall be responsible for paying monthly fees according to the following schedule:

Membership	**PMPM**
1 to 35,000 (35,000 minimum)	$4.12
35,001 to 42,000	$4.00 for all Members
42,001 to 49,000	$3.88 for all Members

49,001 to 52,000	$3.78 for all Members
52,001 to 60,000	$3.68 for all Members
60,001 to 100,000	$3.30 for new Members and $3.68 for first 60,000 Members
100,001 to 150,000	$3.20 each additional Member
150,001 to 175,000	$3.10 each additional Member
175,001 to 200,000	$3.00 each additional Member
200,001 to 225,000	$2.85 each additional Member
225,001 to 250,000	$2.76 each additional Member

Until the 35,000 monthly minimum membership is reached, the minimum monthly fees of $144,200 will be evenly divided among the Client Group participants. The monthly fees shall be shared by all insurers belonging to the Client Group. For purposes of determining each insurer's share of the monthly fee, CGI shall combine their total Members for all insurers as of the first Day of the previous month. CGI shall then apportion the total monthly fee among all insurers according to the number of Members enrolled through each as a percentage of the total Members enrolled through all as of the first Day of the previous month. LAHC shall pay its portion of the monthly fee within thirty (30) Days of receiving an invoice from CGI.

For example, if the Client Group contains CO-OP A with 100,000 Members and CO-OP B with 50,000 Members, the monthly fee would be calculated as follows:

150,000 Members = (60,000 x 3.68)+(40,000 x 3.30)+(50,000 x 3.20) = 512,800/150k =$3.42 pmpm

CO-OP A pays $341,867; CO-OP B pays $170,933

3. Healthation Access Fee. LAHC shall be responsible for paying monthly access fees to CGI which CGI shall pass through directly to Healthation. Beginning October 1, 2013, the Client Group shall be responsible for paying monthly access fees according to the following schedule:

Membership Range	**PMPM**
1 to 30,000 Members (30,000 minimum)	1.21 per Member
30,001 to 50,000	1.21 each additional Member
50,001 to 100,000	1.16 each additional Member
Above 100,000	0.96 each additional Member

Until the 30,000 monthly minimum membership is reached, the minimum monthly access fee of $36,300 will be evenly divided among the Client Group participants. The monthly access fees shall be shared by all insurers belonging to the Client Group. For purposes of determining each insurer's share of the monthly access fee, CGI shall combine the total Members for all insurers as of the first Day of the previous month. CGI shall then apportion the total monthly access fee among all insurers according to the number of Members enrolled through each as a percentage of the total Members enrolled through all as of the first Day of the previous month. LAHC shall pay its portion of the Healthation access fee within fifteen (15) Days of receiving an invoice from CGI.

For example, if the Client Group contains CO-OP A with 100,000 Members and CO-OP B with 50,000 Members, the monthly Healthation fee would be calculated as follows:

150,000 Members = (50,000 x 1.21)+(50,000 x 1.16)+(50,000 x 0.96) = 166,500/150k =$1.11 pmpm

CO-OP A pays $111,000; CO-OP B pays $55,500.

4. Direct Expenses. LAHC shall reimburse CGI at its actual cost for the following direct expenses: postage, paper, card stock, ink, electronic data interchange costs, and such other direct expenses as the Parties may agree in advance. LAHC shall pay this monthly fee within fifteen (15) Days of receiving CGI's invoice. CGI is expected to act as a "prudent purchaser" and thus shall provide cost estimates and invoices for all initial activities in this area, to LAHC Finance Department for review and approval, and upon periodic request. CGI shall supply cost estimates and invoices during any audit or annual oversight meeting to demonstrate that CGI is acting as a competitive, prudent purchaser in the marketplace. Examples include:

PRINTING AND FULFILLMENT FEES: Will be billed separately according to volume and services

ITEM	RATE
LETTTERS	
-Folding/Finishing/Metering	$0.0849 per piece
-Envelope	$0.0195 per piece
-Return Envelope	$.0180 per envelope
-Paper	$0.0060 per piece
-Print	$0.0056 per piece
-Presort	$0.0285 per piece
OTHER	
-Welcome and Renewal Kits	$.60 per kit (8 to 12 components)
-Labels	$0.0095 per piece
-ID Card Stock	$8,000 per m (10,000)
-ID Card Print	$0.0171 per piece
-Envelopes	$0.5168 per piece
-Overnight Shipping	$2.50 per piece
-Postage Pass through	Actual postage with no mark up at presorted rate

5. Credits. Any payments due from LAHC shall be reduced by the amount of the credit(s) accrued as provided below. If CGI's invoice does not reflect the credit, then LAHC shall be entitled to submit a revised invoice showing the calculation of the credit and the explanation therefor, along with payment of the net balance due. If a dispute arises over whether LAHC is entitled to a credit, LAHC shall place the disputed amount of the payment into escrow and pay the balance to CGI while pursuing the dispute resolution procedures in Article 7.

6. Service Level Credits

Service Levels shall be in force beginning with the third month that plan Members receive benefits from the plan. Service level credits shall be calculated as indicated for each Service Level Specification listed

below. Without limiting any of LAHC's rights or remedies, should CGI fail to attain one or more Service Level Specifications, LAHC shall be entitled to the corresponding Service Level Credit, to be applied to the next succeeding invoice(s) but calculated based upon the applicable month's Monthly Fee. The maximum amount of all Service Level Credits payable for which CGI may be liable for failure to meet the Service Levels described below in any given monthly billing period will not exceed ten (10) percent (10%) of the Monthly Fees (pmpm) in Section 2 of this Exhibit 1, except as provided below. Nothing in this Section 6 Service Level Credits shall limit LAHC's ability to invoke the corrective action procedures in Section 3.13 of the Agreement.

Dept.	Service Level	Measurement Frequency	Service Level Specification	Service Level Credit
Claims	Clean Claim Processing Timeliness	Monthly	99.5% of Clean Claims will be adjudicated (paid or denied) within 30 Days of receipt	15%
Claims	Unclean Claim Processing Timeliness	Monthly	100% of all unclean claims will be adjudicated (paid or denied) within 60 Days of receipt	10%
Claims	Claims Processing Accuracy - Procedural	Monthly	97% of adjudicated claims will be adjudicated with clerically accurate processing	5%
Claims	Claims Processing Accuracy - Financial	Monthly	99.5% of total dollars paid, for all claims adjudicated	15%
Member Service	Abandonment Rate	Monthly	Abandonment rate for all calls that have made it to the queue in a month shall be no greater than 4%.	5%
Member Service	Telephonic Average Speed of Answer	Monthly	80% of calls shall be answered within 30 seconds	10%
Member Service	Non-telephonic electronic contact response speed	Monthly	CGI Staff will respond to 100% of non-telephone inquiries whether made by facsimile, electronic mail or web inquiry within one business day	5%
Member Service	Maximum resolution time	Monthly	99.5% of all telephone and written inquiries will be resolved/closed within 21 Calendar Days	10%
Enrollment	Enrollment File loading	Monthly	CGI will load enrollment/eligibility files from the state or federal Health Insurance Exchange (HIX), cooperative website, third party "private" exchanges, or paper submissions into the claim/eligibility system within one (1) Day of receipt. Timeframe begins when a valid file is received by CGI	5%
Enrollment	ID Cards	Monthly	CGI will mail ID cards within five (5) days of completing an accepted enrollment.	5%

Auth	Prior Authorization file loading	Monthly	CGI will load prior authorizations into the system within one (1) Days of receipt. This 1 Day timeframe begins when a valid file is received from LAHC	10%
System	CGI System Availability	Monthly	CGI system will be available 99.75% of scheduled uptime for LAHC users	5%
Premium Billing	Premium Billing Accuracy	Monthly	97% of the Members' premium bills will be financially accurate.	5%

In addition, CGI agrees to add extra weighting to two of the above SLAs that measure claim accuracy and timeliness. **(Clean Claim Processing Timeliness and Claims Processing Accuracy - Financial)**

- CGI will allow 125% of the maximum weighting value on these two SLAs.
- If CGI misses either of these SLAs in two consecutive months, the weighting factor will be increased by 150% and the maximum cap is also increased by 150%.
- At the end of each calendar year LAHC may re-assign one or both of these extra weighting factors from the two service levels described above to a different service level.

The Service Level Credit will be calculated as follows:

- Service Level Credit = A times B times C
    - A is the Monthly Fee or PMPM charge billed for the month in Section 2 of this Exhibit 1
    - B is ten percent (10%) (amount at risk)
    - C is the Service Level Credit percentage for the Service Level(s) missed for the month (if any).

Example: If the total Monthly Fees in Section 2 of this Exhibit 1 are $100,000.00, then A = $100,000; B = $10,000 and C = 5% for System availability for a resulting Service Level Credit of $500.00.

7. Payment Terms. Service Fees may be invoiced on the first (1st) Day of the month for the prior month's Delegated Functions. The invoice shall be accompanied by the Service Level summary report to allow LAHC to determine and verify Service Level Credit status. LAHC will have Access to the data and report details for further review as necessary.

All fees and expenses are to be paid to CGI in United States Dollars, by electronic funds transfer to an account designated by CGI or by check sent to Bank of America, c/o CGI Technologies and Solutions Inc. at 12907 Collections Center Drive, Chicago, IL 60693. CGI's invoices are due and payable in full within thirty (30) days from the date of the invoice. If LAHC withholds any invoiced amount which it disputes in good faith, LAHC must pay all undisputed amounts on the invoice within the agreed payment period and promptly notify CGI of the specific amount in dispute and the reasons why it disputes the amounts. CGI and LAHC will work together in good faith to resolve any timely disputed amount in a prompt and mutually acceptable manner. If a disputed amount is not resolved within thirty (30) days after the original payment due date receipt, the parties will resolve such dispute as provided in Article 7. LAHC will pay any disputed amounts within five (5) days after the dispute has been resolved. Disputes with respect to invoiced amounts will be waived unless the invoiced amounts are either paid or the

disputes are raised in writing as provided in this Section. If LAHC withholds payment of any amount due under an invoice without following the procedures set forth above, or if LAHC withholds all payment for two months or more, CGI may suspend performance. CGI will provide LAHC with fifteen (15) days prior written notice before suspending performance. CGI will resume performance within a reasonable period of time after the payment dispute is resolved.

Late Payment Interest. If LAHC does not pay an invoice when due, CGI may add an interest charge of one and one-half percent (1 1/2%) per month, or the maximum rate allowed by law if less; this interest will begin to accrue on the day after the payment due date and will accumulate on the outstanding balance on a daily basis until paid in full.

EXHIBIT 2
Claims Administration Services

CGI shall perform the Claims Delegated Function in accordance with Agreement and the terms of this Exhibit 2.

1. CGI Obligations.

1.1 Financial Guaranty. CGI shall provide any financial guarantee required to obtain certification as a Third Party Administrator.

1.2 Claim Payment. CGI shall accurately process and pay claims, as applicable, for Covered Services provided to Members by Participating Providers according to the payment terms (timeliness requirements and rates) in the Participating Provider Agreements. CGI shall process and pay claims for Covered Services provided to Members by Providers *other than* Participating Providers in accordance with the non-Participating Provider Payment Rates.

1.3 Claim Adjudication. CGI shall develop a method that must be approved in advance by LAHC and in accordance with Applicable Law for:

1.3.1 Determining Covered Services, paying claims, and tracking utilization for LAHC's Benefit Plans;

1.3.2 Identifying and processing clean and unclean claims (as those terms are defined in Applicable Law), and timely redirecting misdirected claims, if any, to the applicable payor; and drafting payment for clean claims, consistent with Applicable Law.

1.3.3 Collecting and submitting to LAHC all encounter data in the format agreed between the Parties (including data from claims processed by and/or redirected to and/or processed by CGI) for Providers as required by Applicable Regulatory Agencies and/or Accreditation Agencies pertaining to Covered Services;

1.3.4 Transmitting denial notifications to Members and Providers, explanations of benefits to Members, and explanations of payments to Providers in such formats and with such frequency as mutually agreed to in writing by the Parties;

1.3.5 Transmitting initial authorizations and denial notifications, including notice of appeal rights timely to Members and Providers;

1.3.6 Tracking and reporting on its performance of the Claim Administration function using agreed upon reporting formats, not limited to those metrics identified in the Service Level Credits section of Exhibit 1 of the Claims Administration function, using agreed-upon formats; and

1.3.7 Tracking, reporting, and reconciling with a Payor's records Member deductible usage and benefit accumulators.

1.4 Claim Monitoring. If any Participating Providers are paid on other than a fee-for-service basis, CGI shall assist LAHC to correct encounter under-reporting, incomplete and/or inaccurate encounter reporting by Participating Providers. CGI shall provide LAHC with documentation of results of monitoring activities and all corrective actions taken to address such under-reporting incomplete and/or inaccurate encounter reporting.

1.5 Submission of Claims. CGI shall establish a mailing address for providers to submit claims directly to the delegated entity for covered services and communicate this address to participating providers. CGI shall also communicate to Participating Providers that claims for Covered Services provided to Members are required to be submitted directly to CGI. CGI shall provide LAHC with a monthly management report regarding misdirected claims and documenting its process for identifying misdirected claims.

1.6 Interest on Late Paid Claims. If CGI fails to pay claims within time frames required by Applicable Law, CGI shall be responsible for paying any required interest penalty to Providers. However, to the extent that such interest penalty is due, in whole or in part, to the actions or failure to act of LAHC or a Payor (including failure to timely fund claims), then as between CGI and LAHC, LAHC shall be responsible for paying that portion of the interest penalty.

1.7 Claims Administration Performance Standards. In addition to the requirements in the Agreement, CGI shall meet the performance standards in Exhibit 1. CGI shall comply with all Applicable Law and Accreditation Organization requirements to which LAHC is subject with respect to any denial or appeal of claim payment in all communications made to Members, and use only language that has been reviewed and approved by LAHC.

1.8 Fraud, Waste & Abuse and Coordination of Benefits. CGI shall cooperate with LAHC's program to detect patterns and practices indicating fraud, waste and abuse and shall capture coordination of benefits information and report it to LAHC in a mutually agreed-upon format.

2. Current Coding. CGI's claims processes shall be compliant with the most current versions of the American Medical Association's Current Procedural Terminology ("CPT") codes the Healthcare Common Procedure Coding System ("HCPCS") code sets, the International Classification of Diseases, 9th edition or 10th edition, when effective("ICD9" or "ICD10") code sets, Centers for Medicare & Medicaid Services ("CMS") guidelines and national coverage determinations and the CMS Correct Coding Initiative ("NCCI").

3. LAHC Obligations

3.1. If LAHC receives claims from Participating Providers for services to Members, LAHC shall timely transmit them to CGI for processing and payment. LAHC and CGI shall create a management report regarding misdirected claims, document the process to identify misdirected claims, and shall provide said report to CGI monthly and work cooperatively with CGI to minimize incorrect claim submissions.

3.2. LAHC shall provide CGI with Access to the payment provisions of LAHC contracts with Participating Providers and other provisions necessary to ensure CGI's compliance with all legal, regulatory, and contractual requirements, which shall be considered Confidential Information in accordance with Section 3.17 of the Agreement.

3.3. LAHC shall provide CGI with information on Member eligibility, including changes to Member eligibility, through its Member Services Center and will provide information on Member eligibility changes from internal electronic sources (website, brokers, etc.) when received..

3.4. Claims Data. CGI shall transfer "claims paid" data and reports for claims paid for Covered Services to Members by Providers occurring in the previous week to LAHC by the Tuesday of each week, or other mutually agreed date. Such claim data shall be in a mutually agreed upon format and shall include, but not be limited to, claims received, ratio of clean to non-clean claims, claims adjusted, claims paid, claims denied, claims suspended, errant claims submissions, interest owed, claims paid to non-Participating Providers, and average time between receipt and adjudication of clean and non-clean claims. Within ten (10) Days of receipt of a transmission from LAHC of claims for services to Members which were incorrectly submitted, CGI shall provide LAHC with a confirming list acknowledging receipt and processing of all such claims.

3.5. Encounter Data. On request, CGI shall transfer encounter data and reports for encounter activity to LAHC according to mutually agreed schedules and formats.

3.6. Aged Claim Reports. CGI shall, by the fifteenth (15th) Day of each month for monthly reports and within ten (10) Days following the end of each quarter, transmit to LAHC aged claim reports that detail at a minimum the following data: the number of claims received, processed, approved, denied, or pending, as well as the average time for processing claims (*i.e.*, number and percent of claims processed and paid or unprocessed within 30, 60, 90, 120 and 120+ Days.

3.7. Benefit and Deductible and Out-of-Pocket Accumulators. On request, CGI shall cooperate with LAHC efforts to determine and track historical accumulator information. CGI shall track accumulator data associated with Members, which information shall be shared between LAHC and CGI on a mutually agreed upon schedule and format.

3.8. Maintenance of Information on Member Eligibility, Covered Services, Provider Participation. CGI shall receive, retain, and apply weekly reports updating Member eligibility for Covered Services as well as changes to the Covered Services and Participating Providers, and shall integrate this information into its claims processing function.

3.9. Payor Fund Files. The Parties shall agree to establish an Account at a mutually agreed upon financial institution. The Parties further agree to establish mutually agreed upon payment terms, timelines, and procedures to meet all prompt payment requirements and other related Applicable Laws. CGI shall maintain information on the balances in Payor funding files by Payor name, and shall communicate daily funding requirements, fund balances, fund expenditures, etc., to LAHC as requested. CGI shall notify LAHC's CFO of any Payor's failure to adequately and timely fund claims. LAHC shall have Remote Access to CGI Payor Fund Files. On request, at any time LAHC administers Administrative Service Only ("ASO") Benefit Plans for other payors, the Parties shall agree to establish the respective Account, payment terms, timelines, and procedures to meet all prompt payment requirements and other related Applicable Laws. The Parties, and any prospective ASO Client representative, shall meet to finalize the operational flow of funding for the ASO payor to the applicable account in order to ensure timely payment.

LAHC shall maintain information on the balances in the ASO Payor funding files by ASO Payor name, and work with the ASO Payor to ensure all daily funding requirements, fund balances, fund expenditures. etc. are adequate for ongoing operations. LAHC and ASO Payor shall also ensure that CGI will be provided Remote View Access to ASO Payor Fund File Accounts as needed. CGI shall notify LAHC's CFO of any ASO Payor's failure to adequately and timely fund claims.

3.10. Ad Hoc Reporting. CGI agrees to provide up to 500 hours annually of additional ad hoc reporting as reasonably requested by LAHC in order to complete oversight of claims processing and/or denial activity and any other reporting required by CMS, or another Applicable Regulatory Agency or body or to meet Accreditation Agency standards.

3.11. Capturing Payor Override Information. On request, CGI shall have a system for capturing information concerning all claims paid by a Payor, which system shall, at a minimum, deduct the amount paid from the proper account, report on the level, amount, and type of Payor claim payments, as well ensure that the data is included appropriately in its cumulative utilization and claim payment statistics.

4. Payor Payments. CGI acknowledges that LAHC and any payor for whom LAHC is providing administrative services retains the right and final authority to pay any claim for their respective Members, regardless of the delegation of such claim adjudication function to CGI. CGI shall pay such claim upon notice.

5. EOBs, Notices of Appeal Rights. CGI shall ensure that each paid claim is accompanied by the appropriate notice, containing all information required by Applicable Law and Accreditation Agency standards and guidelines, including a description of the applicable appeal process, availability of external review, and the correct addresses for notifying state insurance department contacts and federal Department of Labor contacts and other contacts, as applicable.

6. Handling of Appeals. CGI acknowledges that appeals by Members or others, including Providers acting as a Member's authorized representative (collectively referred to hereinafter as the "Claimant") relating to an organization determination must be directed to LAHC or its designee as soon as reasonably possible for processing. CGI acknowledges that expedited appeals must be processed within 48 hours or as soon as the Member's condition requires. Upon receipt of a Member appeal, CGI shall, as required to meet the expedited time frame, provide LAHC with all records regarding such appeal and all necessary information required to process such appeal including, without limitation, any supporting documentation, such as review by persons of the same medical specialty as the physician ordering the care. For urgent appeals, this information shall be transmitted to LAHC or its designee no later than twelve (12) hours following receipt of the information reasonably indicating that an appealable dispute exists. For standard appeals, this information shall be transmitted to LAHC or its designee no later than one Day following receipt of the information reasonably indicating that an appealable dispute exists. LAHC shall inform CGI of the outcome of the appeal within one Day of the rendering of a decision. CGI shall comply with any full or partial reversal of payment above, or by an external appeals agency.

EXHIBIT 3
CGI Information Technology Security Plan

To be supplied by CGI by May 31, 2013

EXHIBIT 4
CGI Business Continuity Plan
To be supplied by CGI by May 31, 2013

EXHIBIT 5
Business Associate Agreement

EXHIBIT 6
Enrollment Services

CGI shall provide enrollment services in accordance with the Agreement and this Exhibit 6. CGI will process and maintain enrollment and eligibility information of Members and ensure the completeness of the enrollment information.

CGI is responsible for verifying the eligibility of Members for benefits under the Plan based on the information provided by the employer units, Members and LAHC.

CGI will receive and process enrollment data in both hard copy and electronic format from multiple sources:

- State Health Insurance Exchange (if applicable)
- Federal Health Insurance Exchange
- Third Party Exchanges
- LAHC website
- Paper

CGI will collect and maintain HIPAA compliant and demographic information on each Member within the eligibility system.

CGI will provide electronic scanning, storage, and retrieval for health enrollment forms submitted for initial enrollment and enrollment/status changes.

CGI is responsible for providing full administration of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

CGI agrees to provide any eligibility data to state or federal insurance exchanges as required.

CGI agrees to provide eligibility data to third party entities as required by LAHC.

CGI will load enrollment/eligibility records from the state or federal Health Insurance Exchange (HIX), cooperative website, third party "private" exchanges, or paper submissions that are verified as complete into the claim system within one (1) Day of receipt.

Enrollment Performance Standards. In addition to the requirements in the Agreement, CGI shall meet the performance standards in Exhibit 1. CGI shall comply with all Applicable Law and Accreditation Organization requirements to which LAHC is subject.

EXHIBIT 7

Printing, Fulfillment, and Ancillary Services

CGI shall provide printing, fulfillment, and ancillary services in accordance with the Agreement and this Exhibit 7. CGI is responsible for assisting in the design of, as well as printing and distribution of, customized brochures, forms, and other Member/provider material with LAHC's approval, as necessary and required to install and administer the services to Members, employer units, and LAHC. CGI shall seek written approval for all Member fulfillment activities, including, but not limited to: quality, stock replenishment, and order size via a detailed project plan established in cooperation with LAHC designee(s). Examples of these Member materials are, but not limited to:

- ID Card
- Welcome Kits
- Provider Directories
- Explanation of Benefits (EOB)
- Explanation of Payment (EOP)
- Billing Statements
- Surveys
- Delinquent and termination notifications
- Informational Letters
- Benefit Summaries
- Provider Manuals (upon request)
- Ballots, Annual meeting materials

CGI is responsible for producing and mailing Member ID cards, and mailing ID cards to the Member's home address within five Days under the following circumstances:

- Initial enrollment of the Plan
- New hires of Group employees
- Enrollees who change coverage category (e.g. single to family)
- Replacement of lost cards
- Upon request of a Member

CGI will conduct at least one (1) Member satisfaction survey annually. The format and process for conducting the survey must be presented to and approved by LAHC prior to conducting the survey.

Printing, Fulfillment, and Ancillary Services Performance Standards. In addition to the requirements in the Agreement, CGI shall meet the performance standards in Exhibit 1. CGI shall comply with all Applicable Law and Accreditation Organization requirements to which LAHC is subject with respect to the services provided in this Exhibit 7.

EXHIBIT 8
Software Configuration and IT Related Services

CGI shall provide software configuration and IT related services in accordance with the Agreement and this Exhibit 8. CGI will be responsible for the setup, configuration, and administration of all functions of the Healthation software system with LAHC approval.

Appropriate setup and configuration of the software is expected in order to allow the following business functions to be effectively performed:

- Enrollment census management
- Online consolidated invoicing
- Collections
- Agent management and agent commission accounting
- Open enrollment & renewal processing
- Edi (electronic data interchange) for claims, enrollment and other file transfers
- Eligibility file transfer to claims administrator and other vendor and service providers
- Claim processing and auto-adjudication.
- Inbound/outbound transactions and interfaces from state or federal insurance exchanges
- Cobra administration and processing (generation of letters, invoices, etc.)
- Role based security
- Provide information to call center for billing and commissions questions and support
- Provide information to call center to support enrollment/eligibility/claim questions
- Monthly invoice distribution services
- Late notice and termination notice distribution services
- Premium collection and cash processing
- Premium and other fee remittance to all parties
- Reconciliation of commissions and other payments with third parties
- Reconciliation of eligibility with other carriers
- Report generation
- LAHC Access to data

CGI will provide the reporting referenced in the Healthation Core Administrative System Catalog of Reports to LAHC and access to the Healthation Data Warehouse utilizing Microsoft SQL Reporting Services (SSRS), Microsoft SQL Analysis Services (SSAS), and Analyzer™ by Strategy Companion for use by LAHC for development/support of custom or ad-hoc reporting.

CGI will provide a secure provider service website where routine provider service inquiries can be handled. Information available through this website must include, but is not limited to, eligibility and benefits information, deductible accumulation, claim status, and on-line viewing of provider vouchers or payments.

CGI will provide a secure Member website/portal allowing Access to information such as benefit review, plan summary, out-of-pocket and deductible balances, and claims activity

CGI will assure that System availability and business continuity is a priority for the delegated services. System availability must meet at least 99.75% availability during a calendar month and all cause of outage incidents must be reported to LAHC. CGI shall propose a plan to LAHC outlining its strategies and approaches for implementation of Disaster Recovery and Business Continuity for LAHC. CGI should outline the merits of that strategy including tradeoffs that apply to an appropriate balance between

operational efficiency, and risk mitigation. Production infrastructure shall be architected for recovery to an alternate site. In the event of a disaster to the primary physical hosting site, CGI shall have the ability to recover and be fully operational in an alternate site. CGI will assure that LAHC shall not be subject to loss of data. System backup schedules and recovery standards and timeframes shall be defined in the CGI business continuity plan. However the system must, at a minimum, provide for full daily backups and regularly scheduled incremental backups. The Recovery Point Objective (RPO) shall not be greater than 12 hours and the Recovery Time Objective (RTO) shall not be greater than 24 hours.

CGI's Business Continuity / Disaster Recovery Plan shall address how CGI shall safely recover LAHC information or data in the event of a disaster without compromising the integrity of any required or dependent synchronizations between dependent systems. CGI shall submit the Disaster Recovery Plan to LAHC at the agreed upon time and prior to the implementation of any disaster recovery site.

CGI shall notify LAHC 48 hours in advance for scheduled outages unless otherwise agreed upon in a given instance.

All web portals, IVRs, and call centers shall comply with Applicable Laws, including NCQA standards.

CGI will provide training to LAHC employees on the chosen software platform.

CGI/Healthation system will support the integration of, and data exchanges with, LAHC and/or any party vendors that LAHC has retained to provide services on behalf of LAHC. (i.e. a pharmacy benefits manager or medical management vendor). Any new integrations after initial implementation, as defined in a mutually agreed-upon detailed implementation plan as specified in Section 3.5.2, will be addressed via the change control process and for ongoing standard maintenance as needed. These information exchanges can be performed via:

- Web services
- HIPAA Transactions
- Custom Extracts or API's

CGI/Healthation system will comply with Exhibit 3.

Software Configuration and IT Related Services Performance Standards. In addition to the requirements in the Agreement, CGI shall meet the performance standards in Exhibit 1. CGI shall comply with all Applicable Law and Accreditation Organization requirements to which LAHC is subject with respect to the services provided in this Exhibit 8.

Ad Hoc Reporting. CGI agrees to provide up to 500 hours annually of additional ad hoc reporting as reasonably requested by LAHC.

CGI will provide LAHC information on the platform and access to the reporting infrastructure for LAHC technical staff to have the ability to run reports specific to LAHC data.

EXHIBIT 9
Premium Billing and Collection Services

CGI shall provide premium billing services in accordance with the Agreement and this Exhibit 9. CGI will provide and maintain a premium billing and accounts receivable system which is capable of producing monthly statements, tracking account balances, receiving payments, and documenting payment histories for insurance premiums for both group and individual plans.

The billing and receivable system will manage insurance premium reporting and collection for the Plan and be capable of pro-rating monthly premium contributions based on the Member's eligibility date.

CGI shall direct the initial Member enrollee premium contributions to a lockbox account specifically established for premium collections in accordance with policies and procedures as mutually agreed upon by the Parties. LAHC acknowledges that it has authorized the use of the designated bank lockbox account for the primary purpose of safely and securely receiving premiums and transferring those funds daily to the designated LAHC account(s). CGI will maintain a system to track, report, and reconcile all related lockbox financial transactions.

CGI shall establish a premium billing procedure for the accurate invoicing and collection of premiums, on a monthly, quarterly, semi-annual, or annual cycle as appropriate from persons who receive health coverage through LAHC, in accordance with the relevant policies established and regulations promulgated and provided by the LAHC to CGI in writing. CGI shall establish appropriate accounting controls, policies, and procedures to account for premiums and fees collected on LAHC's behalf and amounts owed to LAHC by such persons who receive health coverage through LAHC.

CGI shall report to LAHC, on a monthly basis, the amounts billed to each eligible Member. CGI shall adjust premium rates due to change in attained age, address, level of coverage, mode of payment, employer/employee premium contribution requirements, rate guarantee period, and duration and/or number of insured lives in accordance with LAHC's table of rates.

The billing statements will be based on the employer/employee premium contribution requirements as authorized by LAHC.

Employer Premium billings may include three sections:

- Employer unit billing statement that includes remittance information and a summary of the unit's current amount due and any past due amount,
- Premium billing section that includes a current list of employees participating in the unit, the last 4 digits of the participant's Social Security numbers, payroll locations (if used by the relevant unit), life face value and premium amount, health premium, and the total premium for each employee, and
- Past due detail analysis section that lists information regarding any past due amounts.

Individual market premium billings may include three sections:

- Billing statement with remittance information and a summary of the current amount due and any past due amount,
- Premium billing section that includes a current list of participating dependents, the last 4 digits of all participants' Social Security numbers, and health premium, and
- Past due detail analysis section that lists information regarding any past due amounts.

In addition to paper billings, CGI will produce an electronic billing file containing all employer unit statements and provide these to LAHC. CGI shall have the capability to accept credit card payments from Members and to comply with all Applicable Laws regarding such types of premium bills. CGI will pursue maximizing the Member's payment via credit card, ACH, or EFT remittance processes. LAHC will draft appropriate Member communications for those paying by check to encourage automatic payment methods. CGI will ensure that these communications are delivered as part of the Members' premium bills.

Each check received by CGI shall be logged in the mailroom. CGI shall secure live checks in a deposit safe immediately to be forwarded to the lock box.

CGI shall implement security controls requiring the presence of two authorized staff to retrieve live checks from the deposit safe and total the day's deposit, and shall deposit the initial Member premium contributions in an account specifically established for premium collections in accordance with policies and procedures approved by LAHC. CGI shall deposit checks on the same day as they are received. CGI will maintain a system to track and report all financial transactions, which system shall be subject to the approval of the Client Group.

At least daily, CGI shall reconcile all checks which have been submitted to CGI for reconciliation in the format agreed upon by CGI and LAHC. In the event that LAHC exercises its option to cease using CGI for the aforementioned purposes, any new method of reconciliation of checks that LAHC uses must permit CGI to execute timely processing of applications, premium credits, and claims payments, and ensure appropriate fraud controls are in place.

In the event that an applicant remits a partial premium payment for the initial policy period, CGI shall notify the applicant of the underpayment and request payment of the balance owed as soon as possible, but no longer than the earlier of ten (10) calendar days following receipt or five (5) days before the effective date of coverage. In the event the balance due is not received within 30 calendar days, CGI will refund the partial payment to the applicant with an appropriate explanation that the application was rejected for failure to remit the premium in full. For initial and recurring premiums, CGI shall administer premiums in accordance with LAHC's tolerance levels for specific products ("tolerance level" being defined as the maximum difference between the amount billed and the amount received from an insured for which LAHC will accept such payment).

CGI shall provide up to one invoice, two late notices, and one phone call regarding premiums not received by the due date and in accordance with the relevant policies established and regulations promulgated and provided by LAHC to CGI in writing. Premiums not received by the premium due date shall result in termination of LAHC coverage effective the date through which coverage has been paid, subject to the grace period contained in the relevant policies established and regulations promulgated and provided by LAHC to CGI in writing. Notwithstanding the foregoing provisions of this paragraph, LAHC may amend this section with notice to CGI as needed to comply with Health Insurance Exchange systems.

CGI shall suspend any claims received during the grace period if the date of service is within the grace period.

In the event of a premium rate change, CGI shall provide the systems and processes necessary to appropriately update and bill at the new rate, including any retroactive adjustments that may be required.

CGI shall defer any dispute over the underwriting, rate-setting, or premium determination process to LAHC in accordance with the policy and procedure agreed upon by CGI and LAHC.

CGI will provide daily, weekly, and monthly reports to LAHC, in a form and with a level of detail reasonably satisfactory to the Client Group, showing premium billing and collection activity regarding number of certificates billed and premium amounts billed, premium amounts collected, premium amounts due, premium amounts earned, premium amounts not collected, policies terminated for non-payment of premiums, and policy reinstatements.

CGI shall obtain LAHC approval on all materials, forms, or form letters used in the premium billing process prior to use.

CGI shall be responsible for reinstating and collecting premium for policies that have been cancelled but for which LAHC has made the decision to reinstate such policies. LAHC is solely responsible for any reinstatement decision and for determining any rates or premiums associated with such reinstatement.

CGI shall enter into its system the rates provided by LAHC. The rates will be loaded, tested, and ready for production based on the schedule and timeframes provided by LAHC. CGI will provide appropriate documentation to LAHC to verify and approve correctness of all rate updates.

CGI is responsible for determining the appropriateness and plan compliance of adjustments made by employer units based on eligibility listings and reconcile the accounts receivable each month based on premium payments and additions, terminations, and changes submitted by employer units.

CGI is required to maintain adequate personnel for purposes of maintaining eligibility and premium billing/reconciliation functions.

CGI will perform any required tasks that require interface with the Exchange on transferring/interfacing COBRA participants to exchange health plans.

Monthly Premium Billing bills will be sent by the Day specified in the billing policies.

Premium Billing Services Performance Standards. In addition to the requirements in the Agreement, CGI shall meet the performance standards in Exhibit 1. CGI shall comply with all Applicable Law and Accreditation Organization requirements to which LAHC is subject with respect to the services provided in this Exhibit 9.

EXHIBIT 10

Member and Provider Support Services

CGI Obligations. CGI shall provide Member and Provider Services in accordance with the Agreement and the terms of this Exhibit 10. For purposes of this Exhibit 10, Member services and provider services shall be referred to collectively as "Member Services".

1.1 Communication and Staffing Standards. CGI shall provide a LAHC - specific toll free telephone line and dedicated Member Service staff to service LAHC Members and Providers. At the termination of the Agreement, CGI shall assign or allow the transfer of the toll – free line to LAHC at cost. Member Services Staff will address and respond to inquiries whether made by telephone, fax, electronic mail, or entry into the LAHC web site. Member Services Staff will provide sufficient dedicated staffing to satisfy the following call standards:

1.1.1 Member Services Staff will perform, monitor, and respond to Member calls between 8:00 am and 6:00 pm Eastern Time Monday through Friday and Saturday 8:00 am to 1:00 pm.

1.1.2 Member Services shall be prepared to meet the services standards in this Appendix for non-English speaking Members and Members with hearing impairments or visual impairments.

1.1.3 CGI shall protect LAHC's competitive interests by having Member Services staff identify each Member calling as a Member enrolled through LAHC and ensuring that CGI staff performing the Member Services function are not performing such function for a competitor of LAHC;

1.1.4 Private Labeling of CGI Services. When answering the telephone, the Provider Services staff shall identify themselves as agents of LAHC or use such other identification as LAHC and the Payor require.

1.2 Training Criteria.

1.2.1 CGI will develop and implement policies, procedures, and training materials for performing Member Services which are (i) compatible with LAHC policy, procedure, and performance standards, (ii) in compliance with Applicable Law, and (iii) in compliance with Accreditation Agency standards. No substantive modifications can be made to Member Services policies applicable to LAHC without thirty (30) Days prior written notice to, and consent from, LAHC;

1.2.2 Member services staff shall participate in training sessions (including required fraud, waste, and abuse training), call coaching sessions initiated by LAHC with the intent of measuring staff courteousness, benefit knowledge and administrative capabilities, and such other training as is required by LAHC or a Payor;

1.2.3 Member Services staff will be trained regarding LAHC policies and Benefit Plans and be available to respond to Member inquiries;

1.2.4 Member Services staff shall be trained to identify complaints, grievances, and coverage appeals, including for service denials or reductions or terminations of service, and to promptly forward them to the appropriate Party for resolution.

- Non expedited grievances and appeals shall be forwarded to the appropriate Party for resolution within one Day.
- Expedited grievances and appeals shall be forwarded to the appropriate Party for resolution within the lesser of: two hours or before the close of business on the Day of receipt.
- Member Services shall forward complaints and grievances not related to Covered Services or CGI to the appropriate department within LAHC or the appropriate vendor or service provider (i.e., PBM);

- Develop a system for identifying, logging, and following up on calls indicating urgent situations, including appeals, quality concerns, improper care, health care fraud, or other matters requiring follow up and the process for promptly notifying the appropriate Party to address these concerns.
- Respond to questions from Members about Member elections and governance and preferences for online or mail ballot, and forward this voting information to the appropriate vendor or department.

1.3 Record Keeping and Retention. CGI shall retain records of Member Services date and time of every inquiry, complaint, appeal, or grievance and shall document the nature of the communication, the nature of the issue, Member Service staff personnel's response, Member Service staff personnel identity, timeliness of response, and such other information as LAHC or an Applicable Regulatory Agency shall request. When the call is made by or on behalf of a Provider, Member Services Staff shall maintain records as described above, including a database on each LAHC Provider and Provider, generally. CGI shall record 100% of the Member Services calls and shall provide LAHC with Remote Access to 100% of the recordings pertaining to its Members and Providers.

1.4 Resolution Standards. Inquiries and issues will meet the following standards:

1.4.1 Member Services shall have real time Access to claim payment information and shall have the capability of responding to Provider inquiries regarding claim status.

1.4.2 Member Services shall have real time Access to medical management information and shall have the capability of responding to inquiries regarding the status of any request for coverage.

1.4.3 Member Services shall have Access to an up-to-date database of LAHC Providers for responding to Member and Provider questions.

1.5 Cooperation with Monitoring. CGI shall cooperate with LAHC's efforts to monitor CGI's performance of Member Services to ensure such performance is carried out in accordance with the Agreement and these performance standards, including but not limited to, providing LAHC with such Access as cooperation with LAHC's on-site audits, LAHC monitoring of Member calls, sharing logs of Member calls, and such other audits as LAHC deems necessary.

1.6 Performance Reporting. CGI shall provide LAHC, and Applicable Regulatory Agencies in conjunction with their regulation of LAHC, information related to CGI's performance of Member Services and Access to related books, logs, and records (including but not limited to, Access during the audits) as required to monitor CGI's performance of Member Services. Any expense to CGI from complying with the requirements to share information with LAHC or Applicable Regulatory Agencies shall be borne exclusively by CGI.

1.7 CGI Quality Improvement. CGI shall demonstrate that the Member Services function is incorporated into the QI function in a manner that will effectively monitor CGI's achievement of its quality goals, and notify LAHC immediately of quality issues identified by CGI.

1.8 Change in Capabilities. CGI shall notify LAHC of any change in its ability to satisfy any of the conditions described in this Exhibit 11.

2 Coverage Appeals. CGI understands that all appeals by Members or such Member's designee, which designee may be a Provider ("Member Appeals") must be directed to LAHC or its designee as soon as reasonably possible for processing, and acknowledges that some Member Appeals must be processed within 24 hours if they are deemed to be "expedited," pursuant to Applicable Law.

Therefore, upon receipt of a Member Appeal, CGI shall, as required to meet the 24 hour time frame, provide LAHC with all records regarding such appeal and all necessary information required to process such appeal, including without limitation, any supporting documentation, such as review by persons of the same medical specialty as the physician ordering the care. In the case of an expedited appeal, CGI shall provide such documentation as necessary to meet time frames for expedited appeals. LAHC shall inform CGI of the outcome of the appeal within one Day of the rendering of a decision. CGI shall comply with any full or partial reversal of payment above or by an external appeals agency.

2.1 LAHC shall promptly share with CGI all information regarding Member Appeals.

2.2 If a Member indicates an intent to appeal or a submit a grievance to CGI or a member of its staff, CGI shall have procedures for promptly directing such Member to LAHC.

3 Performance Measurement and Reporting. CGI shall provide LAHC with a weekly performance report of its Member Services performance pertaining to LAHC. CGI shall provide, along with the weekly performance report and as reasonably requested by LAHC and designee(s), all adequate data/metrics on all aspects of Member Service functions, understanding that only those functions listed in Exhibit 1 will be subject to Service Level Credit review. CGI's Member Services function shall satisfy the quality indicators in Exhibit 1. In addition, 90% of survey respondents should indicate they are satisfied or very satisfied with Member services as determined through LAHC Member and Provider satisfaction surveys.

EXHIBIT 11
Participants In Client Group

1) Louisiana Health Cooperative, Inc.
2) Kentucky Health Cooperative, Inc.

EXHIBIT 12
Project Implementation Plan

(Added within 90 days of agreement execution)

Management and Development Agreement

By and between Beam Partners LLC

And the

Louisiana Health Cooperative, Inc.

This Management and Development Agreement ("Agreement") is made as of the Effective Date, by and between Beam Partners LLC, a Georgia Limited Liability Company, having its principal office at 2451 Cumberland Parkway, Suite 3170, Atlanta, GA 30339 ("Developer") and the Louisiana Health Cooperative, Inc., a Louisiana nonprofit corporation located at 3445 North Causeway Blvd, Suite 301A, Metairie, LA 70002 (the "Cooperative").

Recitals

WHEREAS, the Cooperative has been organized to operate as a qualified nonprofit health insurance issuer within the meaning of Section 1322(c)(1) of the Affordable Care Act (Pub. L. 111-148) (the "CO-OP Program"), offering health insurance plans that assist providers to deliver high quality health care to citizens of the State of Louisiana; and

WHEREAS, the Cooperative has had adequate opportunity to observe the services previously provided by Developer and found them to be satisfactory; and

WHEREAS, the Cooperative approves of all activities taken on its behalf to date, including those taken by the Developer; and

WHEREAS, Developer is willing to provide or cause to be provided certain services to the Cooperative as described below and in accordance with the terms set forth below;

NOW, THEREFORE, in consideration of the mutual promises and covenants hereinafter set forth, it is hereby agreed as follows:

Article 1. Definitions

1.1 Applicable Law

All federal or state laws, rules, regulations, and administrative agency directives, such as Louisiana Department of Insurance or the federal Department of Health and Human Services ("HHS") Consumer Operated and Oriented Plan ("CO-OP") program requirements for loan recipients, including sub-regulatory standards such as instructions or guidelines that govern or regulate the actions of the Cooperative or Developer, as applicable.

1.2 Applicable Regulatory Agency.

Any federal agency or agency of the State of Louisiana to the extent that it has jurisdiction or authority over the parties to this Agreement or its subject matter, including but not limited to HHS and the Louisiana Department of Insurance.

1.3 Developer Affiliate

Any person or business entity that is employed by or contracts with Developer to provide services to Developer clients, including professional corporations and "S" Corporations.

EXHIBIT
F

1.4 Effective Date

The date this Agreement becomes effective as indicated on the signature page below.

1.5 Management and Support Services

Those services described in Section 2.1, to be supplied by the Developer and Developer Affiliates in accordance with this Agreement. The Management and Support Services shall also be referred to as the "Services."

1.6 Performance Period

The period of HHS oversight under the CO-OP Program which includes the period during which any CO-OP Program loan is outstanding plus ten (10) years.

Article 2. Description of the Management and Support Services

2.1 Types of Services

For the term of this Agreement, Developer shall make available to the Cooperative the services ("Services") identified on Exhibit 1 as the Cooperative may from time to time request. As the Cooperative's business needs change, the Cooperative and Developer shall revise the description of Services in Exhibit 1 in the manner described in Section 10.4. Administrative Services shall support the day-to-day operation of the Cooperative's business.

2.2 Personnel

Developer shall make available to the Cooperative the Services described in Exhibit 1. Developer shall assign its staff or Developer Affiliates to the Cooperative to provide such Services, and to report as appropriate directly to the Chair of the Board or President and CEO of the Cooperative or his designee, including the appropriate department head of the Cooperative, and to carry out the Cooperative's reasonable and lawful orders in connection with the furnishing of such Services. Developer Affiliates may be assigned on a part or full time basis and shall be compensated by, and shall remain as employees or consultants of Developer. Developer shall ensure that it has appropriate contracts, including confidentiality agreements and business associate agreements, with all Developer Affiliates.

2.2.1 In accordance with Section 10.4, Developer has supplied the Cooperative with a list of Developer Affiliates attached to this Agreement as Exhibit 5, as may be updated from time to time by Developer. The Cooperative may review the credentials of any proposed Developer Affiliate and his or her specific qualifications to perform the Services. The Cooperative may request that a specific Developer Affiliate discontinue services under this Agreement by providing written notice to Developer.

2.2.2 Developer warrants that its arrangements with Developer Affiliates entitle it to bill for, and receive payment for Services provided by such Developer Affiliates under this Agreement. Developer acknowledges that neither Developer nor Developer Affiliates are entitled to any employment-related benefits from the Cooperative. Without limiting the generality of the prior sentence, Developer agrees that neither Developer nor Developer Affiliates are entitled to medical, dental, health, pension or retirement, workers compensation or severance benefits from the Cooperative.

2.3 Requests for and Timing of Services

The Services shall be made available to the Cooperative in accordance with requests made by the Cooperative and shall be performed by Developer Affiliates in a reasonably prompt manner subject to the requirements of Applicable Law and Applicable Regulatory Agencies, the availability of personnel and the level of tasks generally demanded of them. The parties shall establish a project plan containing a detailed set of deliverables and due dates, attached as Exhibit 2. Time is of the essence in the performance of the Services.

2.4 Screening for Individuals Excluded from Federal Programs

Developer agrees not to employ or contract with an individual or entity that is excluded from participation in Medicare or Medicaid, or with an entity that employs or contracts with such an excluded individual or entity. Developer agrees to maintain a system of monitoring its employees and contractors to ensure compliance with this requirement.

2.5 Performance Standards for Administrative Services

Developer shall cooperate with the Cooperative to ensure that the Services performed by Developer Affiliates are in accordance with Applicable Law, consistent with the obligations of the Cooperative in its agreements to arrange for health services, including the CO-OP program, free from undue influence from pre-existing health insurance issuers and in accordance with the performance standards in Exhibit 2. The parties agree that Exhibit 2 shall be amended from time to time as the Cooperative requests specific services and the parties negotiate the performance standards applicable to each service.

Article 3. Responsibility for Oversight

The parties acknowledge that the Cooperative is overseen by and accountable to CMS as a participant in the CO-OP program and shall also be accountable to the Louisiana Department of Insurance as a licensed insurer. The Cooperative shall monitor the operational performance of all Administrative Services on an ongoing basis through regular monitoring, compliance reporting or other mutually agreed upon methods. Developer agrees to comply with the Corrective Action Procedures set forth in Article 7. The Cooperative, being at risk and having ultimate control and responsibility for the functions delegated to Developer, at all times shall have the ultimate authority with respect to all matters pertaining to the business written hereunder and to the general welfare of the Cooperative.

3.1 The Cooperative Remedy for Non-Compliance

In addition to the Cooperative's ability to request removal of an individual Developer Affiliate as described in Section 2.2, the Cooperative shall have the right to terminate this Agreement in accordance with Section 7.2, if Developer or Developer Affiliates fail to comply in a material manner with i) the Performance Standards in Exhibit 2; ii) the Standards for Arms Length Transactions in Exhibit 3; or iii) the requirements of Applicable Law.

3.2 Delegation by Developer

Developer shall not contract or subcontract responsibility for any of the Services to any entity other than an approved Developer Affiliate without first obtaining written authorization from the Cooperative, including assurances that the Cooperative has received any required regulatory approvals. If Developer contracts or subcontracts responsibility for any of the Services to other than an approved Developer Affiliate, Developer shall (i) specify that the contractor or subcontractor shall comply in a material manner with all Applicable Laws; (ii) provide for

oversight to ensure that the contractor or subcontractor complies with its obligations under the contract including exhibits, and with Applicable Law to the same extent as Developer Affiliates; (iii) ensure that the provisions of Section 2.4 apply to such contractor or subcontractor; (iv) obligate the contractor or subcontractor to maintain records and allow audits to the same extent as required by Section 3.3; and (v) provide that Developer or the Cooperative or their designees have the ability to terminate the contractor or subcontractor's responsibilities upon a determination by any of them that the Services are not being performed in accordance with this Agreement.

3.3 Record Keeping

The Cooperative shall keep records of the services provided. Developer shall keep reasonable records as evidence of the basis for its charges to the Cooperative and to document its performance of the Services, including whether and the extent to which it met the Performance Standards in Exhibit 2. Unless applicable statutes or regulations require a longer time period, Developer shall retain and maintain such records and any related contracts for the period in Section 3.4, below.

3.4 Applicable Regulatory Agency Audits and Direct Access

Developer shall allow the Cooperative access upon reasonable notice and at reasonable times to examine records related to the performance of the Services, including books, contracts, medical records, patient care documentation and other records related to the Services performed pursuant to this Agreement. Developer agrees to cooperate with any audit request by an Applicable Regulatory Agency, including allowing access by the Comptroller General and HHS, the General Accounting Office or their designees with jurisdiction over the subject of this Agreement, including permitting on site audits and providing books and records to such government agencies directly or through the Cooperative until the end of the Performance Period or, if later, from the date of completion of any audit, evaluation or inspection, unless HHS determines that there is a special need for retaining the records and gives notice at least 30 days before the normal disposition date; or if: i) the Cooperative has terminated participation in the CO-OP Program; ii) an allegation of fraud or other fault has been made involving the Developer, then for six (6) years following the final resolution of the termination, dispute, fault or fraud allegation.

3.5 Data Submission

If Developer submits data to any Applicable Regulatory Agency on behalf of the Cooperative, Developer will certify to the Cooperative regarding the accuracy, completeness, and truthfulness of the data and acknowledge that the data submitted on behalf of the Cooperative will be used for purposes of obtaining Federal reimbursement.

3.6 Obligation to Report Noncompliance

Developer shall submit a written report to the Cooperative within thirty (30) calendar days of Developer's knowledge of any and all civil judgments and other adjudicated actions or decisions against Developer related to the delivery of any healthcare item or related service (regardless of whether the civil judgment or other adjudicated action or decision is the subject of a pending appeal).

Article 4. Health Data Security and Privacy

4.1 Confidential Health Information

All health data or related information, whether stored electronically or on paper, about individuals enrolled in the Cooperative plans, prospects, members, employees, providers and others is Confidential Information and subject to the terms of this Agreement. Developer shall, and shall require all Developer Affiliates and others providing Services under this Agreement to treat all Protected Health Information as defined by the Health Insurance Portability and Accountability Act of 1996 "HIPAA") and all related provisions, standards, policies, rules and regulations, as proposed and adopted from time to time, with the same care as they protect their own confidential information and in accordance with all applicable Federal and state laws and regulations, and specifically in accordance with HIPAA.

4.2 HIPAA Compliance and Business Associate Agreement

The parties agree that to the extent that Protected Health Information is disclosed to Developer or Developer Affiliates, the receiving party will adhere to the health data and information privacy policies and standards as may be promulgated under HIPAA in final form, and as deemed to be effective and applicable, as well as with any and all applicable health data or information privacy and security standards, rules, regulations and laws of the United States or of any states where the parties conduct business, including without limitation any Cooperative privacy and security standards applicable to Developer's operations. The parties further incorporate by reference, as if fully stated herein, the Business Associate Addendum by and between the Cooperative and Developer, attached hereto as Exhibit 4 and the Data Security Addendum attached as Exhibit 7.

4.3 Return of Health Information

Consistent with the terms of the Business Associate Addendum, upon the termination of this Agreement, for whatever cause or reason, Developer shall and shall ensure that Developer personnel and contractors, promptly return to the Cooperative or its designated representative or destroy, all Protected Health Information except for programs, documents and materials confidential to Developer. The terms, provisions and representations contained in this Article shall survive the termination of this Agreement. Nothing in this Section 4.3 is intended to conflict with the recordkeeping requirements in Section 3.3.

4.4 Protection of Developer Proprietary Information

The Cooperative agrees that it will be exposed to information that is non-public, confidential and/or proprietary in nature such as financial, technical, process or other business information including processes and proprietary software that was developed by and is the pre-existing property of Developer (the "Confidential Information"). The Cooperative further acknowledges that the Confidential Information has or may have competitive value in the market. Developer desires to preserve and protect the confidential nature of the Confidential Information. The Cooperative acknowledges that disclosure of the Confidential Information would cause Developer substantial and irreparable harm. The Cooperative agrees to receive and hold all such Confidential Information in confidence, whether presented in oral, electronic or written form and to use it only for the purpose of performing the Services or evaluating the Services, irrespective of whether the information independently qualifies as entitled to legal protection. The Cooperative shall not, without the prior written consent of Developer, sell, market or disclose (directly or indirectly, in whole or in part) Confidential Information to any third person, firm, corporation, entity or association, or take any action or make any disclosure that permits any third person, firm, corporation, entity or association to use or benefit from such Confidential Information. The Cooperative further agrees to adhere to, and fully comply with, any additional

restrictions or limitations as may be specifically indicated on the disclosed documents or information, or as may be otherwise communicated in writing by Developer or its representative. Such additional restrictions or limitations, or the lack thereof, on any documents or information disclosed by Developer shall not negate in any way the general requirements of this Agreement.

Article 5. Charges for Services

5.1 Payment to Developer. As consideration for the Administrative Services to be provided under this Agreement, the Developer shall bill Cooperative, and Cooperative shall pay Developer weekly at the payment rate set forth in Exhibit 5 on or before 10 business day following receipt of each invoice.

Developer represents and warrants that Developer is an independent contractor and therefore no taxes will be withheld from payments made under this Section. Developer understands and agrees that it will be responsible for any and all federal, state and local taxes, if any, owed on such fees or for Services provided by Developer and Developer Affiliates.

5.2 Developer Expenses

The Cooperative shall pay the reasonable expenses of the Developer and Developer Affiliates, if: i) Developer submits expense reports documenting the expenses; ii) all expenses incurred are consistent with the Cooperative's policies, e.g., travel policies; and iii) the expenses are either prior-approved by the Cooperative or provided for in the Cooperative's budget.

5.3 Member Hold Harmless. Developer agrees that it shall not hold members liable for fees that are the responsibility of the Cooperative. Developer agrees that in no event, including, but not limited to, nonpayment by the Cooperative, the Cooperative's insolvency, or breach of the Agreement with Developer, shall Developer, or its subcontractors, bill, charge, or collect a deposit from, seek compensation, remuneration, reimbursement or payment from, or have recourse against, members for covered services provided pursuant to this Agreement.

5.4 Federal Funds. Developer acknowledges that payments made under this Agreement shall be made, in whole or in part, with federal funds.

Article 6. Responsibility

6.1 Relationship of Parties

Nothing in this Agreement shall be construed as (a) an assumption by Developer of any obligation or legal duty of the Cooperative; (b) a guarantee of the success of the Cooperative's operations; (c) an assumption by Developer of any financial obligation of the Cooperative; (d) the creation of any relationship of employment between the Cooperative and employees or consultants of Developer, Developer Affiliates or associated companies; (e) an assumption by Developer of any responsibility for the work performed by outside suppliers employed by the Cooperative at the suggestion or recommendation of Developer; or (f) the delegation of any function or authority of the Cooperative to Developer or any Developer Affiliate; it being understood that Developer will make recommendations and offer advice pursuant to this Agreement, but that all decisions with respect thereto and otherwise shall be and remain dependent upon appropriate action of the Board of Directors or the authorized officers of the Cooperative.

6.2 Compliance with Developer Agreements and Applicable Law

The Cooperative shall negotiate and administer all agreements with employers, subscribers, providers and health insurance exchanges. The Cooperative maintains ultimate responsibility for complying with the terms of is agreements. Nothing in this Agreement shall be construed to terminate or modify the obligations of the Cooperative set forth in its agreement with any employer, subscriber, provider or health insurance exchange.

6.3 Ownership of Technology

Except as agreed by the parties for innovations related to Services performed specifically for the Cooperative, any patents, copyrights, trade secrets or other property rights arising out of work performed by Developer or Developer Affiliates that is shared with, used for or used by the Cooperative or licensed to the Cooperative shall be the sole property of Cooperative.

Article 7. The Cooperative Monitoring and Oversight

The Cooperative shall be responsible for monitoring the performance of Developer and Developer Affiliates on an ongoing basis to verify that the performance standards applicable to the Administrative Services as set forth in Exhibit 2 are being met.

7.1 CAP Procedure

If the Cooperative determines, in its sole reasonable discretion, that Developer is not performing a Service in accordance with Applicable Law, this Agreement including Exhibits, or the Cooperative policies, procedures or interpretations, the following procedures shall apply:

A. The Cooperative shall issue a corrective action request ("CAR") to Developer;

B. Upon receipt of the CAR, Developer must: (i) if reasonable and possible, take immediate action if such is indicated in the CAR, (ii) submit to the Cooperative a corrective action plan ("CAP"), within thirty (30) business days (unless otherwise specified in the CAR) that includes specific time frames for achieving compliance;

C. Developer shall immediately implement the CAP, provided that the Cooperative may reject (or amend) a CAP if it reasonably determines that such CAP is inadequate. If the Cooperative rejects a CAP, the Cooperative and Developer shall work together to develop a mutually agreeable CAP. The Cooperative may, at the Cooperative's expense, audit Developer to determine Developer's compliance with the CAP;

D. If the parties cannot reach agreement on a CAP or in the event of repeated noncompliance with any provision of a CAP, then the Cooperative, may in addition to any other remedy provided hereunder, revoke delegation of one or more Services that are the subject of the CAR, identify a third party to perform such Service or assume responsibility for performing the Service subject to the approval of any Applicable Regulatory Agency.

If Developer fails to comply with a CAP or notifies the Cooperative that it has determined that it is unable to comply with a CAP, then the Cooperative, in its sole discretion may take one or more of the following actions:

(a) amend the time to comply with a CAP;

(b) increase the frequency of review and audits;

(c) provide Developer with the Cooperative's resources to perform functions necessary to comply; or

(d) revoke any or all Services upon written notice to Developer.

7.2 Immediate Revocation of Services

The Cooperative may revoke any Service immediately upon notice if:

(a) The Cooperative reasonably determines that Developer or Developer Affiliate(s), in performing the Services, threatens the health or safety of a member, or fails to comply with Applicable Law, or may subject the Cooperative to regulatory or legal actions or adverse actions from any Applicable Regulatory Agency or accreditation agency;

(b) As a direct result of Developer's performance of any Service, an Applicable Regulatory Agency acts or threatens to act to: issue an adverse finding against the Cooperative; revoke the Cooperative's license; or terminate any contract with the Cooperative; or impose any sanction or fine; or

(c) two (2) consecutive CARs fail to result in Developer achieving substantial compliance with the Cooperative's requirements for the Service.

Article 8. Term and Termination

8.1 Term

This Agreement shall become effective on the Effective Date and shall remain in full force and effect ending at 11:59 on December 31, 2012, unless sooner terminated in accordance with this Article 8. This Agreement may be renewed for one three month period ending on March 31, 2013 (the Renewal Term). If the Cooperative will not renew the Agreement for the Renewal Term, the Cooperative shall give the Developer fifteen (15) days prior written notice.

Thereafter, this Agreement may be renewed for specific Services and specific intervals at the request of the Cooperative ("Extended Terms").

8.2 Termination for Material Breach

Either party for a Material Breach by the other party may terminate this Agreement. Material Breach shall be defined as (a) non-payment by the Cooperative of any amounts due under this Agreement; (b) the occurrence of an event causing immediate revocation in accordance with Section 7.2; (c) Developer's failure to comply with Section 2.4; (d) Developer's failure to provide Services in accordance with Applicable Law or this Agreement or to complete a CAP in accordance with Section 7.1; (e) the Cooperative's loss of a license necessary to operate or loss of recognition as a qualified nonprofit health insurance issuer; (f) a party becoming insolvent, making a general assignment for the benefit of creditors, suffering or permitting the appointment of a receiver for its business or its assets, or availing itself of, or becoming subject to, any proceeding under federal bankruptcy laws or any state laws relating to insolvency or the protection of rights of creditors; or (g) this contract is required to be revoked because an Applicable Regulatory Agency with jurisdiction over the matter determines that Developer has not performed satisfactorily.

The non-defaulting party may terminate this Agreement for Material Breach by the other party by giving written notice of the reason for termination and effective date for termination. If the

reason for termination is (a), (c) or (d) the non-defaulting party shall allow the defaulting party a reasonable period to cure the default.

8.3 Termination Obligations

Upon termination of this Agreement, there shall be no further liability on the part of Developer or the Cooperative, except for payments owed by the Cooperative to Developer pursuant to this Agreement including (i) all payments for Services provided during any notice period prior to such termination, and (ii) any costs associated with the termination and resulting transition of the Cooperative's business; and (iii) the obligations that survive termination pursuant to Section 8.4. Developer shall cooperate fully and use its best efforts to support the transition of data and any work-in-process to the Cooperative or its designee.

8.4 Obligations that Survive Termination

The following obligations survive termination or non-renewal of this Agreement for any reason:

- Section 2.2.2;
- Section 3.3;
- Section 3.4;
- Article 4;
- Section 5.1;
- Section 5.2;
- Section 5.3;
- Section 6.3
- Section 8.3;
- Section 8.4;
- Section 10.5; and
- Section 10.6.

Article 9. Notices

9.1 Method and Addresses

Any notices required or permitted to be given pursuant to this Agreement shall be given in writing and forwarded charges prepaid, by registered or certified first-class mail, and addressed as follows:

If to the Cooperative: Chair of the Board of Directors
Louisiana Health Cooperative, Inc.
3445 North Causeway Blvd, Suite 301A, Metairie, LA 70002

If to Developer: Terry Shilling, Member
Beam Partners LLC
2451 Cumberland Parkway, Suite 3170
Atlanta, GA 30339

All notices given hereunder shall be deemed to have been received by the party addressed (a) immediately upon personal delivery, (b) within seven (7) days after notice given by registered or certified U.S. mail.

9.2 Change of Address

Either party may give written notice for a change of address in accordance with this Section and any notice or request to be given hereunder shall be forwarded to the new address so provided.

Article 10. Miscellaneous

10.1 Entire Agreement

This Agreement and Exhibits constitutes the entire agreement between the parties with respect to the services described herein to be provided by Developer to the Cooperative and supersedes all previous negotiations, commitments and writings.

10.2 Binding Nature of Agreement.

This Agreement shall be binding upon and inure to the benefit of the parties and their successors and assigns.

10.3 Assignment

This Agreement may not be assigned in whole or in part by either party except with the prior written consent of the other party and the receipt of all approvals required by Applicable Law. Any attempt to assign this Agreement in contravention of this Section shall be void and of no effect. Notwithstanding the foregoing, Developer may assign this Agreement to a wholly owned affiliate providing services to health plans, including a private purchasing council.

10.4 Amendment

Neither this Agreement nor any of its Exhibits may be modified or amended except by a writing duly signed by the authorized representatives of the parties hereto. No amendment shall be effective until it has received any required approvals of Applicable Regulatory Agencies. Notwithstanding the foregoing, this Agreement shall be deemed automatically amended to conform to the requirements of Applicable Law.

10.5 Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the State of Louisiana.

10.6 Dispute Resolution

The parties agree that any claim or dispute arising under, or relating to this Agreement shall be resolved through this dispute resolution process. Either party may initiate the dispute resolution process by a written notice to the other and both parties shall use reasonable efforts to attempt to resolve the dispute informally and quickly. If Developer and the Cooperative are unable to resolve the dispute through informal means after a period of thirty (30) days, either may submit the dispute to arbitration using the arbitration rules of the American Health Lawyers Dispute Resolution Service [http://www.healthlawyers.org/adr], except to the extent that provisions in this Agreement supersede provisions in those rules, this Agreement shall control. If there is a readily determinable amount in dispute and it is $10,000 or less, a single arbitrator shall be used; if the amount exceeds $10,000 or cannot be readily determined, the parties shall each select an independent reviewer/arbitrator with experience in the subject matter of the dispute. The two reviewers/arbitrators shall select the third reviewer/arbitrator. The parties shall share the costs of the arbitrator(s) and any fee imposed by AHLA to use the service. All other costs and expenses of the dispute resolution process, including actual attorney's fees, shall be paid by the party that incurred them. The parties agree that the decision of the arbitration panel is final, binding and

not appealable. Any arbitration must occur in Lexington, Louisiana. Neither the filing of a dispute nor participation in the dispute resolution process pursuant to this Section 10.6 shall constitute grounds for termination of this Agreement.

10.7 Relationship of the Cooperative to Developer. The parties acknowledge that Developer provided services essential to the formation of the Cooperative and its application for CO-OP program loans. Nevertheless, it is the intent of the parties that the Cooperative and Developer operate as unaffiliated entities. Developer shall provide all Services to the Cooperative pursuant to this Agreement on an arms' length basis. It is the intention of the parties that all services provided under this Agreement shall be priced and paid at their fair market value. The provisions of Exhibit 3 are intended to contribute toward accomplishing this goal.

10.8 Headings. Section headings in this Agreement are included for convenience of reference only and shall not constitute a part of this Agreement for any other purpose.

11. List of Exhibits.

Exhibit 1 – List of Services to be provided under this Agreement

Exhibit 2 – Performance Objectives for Services

Exhibit 3 – Standards for Developer's Interactions and Transactions with the Cooperative

Exhibit 4 - Business Associate Addendum

Exhibit 5 – Initial List of Approved Developer Affiliates and Corresponding Rates

Exhibit 6 – IT Security Addendum.

IN WITNESS WHEREOF, the Cooperative and Developer have caused this Agreement to be executed by their respective duly authorized representatives in the manner legally binding upon them as of the date first above written.

Louisiana Health Cooperative, Inc.

By: _____

Name: Warren L Thomas

Title: Chair, Board of Directors

Date: 10/8/2012

Beam Partners LLC

By: _____

Name: Terry S. Shilling

Title: Member

Effective as of: 8/28/12

Exhibit 1

Management and Support Services to be Made Available by Beam

Development Services

- Developer shall provide the following Services to the Cooperative:
- Training and orienting the Board of Directors, as provided in Exhibit 3;
- Developing the application for State licensure, filing and working with the State Insurance Department to obtain approval of the license;
- Obtaining tax-exempt status for the Cooperative;
- Developing a network of providers that meets the network access standards for the State;
- Recruiting, verifying the credentials for and conducting initial interviews for qualified candidates for positions at the Cooperative;
- Creating processes, systems and forms for the operation for the Cooperative.
- Identifying, negotiating and executing administrative services for the operation of the Cooperative.

Management Services

Per the request of the Cooperative, Beam shall arrange Management Services to support the following functions:

Function	Ending date, unless extended
Chief Executive Officer – Overall Plan Management and advice concerning strategic direction	12/31/12
Chief Financial Officer and Head of Finance – Overall financial management, planning, reporting	12/31/12
Head of Member and Group Services – Member enrollment, public education and advice concerning strategic direction	12/31/12
Compliance Support – Guidance concerning the requirements of Applicable Law and Applicable Regulatory Agencies	12/31/12
Head of Clinical Care - Benefit development, Pharmacy Plan Management and advice concerning strategic direction	12/31/12
Head of Operations and Information Technology - Coordinates the internal	12/31/12

operations of the Plan	
Head of Provider Relations/Network Development – Network management services, including strategic direction, network adequacy and provider relations initiatives.	12/31/12
Project Management – specific projects as needed	12/31/12
Other functions, as requested by the Cooperative	12/31/12

Support Services:

- Board orientation and training
- Vendor Oversight – Business Process Organization (BPO), Pharmacy Benefits Manager (PBM) or other delegated services
- HCC Analysis, both prospective and retrospective
- Other functions, as agreed to by the parties

Reporting Requirements

As part of each request for Services, Beam and the Cooperative shall agree on the reporting requirements to accompany such Services. At a minimum, the reporting shall be sufficient to allow the Cooperative to provide oversight to the Cooperative in the performance of any delegated functions.

Exhibit 3

Standards for Arms' Length Transactions Between Developer and the Cooperative

It is the intent of the parties that they conduct their interactions in accordance with the principles and procedures in this document. The purpose of this document is to establish a set of principles, procedures and standards for interactions that will protect the Cooperative from being dominated by Developer and to protect Developer from the appearance of impropriety in its interactions with the Cooperative. The parties fully expect that these principles and procedures will, over time result in an arms' length relationship between the parties. For purposes of this Exhibit 3, references to the "Cooperative" include the Cooperative's governing Board and senior level staff.

1) Developer will perform all tasks assumed under the Agreement and will ensure that it structures its tasks to push progress reports and data to the Cooperative at regularly scheduled intervals and logs all responses and feedback received from the Cooperative.

2) In addition to "push reports", Developer will structure its projects using its web-based tracking system and will allow access to its tracking reports related to the Cooperative to Directors and individuals at the Cooperative responsible for monitoring the Services.

3) Developer will provide the Cooperative with all information requested concerning the performance and activities of the Cooperative, individually and on a comparative basis with other Cooperatives. Examples of such information include information about the fair market value of any component of the Services, accepted industry performance standards for measuring the performance of the Services.

4) Developer will provide the Cooperative with complete, accurate and truthful information about its performance to the best of Developer's knowledge.

5) Developer will maintain complete, accurate and detailed records of its performance of the Services.

6) If Developer is aware of additional information not requested by the Cooperative that is typically requested or required or helpful to assist the Cooperative to analyze its performance, Developer will volunteer that information to the Cooperative.

7) To ensure Directors' active and knowledgeable participation in the oversight of the Cooperative, Developer will make available a detailed orientation for all Directors, including the Directors' duties of care, loyalty and obedience to Applicable Law, the Cooperative's formation documents, the requirements for the CO-OP program, work plan for 1/1/2014, the milestones, how reporting will occur and how to access the tracking system.

8) In addition to the general overview, Developer will begin to train the Directors on the compliance issues the Cooperative will face and its obligations under Applicable Law.

9) Developer acknowledges that Directors, in the exercise of their duty of proper care, will periodically audit Developer's records related to the Services. Developer shall cooperate fully with audits by Directors or Cooperative staff, whether performed directly or conducted by an agent of the Cooperative. Notwithstanding the foregoing, Developer shall be entitled to require any auditor to agree to maintain the confidentiality of records and proprietary information it encounters as a result of the audit.

10) Developer shall and shall require all individuals providing Services through Developer, including subcontractors, to disclose potential conflicts with the Developer, the Cooperative or its executives or Directors. Developer shall document all such disclosed potential conflicts and maintain the documents accessible to the Directors. Individuals with conflicts shall be prohibited from participating in discussions on matters related to the conflict. For example, if Developer's staff member owns an interest in a printing company, this interest shall be disclosed and the staff member shall be prohibited from participating in discussions concerning the selection of the printer – whether the discussion relates to selection of the printer by Developer or by the Cooperative.

11) Developer shall accurately record and clearly report the costs to the Cooperative for providing the Services. Developer will provide the report in such format and with such frequency as the Board shall request.

Exhibit 4

BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum ("Addendum") is effective as of August 28, 2012 and by and between Louisiana Health Cooperative, Inc. ("Cooperative") and Beam Partners LLC ("Developer").

Developer understands that as a result of the services that Developer will provide to Cooperative under the Services Agreement, that Developer is a Business Associate of Cooperative as that term is defined by Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq. ("HIPAA").

Developer hereby agrees to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq. as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the regulations promulgated thereunder including the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164 (the "Privacy Rules"), and the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Parts 160 and 164 (statute and regulations, as any of these are amended from time to time, hereafter collectively referred to as "HIPAA") as they apply to Protected Health Information and electronic forms of Protected Health Information (collectively, "PHI") (as defined in 45 C.F.R. 164.501) provided or made available to Developer by Cooperative or created by Developer in the course of its services on behalf of Cooperative. These requirements are described below.

1. GENERAL PROVISIONS

1.1 Effect. Any ambiguity in this Addendum or between this Addendum and the contract with Developer, or between this Addendum and the Services Agreement shall be resolved to permit Cooperative to comply with HIPAA.

1.2. Change in Law/Amendment. Developer agrees to take such action as is necessary to amend this Addendum from time to time as is necessary to permit either party to comply with the requirements of HIPAA or other applicable laws or regulations.

1.3 Definitions. All capitalized terms used herein and not otherwise defined in this Addendum shall have the meanings established in HIPAA.

1.4 Responsibility for Developer Staff. Developer agrees to take all reasonable steps to educate its employees and other agents about the obligations of this Business Associate Agreement. In addition, Developer agrees to supervise its employees and other agents who have access to PHI through their work on behalf of Developer or their exposure to Cooperative documents and data to ensure that the obligations of this Business Associate Agreement are fulfilled by each such employee or agent.

2. OBLIGATIONS OF BUSINESS ASSOCIATE ASSUMED BY DEVELOPER

2.1 Prohibition on Unauthorized Use or Disclosure. Developer agrees that it shall not, directly or indirectly, use or disclose or permit its staff to use or disclose PHI provided, obtained from or otherwise made available by Cooperative (including through Developer) for any purpose other than as expressly permitted or required by this Addendum or as required by HIPAA or other applicable law.

2.2 Use and Disclosure of PHI Under Addendum. Except as otherwise limited in this Addendum, Developer is permitted to use and/or disclose PHI it creates or receives from or on behalf of Cooperative for the following purpose(s): management and administrative services as set forth in and consistent with its obligations in the Services Agreement, provided that such use or disclosure would not violate HIPAA if done by Cooperative.

2.3 Use of PHI for Management, Administration and Legal Responsibilities. Developer may use and/or disclose PHI if

2.3.1 the use is for (a) the proper management and administration of the Developer / Business Associate or to carry out the legal responsibilities of Business Associate, or (b) to provide data aggregation services relating to the health care operations of Cooperative if such services are required under the Services Agreement; or

2.3.2 the disclosure is for the proper management and administration of Developer or to carry out the legal responsibilities of Developer, provided (i) the disclosure is Required by Law; or (ii)(A) Developer obtains reasonable assurances from the person or entity to whom PHI is disclosed that PHI will be held confidentially and used or further disclosed by such person or entity only as Required by Law or for the purpose(s) for which it was disclosed to such person or entity; and (B) the person or entity to whom PHI is disclosed will use all appropriate safeguards to prevent the use or disclosure of PHI; and (C) the person or entity to whom PHI is disclosed immediately notifies Cooperative upon learning of any breach of the confidentiality of such PHI.

2.4 Safeguards. Developer shall establish, implement, use and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of and to prevent non-permitted use or disclosure of the PHI, including, without limitation: red flag compliance policies, encrypting and securing PHI in accordance with the HHS "Guidance Specifying Technologies and Methodologies that Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals", establishing appropriate policies and procedures (and informing Cooperative of the same upon request) to ensure the privacy and security of all PHI disclosed to Developer or received, created, maintained or transmitted by Developer on behalf of Cooperative.

2.5 Mitigation. Developer shall have procedures in place for mitigating, to the maximum extent practicable, any deleterious effect from the use or disclosure of PHI in a manner contrary to this Addendum or HIPAA, including notifying persons whose unsecured PHI is inappropriately disclosed, as required by applicable law. Developer shall develop and implement a system of meaningful sanctions for any employee, subcontractor or agent of Developer who violates this Addendum or HIPAA.

2.6 Reports of Improper Use or Disclosure. Developer shall report to Cooperative within five (5) business days of Developer's discovery, any use or disclosure of PHI not provided for or permitted by this Addendum by Developer or any of its officers, directors, employees, contractors or agents, whether or not such disclosure compromises the security or

privacy of any PHI. In addition, Developer shall report to applicable regulatory agencies when and as required by applicable law.

The report shall be in writing, giving notice, of the possible breach, when discovered and shall include a risk assessment of whether or not a breach occurred as a result of the improper acquisition, access, use or disclosure of PHI. If the disclosure compromises the security or privacy of the PHI, in other words, the disclosure imposes a significant risk of financial, reputational or other harm to the individual, a breach has occurred. The disclosure shall include all information necessary to allow the Cooperative to make a legally sufficient disclosure to affected individuals.

Factors the Business Associate should consider in the risk assessment include: (a) who used the PHI; (b) who received the PHI; (c) whether the disclosure was to a covered entity or business associate of a covered entity; (d) whether evidence indicates that the PHI was accessed; (e) the nature of the information disclosed; and (f) whether the business associate was able to take immediate steps to mitigate the harm.

The risk assessment must be fact specific and documented with the factors considered to support the conclusion of whether or not a breach occurred. The report shall also include any other information to allow the covered entity to determine if it will give notice to the individual(s). If Developer or a Developer agent causes or permits the breach, Developer shall be responsible for the cost of the notice to the individual(s). A possible breach is discovered on the first day Developer knows of the possible breach or would have known had it exercised reasonable diligence.

2.7 Records. Developer shall maintain records of PHI received from, or created or received on behalf of, Cooperative and shall document subsequent uses and disclosures, except for (i) uses and disclosures for treatment, payment or healthcare operations; (ii) uses and disclosures pursuant to a valid authorization from an Individual; or (iii) uses and disclosures otherwise excepted from the accounting requirement (see 45 C.F.R. 164.528) under HIPAA, made by Developer. Developer shall upon request provide Cooperative with immediate access to examine and copy such records and documents of Developer during normal business hours.

2.8. Secure Destruction. Developer shall securely destroy all PHI. The valid destruction practice for paper, film or other hard copy media is to shred or destroy in such a way that the PHI cannot be read or otherwise reconstructed. Electronic media must be cleared, purged or destroyed so that PHI cannot be retrieved consistent with NIST Special Publication 800-88 (available at http://www.csrc.nist.gov).

2.9 Agreements with Third Parties. Developer shall enter into and maintain an agreement with each agent and subcontractor that has or will have access to PHI under which agreement the agent or subcontractor is legally bound by the same restrictions with respect to PHI that apply to Developer pursuant to this Addendum. Developer agrees to provide Cooperative with advance notice of any arrangement that involves sharing of PHI with a subcontractor or delegate, and an opportunity to approve the delegation / subcontracting arrangement. Developer agrees to permit Cooperative, upon reasonable request, to review and inspect all such subcontracts with subcontractors and agents in order to confirm Developer's compliance with this Addendum. Developer further agrees that it will disclose to its subcontractors, agents or third parties, and request from Cooperative, only the minimum

necessary PHI to perform or fulfill a specific function required or permitted under such subcontracts. Nothing in this Section 2.7 shall supersede Sections 1 and 5 of the Services Agreement.

2.10 Accounting of Disclosures. Within fifteen (15) calendar days of receipt of notice from Cooperative that it has received a request for an accounting of disclosures of PHI in accordance with HIPAA, Developer shall provide to Cooperative the information in Developer's possession that is required for the accounting required by 45 C.F.R. 164.528(b) and (c). At a minimum, Developer shall provide Cooperative with the following information for each disclosure: (i) the date of the disclosure; (ii) the name of each 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. If an individual's request for an accounting is delivered directly to Developer, Developer shall within two (2) business days of receipt forward such request to Cooperative. Developer agrees to implement an appropriate record-keeping process to enable it to comply with the requirements of this section.

2.11 Amendments. Developer agrees to make any amendment(s) to PHI in a Designated Record Set that Cooperative directs or to which Cooperative agrees pursuant to 45 C.F.R. 164.526, at the request of Cooperative, and within five (5) business days of receipt of such request. In the event an Individual's request for an amendment is delivered directly to Developer, Developer shall within two (2) business days of receipt notify Cooperative of such request and coordinate with Cooperative any amendments to which Cooperative agrees.

2.12 Access to Information. Developer shall make available and provide Cooperative with access to an individual's PHI in a Designated Record Set in accordance with all of the requirements set forth in HIPAA. Within five (5) business days of receipt of a request by Cooperative for access to PHI contained in an individual's Designated Record Set, Developer shall provide to Cooperative such information. If any individual requests access to his or her PHI directly from Developer, Developer shall within two (2) days of receiving such request, forward such request to Cooperative and coordinate any responses or disclosures with Cooperative.

2.13 Availability of Books and Records. Developer 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 Developer on behalf of Cooperative available to the Secretary of HHS or his/her designee ("Secretary") in a time and manner designated by the Secretary, for purposes of determining Cooperative's compliance with HIPAA. Developer agrees to cooperate fully and in good faith with and to assist Cooperative in complying with the requirements of HIPAA and any investigation of Cooperative regarding compliance with HIPAA conducted by the HHS Office of Civil Rights, or any other administrative or judicial body with jurisdiction, including, but not limited to, disclosing or providing access to or an accounting of PHI as Cooperative may request. Developer further agrees to make available to Cooperative its practices, books and records relating to the use and disclosure of PHI within five (5) business days of such request, for purposes of enabling Cooperative to determine Developer's compliance with the terms of this Addendum.

3. SECURITY OBLIGATIONS

3.1 Safeguards. Developer agrees to implement appropriate administrative, physical, technical service and technical security measures to protect the integrity, confidentiality and availability of any PHI that it may receive, transmit or maintain as a result of Developer's services on behalf of Cooperative.

3.2 Compliance. Developer agrees that all such security measures will be consistent with 45 CFR 164 subpart C (HIPAA Security Rule) and in compliance with the requirements of HIPAA Security Rule as of the effective date of the regulation and as amended from time to time..

3.3 Agents. Developer agrees to ensure that any agent, including a subcontractor, to whom it provides PHI, agrees to implement reasonable and appropriate safeguards to protect the integrity, confidentiality and availability of such PHI.

3.4 Security Incidents. Developer agrees to report to Cooperative any Security Incident (as defined by 45 CFR 164.304) of which it becomes aware, as required by 45 CFR 164.314(a)(2)(i).

4. OBLIGATIONS OF COOPERATIVE

4.1 Changes. Cooperative shall provide Developer with any of the following, to the extent it may affect Developer's use or disclosure of PHI: (a) any limitation(s) in Cooperative's Notice of Privacy Practices; (b) any changes in, or revocation of, permission by an owner of PHI to use or disclose PHI; and (c) any restriction to the use or disclosure of PHI to which Cooperative has agreed in accordance with 45 C.F.R. 164.522.

4.2 Cooperative shall not request Developer to use or disclose PHI in any manner that would not be permissible under HIPAA if done by Cooperative.

5. TERMINATION

5.1 Termination upon Breach. If either party, in its reasonable discretion, determines that the other has violated a material term of this Addendum, the non offending party may terminate this Addendum and Developer's participation under the Services Agreement. Upon such determination, the non offending party shall at its option (a) require cure of the breach within five (5) days or/this Addendum shall be terminated if the breach is not cured to the reasonable satisfaction of the non-offending party, within that period; or (b) immediately terminate the Addendum if a material term of this Addendum has been breached and cure is not possible, in the non offending party's reasonable discretion. Each party acknowledges that if termination of this Addendum is not feasible in the non offending party's sole discretion, the non offending party has the right to report the breach to the Secretary.

5.2 Effect of Termination.

5.2.1 Except as provided in Section 5.2.2, upon termination for any reason of: i) this Addendum; or ii) the Services Agreement, Developer shall return or destroy all PHI received from Cooperative, or received or created by Developer on behalf of Cooperative in the time period directed by Cooperative. This provision shall apply to PHI that is in the possession of subcontractors or agents of Developer. Developer shall retain no copies

of the PHI, including any electronic medium under Developer's custody or control. All data destruction shall be in accordance with Section 2.8.

5.2.2 If Cooperative determines that returning or destroying the PHI is not feasible, Developer understands and agrees that it shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Developer maintains such PHI.

6. MISCELLANEOUS

6.1 Property Rights. Developer hereby acknowledges that, as between Developer and Cooperative, all PHI shall be and shall remain solely the property of Cooperative, including any and all forms thereof developed by Developer in the course of fulfilling its obligations pursuant to: i) this Addendum; ii) Developer's contract with the Business Associate; or iii) the Services Agreement.

6.2 No Third Party Beneficiaries. Nothing express or implied in this Addendum shall confer upon any person, other than Developer and Cooperative and their respective successors and permitted assigns, any rights, remedies, obligations or liabilities whatsoever.

6.3 Injunctive Relief. Notwithstanding any rights or remedies provided for in the Services Agreement, Cooperative hereby retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by Developer or by any agent or subcontractor of Developer or by any third party that receives or otherwise obtained PHI from Developer.

6.4 Waiver. Neither the failure nor any delay by Cooperative to exercise a right, remedy or privilege under this Addendum shall operate as a waiver thereof, nor shall any single or partial exercise by Cooperative of a right, remedy or privilege preclude any further exercise of the same.

6.5 Counterparts. This Addendum may be executed in any number of counterparts, each of which shall be deemed an original.

IN WITNESS WHEREOF, the Parties have executed this Business Associate Addendum through their duly authorized representatives as of the date first written above.

Louisiana Health Cooperative, Inc.

By _____

Name: Warner Thomas

Title: Chair, Board of Directors

Date: 10/8/2012

Beam Partners LLC

By _____

Terry S. Shilling

Title: Member

Effective as of: 8/28/12

Exhibit 5

Initial List of Approved Developer affiliates and Corresponding Rates

CONFIDENTIAL – EXEMPT FROM LOUISIANA FREEDOM OF INFORMATION ACT DISCLOSURE La. Rev. Stat. Ann. §44:3.2

Beam Level	Representative LAHC Title	Initially assigned individuals	Hourly Rate ($)
Member	Chief Executive Officer	Terry Shilling	$210
Principal	Chief Financial Officer, Head of Finance	Lisa Blume	$185
Associate II	Head of function, Project Manager	Alan Bayham Jim McHaney Jim Krainz Mark Gentry Jim Pittman Jim Starnes Michael Hartnett	$160
Associate I	Recruiter, Selected Staff personnel	Karin Anders Eric LeMarbre	$110

Cooperative acknowledges that it has agreed to a list of milestones incorporated in the Cooperative's agreement with CMS. Beam agrees to monitor achievement of these milestones for the period(s) covered by this Agreement. At the end of a milestone reporting period (generally the close of a calendar quarter), and in addition to the hourly rates billed above, Beam shall be entitled to bill and collect $15.00 per hour from the Cooperative for all hours billed or expended for a milestone due in the reporting period if Beam achieves that milestone within the timeframe noted for each milestone, including any grace period allowed by CMS.

Cooperative further acknowledges Beam may assign individuals to projects or work contemplated under this Agreement, upon reasonable notice to Cooperative.

Exhibit 6

Information Security Addendum

This Information Security Addendum ("ISA") is made pursuant to and attached to the Development Agreement (the "Agreement") executed by and between Beam Partners LLC ("Developer") and the Louisiana Health Cooperative, Inc., a Louisiana nonprofit corporation ("LAHC"). If an express conflict arises between this ISA and the Agreement, the terms of this ISA shall control with respect to the specific subject matter hereof: information security standards and requirements.

WHEREAS, the Parties recognize that information security practices play an important role in their relationship; and

WHEREAS, the Parties wish to memorialize those information technology security practices which they will adhere to;

NOW THEREFORE, LAHC and Developer hereby agree as follows:

1) Overview: Developer has been retained to assist LAHC to become operational, including assisting LAHC to identify and select vendors, setting up LAHC's systems and ensuring that the systems are integrated so that LAHC's interface with providers, employers, the health insurance exchanges and enrollees is successful. The Parties agree that:
   a) Each Party must comply with HIPAA privacy requirements and State of Louisiana rules regarding privacy, and ensure data integrity at their respective organizations;
   b) The Parties will execute a Business Associate if Developer will have access to any Protected Health information in the course of performing the Services for LAHC;
   c) Shared data will be limited to de-identified Protected Health Information unless all Parties determine otherwise for specific initiatives; and
   d) Data stored at LAHC shall be treated in a manner consistent with the HIPAA privacy rule and State of Louisiana rules governing privacy; and
   e) The Parties will comply with this ISA, as amended from time to time to ensure that their data is maintained securely.
2) Definitions: Any term not defined herein shall have the meaning ascribed to it in the Agreement.
   a) "Confidential Information" means:
      i) All past, present and future business activities and all information related to the business of either Party and its members and/or patients, that may be obtained from any source, whether written or oral, as well as trade secrets, all information on any Device or under the ownership or control of either Party or its Personnel or contained in the Software on any Device.
      ii) Confidential Information also includes any information relating to the pricing, software or technical information, hardware, methods, processes, financial data, lists, apparatus, statistics, program, research, development or related information of a

Party, its members and/or enrollees concerning past, present or future business activities, and/or the results of the provision of Services performed pursuant to the Agreement.

iii) Confidential Information does not include information that:

(1) Was previously published or is now or becomes public knowledge through no fault of the other Party; or

(2) Can be established to have been made available to the other Party, without restriction on disclosure, by a third person not under obligation of confidentiality with respect to the disclosed information; or

(3) Can be established to have been independently developed by the other Party; or

(4) Constitutes know-how which in ordinary course becomes indistinguishable from the know-how of the other Party; or

(5) Is in response to a valid order by a court of competent jurisdiction or otherwise required by law.

b) "Device" means any personal computer, laptop, personal digital assistant ("PDA"), mainframe, network, LAN, workstation or MFD.

c) "Information Security" means protecting information and information systems from unauthorized access, use, disclosure, disruption, modification or destruction.

d) "Multi-Function Device" or "MFD" means an office machine which incorporates the functionality of multiple devices in one, including typically: Printing, Scanning, Photocopying, Faxing and / or E-mailing.

e) "Party" shall mean either Developer or LAHC and "Parties" shall mean both.

f) "Personal Computer" or "PC" means any laptop, notebook, desktop, netbook, or other personal computing device that is used to access, process or display information. This definition does not include computing devices operating as servers in a hardened, controlled access, secured datacentre.

g) "Personnel" means a Party's employees or subcontractors.

h) Software includes all software, middleware, firmware, groupware and licensed internal code whether owned or licensed currently or in the future accessed by a Party's personnel by any direct or remote access method.

3) **Best Practices:**

a) Parties shall adhere to industry best practice standards related to information security relating to its Devices and Software.

b) Each Party shall develop and maintain a comprehensive control framework based upon generally accepted best practices using a standard set of controls, including commercially available and widespread use of precautionary measures.

c) Each Party shall secure access to its offices.

d) Each Party shall limit access to Confidential Information to authorized Personnel only.

e) Each Party shall provide periodic and mandatory Information Security training to its Personnel.

f) Each Party shall ensure that commercially reasonable standards are followed to limit Personnel access to view, copy, transfer and edit data to the minimum necessary to allow them to perform their required task, including log ins required to move from one type of file to another (e.g. clinical treatment to payment)

g) Each Party shall limit access to Confidential Information to the minimum necessary dataset required to accomplish the intended purpose or use.

4) Security Policy

a) Each Party shall develop and maintain a comprehensive Information Security Policy ("Policy"), which it shall review annually, or whenever there is a material change in its practices. Each Party shall designate a staff member as its Security Officer to maintain its Policy and shall monitor its Policy to ensure that it is reasonably calculated to prevent unauthorized access. The Policy shall address at a minimum:

i) The role of the Security Officer as the primary security liaison between the Parties and as the individual primarily responsible for ensuring Information Security.

ii) Access controls, including physical and electronic access controls such as passwords

iii) Security monitoring systems that identify users, locations and times and limit access to those who need access to perform their services.

iv) Use of unsecured wireless fidelity ("Wi-Fi") or any other unsecured wireless technology by agents of either Party.

v) Use of encryption.

vi) Software updates and patches and use of anti-virus software and virus / malware / spyware scanning.

vii) Firewalls.

viii) Secure destruction and disposal of devises, storage media following National Institute of Standards and Technology ("NIST") Special Publication 800-88.

ix) Procedures for recovering devices and media from Personnel when their active participation in the Services ends.

x) Processes to detect, mitigate and report security breaches.

xi) Policies to regulate guest use of systems and devices and to establish security protocols for guest access by incoming guests or by Personnel using other facilities.

xii) Transfer or return of all information and coordinating the disconnection of all systems and devices following the termination of this Agreement.

5) Modification of Requirements. This ISA contains minimum standards intended to protect the Parties' Confidential Information. Each Party remains responsible to take any additional precautions necessary to ensure that the Parties' confidential information is protected from unauthorized disclosure and use.

6) The Parties agree that a failure by either Party to make a good faith effort to comply with this ISA shall be grounds for termination of the Agreement.

IN WITNESS HEREOF, the parties hereto, each acting under due and proper authority, have caused this ISA to be signed by their authorized representatives on the respective dates following their signatures below.

For: LAHC:

By: Warner Thomas

Name: Warner Thomas

Title: Chair, Board of Directors

Date: 10/8/12

For: Beam Partners LLC

By:

Name: Terry S. Shilling

Title: Member

Effective Date: August 28, 2012

Amendment 1

To the

Management and Development Agreement

By and between Beam Partners, LLC

And the

Louisiana Health Cooperative, Inc.

This First Amendment to the Management and Development Agreement is made as of the Effective Date below.

Recitals

WHEREAS, a Management and Development Agreement is in effect between Developer and the Cooperative; and

WHEREAS, the Cooperative has had adequate opportunity to observe the services previously provided by Developer and found them to be satisfactory; and

WHEREAS, the parties desire to amend the Agreement in accordance with the terms of this First Amendment,

NOW, THEREFORE, the Agreement is amended as follows:

1) Section 8.1 is deleted in its entirety and replaced with the following:

8.1 Term. This Agreement shall become effective on the Effective Date and shall remain in full force and effect ending at 11:59 on March 31, 2013, unless sooner terminated in accordance with this Article 8. Thereafter, this Agreement may be renewed for specific Services and specific intervals at the request of the Cooperative ("Extended Terms").

2) Exhibit 1 is deleted in its entirety and replaced with the Exhibit 1 attached hereto.

3) Exhibit 5 is deleted in its entirety and replaced with the Exhibit 5 attached hereto.

4) Except as modified herein, the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the Cooperative and Developer have caused this first Amendment to be executed by their respective duly authorized representatives in the manner legally binding upon them as of the date first above written.

Louisiana Health Cooperative, Inc.

By: _____

Name: Warner L. Thomas

Chair, Board of Directors or Chief Executive

Date: 1

Beam Partners, LLC

By: _____

Name: Terry S. Shilling

Member

Effective as of: December 31, 2012

Exhibit 1 – as amended by Amendment 1

Management and Support Services to be Made Available by Beam

Development Services

- Developer shall provide the following Services to the Cooperative:
- Training and orienting the Board of Directors, as provided in Exhibit 3;
- Developing the application for State licensure, filing and working with the State Insurance Department to obtain approval of the license;
- Obtaining tax-exempt status for the Cooperative;
- Developing a network of providers that meets the network access standards for the State;
- Recruiting, verifying the credentials for and conducting initial interviews for qualified candidates for positions at the Cooperative;
- Creating processes, systems and forms for the operation for the Cooperative.
- Identifying, negotiating and executing administrative services for the operation of the Cooperative.

Management Services

Per the request of the Cooperative, Beam shall arrange Management Services to support the following functions:

Function	Ending date
Chief Executive Officer – Overall Plan Management and advice concerning strategic direction	3/31/13
Chief Financial Officer and Head of Finance – Overall financial management, planning, reporting	
Head of Member and Group Services – Member enrollment, public education and advice concerning strategic direction	
Compliance Support – Guidance concerning the requirements of Applicable Law and Applicable Regulatory Agencies	
Head of Clinical Care – Benefit development, Pharmacy Plan Management and advice concerning strategic direction	
Head of Operations and Information Technology – Coordinates the internal operations of the Plan.	
Head of Provider Relations/Network Development – Network management services, including strategic direction, network adequacy and provider relations initiatives.	

Project Management – specific projects as needed	
Human Resources – Provide or arrange for support with hiring, benefits management and other human resources processes	
Technology acquisition support – Provide advice and information concerning hardware for IT infrastructure.	
Other functions, as requested by the Cooperative	

Support Services:

- Board orientation and training
- Vendor Oversight – Business Process Organization (BPO), Pharmacy Benefits Manager (PBM) or other delegated services
- HCC Analysis, both prospective and retrospective
- Other functions, as agreed to by the parties

Reporting Requirements

As part of each request for Services, Beam and the Cooperative shall agree on the reporting requirements to accompany such Services. At a minimum, the reporting shall be sufficient to allow the Cooperative to provide oversight to the Cooperative in the performance of any delegated functions.

Exhibit 5 – as amended by Amendment 1

Initial List of Approved Developer affiliates and Corresponding Rates.

CONFIDENTIAL – EXEMPT FROM LOUISIANA FREEDOM OF INFORMATION ACT DISCLOSURE, INCLUDING UNDER EXCEPTION La. Rev. Stat. Ann. §44:3.2

Beam Level	Representative LAHC Title	Initially assigned individuals	Hourly Rate ($)
Member	Chief Executive Officer	Terry Shilling	$210
Associate II	Head of function, Project Manager	Debby Sidener Alan Bayliam Jim McHancy Jim Krainz Mark Gentry Jim Pittman Jim Starnes Michael Hartnett	$160
Associate I	Recruiter, Selected Staff personnel	Karin Anders Eric LeMarbre	$110

Cooperative acknowledges that it has agreed to a list of milestones incorporated in the Cooperative's agreement with CMS. Beam agrees to monitor achievement of these milestones for the period(s) covered by this Agreement. At the end of a milestone reporting period (generally the close of a calendar quarter), and in addition to the hourly rates billed above, Beam shall be entitled to bill and collect $15.00 per hour from the Cooperative for all hours billed or expended for a milestone due in the reporting period if Beam achieves that milestone within the timeframe noted for each milestone, including any grace period allowed by CMS.

Cooperative further acknowledges Beam may assign individuals to projects or work contemplated under this Agreement, upon reasonable notice to Cooperative.

Amendment 2
To the
Development Agreement
By and between Beam Partners LLC
And the
Louisiana Health Cooperative, Inc.

This Second Amendment to the Management and Development Agreement (the "Agreement") is made as of the Effective Date below.

Recitals

WHEREAS, a Management and Development Agreement is in effect between the Beam and the Cooperative; and

WHEREAS, the Cooperative has had adequate opportunity to observe the services previously provided by Beam and found them to be satisfactory; and

WHEREAS, the parties desire to amend the Agreement in accordance with the terms of this Second Amendment;

NOW, THEREFORE, the Agreement is amended as follows:

1) Section 8.1 is deleted in its entirety and replaced with the following:

8.1 **Term**. This Agreement shall become effective on the Effective Date and shall remain in full force and effect until 11:59 on December 31, 2013, unless sooner terminated in accordance with this Article 8. Thereafter, this Agreement may be renewed for specific Services and specific intervals at the request of the Cooperative ("Extended Terms").

2) Exhibit 4 is deleted in its entirety and is replaced with the Exhibit 4 (updated Business Associate Agreement) attached hereto.

3) Except as modified herein, the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the Cooperative and Beam have caused this Amendment to be executed by their respective duly authorized representatives in the manner legally binding upon them as of the date first above written.

Louisiana Health Cooperative, Inc.

By: _____
Name: Warner L. Thomas
Title: Chair, Board of Directors
Date: 4/21/13

Beam Partners LLC

By: _____
Name: Jerry S. Shilling
Title: LLC Member
Effective as of: March 31, 2013

Exhibit 4 – as amended by Amendment 2

Business Associate Addendum

(Effective 01/04/2013)

This Business Associate Agreement ("Agreement") effective on January 1, 2013 ("Effective Date") is entered into by and between Vendor, Inc. ("Business Associate") and CO-OP ("CO-OP").

RECITALS

CO-OP and Business Associate are parties to an agreement ("Underlying Agreement") pursuant to which Business Associate provides certain services to CO-OP and, in connection with those services, CO-OP discloses to Business Associate certain Protected Health Information ("PHI") that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Title XIII, The Health Information Technology for Economic and Clinical Health Act ("HITECH"), of the American Recovery and Reinvestment Act ("ARRA").

The parties desire to comply with the requirements set forth in the Privacy and Security Regulations and HITECH concerning the privacy of PHI.

The purpose of this Agreement is to comply with the requirements of the Privacy Rule, the Security Rule, and HITECH, including but not limited to the Business Associate Requirements at 45 C.F.R. Section 164.504(e).

Therefore, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

SECTION I – DEFINITIONS

1.1 Definitions. Unless otherwise provided in this Agreement, capitalized terms shall have the same meaning as set forth in the HIPAA regulations, 45 C.F.R. Sections 160 and 164, and HITECH and its related regulations.

SECTION II – OBLIGATIONS OF BUSINESS ASSOCIATE

2.1 Use/Disclosure of PHI. In connection with its use and disclosure of PHI, Business Associate agrees that it shall use and/or disclose PHI only as permitted or required by this Agreement or as otherwise required by law.

2.2 Safeguards for Protection of PHI. Business Associate agrees to use reasonable and appropriate safeguards to prevent the use or disclosure of PHI other than as provided in this Agreement, including compliance with Security Standards of the HIPAA Rules.

2.3 Compliance with HITECH Act and Regulations. Business associate will comply with the requirements of HITECH, codified at 42 U.S.C. §§ 17921-17954, which are applicable to Business Associate, and will comply with all regulations issued by the Department of Health and Human Services to implement these referenced statutes including but not limited to 45 C.F.R. 164.400 - .414, as of the date by which Business Associate is required to comply with such referenced statutes and HHS regulations.

2.4 General Reporting. Business Associate shall report to CO-OP any use or disclosure of PHI which is not provided for by this Agreement of which Business Associate becomes aware, including breaches of unsecured PHI required by 45 C.F.R. 164.410.

2.5 Reporting of Breaches of Unsecured Protected Health Information. Business Associate will report in writing to CO-OP's Privacy Officer any Breach of Unsecured PHI, as defined in the Breach Notification Regulations, within 5 business days of the date Business Associate learns of the incident giving rise to the Breach. Business Associate will provide such information to CO-OP as required in the Breach Notification Regulations. For any Beach caused by Business Associate or Business Associate's subcontractors or agents, Business Associate will reimburse CO-OP for any reasonable expenses CO-OP incurs in the investigation and assessment of the Breach and obligations of notification, providing notice of the Breach to individuals, the media or the Secretary and for reasonable measures taken by CO-OP to mitigate harm to those individuals. Business Associate shall defend, hold harmless and indemnify CO-OP and its employees, agents, officers, directors, members, contractors, and subsidiary and affiliate entities, from and against any claims, losses, damages, liabilities, costs, expenses, penalties or obligations (including in-house and external attorneys' fees) which CO-OP may incur due to a Breach caused by Business Associate or Business Associate's subcontractors or agents.

2.6 Mitigation. Business Associate shall make reasonable efforts to mitigate, to the greatest extent possible, any harmful effects arising from any improper use and/or disclosure of PHI.

2.7 Subcontractors. Business Associate shall ensure that any agents, including any subcontractor, that creates, receives, maintains or transmits PHI on behalf of Business Associate agrees to the same restrictions and conditions that apply to the Business Associate with respect to PHI. If Business Associate learns of Subcontractor's non-compliance with its privacy, security, reporting and other obligations relating to PHI, Business Associate shall take all steps required by the Privacy Rule, the Security Rule, and HITECH Act, including prompt notice to Covered Entity of the non compliance, reporting of an unauthorized use or disclosure of PHI, including breaches of Unsecured PHI, and taking appropriate steps to terminate the agreement with the Subcontractor or otherwise cure the noncompliance to the satisfaction of and within the time determined the Covered Entity and, as may be required under the circumstances, retrieve all PHI within the possession or control of the subcontractor for return to Business Associate or Covered Entity.

2.8 Access by Individuals. Business Associate shall allow individuals who are the subject of the PHI to inspect and copy their PHI maintained in a Designated Record Set in the possession of Business Associate upon instruction by the Covered Entity. If an Individual requests access to PHI contained in a Designated Record Set directly from Business Associate or its agents or subcontractors, Business Associate will notify Covered Entity in writing within 10 days of receiving such request. Business Associate agrees to promptly make any arrangement(s) for access to such PHI that Covered Entity directs.

2.9 Access by Department of Health and Human Services. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or related or received by the Business Associate on behalf of the CO-OP, available to the Secretary of the Department of Health and Human Services for purposes of determining CO-OP's compliance with the HIPAA privacy regulations.

2.10 Access by CO-OP. Upon reasonable notice, Business Associate shall make its internal practices, book, and records relating to the use and disclosure of PHI available to CO-OP for purposes of determining Business Associate's compliance with the terms of this Agreement and Business Associate's compliance with HIPAA and HITECH.

2.11 Accountings of Disclosures. Business Associate agrees to document each disclosure of PHI that Business Associate creates or receives for or from Covered Entity not excepted from disclosure accounting pursuant to 45 CFR 164.528. Such accounting shall include the information necessary for CO-OP to provide an Accounting of Disclosures to any Individual who requests such an Accounting as more fully set forth in 45 CFR 164.528. If requested by CO-OP, Business Associate shall provide an accounting of disclosures directly to the requesting Individual.

2.12 Amendment of PHI. Business Associate agrees to make any amendment(s) to PHI maintained in a Designated Record Set that CO-OP directs or agrees to pursuant to CO-OP's obligations under the Privacy Rule. If an Individual requests an amendment of PHI maintained in a Designated Record Set directly from Business Associate or its agents or subcontractors, Business Associate must notify Covered Entity in writing within ten (10) days of receiving such request.

2.13 Minimum Necessary. In any instance when Business Associate uses, requests or discloses PHI under this Agreement or in accordance with other agreements that exist between Covered Entity and Business Associate, Business Associate may use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose.

2.14 To the extent Business Associate is to carry out one or more of CO-OP's obligation(s) under the Privacy Rule (Subpart E of 45 C.F.R. Part 164), Business Associate shall comply with the requirements of the Privacy Rule Subpart E that apply to CO-OP in the performance of such obligation(s).

2.15 To the extent Business Associate or Business Associate Subcontractor or agent is a Group Health Plan, the Plan Documents shall provide that, except for electronic PHI disclosed to a Plan Sponsor pursuant to 45 USC 164.504(f)(1)(ii) or (iii) or as authorized under 45 C.F.R. 164.508, the Plan Sponsor will reasonably and appropriately safeguard electronic PHI created, received, maintained or transmitted to the Plan Sponsor on behalf of the Group Health Plan, including

a. implementing administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains or transmits on behalf other group health plan;

b. ensure that adequate separation required by 45 USC 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

c. ensure that any agent to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

d. reports to the group health plan any security incident of which it becomes aware.

SECTION III – PERMITTED USES AND DISCLOSURES

3.1 General. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, CO-OP as specified in the Underlying Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by CO-OP.

Business Associate may use PHI it creates or receives for or from Covered Entity as necessary for Business Associate to carry out Business Associate's proper management and administration or to carry out the legal responsibilities of the Business Associate and may disclose PHI received in its capacity as a Business Associate for such purposes if required by law or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or disclosed only as required by law or for the purpose for which it was disclosed to the person and the person notifies the business associate of any instances in which it is aware in which the confidentiality of the information has been breached.

SECTION IV – OBLIGATIONS OF CO-OP

4.1 Notice of Privacy Practices. CO-OP has included and will continue to include, in the CO-OP Notice of Privacy Practices information advising Individuals that CO-OP may disclose their PHI to Business Associates.

4.2 Consents/Authorizations. CO-OP has obtained and will continue to obtain, from Individuals, consents, authorizations and other permissions that may be required by the Privacy Rule or applicable state laws and/or regulations prior to furnishing Business Associate PHI pertaining to Individuals.

4.3 Restrictions. CO-OP will promptly notify Business Associate in writing of any restrictions on the use and disclosure of PHI about Individuals that CO-OP has agreed to that may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Agreement.

4.4 Revocation of Authorization. CO-OP shall promptly notify Business Associate in writing of any change in, or revocation of, permission by an Individual to use or disclose PHI, if such changes or revocation may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Agreement.

SECTION V – SECURITY

5.1 Business Associate agrees to implement the Security Rule (security standards as set out in 45 C.F.R. parts 160, 162 and 164), Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the electronic PHI that Business Associate creates, receives, maintains, or transmits on behalf of the Covered Entity.

5.2 Business Associate agrees to report to Covered Entity any security incident within 5 business days of when Business Associate becomes aware of such incident, including breaches of unsecured PHI as required by 45 CFR 164.410.

5.3 Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by, Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this

Agreement to Business Associate with respect to such PHI.

5.4 Business Associate will ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement the Security Rule, Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the electronic PHI.

5.5 Business Associate agrees to make its policies, procedures, and documentation relating to the safeguards described herein available to the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Security Rule.

SECTION VI – TERM & TERMINATION

6.1 Term and Termination. This Agreement shall be effective as of the Effective Date and shall terminate when all of the PHI provided by CO-OP to Business Associate, or created or received by Business Associate on behalf of CO-OP, is destroyed or returned to CO-OP. The parties acknowledge and agree that the terms and conditions stipulated in this Agreement shall apply to any future written or oral agreements between CO-OP and Business Associate which require the disclosure of PHI, whether or not this Agreement is incorporated by reference into future agreements executed between the parties.

6.2 Termination for Cause. CO-OP may terminate this Agreement if CO-OP determines that Business Associate has breached a material term of this Agreement. Alternatively, CO-OP may choose to provide Business Associate with notice of the existence of an alleged material breach and provide Business Associate an opportunity to cure the alleged material breach within the time specified by CO-OP. In the event Business Associate fails to cure the breach to the satisfaction of CO-OP, CO-OP may immediately terminate this Agreement.

6.3 Effect of Termination. Upon termination of this Agreement, for any reason, Business Associate shall, if feasible, return or destroy all of the PHI that Business Associate still maintains in any form and shall not retain any copies of such PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the PHI and shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible, including the following:

- Retain only that which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities or which makes the return or destruction infeasible;
- Return or destroy the remaining PHI that the Business Associate still maintains in any form based upon consultation and instruction by CO-OP;
- Continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;
- Not use or disclose PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Sections II and III which applied prior to termination; and
- Return or destroy PHI retained by Business Associate when it is no longer needed by

Business Associate for its proper management and administration, to carry out its legal responsibilities or other condition which makes return or destruction infeasible based upon consultation and instruction by CO-OP.

- Return or destroy PHI created, received or maintained by Business Associate subcontractors based on consultation and instruction by CO-OP.

SECTION VII – MISCELLANEOUS

7.1 Amendment. The Parties agree to take such action as is necessary to amend this agreement from time to time as is necessary for compliance with the requirements of the HIPAA rules and any other applicable law. Notwithstanding, this Agreement shall be deemed to amend automatically, by force of law and without further act of the parties, if necessary to bring the Agreement into compliance with any changes in HIPAA, HITECH or any related regulations that are made after the date of execution of this Agreement.

7.2 Interpretation. Any ambiguity in this Agreement shall be resolved in a manner that brings the Agreement into compliance with the then most current version of HIPAA regulations, 45 C.F.R. Sections 160 and 164 and HITECH and its related regulations.

7.3 No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any other person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

7.4 Notice. Any notice required to be provided pursuant to this Agreement shall be made as follows:

To CO-OP: CO-OP's Privacy Officer
3445 Causeway Boulevard, Suite 800
Metairie, LA 70003

To Business Associate: Terry S Shilling
2451 Cumberland Parkway, Suite 3170
Atlanta, GA 30339

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement on the dates set forth below.

Beam Partners LLC

By: _____

Title: LLC Member Date: 3/31/13

Louisiana Health Cooperative, Inc.

By: _____

Title: Chair, Board of Directors Date: 3/31/13

Amendment 3
To the
Development Agreement
By and between Beam Partners LLC
And the
Louisiana Health Cooperative, Inc.

This Third Amendment to the Management and Development Agreement (the "Agreement") is made as of the Effective Date below.

Recitals

WHEREAS, a Management and Development Agreement is in effect between the Beam and the Cooperative which, by its terms terminates as of December 31, 2013; and

WHEREAS, the Cooperative has had adequate opportunity to observe the services previously provided by Beam and found them to be satisfactory; and

WHEREAS, the parties desire to amend the Agreement in accordance with the terms of this Third Amendment;

NOW, THEREFORE, the Agreement is amended as follows:

1) Section 8.1 is deleted in its entirety and replaced with the following:

8.1 Term. This Agreement shall become effective on the Effective Date and shall remain in full force and effect until 11:59 on March 31, 2014, unless sooner terminated in accordance with this Article 8. Thereafter, this Agreement may be renewed for specific Services and specific intervals at the request of the Cooperative ("Extended Terms").

2) As of the Effective Date, Exhibit 1 is replaced with the Exhibit 1 attached hereto.

3) Effective with the effective date of this Third Amendment, Paragraphs 7, 8 and 11 of Exhibit 3 are deleted in their entirety. The parties acknowledge that the Cooperative has hired its own personnel who are responsible for evaluating and making purchasing decisions about the services of all vendors and contractors, including Beam and, therefore, these provisions are no longer applicable.

4) As of the effective date of this Third Amendment, Exhibit 5 is deleted in its entirety and replaced with the Exhibit 5 (Beam Associates and Corresponding Rates) attached hereto.

5) Except as modified herein, the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the Cooperative and Beam have caused this Amendment to be executed by their respective duly authorized representatives in the manner legally binding upon

them as of the effective date below.

Louisiana Health Cooperative, Inc.

By: _____

Name: Greg Cromer

Title: Chief Executive Officer

Date: 12/27/13

Beam Partners, LLC

By: _____

Name: Terry S. Shilling

Title: Member

Effective as of: January 1, 2014

Exhibit 1 - Management and Support Services to be Made Available by Beam

Beam shall provide the following Support Services upon request from the Cooperative:

- Financial support
- Board orientation and training
- Vendor Oversight – Business Process Organization (BPO), p-Pharmacy Benefits Manager (PBM) or other delegated services
- HCC Analysis, both prospective and retrospective
- Creating processes, systems and forms for the operation for the Cooperative.
- Other functions, as agreed to by the parties

Exhibit 5 – as amended by Amendment 3

Exhibit 5

Beam Associates and Corresponding Rates

CONFIDENTIAL – EXEMPT FROM LOUISIANA PUBLIC RECORDS ACT DISCLOSURE

Beam Level	Hourly Rate ($)
Member	$235
Other Beam Associates	$195

As of the effective date for the Third Amendment (January 1, 2014) the performance bonus is deleted for all future periods.

Cooperative acknowledges Beam may assign individuals to projects or work contemplated under this Agreement, upon reasonable notice to Cooperative.

JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO.: 651,069 SECTION: 22
	:	19TH JUDICIAL DISTRICT COURT
versus	:	PARISH OF EAST BATON ROUGE
CGI TECHNOLOGIES AND SOLUTIONS, INC., *ET AL.*	:	STATE OF LOUISIANA

MOTION FOR LEAVE TO FILE PLAINTIFF'S FIFTH AMENDED PETITION FOR DAMAGES AND REQUEST FOR JURY TRIAL AND INCORPORATED MEMORANDUM IN SUPPORT

NOW INTO COURT, through undersigned counsel, comes Plaintiff, James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc. ("LAHC"), through his duly appointed Receiver, Billy Bostick ("Plaintiff" or the "Commissioner"), who respectfully moves this Honorable Court for leave to file the attached Fifth Amended Petition for Damages and Request for Jury Trial ("Fifth Amended Petition"), pursuant to the court's applicable Case Management Schedule ("CMS"), Louisiana Code of Civil Procedure article 1151, and Local Rule 9.9(g)(4).

Plaintiff is removing all claims against all directors and officers and their insurers from this lawsuit, along with all other previously named defendants who have resolved Plaintiffs' claims against them. Additionally, Plaintiff is amending and supplementing his factual allegations against defendants, asserting new claims against defendants, and adding the insurer of GRI as a defendant pursuant to Louisiana's Direct Action Statute. Plaintiff therefore respectfully moves for leave of Court to file the attached, Fifth Amended Petition, which specifically supplements and amends all of Plaintiff's previously filed Petitions herein.

The filing of this Fifth Amended Petition will not delay this case or cause any undue hardship whatsoever on the defendants. Discovery is in the initial stages. No depositions have yet been taken. The CMS signed by this Honorable Court on September 14, 2020, sets an April 1, 2021, deadline to amend pleadings. No trial date has been set.

EXHIBIT G

WHEREFORE, Plaintiff prays that this Motion for Leave be granted, and that his Fifth Amended Petition for Damages be filed without delay.

Respectfully submitted,

J. E. Cullens, Jr., T.A., La. Bar #23011
Edward J. Walters, Jr., La. Bar #13214
Darrel J. Papillion, La. Bar #23243
Andrée M. Cullens, La. Bar #23212
S. Layne Lee, La. Bar #17689
WALTERS, PAPILLION, THOMAS, CULLENS, LLC
12345 Perkins Road, Bldg One
Baton Rouge, LA 70810
Phone: (225) 236-3636

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing has been furnished via e-mail to all counsel of record as follows, this 1st day of April, 2021, in Baton Rouge, Louisiana.

W. Brett Mason
Michael W. McKay
Stone Pigman
301 Main Street, #1150
Baton Rouge, LA 70825

Harry Rosenberg
Phelps Dunbar
365 Canal Street
Suite 2000
New Orleans, LA 70130

James A. Brown
Sheri Corales
Liskow & Lewis
One Shell Square
701 Poydras Street, #5000
New Orleans, LA 70139

Justin Kattan
Catharine Luo
Justine Margolis
Reid Ashinoff
DENTONS US
1221 Avenue of the Americas
New York, NY 10020

J. E. Cullens, Jr.

JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO.: 651,069 SECTION: 22 19TH JUDICIAL DISTRICT COURT
versus	:	PARISH OF EAST BATON ROUGE
CGI TECHNOLOGIES AND SOLUTIONS, INC., *ET AL.*	:	STATE OF LOUISIANA

ORDER

Considering Plaintiff's Motion for Leave to File Fifth Amended Petition for Damages and Request for Jury Trial (with Incorporated Memorandum):

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that the Motion for Leave is **GRANTED**, and the Plaintiff's Fifth Amended Petition for Damages and Request for Jury Trial be deemed filed as of April 1, 2021.

SIGNED this ___ day of April, 2021, at Baton Rouge, Louisiana.

HONORABLE JUDGE TIMOTHY KELLEY
19th JUDICIAL DISTRICT COURT

PLEASE PROVIDE NOTICE
PURSUANT TO LSA–CCP ART. 1913

JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO.: 651,069 SECTION: 22
	:	19TH JUDICIAL DISTRICT COURT
versus	:	
GROUP RESOURCES INCORPORATED, MILLIMAN, INC., BUCK GLOBAL, LLC. AND IRONSHORE SPECIALTY COMPANY	:	PARISH OF EAST BATON ROUGE
	:	STATE OF LOUISIANA

FIFTH SUPPLEMENTAL, AMENDING AND RESTATED PETITION FOR DAMAGES AND REQUEST FOR JURY TRIAL

NOW INTO COURT, through undersigned counsel, comes James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc., through his duly appointed Receiver, Billy Bostick, who respectfully requests that this FIFTH SUPPLEMENTAL, AMENDING AND RESTATED PETITION FOR DAMAGES AND REQUEST FOR JURY TRIAL be filed herein and served upon all named Defendants; and respectfully represents:

1.

That the caption of this matter be amended to read as follows:

JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO.: 651,069 SECTION: 22
	:	19TH JUDICIAL DISTRICT COURT
versus	:	
GROUP RESOURCES INCORPORATED, MILLIMAN, INC., BUCK GLOBAL, LLC. AND IRONSHORE SPECIALTY COMPANY	:	PARISH OF EAST BATON ROUGE
	:	STATE OF LOUISIANA

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JURISDICTION AND VENUE

2.

This Court has jurisdiction over this dispute involving Louisiana Health Cooperative, Inc., ("LAHC") a Louisiana Nonprofit Corporation that holds a health maintenance organization ("HMO") license from the Louisiana Department of Insurance, is domiciled, organized and doing business in the State of Louisiana, and maintains its home office in Louisiana.

3.

This Court has jurisdiction over all of the named Defendants because each of them has transacted business or provided services in Louisiana, has caused damages in Louisiana, and because each of them is obligated to or holding assets of Louisiana Health Cooperative, Inc.

4.

Venue is proper in this Court pursuant to the provision of the Louisiana Insurance Code, including La. R.S. 22:257, which dictates that the Nineteenth Judicial District Court has exclusive jurisdiction over this proceeding and La. R.S. 22:2004, which provides for venue in this Court and Parish, as well as other provisions of Louisiana law.

PARTIES

5.

Plaintiff

The Plaintiff herein is James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc., through his duly appointed Receiver, Billy Bostick ("Plaintiff").

6.

Louisiana Health Cooperative, Inc. ("LAHC") is a Nonprofit Corporation incorporated in Louisiana on or about September 12, 2011. LAHC was organized in 2011 as a qualified nonprofit health insurer under Section 501(c)(29) of the Internal Revenue Code, Section 1322 of the Patient Protection and Affordable Care Act of 2010, the Louisiana Nonprofit Corporation Law, and Louisiana Insurance Law.

7.

A Petition for Rehabilitation of LAHC was filed in the 19th JDC, Parish of East Baton Rouge, on September 1, 2015; on September 1, 2015, an Order of Rehabilitation was entered, and on September 21, 2015, this Order of Rehabilitation was made permanent and placed LAHC into

rehabilitation and under the direction and control of the Commissioner of Insurance for the State of Louisiana as Rehabilitator, and Billy Bostick as the duly appointed Receiver of LAHC.

8.

Plaintiff has the authority and power to take action as deemed necessary to rehabilitate LAHC. Plaintiff may pursue all legal remedies available to LAHC, where tortious conduct or breach of any contractual or fiduciary obligation detrimental to LAHC by any person or entity has been discovered, that caused damages to LAHC, its members, policyholders, claimants, and/or creditors.

9.

Defendants

Named Defendants herein are the following:

10.

TPA Defendant

a. **GROUP RESOURCES INCORPORATED ("GRI"),** a foreign corporation believed to be domiciled in Georgia with its principal place of business in Georgia. From approximately May 2014 to approximately May 2016, GRI served as the Third Party Administrator of LAHC. GRI contracted with and did work for LAHC in Louisiana.

b. **IRONSHORE SPECIALTY INSURANCE COMPANY** ("Ironshore"), a foreign insurer, doing business in the State of Louisiana, who issued an applicable policy or policies to GRI that provide coverage for the claims asserted herein.

11.

Actuary Defendants

a. **MILLIMAN, INC. ("Milliman"),** a foreign corporation believed to be domiciled in Washington with its principal place of business in Washington. From approximately August 2011 to March 2014, Milliman provided professional actuarial services to LAHC.

b. **BUCK GLOBAL, LLC f/k/a BUCK CONSULTANTS, LLC ("Buck"),** a foreign corporation believed to be domiciled in Delaware with its principal place of business in New York. From approximately March 2014 through July 2015, Buck provided professional actuarial services to LAHC.

DEFINED TERMS

12.

As used herein, the following terms are defined as follows:

1. "**TPA Defendant**" shall refer to and mean the third party administrators hired by LAHC to oversee, manage, and otherwise operate LAHC; specifically: GRI and its insurer, Ironshore.

2. **"Actuary Defendants"** shall refer to and mean those actuaries hired by LAHC to perform actuarial services for LAHC and named as Defendants herein, specifically: Milliman, Inc. ("Milliman") and Buck Global, LLC ("Buck").

3. "**LDI**" shall refer to and mean the Louisiana Department of Insurance.

4. "**CMS**" shall refer to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

FACTUAL BACKGROUND

13.

The Patient Protection and Affordable Care Act ("ACA") established health insurance exchanges (commonly called "marketplaces") to allow individuals and small businesses to shop for health insurance in all states across the nation. To expand the number of available health insurance plans available in the marketplaces, the ACA established the Consumer Operated and Oriented Plan ("CO-OP") program. The ACA further directed the Secretary of Health and Human Services to loan money to the CO-OP's created in each state. Beginning on January 1, 2014, each CO-OP was allowed to offer health insurance through the newly minted marketplaces for its respective state. A total of 23 CO-OP's were created and funded as of January 1, 2014. State regulators, like the Louisiana Department of Insurance ("LDI"), have the primary oversight of CO-OP's as health insurance issuers.

14.

In Louisiana, the CO-OP created and funded pursuant to the ACA was Louisiana Health Cooperative, Inc. ("LAHC"), a Louisiana Nonprofit Corporation that holds a health maintenance organization ("HMO") license from the LDI. Incorporated in 2011, LAHC eventually applied for and received loans from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") totaling more than $65 million. Specifically, according to the 2012 Loan Agreement with LAHC, the Louisiana CO-OP was awarded a Start-up Loan of

$13,176,560, and a Solvency Loan of $52,614,100. Pursuant to the ACA, these loans were to be awarded only to entities that demonstrated a high probability of becoming financially viable. All CO-OP loans must be repaid with interest. LAHC's Start-up Loan must be repaid no later than five (5) years from disbursement; and LAHC's Solvency Loan must be repaid no later than fifteen (15) years from disbursement.

15.

From the start, because of the gross negligence of the Defendants named herein, LAHC failed miserably. Before ever offering a policy to the public, LAHC lost approximately $8 million in 2013. While projecting a modest loss of about $1.9 million in 2014 in its loan application to CMS, LAHC actually lost about $20 million in its first year in business. And although LAHC projected turning a modest profit of about $1.7 million in 2015, it actually lost more than $54 million by the end of that year.

16.

The actuaries hired by LAHC to determine the CO-OP's feasibility, assess its funding needs, and set the premium rates to be charged by LAHC in both 2014 and 2015, breached their respective duties owed to LAHC. The actuaries hired by LAHC grossly underestimated the level of expenses that LAHC would incur, made erroneous assumptions regarding LAHC's relative position in the marketplace, and grossly misunderstood or miscalculated how the risk adjustment component of the ACA would impact LAHC.

17.

Not only did LAHC lose a tremendous amount of money, but, from its inception, LAHC was unable to process and manage the eligibility, enrollment, and claims handling aspects of the HMO competently. Almost every aspect of LAHC's eligibility, enrollment, and claims handling process was deficient, resulting in numerous unpaid claims, untimely paid claims, and erroneously paid claims.

18.

By July 2015, only eighteen months after it started issuing policies, LAHC decided to stop doing business. The LDI placed LAHC in rehabilitation in September 2015, and a Receiver, Billy Bostick, was appointed by this Court to take control of the failed Louisiana CO-OP.

19.

From the beginning of its existence, LAHC was completely ill-equipped to service the needs of its subscribers (i.e., its members / policyholders), the healthcare providers who provided medical services to its members, and the vendors who did business with LAHC. As described in detail herein, the conduct of the Defendants named herein went way beyond simple negligence. For instance, when the LDI took over the operations of LAHC, the CO-OP had a backlog of approximately 50,000 claims that had not been processed. Because of Defendant's gross negligence, as of December 31, 2015, LAHC had lost at least tens of millions of dollars

20.

As set forth herein, Defendants are liable to Plaintiff for all compensatory damages caused by their actionable conduct. Plaintiff makes no claim for post-Receivership administrative expenses or attorneys' fees.

CAUSES OF ACTION

Count One: Breach of Contract (Against GRI, the TPA Defendant)

21.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

22.

GRI was not qualified to render the services as a third party administrator ("TPA") that LAHC needed to be successful. Rather than decline taking on a job that was outside of its capabilities, GRI wrongly agreed to replace CGI and serve as TPA for LAHC. GRI's decision to serve as LAHC's TPA constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors. But for GRI's gross negligence, most of LAHC's substantial, compensatory damages would have been avoided.

23.

In or before July 2014, LAHC and GRI entered into an Administrative Services Agreement whereby GRI agreed to perform certain administrative and management services to LAHC in exchange for certain monetary compensation as set forth in the Administrative Services Agreement. The Administrative Services Agreement had an effective date of July 1, 2014. The Administrative Services Agreement was amended both in September 2014 and December 2014. A true and correct copy of the Administrative Services Agreement and all

amendments and exhibits are collectively referred to as the "Agreement" and were attached and incorporated by reference in the original Petition for Damages as "Exhibit 2." Attached to the First Supplemental, Amended, and Restated Petition for Damages and Request for Jury Trial as "Exhibit 2A" was and is a true and correct copy of the Delegation Agreement between LAHC and GRI effective August 20, 2014.

24.

Under the terms of the Agreement, GRI represented and warranted that "GRI personnel who perform or provide the Delegated Services specified services under this Agreement shall possess the appropriate authorization, license, bond and certificates, and are full and appropriately trained, to properly perform the tasks assigned to them."

25.

Under the terms of the Agreement, GRI was, among other things, obligated to:

a. Accurately process and pay claims for covered services provided to LAHC's members by participating providers according to payment terms regarding timeliness and the rates and amounts set forth in LAHC's Participating Provider Agreements.

b. Accurately process and pay claims for covered services provided to LAHC's members by providers;

c. Competently perform all of those tasks set forth in the Agreement, including Exhibit A-1 to the agreement, such as paying claims, adjudicating claims, determining covered services, identifying and processing clean and unclean claims, collecting and processing all encounter data, transmitting denial notifications to members and providers, transmitting all required notices, tracking and reporting its performance, tracking, reporting and reconciling all records regarding deductibles and benefit accumulators, monitoring all claims, submitting all claims, tracking, reporting, and paying all interest on late paid claims, coordinating the payment and processing of all claims and EOBs, and developing and implementing a functional coding system; and

d. Competently perform all of those task expected and required of a Third Party Administration, whether specified in the Agreement or not.

26.

GRI breached its obligations and warranties set forth in the Agreement in a grossly negligent manner, all in the following, non-exclusive ways:

a. GRI failed to meet most, if not all, of the performance standards mandated by the Services Agreement of July 1, 2014;

b. GRI was unqualified, ill-equipped, and unable to service the needs of LAHC, its member, providers, and creditors;

c. GRI knew or should have known that it was unqualified to service the needs of LAHC;

d. Pursuant to GRI's Service Agreement, GRI was responsible for critical processes that are typically covered by such a health insurance administrative service provider contracts, including the receipt and processing of member premium payments, the calculation and payment of broker commissions, and the process of managing calls into LAHC;

e. GRI wholly failed to provide sufficient and adequately trained personnel to perform the services GRI agreed to perform under the Agreement;

f. Failed to process and pay claims on a timely basis, resulting in interest payment alone in excess of $1,056,876.24;

g. Failed to pay claims at the proper contract rates and amounts, thus resulting in an overpayment of claims;

h. Failed to accurately and properly process enrollment segments and failed to timely reconcile enrollment segments;

i. Erroneously terminated coverage for fully subsidized subscribers ($0 Invoices);

j. Failed to provide proper notice to providers regarding member terminations and lapses due to non-payment of premiums;

k. Failed to timely process enrollment interface (ANSI 834) from CMS;

l. Failed to accurately process enrollment interface (ANSI 834) from CMS;

m. Failed to pass CMS data edits for CMS Enrollment Reconciliation Process;

n. Submitted inaccurate data to the CMS Enrollment Reconciliation Process causing erroneous terminations;

o. Failed to pass CMS data edits for Enrollment Terminations & Cancellations Interface (ANSI 834) to CMS;

p. Failed to pass CMS data edits for Edge Server Enrollment Submissions to CMS;

q. Failed to use standard coding for illustrating non-effectuated members (using years 1915 and 1900 as termination year);

r. Failed to provide proper notice (delinquency letters) to subscribers prior to terminating coverage;

s. Failed to invoice subscribers accurately when APTC changed;

t. Failed to invoice subscribers for previously unpaid amounts (no balance forward);

u. Failed to cancel members for non-payment of binder payment;

v. Failed to cancel members after passive enrollment;

w. Failed to administer member benefits (maximum out-of-pockets exceeded);

x. Failed to pay interest on claims to providers;

y. Failed to pay claims within the contractual timeframes;

z. Failed to adjust claims after retroactive disenrollments;

aa. Failure to examine claims for potential subrogation

bb. Failed to maintain adequate customer service staffing and call center technology;

cc. Failed to process APTC changes from CMS within an appropriate timeframe;

dd. Failed to capture all claims diagnoses data from providers;

ee. Failed to pass CMS data edits for Edge Server claims submissions to CMS;

ff. Failed to load the 1,817 claims from the 4/29/16 and 5/2/16 check runs onto the EDGE Server;

gg. Incorrectly calculated claim adjustments, especially as it pertains to a subscriber's maximum out-of-pocket limit;

hh. Paid claims for members that never effectuated;

ii. Failed to protect the personal health information of subscribers;

jj. Failed to issue ID cards to members accurately and timely and without effective dates;

kk. Failed to have in place and/or to implement a financial policy or procedure to verify credit card expenditures;

ll. Failed to understand, implement, and enforce the applicable "grace period" pertaining to subscribers as per the ACA and Louisiana Law, La. R.S. 22:1260.31, *et. seq.*;

mm. Failed to record and report LAHC's claims reserves (IBNR) accurately;

nn. Failed to report and appoint agents and brokers appropriately;

oo. Failed to record and report the level of care provided to LAHC members, enrollees, and subscribers accurately; and

pp. Failed to maintain an Information Technology environment with adequate controls and risk mitigation to protect the data, processes, and integrity of LAHC data.

qq. Failed to submit correct Taxpayer Identification Numbers associated with 1099s, resulting in IRS penalties and fines of $37,700.

27.

According to the Agreement, GRI was obligated to pay claims within the time frame required by applicable law; and if claims were paid untimely because of GRI's conduct, GRI "shall be responsible for paying any required interest penalty to Providers." Because of GRI's gross negligence and non-performance of its contractual obligations owed to LAHC, numerous claims were paid late and significant interest penalties were incurred and paid by LAHC. GRI is obligated to pay all such interest penalties.

28.

GRI's gross negligence and breaches of its warranties and obligations in the Agreement have directly caused LAHC to incur substantial, compensatory damages which are recoverable by Plaintiff herein.

Count Two: Gross Negligence and Negligence
(Against GRI, the TPA Defendant)

29.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

30.

GRI had a duty to ensure that its personnel who performed services for LAHC were adequately and appropriately trained, licensed, and certified to perform the services and functions delegated by LAHC to each of them.

31.

GRI had a duty to accurately process and pay claims on LAHC's behalf in a timely manner at the correct rates and amounts.

32.

GRI had a duty to perform its obligations in a reasonable, competent, and professional manner.

33.

GRI breached its duties in that it negligently failed to cause LAHC to accurately process and pay health insurance claims in a timely manner at the correct rates and amounts.

34.

GRI breached its duties in that it negligently and wholly failed to perform its obligations in a reasonable, competent, and professional manner.

35.

GRI was grossly negligent in that it wantonly failed to provide a sufficient number of adequately trained personnel who had sufficient knowledge of the system program utilized by LAHC to process and pay health insurance claims at the correct rates and amounts in complete and reckless disregard of the rights of LAHC, its members, providers, and creditors.

36.

GRI was grossly negligent in that they wantonly failed to cause LAHC to accurately process and pay health insurance claims in a timely manner at the correct health insurance rates and amounts in complete and reckless disregard of the rights of LAHC, its members, providers, and creditors.

37.

As a direct and proximate result of GRI's negligence or gross negligence, LAHC has incurred substantial, compensatory damages, which are recoverable herein by Plaintiff.

Count Three: Professional Negligence, Gross Negligence And Breach of Contract (Against the Actuary Defendants)

38.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

Milliman

39.

At all relevant times, Milliman held itself out as having expertise to provide actuarial services and advice to health insurers like LAHC.

40.

In or around August 2011, Milliman was engaged by Shilling on behalf of Beam Partners and/or LAHC to provide "actuarial support" for LAHC, including the production of a "feasibility study and loan application as directed by the Funding Opportunity Announcement (Funding Opportunity Number: 00-COO-11-001, CFDA 93.545) released from the U.S. Department of Health Services ("HHS") on July 28, 2011." This engagement letter pre-dated LAHC's formal contract with Beam Partners by a year; the engagement letter dated August 4, 2011, was addressed to Shilling as "Owner/Partner" of "Beam Partners," and was signed by Shilling on August 15, 2011, on behalf of LAHC. Indeed, this engagement letter pre-dated the incorporation of LAHC by about a month or so (LAHC was first registered with the Louisiana Secretary of State's Office on or about September 12, 2011).

41.

In the feasibility study dated March 30, 2012, prepared by Milliman for LAHC to use in support of its loan application to CMS, Milliman concluded that, in general, LAHC "will be economically viable based upon our [Milliman's] base case and moderately adverse scenarios." According to Milliman's actuarial analysis, "the projections for the scenarios are conservative, and in each of the scenarios modeled, LAHC remains financially solvent and is able to pay back federal loans within the required time periods." Furthermore, Milliman estimated that "LAHC will be able to meet Louisiana's solvency and reserve requirements."

42.

The Milliman feasibility study was prepared using unrealistic assumption sets. None of the enrollment scenarios considered the possibility that LAHC would have trouble attracting an adequate level of enrollment (which is what actually happened in 2014 and 2015) and every economic scenario assumed that the loss ratio in nearly every modeled year would be 85% (an outlier loss ratio was never higher than 91%). These assumptions completely disregarded the very real possibility that there would be significant volatility in enrollment and/or the medical loss ratio. With all of the uncertainty within the ACA, a competent actuary would have understood that it was a very realistic possibility that LAHC would fail to be viable. Some of the modeled scenarios should have reflected this possibility. The Milliman feasibility study would imply that two "black swan" events occurred in 2014 and 2015 with low enrollment and very high medical costs. In actuality, these possibilities should have been anticipated by Milliman when they prepared the LAHC feasibility study.

43.

If CMS is considered to be a regulatory body, the actuary who prepared the feasibility study would be guided by Actuarial Standard of Practice (ASOP) No. 8 – Regulatory Filings for Health Benefits, Accident & Health Insurance, and Entities Providing Health Benefits. The following paragraphs are applicable:

- Paragraph 3.4.2 of ASOP No. 8 states that the actuary "should consider the impact of future changes in the underlying covered population on the projected claims. These changes may include, but are not limited to, changes in demographics, risk profile, or family composition". In the context of this feasibility study, Milliman should have considered the possibility that LAHC would not be able to successfully attract the level of enrollment necessary for LAHC to remain viable as an entity.

- Paragraphs 3.4.3 and 3.4.6 of ASOP No. 8 deal with claim morbidity and health cost trends. Given the enormous level of uncertainty with respect to the claim morbidity of the population that would be covered under the ACA (including many individuals who were previously uninsurable due to known medical conditions), Milliman should have generated economic scenarios that considered the possibility that the loss ratio of LAHC would have exceed 91%. Established insurance entities with statistically credible claim experience will occasionally misprice their insurance products with resulting loss ratios exceeding 100%. Milliman should have recognized that high loss ratios were a very real possibility (given the known uncertainty of the covered population) for LAHC and illustrated such scenarios in the feasibility study.

44.

Milliman's failure to consider the possibility of these adverse enrollment and/or medical loss ratio scenarios resulted in a feasibility study where every single scenario illustrated that LAHC

would be generating significant cash earnings over the mid to long term time period. The only question to the reader of the feasibility study was how much money would be earned by LAHC.

45.

Upon information and belief, Milliman conditioned payment for its preparation of LAHC's feasibility study upon LAHC being awarded a loan by CMS. That is, Milliman would only receive payment for its services if LAHC's efforts to secure a loan from CMS were successful. By conditioning payment upon a successful result, Milliman compromised its independence as an actuary and thereby breached its duty to LAHC.

46.

Milliman served as the actuary for not only LAHC, but for the vast majority of the other, 23 CO-OP's originally created under the ACA around the country. To date, at least 19 of the 23 CO-Ops have ceased operation. Upon information and belief, Milliman used this same financing model (i.e., conditioning payment upon approval by the federal government) with all CO-OP's)who hired Milliman to do actuarial work.

47.

The terms of the Agreement between LAHC AND Milliman (AND Millimand tnhe the other CO-OPscreated an improper incentive for Milliman to convince federal officials to approve and fund the project. Approval and funding was the only way Milliman could recover its fee for the initial feasibility study and business plan, and also ensure future fees for the provision of additional actuarial services to LAHC and the other similarly situated CO-OPs around the nation. The improper financial motivation compromised Milliman's objectivity and independence in certifying the feasibility study and business plan.

48.

Milliman did not disclose its financial interest in LAHC (and the other CO-OPs) receiving federal funding approval or its potential conflict of interest to CMS, nor did Milliman disclose and describe the implications of its financial interest and potential conflict to LAHC

49.

Percept 7 of the American Academy of Actuaries (AAA) code of professional conduct provides that when a conflict of interest exists, as it does here, Milliman should disclosure any such conflict and advise all interested parties that it cannot act fairly in an unimpaired way.

50.

According to ASOP 41 regarding the professional standard for communications by actuaries like Milliman, Section 3.4.2 provides that Milliman should have disclosed this conflict of interest in their feasibility study so that any reader of the study would know that Milliman was impaired.

51.

Based in large part on the work performed by Milliman and relied upon by LAHC, in September 2012, LAHC was awarded a loan to become a qualified nonprofit health insurance issuer under the Consumer-Operated and Oriented Plan (CO-OP) Program established by Section 1322 of the ACA and applicable regulations. In other words, based in large part on the work performed by Milliman and relied upon by LAHC, the federal government authorized a Start-up Loan of $13,176,560 to LAHC, and a Solvency Loan of $52,614,100, plus approximately $13.5 million in penalties and interest to date, to LAHC. In a very real sense, Milliman is responsible for the existence of LAHC and all resulting compensatory damages.

52.

Because Milliman provided a pro forma, cookie-cutter analysis of each CO-OP's financial condition and viability, as opposed to undertaking a detailed, market / state specific analysis for each and every individual CO-OP like LAHC, Milliman grossly deviated from acceptable actuarial practice. By using essentially the same methodology and analysis in each of the approximately 18 CO-OP's which Milliman compiled the feasibility studies for submission to the federal government, Milliman grossly breached its professional duty of care owed to LAHC and the other CO-Ops who contracted with Milliman to do this essential work.

53.

In or around November 2012, Milliman was engaged by Shilling on behalf of LAHC to "develop 2014 premium rates in Louisiana" for LAHC. This engagement letter dated November 13, 2012, was addressed to Shilling as "Chief Executive" of LAHC and was signed by Shilling on behalf of LAHC on November 14, 2012.

54.

In the "Three Year Pro Forma Reports" dated August 15, 2013, prepared by Milliman and relied upon by LAHC, Milliman concluded and projected that, in general, LAHC would be

economically viable, able to remain financially solvent, able to pay back federal loans within the required time periods, and would be able to meet Louisiana's solvency and reserve requirements. In reliance upon Milliman's professional services and actuarial estimates and projections, LAHC set its premium rate for 2014.

55.

The actuarial work performed by Milliman for LAHC, including the feasibility study and pro forma reports, were unreliable, inaccurate, and not the result of careful, professional analysis.

56.

For instance, according to the actuarial work performed by Milliman and relied upon by LAHC and the federal government as part of the ACA process, Milliman estimated that LAHC would lose $1,892,000 in 2014 (i.e., that LAHC's net income in 2014 would be negative $1,892,000). In actuality, LAHC reported a statutory loss of more than $20 million in 2014 (i.e., LAHC's statutory net income in 2014 was actually negative $20 million+). Milliman and LAHC's projections for 2014 were off by a factor of more than 10. For 2015, Milliman's projections were even more inaccurate: although Milliman projected that LAHC would earn $1,662,000 in 2015 (i.e., LAHC's net income in 2015 would be positive $1,662,000), in actuality, LAHC reported a statutory loss of more than $54 million in 2015 (i.e., LAHC's statutory net income in 2015 was actually negative $54 million+). Milliman and LAHC's projections for 2015 were off by a factor of more than 32.

57.

Milliman owed a duty to LAHC to exercise reasonable care, and to act in accordance with the professional standards applicable to actuaries in providing its services to LAHC.

58.

Milliman's actuarial memorandums prepared as part of the 2014 rate filings for the individual and small group lines of business indicate that they assumed that LAHC would achieve provider discounts on their statewide PPO product that were equal to Blue Cross Blue Shield of Louisiana ("BCBSLA"). No support was provided for the basis of this assumption.

59.

Provider discounts are a key driver of the unit costs of medical (non-pharmacy) expenses that are incurred by LAHC members. Since providers (hospitals and physicians) typically provide the largest insurance carriers with the highest (compared to smaller carriers) discounts off billed

charges, it was not reasonable for Milliman to assume that a start-up insurance entity with zero enrollment would be in a position to negotiate provider discounts as large as BCBSLA. Since LAHC was utilizing a rental network in 2014 (rather than building their own network), Milliman should have analyzed the level of discounts that would be present in the selected network (Verity Healthnet, LLC) and quantify the difference between these discounts and the BCBSLA discounts since a primary basis of the 2014 rate manual was the level of 2013 BCBSLA rates for their most popular individual and small group products.

60.

When developing estimates of the level of insured claims expense loads for 2014, Milliman would be guided by Actuarial Standard of Practice (ASOP) No. 5 – Incurred Health and Disability Claims. Paragraph 3.2.2 of ASOP No. 5 states that the actuary should consider economic influences that affect the level of incurred claims. ASOP No. 5 specifically says that should consider changes in managed care contracts and provider fee schedule changes when developing estimates of incurred claims.

61.

Based on a review of the LAHC actuarial memorandums for individual and small group, upon currently available information and belief, no support has been provided for the assumption that LAHC would achieve provider discounts equal to BCBSLA. This assumption was not reasonable; if Milliman assumed a lower level of provider discounts, the calculated premium rates would have been higher. As a result, LAHC's statutory losses in 2014 would have been lower.

62.

Milliman grossly underestimated the level of non-claim expenses in 2014. In Milliman's 2014 rate development, they assumed that the "per member per month" (PMPM) level of administrative expenses, taxes, and fees (non-claim expenses) would be $70.85 PMPM for the individual line of business. For the small group line of business, the level of non-claim expenses built into the rate development was $87.00 PMPM. Milliman projected total 2014 member months of 240,000 and 96,000 for the individual and small group lines of business respectively.

63.

The actual level of expenses in 2014 was significantly higher. On a composite basis, the PMPM level of non-claim expenses was $145.70. Total member months were 111,689 of which 98.9% were from the individual line of business. At least part of the pricing error was due to

Milliman significantly over-estimating the level of 2014 enrollment. For the component of LAHC expenses that were fixed, the impact of this incorrect enrollment estimate would be that they would need to be spread over a fewer number of members. This would result in the significantly higher level of expenses on a per member basis.

64.

When developing expense loads for 2014, Milliman would be guided by Actuarial Standard of Practice (ASOP) No. 8 – Regulatory Filings for Health Benefits, Accident & Health Insurance, and Entities Providing Health Benefits. The following sections of ASOP No. 8 are relevant for LAHC:

- Paragraph 3.4.2 of ASOP No. 8 states that the actuary "should consider the impact of future changes in the underlying covered population on the projected claims. These changes may include, but are not limited to, changes in demographics, risk profile, or family composition."

- Paragraph 3.4.4 of ASOP No. 8 instructs the actuary to "use appropriate methods and assumptions for calculating the non-benefit expenses component of premium rates. Possible methods include, but are not limited to, the use of a target loss ratio or the estimation of expenses appropriately attributed to the health benefit on a percentage of premium or fixed-dollar basis. When estimating the latter amounts, the actuary should consider the health plan entity's own experience, reasonably anticipated internal or external future events, inflation, and business plans. The actuary may also consider relevant external studies. The actuary should consider the reasonableness of the non-benefit expense component of premium rates relative to projected expenses."

65.

While there clearly was uncertainty about the overall size of the overall ACA Marketplace, it was unreasonable for Milliman to assume that LAHC, as an unknown entity in the Louisiana health insurance market, would be able to enroll 28,000 members (20,000 individual and 8,000 small group) in the first year of operation. While assuming a lower level of enrollment would have resulted in higher premiums, Milliman was aware that a significant percentage of the individual enrollment would be receiving government subsidies and thus would have limited sensitivity to pricing differences between the various plans offered on the ACA exchange.

66.

Assuming 100% individual members, the impact of this expense miscalculation is 111,689 times ($145.70 - $70.85), or about $8.4 million.

67.

When developing their estimate of the level of Risk Adjustment ("RA") transfer payments to build into the 2014 premium rates, Milliman assumed that there would be no difference in coding intensity between LAHC and the other insurance carriers in the State of Louisiana. This

assumption was not reasonable as Milliman should have known that a small start-up health insurance carrier would be in no position to code claims as efficiently as Blue Cross Blue Shield of Louisiana ("BCBSLA") and other established insurance carriers.

68.

Whatever difference that Milliman assumed as the true morbidity difference between the members that LAHC would enroll and the average state enrollment, it was not reasonable to assume that there would be no difference in claim coding intensity. If Milliman had assumed a lower level of coding intensity for LAHC, this would have resulted in a lower assumed average risk score for LAHC for 2014. As a result, the calculated premiums would have been higher.

69.

When developing estimates of average LAHC risk scores for 2014, Milliman would have been guided by Actuarial Standard of Practice (ASOP) No. 45 – The Use of Health Status Based Risk Adjustment Methodologies. The following sections of ASOP No. 45 are relevant for LAHC with respect to the estimation of relative coding intensity:

- Paragraph 3.2.3 states that "Because risk adjustment model results are affected by the accuracy and completeness of diagnosis codes or services coded, the actuary should consider the impact of differences in the accuracy and completeness of coding across organizations and time periods."

70.

There is no indication that any meaningful assessment of LAHC claim coding capabilities took place by Milliman which resulted in the unreasonable assumption that LAHC's coding efficacy would be the same as larger established health insurance carriers which have years of experience paying claims optimizing the RA coding for some of those claims under other RA programs such as the long established RA program in the Medicare Advantage product.

71.

In their 2014 rating, Milliman assumed that LAHC would actually receive $3.20 PMPM for the individual line of business and $0.00 for the small group line of business. In actuality, the company was assessed a 2014 RA liability of $7,456,986 and $36,622 for the individual and small group lines of business respectively in June 2015 by the Center for Medicare and Medicaid Services (CMS). If Milliman had used a more reasonable assumption with respect to claim coding intensity, some of this liability would have been built into the 2014 premium rates.

72.

Milliman breached its duty by failing to discharge its duties to LAHC with reasonable care, and to act in accordance with the professional standards applicable to actuaries, by failing to produce a feasibility study that was accurate and reliable, by failing to set premium rates for LAHC that were accurate and reliable, and, in general, by failing to exercise the reasonable judgment expected of professional actuaries under like circumstances.

73.

Milliman's failure to exercise reasonable care, and its failure to act in accordance with the professional standards applicable to actuaries, and its breach of contract, was the legal cause of all of, or substantially all of, LAHC's damages as set forth herein.

74.

As alleged in detail herein, the conduct of Milliman went way beyond simple negligence. Milliman's substandard conduct constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors. But for Milliman's gross negligence, most of LAHC's substantial, compensatory damages would have been avoided.

Buck

75.

At all relevant times, Buck held itself out as having expertise to provide actuarial services and advice to health insurers like LAHC.

76.

In or around March 2014, Buck was engaged by LAHC to perform "certain actuarial and consulting services" for LAHC, including but not limited to: a review of the actuarial work previously performed by Milliman, "develop cost models to prepare 2015 rates for Public Exchange," "present target rates for review and revision," "review and price new plan designs," and "prepare and submit rate filings and assist" LAHC with "state rate filing" with LDI. Buck's engagement letter was signed by Patrick C. Powers on behalf of LAHC on April 4, 2014, and had an effective date of April 1, 2014. On or about December 1, 2014, this contract was amended, *inter alia*, to extend the term of Buck's engagement through November 30, 2015, and provided for an additional fee of $380,000 to be paid to Buck for its actuarial services provided to LAHC.

77.

On or about April 2, 2015, Buck issued its "Statement of Actuarial Opinion" to LAHC which was relied upon by LAHC and used to support its periodic ACA reporting requirements to the federal government. In Buck's actuarial opinion, "the March 2015 pro forma financial report is a reasonable projection of LAHC's financial position, subject to the qualifications noted below." In effect, Buck vouched for LAHC's economic health and continuing viability. Buck's professional opinion was clearly inaccurate and unreliable. LAHC would close its doors about three (3) months after Buck issued its April report, and LAHC would ultimately lose more than approximately $54 million in 2015 alone.

78.

The actuarial work performed by Buck was unreliable, inaccurate, and not the result of careful, professional analysis. Furthermore, upon information and belief, Buck may have been unqualified, given its limited experience with insurers like LAHC, to provide actuarial services to LAHC.

79.

Buck owed a duty to LAHC to exercise reasonable care, and to act in accordance with the professional standards applicable to actuaries in providing its services to LAHC.

80.

When Buck developed individual and small group premium rates for 2015, they essentially disregarded the claim experience that had emerged from the start of LAHC operations on January 1, 2014 until the filing was finalized in August 2014. Buck's explanation for not utilizing the claim experience was that it was not statistically credible. Although the claim data was not fully credible, it was unreasonable for Buck to completely disregard LAHC's claim data and incurred claim estimates that were made for statutory financial reporting.

81.

When analyzing credibility of claim data, the actuary would be guided by Actuarial Standard of Practice (ASOP) No. 25 – Credibility Procedures. ASOP No. 25 discusses the concept of two types of experience:

- Subject experience - A specific set of data drawn from the experience under consideration for the purpose of predicting the parameter under study.
- Relevant Experience - Sets of data, that include data other than the subject experience, that, in the actuary's judgment, are predictive of the parameter under study (including

but not limited to loss ratios, claims, mortality, payment patterns, persistency, or expenses). Relevant experience may include subject experience as a subset.

82.

For the 2015 pricing exercise, the Subject Experience would be the LAHC claims data and the Relevant Experience was the manual claim data (obtained from Optum) that Buck used to develop rates for 2015. Buck judgmentally applied, through a credibility procedure, 100% weight to the manual claim data (Relevant Experience) and 0% weight to the actual claim experience of LAHC.

83.

By the time the 2015 rate filing was submitted, LAHC would have already prepared their June 30, 2014 statutory financial statements that reported a level of incurred claims of $23.3 million gross of Cost Sharing Reductions (CSR). This level on claims, on a per capita level, implies that LAHC would need a rate increase in the range of at least 40%. The incurred claim estimate prepared for statutory reporting effectively amounts to a data set of "Subject Experience" that was ignored by Buck.

84.

ASOP No 25 provides the following guidance to actuaries:

- Paragraph 3.2 states that "The actuary should use an appropriate credibility procedure when determining if the subject experience has full credibility or when blending the subject experience with the relevant experience."
- Paragraph 3.4 states that "The actuary should use professional judgment when selecting, developing, or using a credibility procedure."

85.

Buck's professional judgement in this case was to completely disregard the LAHC data that was available because they concluded that it had no predictive value in their credibility procedure. They arrived at this conclusion even though the filed rate increase for 2015 was inconsistent with the necessary rate increase that was implied by the incurred claim estimates reported on the LAHC statutory financial statements.

86.

At the time the 2015 rate filing was submitted in August 2014, there were already claims incurred and paid in the period from 1/1/2014 to 6/30/2014 of $220 PMPM (paid through July 2014) gross of Cost Sharing Reduction subsidies ("CSR"). It was readily apparent that there were very significant claim adjudication issues with LAHC's TPA and that the actual ultimate level of

incurred claims would be significantly higher than $220 PMPM and much higher than Buck's estimate of the manual level of LAHC claims.

87.

Buck underestimated the level of non-claim expenses in 2015. In Buck's 2015 rate development, they assumed that the "per member per month" (PMPM) level of administrative expenses, taxes, and fees (non-claim expenses) would be $96.24 PMPM for the individual line of business. For the small group line of business, the level of non-claim expenses built into the rate development was $96.70 PMPM. Per Buck, the expense load was based on a May 2014 expense budget that was prepared by LAHC.

88.

When developing expense loads for 2015, Buck would be guided by Actuarial Standard of Practice (ASOP) No. 8 – Regulatory Filings for Health Benefits, Accident & Health Insurance, and Entities Providing Health Benefits. The following sections of ASOP No. 8 are relevant for LAHC:

- Paragraph 3.4.2 of ASOP No. 8 states that the actuary "should consider the impact of future changes in the underlying covered population on the projected claims. These changes may include, but are not limited to, changes in demographics, risk profile, or family composition".

- Paragraph 3.4.4 of ASOP No. 8 instructs the actuary to "use appropriate methods and assumptions for calculating the non-benefit expenses component of premium rates. Possible methods include, but are not limited to, the use of a target loss ratio or the estimation of expenses appropriately attributed to the health benefit on a percentage of premium or fixed-dollar basis. When estimating the latter amounts, the actuary should consider the health plan entity's own experience, reasonably anticipated internal or external future events, inflation, and business plans. The actuary may also consider relevant external studies. The actuary should consider the reasonableness of the non-benefit expense component of premium rates relative to projected expenses."

89.

The actual level of expenses in 2015 was moderately higher. On a composite basis, the PMPM level of non-claim expenses was $111.05. Total member months were 165,682 of which 99.4% were from the individual line of business.

90.

When developing their estimate of the level of Risk Adjustment ("RA") transfer payments to build into the 2015 premium rates, Buck assumed that there would be no difference in coding intensity between LAHC and the other insurance carriers in the State of Louisiana. This assumption was not reasonable as Buck should have known that a small start-up health insurance

carrier would be in no position to code claims as efficiently as BCBSLA and other established insurance carriers.

91.

Whatever difference that Buck assumed as the true morbidity difference between the members that LAHC would enroll and the average state enrollment, it was not reasonable to assume that there would be no difference in claim coding intensity. If Buck had assumed a lower level of coding intensity for LAHC, this would have resulted in lower assumed average risk score for LAHC for 2015. As a result, the calculated premiums would have been higher.

92.

In their rate filing, Buck also noted that the average age of the LAHC enrollees was lower than the State of Louisiana average. Since age is component of the risk score calculation, the younger than average population provided some evidence that the average risk score for the LAHC would be lower than the state average. It was not reasonable for Buck to ignore this known difference in member ages between LAHC and the state average.

93.

When developing estimates of average LAHC risk scores for 2014, Buck would be guided by Actuarial Standard of Practice (ASOP) No. 45 – The Use of Health Status Based Risk Adjustment Methodologies. The following sections of ASOP No. 45 is relevant for LAHC with respect to the estimation of relative coding intensity:

- Paragraph 3.2.3 states that "Because risk adjustment model results are affected by the accuracy and completeness of diagnosis codes or services coded, the actuary should consider the impact of differences in the accuracy and completeness of coding across organizations and time periods."

94.

There is no indication that any meaningful assessment of LAHC claim coding capabilities took place by Buck which resulted in the unreasonable assumption that LAHC's coding efficacy would be the same as larger established health insurance carriers which have years of experience paying claims optimizing the RA coding for some of those claims under other RA programs such as the long established RA program in the Medicare Advantage product.

95.

Data Quality is also relevant with respect to Buck ignoring the known demographic data when developing an estimate of the RA transfer payment that should be built into the 2015 rates. Paragraph 3.2 of ASOP No. 23 states "In undertaking an analysis, the actuary should consider

what data to use. The actuary should consider the scope of the assignment and the intended use of the analysis being performed in order to determine the nature of the data needed and the number of Alternative data sets or data sources, if any, to be considered." Because demographic data was available, Buck should have used it to build in some level of RA transfer payment just on that basis alone (without regard for the coding intensity issue).

96.

In their 2015 rating, Buck assumed that LAHC would have a $0 RA transfer payment. In actuality, the company was assessed a 2015 RA liability of $8,658,833 and $177,963 for the individual and small group lines of business respectively in June 2016 by the Center for Medicare and Medicaid Services (CMS). If Buck had incorporated the known demographic information and used a more reasonable assumption with respect to claim coding intensity, some of this liability would have been built into the 2015 premium rates.

97.

Buck breached its duty by failing to discharge its duties to LAHC with reasonable care, and to act in accordance with the professional standards applicable to actuaries, by failing to produce a feasibility study that was accurate and reliable, by failing to set premium rates for LAHC that were accurate and reliable, and, in general, by failing to exercise the reasonable judgment expected of professional actuaries under like circumstances.

98.

Buck's failure to exercise reasonable care, and its failure to act in accordance with the professional standards applicable to actuaries was the legal cause of all of, or substantially all of, LAHC's damages as set forth herein.

99.

As alleged in detail herein, the conduct of Buck went way beyond simple negligence. Buck's substandard conduct constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors. But for Buck's gross negligence, most of LAHC's substantial, compensatory damages would have been avoided.

Count Four: Negligent Misrepresentation
(Against the Actuary Defendants)

100.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

Milliman

101.

At all relevant times, Milliman held itself out as having expertise to provide actuarial services and advice to health insurers like LAHC.

102.

At all relevant times, Milliman held a special position of confidence and trust with respect to LAHC.

103.

LAHC justifiably expected Milliman to communicate with care when advising LAHC concerning its funding needs and the appropriate premium for LAHC.

104.

In Milliman's reports concerning LAHC's funding needs and premium rates, Milliman negligently misrepresented the actual funding needs and premium rates of LAHC. Milliman's negligent misrepresentations regarding LAHC's actual funding needs and premium rates were made to LAHC. LAHC relied upon these negligent misrepresentations to its detriment.

105.

Milliman had a duty to provide accurate and up-to-date information to LAHC that Milliman knew or should have known LAHC would rely on in making its decision concerning the amount of premium to charge policyholders.

106.

As alleged in detail herein, the conduct of Milliman went way beyond simple negligence. Milliman's substandard conduct constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors. But for Milliman's gross negligence, most of LAHC's substantial, compensatory damages would have been avoided.

Buck

107.

At all relevant times, Buck held itself out as having expertise to provide actuarial services and advice to insurers such as LAHC.

108.

At all relevant times, Buck held a special position of confidence and trust with respect to LAHC.

109.

LAHC justifiably expected Buck to communicate with care when advising LAHC concerning its funding needs and the appropriate premium rates for LAHC.

110.

In Buck's reports concerning LAHC's funding needs and premium rates, Buck negligently misrepresented the actual funding needs and premium rates of LAHC. Buck's negligent misrepresentations regarding LAHC's actual funding needs and premium rates were made to LAHC. LAHC relied upon these negligent misrepresentations to its detriment.

111.

Buck had a duty to provide accurate and up-to-date information to LAHC that Buck knew or should have known LAHC would rely on in making its decision concerning the amount of premium to charge policyholders.

112.

As alleged in detail herein, the conduct of Buck went way beyond simple negligence. Buck's substandard conduct constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors. But for Buck's gross negligence, most of LAHC's substantial, compensatory damages would have been avoided.

Count Five: Breach of Fiduciary Duty
(Against GRI and the Actuary Defendants)

GRI

113.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

114.

The contract between GRI and LAHC created an agency (mandate) relationship, with GRI acting as the agent on behalf of LAHC, the principal. As an agent, GRI inherently owed fiduciary duties to LAHC, its principal.

115.

LAHC placed substantial faith, confidence, trust, and reliance on the work done by GRI for LAHC, and the advice and representations of GRI. This resulted in GRI owing LAHC fiduciary duties, including duties of candor, honesty, good faith, and to avoid any conflict of interest or potential self-dealing.

116.

As LAHC's agent, GRI handled and managed the assets of LAHC (e.g. premiums and funds used to pay providers, etc.) and was heavily involved in the day-to-day administration of LAHC. Because GRI had and exercised discretionary authority and/or had discretionary control regarding the management of LAHC, including management or disposition of LAHC's assets, GRI owed a fiduciary duty to LAHC. Because GRI had discretionary authority and/or discretionary responsibility regarding the administration of LAHC, GRI owed a fiduciary duty to LAHC.

117.

GRI breached its fiduciary duties by, among other things, engaging in that specific conduct alleged in detail in Paragraphs 21-28, *supra*.

118.

GRI's breaches of fiduciary duty proximately caused compensatory damage to LAHC, policyholders, and creditors, causing tens of millions in damages.

Milliman

119.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

120.

Because it was a start-up insurance company with no access or ability to confirm Milliman's confidential actuarial guidelines and protocols, LAHC placed substantial faith, confidence, trust, and reliance on the advice and representations of Milliman. This resulted in Milliman owing LAHC fiduciary duties, including duties of candor, honesty, good faith, and to avoid any conflict of interest or potential self-dealing.

121.

LAHC developed a great deal of trust and confidence in the work performed by Milliman. The very existence of LAHC depended upon Milliman's feasibility study submitted to the federal government. The soundness of Milliman's analysis would determine whether LAHC would ever write policies or operate as a CO-OP under the ACA. LAHC relied upon Milliman's confidential actuarial work to its grave detriment.

122.

Milliman owed fiduciary duties to LAHC.

123.

There were also much wider ramifications for Milliman than just LAHC. Milliman had touted the other start-up CO-OPs and touted the strength of its Confidential Guidelines. Milliman secured engagements with the vast majority of the other start-up CO-OPs and played an instrumental role in those CO-OPs securing millions in federal funds and first-year rate approval.

124.

If Milliman had revealed the true financial condition of LAHC, it would have cast doubt on Milliman's work for the other companies, many of which were also at varying stages of financial distress.

125.

Today, only about four of the 23 CO-OPs remain, and they are under varying degrees of financial distress and regulatory oversight. The remaining 19 were put under some form of regulatory action (e.g., supervision or liquidation) and ultimately closed.

126.

Milliman breached their fiduciary duties by, among other things engaging in that conduct specifically pled at paragraphs 39-74, *supra*, and:

a. Failing to disclose Milliman's conflict or potential conflict of interest caused by Milliman's financial stake in LAHC securing federal funding approval.

b. Putting its own interest ahead of LAHC's in order to protect Milliman's reputation throughout the healthcare industry, as well as its lucrative financial relationships with the other CO-OPs.

c. Failing to be honest, forthright, and candid with LAHC and CMS that Milliman had substantially underpriced some of LAHC 's health plans.

d. Failing to be honest, forthright, and candid with LAHC and CMS about the risks associated with the underpriced plans.

e. Once LAHC started covering claims, and the risks associated with the underpriced plans began to come to fruition, resulting in alarming financial losses and trends, Milliman failed to be honest, forthright, and candid with LAHC and CMS about the true and accurate financial condition of the company.

f. Failing to timely advise LAHC and CMS through accurate projections and actuarial certifications, of the financial ramifications associated with LAHC's underpriced plan rates.

127.

Milliman's breaches of fiduciary duty proximately caused compensatory damage to LAHC, policyholders, and creditors, causing tens of millions in damages.

Buck

128.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

129.

Buck owed fiduciary duties to LAHC.

130.

Because it was a relatively new insurance company with no access or ability to confirm Buck's confidential actuarial guidelines and protocols, LAHC placed substantial faith, confidence, trust, and reliance on the advice and representations of Buck. This resulted in Buck owing LAHC fiduciary duties, including duties of candor, honesty, good faith, and to avoid any conflict of interest or potential self-dealing.

131.

Buck breached its fiduciary duties by, among other things, engaging in that specific conduct alleged in detail in Paragraphs 75-99, *supra*.

132.

Buck's breaches of fiduciary duty proximately caused compensatory damage to LAHC, policyholders, and creditors, causing tens of millions in damages.

133.

Ironshore issued an applicable policy or policies to GRI that provide coverage for the claims asserted against GRI herein; as such, Ironshore is jointly and severally liable with GRI to the extent of the policy limits of any such policy.

DAMAGES

134.

As a direct and proximate result of the gross negligence and foregoing failures of the Defendants to perform their contractual and tort obligations, LAHC, its members, its providers and its creditors have sustained substantial, compensable damages for which the Defendants are liable, and for which Plaintiff is entitled to recover in this action.

135.

The compensable damages caused by the Defendants' grossly negligent conduct, if not willful conduct, include, but are not limited to:

a. damages in the form of all losses sustained by LAHC from its inception (i.e., they should have never started LAHC in the first place);

b. damages in the form of lost profits (i.e., the amount LAHC would have earned, if any, but for their conduct);

c. damages in the form of excessive losses (i.e., the difference between the amount LAHC would have lost, if any, and the amount LAHC did lose, because of their conduct);

d. damages in the form of deepening insolvency (i.e., the damages caused by their decision to prolong the corporate existence of LAHC beyond insolvency);

e. damages in the form of all legitimate debts owed to creditors of LAHC, including but not limited to those unpaid debts owed to health care providers who delivered services to members of LAHC, any debts owed to members of LAHC that were not paid, and the debt owed to CMS (both principal and interest) as a result of LAHC's gross negligence as pled herein;

f. disgorgement of all excessive payments, bonuses, profits, benefits, and other compensation inappropriately obtained by them;

g. damages in the form of all excessive administrative, operational, and/or management expenses incurred by LAHC prior to Receivership including:

   i. Untimely payment of member and provider claims;

   ii. Incorrect payment of member and provider claims;

   iii. Increased interest expense due to incorrect and/or untimely claims payments:

   iv. Increased expenses due to incorrect and/or untimely claims payments;

   v. Incorrect and/or untimely payment of agent/broker commissions:

   vi. Inaccurate and/or untimely collection of premium due for health coverage;

   vii. Increased expenses for services from LAHC vendors other than the third party administrator;

   viii. Increased expenses for provider networks and medical services;

   ix. Loss of money due to LAHC from the Center for Medicare and Medicaid Services ("CMS") for risk adjustments;

x. Fines incurred for failure to have agents/brokers properly appointed; and

xi. Inability to repay the millions of dollars loaned to LAHC by the federal government.

h. all other compensatory and equitable damages allowed by applicable law.

PRESCRIPTION AND DISCOVERY OF TORTIOUS CONDUCT

136.

Plaintiff shows that LAHC was adversely dominated by the Defendants named herein, who effectively concealed the bases for the causes of action stated herein. Plaintiff did not discover the causes of action stated herein until well after the Receiver was appointed and these matters were investigated as part of the pending Receivership proceeding. Furthermore, Plaintiff had no ability to bring these actions prior to receiving authority as a result of the Receivership orders entered regarding LAHC. Further, none of the creditors, claimants, policyholders or members of LAHC knew or had any reason to know of any cause of action for the acts and omissions described in this Petition until after LAHC was placed into Receivership.

137.

Plaintiff further shows that the activities of the Defendants named herein constituted continuing torts which began in 2011 and continued unabated until shortly before LAHC was placed into Receivership, or at least in the case of GRI, continued until its services were terminated by LAHC in May 2016.

138.

Applicable statutes of limitations and prescriptive/peremptive periods did not commence as to Plaintiff until shortly before LAHC was placed into Receivership, at the earliest.

139.

Further, according to applicable Louisiana law, once the Commissioner of Insurance filed suit seeking an order of rehabilitation regarding LAHC on September 1, 2015, the running of prescription and preemption as to all claims in favor of LAHC was immediately suspended and tolled during the pendency of the LAHC Receivership proceeding; La.R.S. 22:2008(B).

JURY DEMAND

140.

Plaintiff is entitled to and hereby demands a trial by jury on all triable issues.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc., through his duly appointed Receiver, Billy Bostick, prays and demands that the following Defendants named herein, Group Resources Incorporated, Milliman, Inc., Buck Global f/k/a Buck Consultants, LLC, and Ironshore Specialty Insurance Company, be cited to appear and answer, and that upon a final hearing of the cause, judgment be entered against Defendants and in favor of Plaintiff for all compensable damages in an amount reasonable in the premises, including:

a. All compensatory damages allowed by applicable law caused by Defendants' actionable conduct;

b. all fees, expenses, and compensation of any kind paid by LAHC to Defendants, GRI, Milliman, and Buck;

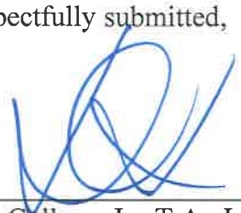
c. all recoverable costs and litigation expenses incurred herein;

d. all judicial interest;

e. any and all equitable relief to which Plaintiff may appear properly entitled; and

f. all further relief to which Plaintiff may appear entitled.

Respectfully submitted,



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Phone: (225) 236-3636

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing has been furnished via e-mail and U.S. Mail, postage prepaid, to all counsel of record as follows, this 1st day of April, 2021, in Baton Rouge, Louisiana.

W. Brett Mason
Michael W. McKay
Stone Pigman
301 Main Street, #1150
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Justin Kattan
Catharine Luo
Justine Margolis
Reid Ashinoff
DENTONS US
1221 Avenue of the Americas
New York, NY 10020

J. E. Cullens, Jr.

PLEASE SERVE THE FOLLOWING DEFENDANT WITH THE PETITION FOR DAMAGES AND JURY DEMAND *AND* FIRST SUPPLEMENTAL, AMENDING AND RESTATED PETITION *AND* SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION, *AND* THIRD SUPPLEMENTAL, AMENDING AND RESTATED PETITION, *AND* FOURTH SUPPLEMENTAL, AMENDING AND RESTATED PETITION, *AND* FIFTH SUPPLEMENTAL, AMENDING AND RESTATED PETITION AS FOLLOWS:

IRONSHORE SPECIALTY INSURANCE COMPANY
Through its agent for service of process:
The Louisiana Secretary of State
8585 Archives Avenue
Baton Rouge, LA 70809