Solicitation

1. Solicitation #: HMO RFP #H0020 **2. Solicitation Issue Date: 05/31/2016**

3. Brief Description of Requirement:

HMO RFP #H0020– Health Benefits for State of Oklahoma Employees for Calendar Year 2017

**Questions Due – please reference Section I.D.4 regarding deadline for questions

PLEASE NOTE: DUE TO CHANGES IN THE SOLICITATION PROCESS THERE IS NO LONGER A PART I AND PART II.

4. Response Due Date[1]: 06/16/2016 **Time**: 3:00PM CST/CDT

5. Issued By and RETURN SEALED BID TO[2]:

Personal, U.S. Postal or Common Carrier Delivery:

Office of Management and Enterprise Services
Central Purchasing
5005 N. Lincoln Blvd., Suite 300
Oklahoma City, OK 73105

6. Solicitation Type (type "X" at one below)**:**

- ☐ Invitation to Bid
- ☒ Request for Proposal
- ☐ Request for Quote

7. Requesting Agency: Office of Management and Enterprise Services/Employee Benefits

8. Contracting Officer:

Name: Rickey Thomas
Phone: 405-522-8160
Email: rickey.thomas@omes.ok.gov

[1] Amendments to solicitation may change the Response Due Date (read GENERAL PROVISIONS, section 3, "Solicitation Amendments")
[2] If "U.S. Postal Delivery" differs from "Carrier Delivery, use "Carrier Delivery" for courier or personal deliveries

Responding Bidder Information

"Certification for Competitive Bid and Contract" ***MUST*** *be submitted along with the response to the Solicitation.*

1. RE: Solicitation # HMO RFP #H0020

2. Bidder General Information:

FEI / SSN : _____ VEN ID: _____

Company Name: _____

3. Bidder Contact Information:

Address: _____

City: _____ State: ____ Zip Code: _____

Contact Name: _____

Contact Title: _____

Phone #: _____ FAX#: _____

Email: _____ Website: _____

4. Oklahoma Sales Tax Permit[1]:

☐ YES – Permit #: _____

☐ NO – Exempt pursuant to Oklahoma Laws or Rules

5. Registration with the Oklahoma Secretary of State:

☐ YES - Filing Number: _____

☐ NO - Prior to the contract award, the successful bidder will be required to register with the Secretary of State or must attach a signed statement that provides specific details supporting the exemption the supplier is claiming (www.sos.ok.gov or 405-521-3911).

6. Workers' Compensation Insurance Coverage:

Bidder is required to provide with the bid a certificate of insurance showing proof of compliance with the Oklahoma Workers' Compensation Act.

☐ YES – include a certificate of insurance with the bid

☐ NO - attach a signed statement that provides specific details supporting the exemption you are claiming from the Workers' Compensation Act (Note: Pursuant to Attorney General Opinion #07-8, the exemption from 85 O.S. 2011, § 311 applies only to employers who are natural persons, such as sole proprietors, and does not apply to employers who are entities created by law, including but not limited to corporations, partnerships and limited liability companies.)[2]

_____ _____

Authorized Signature Date

_____ _____

Printed Name Title

[1] **For frequently asked questions concerning Oklahoma Sales Tax Permit, see http://www.tax.ok.gov/faq/faqbussales.html**

[2] **For frequently asked questions concerning workers' compensation insurance, see** http://www.ok.gov/oid/faqs.html#c221

Certification for Competitive Bid and/or Contract (Non-Collusion Certification)

NOTE: A certification shall be included with any competitive bid and/or contract exceeding $5,000.00 submitted to the State for goods or services.

Solicitation or Purchase Order #: HMO RFP #H0020

Supplier Legal Name: _____

SECTION I [74 O.S. § 85.22]:

A. For purposes of competitive bid,

1. I am the duly authorized agent of the above named bidder submitting the competitive bid herewith, for the purpose of certifying the facts pertaining to the existence of collusion among bidders and between bidders and state officials or employees, as well as facts pertaining to the giving or offering of things of value to government personnel in return for special consideration in the letting of any contract pursuant to said bid;
2. I am fully aware of the facts and circumstances surrounding the making of the bid to which this statement is attached and have been personally and directly involved in the proceedings leading to the submission of such bid; and
3. Neither the bidder nor anyone subject to the bidder's direction or control has been a party:
    a. to any collusion among bidders in restraint of freedom of competition by agreement to bid at a fixed price or to refrain from bidding,
    b. to any collusion with any state official or employee as to quantity, quality or price in the prospective contract, or as to any other terms of such prospective contract, nor
    c. in any discussions between bidders and any state official concerning exchange of money or other thing of value for special consideration in the letting of a contract, nor
    d. to any collusion with any state agency or political subdivision official or employee as to create a sole-source acquisition in contradiction to Section 85.45j.1 of this title.

B. I certify, if awarded the contract, whether competitively bid or not, neither the contractor nor anyone subject to the contractor's direction or control has paid, given or donated or agreed to pay, give or donate to any officer or employee of the State of Oklahoma any money or other thing of value, either directly or indirectly, in procuring this contract herein.

SECTION II [74 O.S. § 85.42]:

For the purpose of a contract for services, the supplier also certifies that no person who has been involved in any manner in the development of this contract while employed by the State of Oklahoma shall be employed by the supplier to fulfill any of the services provided for under said contract.

The undersigned, duly authorized agent for the above named supplier, by signing below acknowledges this certification statement is executed for the purposes of:

☐ **the competitive bid attached herewith and contract, if awarded to said supplier;**

OR

☐ the contract attached herewith, which was not competitively bid and awarded by the agency pursuant to applicable Oklahoma statutes.

Supplier Authorized Signature	Certified This Date
Printed Name	Title
Phone Number	Email
Fax Number	

SECTION I
PROCUREMENT INFORMATION AND CONTRACT TERMS

I.A. Introduction

I.A.1. Human Capital Management (HCM), Division of the Office of Management and Enterprise Services (OMES).

The State of Oklahoma Human Capital Management (HCM) one of the agencies consolidated within the Office of Management and Enterprise Services (OMES) pursuant to 62 O.S. §(2012) 34.3.1. OMES further consolidated the Oklahoma State Employees Benefits department (EBD) and the Employees Group Insurance Department (EGID) within HCM. In addition to administering the Oklahoma Personnel Act, HCM is responsible for administering the Oklahoma Employees Insurance and Benefits Act. 74 O.S. § 1301 et seq. and the Oklahoma State Employees Benefits Act. 74 O.S. § 1361 et seq.

As such, HCM must provide for health and dental benefit choices for active State employees and their eligible dependents, HCM through its Employees Group Insurance Department (EGID), and pursuant to 74 O.S. § 1301 et seq. is also responsible for preparing, overseeing, and providing health and dental benefits choices for (1) participating Medicare eligible former State employees (Medicare supplement) and their eligible dependents, (2) participating non-Medicare eligible former State employees and their eligible dependents (3) current and participating education former employees and their eligible dependents, and (4) current and participating former employees of other eligible participating groups/agencies and their eligible dependents. Former employees and their dependents may or may not be eligible for Medicare. HCM is responsible for contracting with carriers, producing employee benefit communication material, and collecting premiums from the carriers.

I.B. Introduction and Objectives

I.B.1. Introduction

This Request for Proposal (RFP) is issued by the Office of Management and Enterprise Services/Central Purchasing (OMES/CP), on behalf of HCM for the purpose of soliciting proposals from HMO vendors that meet the requirements outlined in the *Health Maintenance Organization Act*, 36 O.S. § 6901 et seq., and Section I.D. of this RFP for the procurement of managed health care plans for participating members specified in Section I.A. of this RFP. OMES/CP may request proposals on a single plan or any combination of plans. Vendors must be authorized by the Oklahoma Insurance Department to offer an HMO plan to the participating members.

I.B.2. Objectives

HCM primary objectives are to:

- Offer cost effective managed care service alternatives to its population statewide; and
- Provide improvements and initiatives in health care benefits which are available in Oklahoma while maintaining a cost efficient program and a rising level of quality health care services.

I.C. Purpose

The purpose of this RFP is to solicit competitive proposals from qualified vendors for managed health care benefits as specified in this RFP for the participating members outlined in Section I.A of this RFP. This RFP describes the participation standards for the vendor. It also describes the proposal submission steps, which must be followed by the vendors. Vendors are cautioned to carefully review all participation standards and proposal submission requirements. OMES/CP and EBD reserves the right to reject as non-responsive any proposal that does not demonstrate full compliance with the participation standards and which otherwise does not conform fully to the proposal submission instructions. OMES/CP along with the HCM Employee Benefits Department (EBD) will determine whether a plan meets the requirements specified herein and its determination will be final.

I.D. Proposal Submission/Procurement Terms and Conditions

I.D.1. HMO Licensure

As terms of this RFP, successful vendors must agree to accept all terms, conditions and requirements as set forth in this RFP, and comply with any subsequent requirements announced by the State or Federal government that impacts the delivery of coverage for HMO members. OMES/CP terms and conditions specified in this RFP shall not be amended by a vendor's proposal. Vendor(s) submitting a proposal with exceptions and/or proposed alternatives to OMES/CP RFP terms and conditions and/or who refuse to accept OMES/CP RFP terms and conditions as specified in the RFP may not be considered and may not be accepted by OMES/CP. **A successful vendor must have its HMO licensure completed with the proper licensing authority.** All proposals must be submitted in accordance with the policies, procedures, requirements, and dates set forth below.

I.D.2. Vendor Eligibility

Vendors seeking to contract with HCM to provide health benefit plans pursuant to the terms and conditions of this RFP must be a registered vendor with OMES/CP. Vendors are required to submit HMO Utilization Experience Data as specified herein from HMOs meeting the requirements outlined in 36 O.S. 6901 et seq. **The specification made in prior years shall not serve as precedent for specifications that may be specified in this RFP.** Vendors who are currently under contract with the State for Plan Year 2016 must complete Attachment M, Attachment N, Attachment O, Attachment P, Attachment

Q, Attachment R, and Attachment S. Information contained in Attachment N, Attachment O, Attachment P, Attachment Q, and Attachment R will be provided in accordance with industry standards to vendors not under contract with the State of Oklahoma for Plan Year 2014, 2015, and 2016 if requested. Vendors that are not under contract with the State for Plan year 2016 must provide the information contained in Attachment S for their Oklahoma book of business. **Compliance with this paragraph shall be strictly enforced. Proposals that fail to provide the information requested shall be deemed non-responsive and the vendor shall be ineligible to bid on this HMO RFP #H0020.**

Information should be marked as confidential (see I.G.)

I.D.3. Proposal Closing

Proposals in response to this RFP must be received at the following address no later than Thursday, June 23 , 2016, 3:00 p.m., CDT:

Rickey Thomas, Contracting Officer
Office of Management and Enterprise Services, Central Purchasing
5005 N. Lincoln Blvd., Suite 300
Oklahoma City, Oklahoma 73105

Proposals received after 3:00 p.m., CDT, Thursday, June 23, 2016 will be returned unopened to the vendor. **Faxed or emailed proposals shall not be accepted.** All proposals shall be stamped with the time and date upon receipt at the office of the OMES/CP. Envelopes or containers must contain responses to only one RFP, and be sealed, and the name and address of the vendor must be affixed in the upper left-hand corner. The RFP number and closing date must appear on the face of the envelope or container.

The proposals shall be placed in a secured bid room until the date and time for the scheduled proposal closing. Access to the room is limited to OMES/CP and their designees until the proposal opening. A proposal opening record shall be completed and maintained in the proposal file.

I.D.4. Questions and Answers

Vendors may submit written questions by email regarding this RFP (Q & As). Written questions are to be emailed on or before 3:00 p.m., CDT Wednesday, June 8, 2016. Written questions relating to this HMO RFP #H0020 must be labeled as such. Written questions received after 3:00 p.m., CDT, Wednesday , June 8, 2016 will not be considered. All written questions received within the date and time as specified in this section shall be answered in writing with all questions and all answers disseminated to all qualified registered vendors. All written answers provided shall be considered as the final set of answers and shall amend the RFP accordingly. Questions must be in writing and addressed to:

Rickey Thomas, Contract Officer
Office of Management and Enterprise Services, Central Purchasing
5005 N. Lincoln Blvd., Suite 300
Oklahoma City, Oklahoma 73105
Email: rickey.thomas@omes.ok.gov

I.D.5. Proposal Response Format

The vendors's proposal must follow the format and respond to the Proposal Questionnaire detailed in Section III.B. HCM seeks an accurate and concise description of the vendor's compliance with all standards and requirements in this RFP. Proposals should not require extra review because of irrelevant or redundant material. All materials required to be submitted with the proposal must be received by OMES/CP no later than the date and time specified in Section I.D.3 of this RFP. Materials received after the date and time described in Section I.D.3 of this RFP will not be considered.

I.D.6. Prohibited Communication

Any communication from vendors that relates to the HMO RFP #H0020 must be directed to Rickey Thomas, Contracting Officer, OMES/CP.

I.E. Competitive Negotiation – Best and Final Offer (BAFO)

I.E.1. Best and Final Offer (BAFO) Process

Contracts for health plans provided by qualified vendors may be awarded based on best and final offer (BAFO) through confidential competitive negotiation. In the sole discretion of HCM, a BAFO process shall be conducted with qualified vendors if it is considered by HCM to be in the best interest of the State. In the event OMES/CP and HCM considers a BAFO process to be in the best interest of the State, all qualified vendors meeting the minimum requirements of the RFP shall be afforded an opportunity to negotiate a BAFO with HCM. OMES/CP on behalf of HCM shall issue a written request to all qualified vendors for a BAFO. Only qualified vendors who satisfy the minimum bid requirements specified in the HMO RFP shall be allowed to participate in any BAFO negotiation process. OMES/CP HCM retains the right to accept or reject qualified vendor(s) BAFO. OMES/CP HCM shall retain as confidential information contained in the initial proposals submitted by qualified vendor(s) as well as any subsequent bid offers made by qualified vendors (s) prior to final contract award as part of the BAFO negotiation process. The BAFO negotiation process shall allow for modification and alteration of vendor(s) proposal content and vendor(s) proposal price after proposals are submitted and during the evaluation process. Upon request for a public bid opening, only the name(s) of the qualified vendor(s) shall be move to closing date revealed; neither price nor proposal content shall be revealed and made public until after the BAFO process is complete and notice of intent to award is announced by OMES/CP HCM. Only the final, agreed-upon price and final, agreed-upon proposal content shall be made public after the BAFO process is complete and notice of intent to award is announced by HCM. Information clearly designated in the RFP as proprietary shall be held confidential pursuant to 74 O.S. § 1304.1(M)(12). After an initial proposal is

received and opened by OMES/CP following the bid closing date and time, the initial proposal offered by qualified HMO vendor(s) may be discussed for clarification and/or modification if OMES/CP and HCM deems it advantageous to do so. In this context, "discussion" shall mean clarification, modification, and negotiation, or any of these. Discussion(s) with a qualified HMO vendor(s) during negotiation and/or clarification shall be conducted individually and privately with qualified HMO vendor(s) and may be tape recorded by HCM. OMES/CP and HCM shall hold all tape recordings, transcripts and notes of discussion(s) confidential. Changes shall not be allowed in qualified HMO vendor(s) proposal or price after BAFOs are received, unless HCM determines, in its sole discretion, that re-submission would be in the best interest of the State.

I.E.2. Best and Final Offer (BAFO) Criteria

The specific criteria of the BAFO shall include, but not be limited to the following:

OMES/CP and HCM may assess the rates that the vendor(s) proposes in response to this RFP. OMES/CP on behalf of HCM may request that the vendor(s) provide additional information regarding the basis for the quoted rates, including assumptions relating to trend, utilization, participation, margin and other rate elements. OMES/CP and HCM may also request that the vendor(s) identify the cost impact in the quoted rates of other factors typically considered in the underwriting and rate development process, such as the administrative costs and experience data reported in the RFP #H0020, and in the vendor(s) quarterly experience and utilization reports to HCM. Following its assessment, OMES/CP and HCM may inform the vendor(s) that the rate quoted in response to this RFP is considered excessive and request that the vendor(s) reassess its offer rate quotation. HCM will then review the BAFO quote. If the BAFO rate quote is determined by the OMES/CP and HCM to be excessive, OMES/CP and HCM shall have the authority to reject the bid or restrict enrollment in any vendor(s) for which HCM determines the benefit price to be excessive.

I.E.3. Designation of Best and Final Offer (BAFO) Personnel

The vendor shall provide the name and title of the personnel authorized to enter into competitive negotiation(s) with HCM in the event OMES/CP and HCM wishes to negotiate rates for a BAFO. During a competitive negotiation process, the vendor shall correspond with OMES/CP and HCM designated personnel utilizing any written means of communication; including but not limited to email, fax, overnight mail, etc. However, the vendor's original copy of the BAFO must be executed and submitted by the vendor's CEO or CFO and received by OMES/CP and HCM designated personnel via mail or overnight delivery. The vendor's designated personnel authorized to enter into competitive negotiations shall be submitted as part of the vendor's Executive Summary. In the event the vendor's designated personnel changes, the vendor's shall notify OMES/CP immediately in writing.

I.F. Award of Contract

I.F.1. Order of Precedence and Assignability

Upon such time as OMES/CP and HCM accepts a vendor(s) proposal, said accepted proposal shall be accepted as a binding offer and the RFP and the vendor's proposal shall constitute a contract between the successfully awarded vendor's and HCM. In the event any contradiction or variation occurs between a vendor's proposal and the RFP, the RFP document shall take precedence. No duties, obligations or rights arising from the terms of the RFP shall be transferred or assigned without prior approval of HCM.

I.F.2. Number of Contracts

OMES/CP and HCM shall identify and apply criteria within the RFP and the proposals for final selection and award of contracts. The evaluation process may allow for the selection of less than all of the responsive qualifying proposals, as allowed by law and as determined to be in the best interest of the State.

I.F.3. Minor Deficiencies

The State purchasing Director has the right to waive minor deficiencies or informalities in a proposal provided that the best interest of the State would be served without prejudice to the rights of the other vendors.

I.F.4. Conflict of Interest

All ethics, rules and laws related to conflicts of interest and doing business with public officials applies to any contract with The State of Oklahoma.

I.F.5. Evaluation and Selection Process

The *Oklahoma State Employees Benefits Act*, 74 O.S. § 1371(C) states that all plans offered by vendor(s) meeting the proposal requirements as determined by HCM shall be accepted. The determination of compliance with proposal requirements shall be made by OMES/CP and HCM. HCM shall be responsible and have the final decision regarding compliance with administrative rules and regulations. Responses to the Proposal Questionnaire in Section III.B will be used to evaluate the proposals submitted by the vendor(s).

I.F.6. Contract Period

This Agreement binds the vendor as of the date of award to provide services, as awarded, for Plan Year 2017 (January 1, 2017 through December 31, 2017).

I.F.7. Cancellation of Procurement

HCM reserves the right to cancel this procurement activity at any time and for any reason as determined to be in the best interest of the State.

I.F.8. Costs Incurred

OMES/CP and HCM specifically assumes no responsibility for expenses incurred by the vendor in the submission or review of any proposal in response to this RFP. All such costs shall be the vendor's responsibility, whether or not a contract is awarded.

I.G. Proposal Ownership and Confidentiality

All proposals and materials submitted in response to this RFP become the property of the State of Oklahoma. Pursuant to 74 O.S. § 1304.1(M) (12), "Human Capital Management shall have the duty, responsibility and authority with respect to the administration of the plan to retain as confidential information, the initial RFP offers as well as any subsequent bid offers made by the health plans prior to final contract awards and as part of the BAFO negotiation process for the benefit plan."

As specified in Paragraph I.D.II , the information requested in Attachment M, Attachment N, Attachment O, Attachment P, Attachment Q, Attachment R, and Attachment S of this RFP, is deemed proprietary and shall be held confidential and are not subject to the Open Records Act pursuant to Title 51 O.S. §24A.10(B).

The information requested in Attachment M, Attachment N, Attachment O, Attachment P, Attachment Q, Attachment R, and Attachment S shall be sealed in an envelope that shall be clearly labeled "CONFIDENTIAL" in bold ink. Both the front and back of the sealed envelope shall bear the "CONFIDENTIAL" label as specified in this section. Situated immediately below the "CONFIDENTIAL" label shall be the name of the vendor submitting the proposal and the RFP Number labeled as HMO RFP #H0020.

I.G.2 Actuary Certification

Vendors are required to submit a statement from a qualified HMO actuary certifying that the vendor's information submitted in response to Attachment M, Attachment N, Attachment O, Attachment P, Attachment Q, Attachment R, and Attachment S is true, complete, and accurately reflects the experience of this account. The qualified HMO's actuary certification shall be submitted as part of the vendor's response to this RFP. A "qualified HMO actuary" as used herein shall be a person recognized by either the American Academy of Actuaries or the Society of Actuaries as being qualified for such actuarial evaluation and certification. Proposals received without the required HMO actuary certification will not be accepted and the vendor shall be ineligible for award of contract for Plan Year 2017.

I.H. Readiness Reviews

OMES/CP and HCM shall conduct scheduled meetings to the service provider for purposes of testing the readiness of the provider. These reviews will take no more than one (1) day each. HCM staff members, as well as consultants for the State as needed, will interview appropriate HMO personnel in all major organizational areas, and will perform document and process reviews where appropriate. Details of the schedules, agendas, and content of the readiness reviews will be distributed to the contracting HMOs in a timely manner. Submission of a proposal in response to this RFP commits the bidding HMO to cooperate and participate in these reviews, as required by HCM.

I.H.1. Pre-Readiness Review Questions

Prior to the Readiness Review meetings described in Section I.H. of this RFP, OMES/CP and HCM may submit a written list of questions to the vendor. These questions should be completed by the vendor and returned to HCM no later than the time scheduled for the vendor's.

I.I. General Contract Terms

I.I.1. Records

A Vendor who is awarded a contract agrees to maintain all necessary records relating to the services performed under this RFP. Such records shall be adequately safeguarded and shall be kept for a minimum of six (6) years following the expiration or termination of any contract resulting from this RFP. The state auditor and inspector, HCM or its designated representative, and any other State or Federal entity authorized by law, shall have the right of access and inspection to all HMO files and records relevant to the contract for examination and audit.

I.I.2. Laws and Regulations

The vendor agrees to abide by all State and Federal statutory requirements and administrative rules, including grievance processes, and any other laws governing State employees' health coverage as applicable to the procurement of health benefits. This RFP is subject to all applicable Oklahoma State Statutes. Any provision of this RFP which is not in conformity with existing or future legislation shall be considered amended to comply with such legislation. Any interpretation or disputes with respect to the RFP shall be resolved in accordance with the laws of the State of Oklahoma.

I.I.3. Administrative Assessment

The quoted rates shall include an administrative cost adjustment to reimburse EBD and EGID of HCM for administrative activities including, but not limited to, enrollment, record keeping, accounting, and employee communication functions. The amount of this adjustment shall be $4.624 Per Member Per Month (PMPM) rate collected by EBD and

EGID. This fee is determined annually by EBD and EGID respectively and is subject to change either up or down in pricing.

I.I.4. Notice

Whenever notice is required to be given to the other party, it shall be made in writing and delivered to that party. Delivery shall be deemed to have occurred if a signed receipt is obtained, either when delivered by hand or return receipt requested. Delivery shall also be deemed to have occurred three (3) days after mailing by certified or registered mail. Notices shall be addressed as follows:

In case of notice to the vendor:

Designated Contract Officer
Vendor's Name
Vendor's Address
Vendor's Telephone Number
Vendor's Fax Number

In case of notice to the HCM/Employee Benefits Department:

Mr. Jimmy Trotter, Director
Administrator of Benefits and Contracts
Human Capital Management
Employee Benefits Department
Will Rogers Building
2401 N. Lincoln Blvd, Suite 106
Oklahoma City, Oklahoma 73105

In case of notice to EGID:

Diana O'Neal, Deputy Administrator
Office of Management and Enterprise Services
Employees Group Insurance Department,
3545 N.W. 58th Street, Suite 110
Oklahoma City, OK 73112

Such notices shall become effective on the date of delivery or the date specified within the notice, whichever comes later. Either party may change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

I.I.5. Severability

The terms and provisions of this RFP and resulting agreement and contract shall be deemed to be severable one from the other, and any determination at law or in court of

equity that one term or provision is unenforceable, shall have no effect on the remaining terms and provisions of this RFP, or any one of them, in accordance with the intent and purposes of the parties hereto.

I.I.6. Termination

HCM may terminate the contract in whole or in part, whenever it determines that an HMO or its subcontractors has failed to meet its responsibilities and duties under the contract and is unable or unwilling to cure such failure within a reasonable period of time, as specified in writing by the State, through HCM, taking into account the gravity and nature of the default. HCM shall provide the HMO with a thirty (30) day written notification of termination; however, an immediate termination shall be administered when a violation(s) is found to be an impediment to the State. The contract shall not be cancelled by any HMO for any reason during the contract period.

I.I.7. Amendment and Modification

OMES/CP and HCM may hereafter supplement the RFP for the purposes of enumerating, defining, and clarifying duties, functions, terms and conditions.

I.I.8. Choice of Law

The RFP and contract shall be governed in all respects by the laws and statutes of the State of Oklahoma. The vendor, by submitting a proposal, agrees to submit to the jurisdiction of the State of Oklahoma should any dispute, disagreement or any controversy of any kind arise or result out of the terms, conditions, or interpretation of the RFP and contract. The selected health plan, by submitting a proposal, agrees to submit to the jurisdiction of the courts of the State of Oklahoma and agree that venue for any legal proceeding against the State regarding the RFP and contract shall be filed in the District Court of Oklahoma County. Any contract resulting from this RFP and any dispute arising there from, shall be in conformance with and governed by the laws of the State of Oklahoma.

I.I.9. Hold Harmless

The State of Oklahoma shall not be responsible for the work, direction and compensation of all HMO employees, consultants, agents and subcontractors. Nothing in this RFP and contract, or the performance thereof by the HMO, shall impose any liability or duty whatsoever on the State, including but not limited to any liability for taxes, compensation, disability benefits, Social Security or other employee benefits for any person or entity.

HMO shall hold harmless, defend and indemnify the State of Oklahoma, its officers and employees, and employee representatives from and against any injury, damage, loss or liability to persons or property resulting from or arising out of the acts, omissions, liabilities or obligations of the HMO in the performance of the contract.

I.I.10. Certification of HMO Status

By submitting a proposal in response to this RFP, the vendor shall certify it meets all HCM requirements for a State defined HMO as specified in the laws of Oklahoma and the rules of the Oklahoma Insurance Department.

I.I.11. Significant Events

The Vendor shall immediately notify HCM Employee Benefits Department and EGID of any current or prospective "significant event" on an ongoing basis. All notifications shall be submitted in writing to Jimmy Trotter, Director, Benefits and Contracts, for the HCM Employee Benefits Department and Diana O'Neal, Deputy Administrator, for EGID. Notification to Jimmy Trotter, Director, Benefits and Contracts shall be to the address listed in Section I.I.4 of this RFP. Notification to Diana O'Neal, Deputy Administrator, shall also be to the address listed in Section I.I.4 of this RFP. As used in this provision, a "significant event" is any occurrence or anticipated occurrence which might reasonably be expected to have a material effect upon the HMOs ability to meet its contractual obligations to HCM. Significant events may include but not be limited to the following:

- Disposal of major assets;
- Any major computer software conversion, enhancement or modification to the operating systems, security systems, and application software, used in the performance of this contract;
- Termination or addition of provider contracts;
- The HMOs insolvency or the imposition of, or notice of the intent to impose, a receivership, conservatorship or special regulatory monitoring or any bankruptcy proceedings, voluntary or involuntary, or reorganization proceedings;
- The withdrawal of, or notice of the intent to withdraw from the Joint Commission or the National Committee for Quality Assurance (NCQA) certification;
- Impairment of the security offered as a performance guarantee;
- strikes, slow-downs or substantial impairment of the HMOs facilities or of other facilities used by the HMO in the performance of this contract;
- Reorganization, reduction and/or relocation in key personnel such as, but not limited to, customer service representatives or claims adjusters;
- Known or anticipated merger or acquisition;
- Known, planned or anticipated stock sales;
- Any litigation filed by a member against the HMO;
- Any sale or merger; or
- Significant changes in market share or product focus;
- HIPAA violation; and
- 6055 IRS reporting deficiencies

I.I.12. Contract Obligations and Enforcement

The vendor understands that by bidding on the RFP, it assumes a legal obligation to perform in good faith according to the terms specified in this RFP during the entire contract period. Vendors who fail to so perform are hereby notified that HCM reserves the right to undertake all measures, including legal proceedings, to protect the interests of the parties to and the beneficiaries under this agreement.

SECTION II
SCOPE OF SERVICES
PERFORMANCE STANDARDS AND PLAN REQUIREMENTS

II.A. General Scope of Service

II.A.1. Eligibility/Enrollment

HCM has the responsibility and authority to decide all questions of eligibility. Each fall preceding the beginning of the plan year, Option Period occurs during which time members may choose elections of health plans. Eligible dependents may be added under the State's eligibility regulations. No evidence of insurability will be required for eligible health plan enrollees. A Medicare plan may also be provided by each vendor as required by Section IV, Appendix K.

Active employees may enroll in coverage the first day of the month following the month of employment or the date he becomes eligible. If the employee elects dependent coverage, the employee must cover all eligible dependents, unless the dependent is covered by other insurance. The employee also has (30) thirty days after acquiring a new dependent in which to add that dependent. Members or dependents not enrolled when initially eligible or within thirty (30) days of a midyear qualifying event, cannot elect coverage until the next Option Period.

Coverage for newborn dependents will be effective the first of the birth month only if the member enrolls the newborn within thirty (30) days of the birth event. Premiums for the newborn are due for each month the child is covered through the employer.

In order to select an HMO option, the employee must reside or be employed (live or work) within the selected HMO's service area. Eligible dependents must reside within the selected HMOs service area to participate in the HMO.

Prevention of enrollment of employees during the aforementioned Option Period or during the plan year as mentioned previously is prohibited. Furthermore, unilateral disenrollment of a member by the HMO, unless agreed to in writing by EGID, is not allowed except in the event of relocation of service area.

During 2016, EBD and EGID are working together to change the flow of eligibility data and premium dollars. Once complete, EGID will communicate all eligibility data and remit all premium dollars to carriers.

EGID will furnish the vendor with updated eligibility data on a weekly basis at a minimum. Confirmation must be provided to EGID after eligibility has been received. Information on eligibility reconciliation will also be furnished on a periodic basis. EGID will maintain individual eligibility records. The vendor will be required to maintain its eligibility records from the data provided in a timely and accurate manner. Eligibility information sent as "urgent" must be processed and confirmed within (24) twenty-four hours. The eligibility file layout for EGID is as follows:

Eligibility File Layout

The HMO must accept EGID's eligibility file layout as described in Appendix J. The following is a list of various eligibility transactions included in a typical incremental file. Any of the following could have future or retroactive dates.

- New member/dependent enrollment
- Member/dependent termination
- Member/dependent adding and/or dropping various benefits
- Member moves between participating employer groups
- Dependent moves from participating primary member to another primary member
- Member/dependent status changes from active to retiree or COBRA status
- Member/dependent becomes eligible for Medicare
- A lapse is added to a member/dependent coverage
- Member address changes

The above listing is provided for informational purposes and should not be considered an all-inclusive list of eligibility transactions.

Confirmation must be provided to EGID after eligibility information has been received. Notice to EGID should be sent to sib.edi@sib.ok.gov stating that the eligibility file has been received. Confirmation must also be provided to EGID if eligibility has not been processed within three (3) business days of receipt. Notice to EGID should be sent to sib.edi@sib.ok.gov stating what has not been processed and the reason for it.

The vendor must verify and commit that during the length of the contract, it shall provide no less than thirty (30) day notice to EGID prior to performing changes, fixes, modifications and enhancements that may impact the exchange of eligibility or any other shared business processes. The vendor must also include a test plan and provide resources to EGID to verify changes are valid and will not disrupt business processes. Changes will not be implemented until both parties mutually agree the changes are ready to be put into production.

All operational data, including but not limited to email messages, EPHI (electronic protected health information), batch eligibility files, reports and pre-edits, shall be encrypted when transmitted in any manner outside of the protected (trusted) network. Data must remain encrypted when at rest in a publicly accessible manner, to include FTP servers and portable media such as flash drives, CD, and DVD media. The data shall be transmitted in a secure, encrypted manner. The preferred method of connectivity between vendors and EGID is TLS for email communications.

The vendor shall use appropriate security and encryption to protect the confidentiality of EGID’s data. EGID currently uses Pretty Good Privacy (PGP) as its standard data file encryption application. Data file transmissions will be performed utilizing the SFTP (Secure FTP) protocol.

The State of Oklahoma will adhere to all parts of the Department of Health and Human Services Security Standards for Health Insurance Reform (45 CFR Parts 160, 162, and 164).

II.A.2. Dependents Residing at a Different Address

Eligible dependents residing at an address different from the employee's address may select a primary care physician (PCP) in the service area covering the dependent's address within the state of Oklahoma.

II.A.3. Scope of Benefits

Vendors are required to meet and offer the benefits and copayments as outlined in, Section IV, Appendix B. HCM/EBD may also request additional plans such as a Point of Service, Value Based Networks, or Accountable Care Organization option. Vendors must also provide a Medicare plan as described in Section III, Appendix K only if the vendor offers a Medicare supplement product to other entities within Oklahoma. Vendors must meet or exceed the Medicare plan as specified in Section III, Appendix K. Terms relating to Medicare plans are not negotiable.

In addition to the benefits provided in Section III, Appendices B and L, vendors must provide any benefits and reporting (such as 6055) required by state or federal law.

II.A.4. Service Enhancements

Vendors may offer enhancements in an effort to make their plans more attractive and competitive, including, but not limited to, the following:

- 24-Hour Toll-Free Nurse Line
- Well Woman Self-Referral
- Wellness/Health Education
- Health and Fitness Discounts
- Healthy Pregnancy Program
- Vision

The enhancements must be clearly identified and consolidated into one page in vendor's response to this RFP and in any material submitted to HCM/EBD and EGID to be disseminated to members.

II.A.5. Standardized Service Areas and Access Standards

The HCM Employee Benefits Department has a standardized geographic service area that includes every zip code within the geographic borders of the State of Oklahoma. Vendors are encouraged to provide services in the standardized geographic service area; however, vendors are not required to offer enrollment in every service area. Vendors should clearly

identify the zip codes of all areas in which it will offer services in Section IV, Appendix A. Access standards for the standardized service area and those areas which fall outside the standardized service area offered by the vendor shall meet the minimum requirements of the Oklahoma Insurance Department.

The HMO may provide a plan of benefits for those participants that live outside the State of Oklahoma. A census report (CD) Appendix I, included with this RFP, clearly identifies by age, sex, zip code and the number of participants the areas of the United States in which participants are located. The premium for coverage to participants outside the State of Oklahoma must be the same as quoted for participants within the State of Oklahoma.

II.A.6. Levels of Coverage

The State of Oklahoma offers four levels of coverage for both eligible current and eligible former employees and their eligible dependents. Rates must be quoted for all four levels as specified below. Rate quotes for coverage levels other than the four levels specified below shall not be considered. The vendor will be required to describe the methodology for developing the rates as outlined in Section III.D. The four levels of coverage are as follows.

- Employee Only
- Spouse
- One Child
- Two or More Children

If a Vendor must provide a Medicare plan per Section II.A.3, such a vendor must be able to provide service to members and dependents where one is eligible for Medicare and the other is not. For example, if a member is pre-Medicare and the dependent is eligible for Medicare, EGID will bill the pre-Medicare rate for the primary member and the Medicare dependent rate for the dependent.

II.A.7. Premium Rates

Each vendor shall submit a specific schedule of premium rates in accordance with actuarial principles for all categories of participants, and levels of coverage as described herein. In addition, the vendor shall submit premium rates for benefit descriptions as specified by Appendix B. Each vendor must bid on all categories, including both eligible current and former eligible employees and their eligible dependents. The premium rates shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified actuary as to the appropriateness of the method, based on reasonable assumptions, shall accompany the proposals along with adequate supporting information. Premium rate submission is detailed in Section III.D.1 of this RFP. All confidential proposed rates and copays shall be submitted in a sealed envelope separate from the vendor's proposal binder. The sealed envelope shall be labeled confidential in accordance with the format specified in Appendix D. Although vendor are required to submit an original hard copy and two (2) copies on CD of the proposal, only one original rate sheet shall be submitted with the hard copy **(Do not include on CD)**. **Vendors are cautioned not to include confidential quoted rates and copays anywhere within the vendor's proposal binder.** The qualified actuary certification and adequate supporting information shall be attached to the vendor's rate sheet. For accounting purposes, any cents quoted in the vendors's rates shall be divisible by two.

II.A.8. Risk Adjustments

In order to allocate the risk for all health care choices in an equitable manner, the State hereby prescribes the following risk adjustment factors to adjust premiums of all insured members including dependents (actives and non-Medicare retirees) affected by this RFP. These factors consider age and gender–components to adjust the employee's premium rates contracted by all health care choices available to members affected by this RFP.

This risk adjustment will be calculated for each health care choice available to affected members based on the actual enrollment (actives and non-Medicare retirees) as of the first day of the contract year and will remain constant for the entire contract year.

To the extent that a health care choice enrollment reflects a lower average risk, an adjustment (reflecting the difference of the average risk values) will be deducted from the remitted premiums to the health care choice. Conversely, a health care choice with a higher average risk will receive a positive adjustment (reflecting the excess of the average risk value). There is no risk adjustment for Medicare primary participants.

The risk adjustment for each health care choice will be calculated using the demographic table (Chart 1) published in "Health Care Costs – From Birth to Death", June 2013, sponsored by the Society of Actuaries. Upon request, HCM will be available to discuss this methodology during the Best and Final Offer process if any a health care choice has any questions.

II.A.9. Premium Accounting Requirements

The vendor shall provide EGID a monthly discrepancy report no later than sixty (60) days from the month that the premium payment represents. A verification procedure will be used for compliance.

Monthly discrepancy reports received by EGID should not go back further than the month being reconciled.

Discrepancies older than those indicated above will not be reconciled and EGID will not assume financial responsibility for a vendor's failure to comply with reconciliation efforts. Please note that no member coverage will be affected by a vendor's failure to comply with above.

During 2016, EBD and EGID are working together to change the flow of eligibility data and premium dollars. Once complete, EGID will communicate all eligibility data and remit all premium dollars to carriers. EGID remits premiums to vendors based on eligibility. If, due to retroactive adjustments, premiums must be refunded to a member or participating entity, EGID will recover those premiums from a future vendor remittance.

The vendor must notify both EBD and EGID if the HMO's medical loss ratio is at a level that would require rebates to consumers under the Patient Protection and Affordable Care Act. Procedures for ensuring that rebates are properly allocated between individuals and employees must be discussed and approved by EBD for active state

employees and EGID for education and local government employees and former employees.

II.A.10 Premium Discrepancy Reporting Procedures for Vendors

Premium Discrepancy Reporting is for vendors to submit issues concerning their premiums to EGID. The process is documented below for submission of premium discrepancies.

1. Create an Excel spreadsheet by the 25th of each month with **only** the following five fields in this order:
    a. SSN – Length 9
    b. Last Name
    c. First Name
    d. Amount of premium discrepancy
    e. Vendor comments

No additional fields are needed or wanted.

2. Please note the file layout for Premium File Discrepancy appears in Appendix J. No additional fields are needed or wanted.

3. Email the monthly discrepancy report utilizing encryption through either secure email or enforced TLS between both parties to Tasha Franklin (tasha.franklin@omes.ok.gov and David Sinclair (david.sinclair@omes.ok.gov).

II.A.11. Prohibited Limitations and Exclusions

The Vendor agrees to waive all pre-existing condition limitations and evidence of insurability requirements for all beneficiaries covered under this RFP.

II.A.12. Consolidated Omnibus Budget Reconciliation Act

Continuation of coverage must be extended to all qualified members in such a manner as to fully comply with State law and the *Consolidated Omnibus Budget Reconciliation Act* of 1985 (COBRA) and all amendments thereto that have been or may be enacted.

Qualified COBRA beneficiaries will have the option of changing enrollment elections during any Option Period, which occurs during the term of their coverage continuation. Such continuation of coverage will be administered by the plan under whose contract coverage is being continued. The employing entity will be responsible for the initial notification to the members when they have the option of continuing coverage. Thereafter, EGID will handle the premium billing, collection and termination procedures.

The monthly rates which eligible participants under COBRA are charged for HMO coverage will include the various loadings (e.g., administrative, reserves, etc.) also charged active employees as discussed in this RFP. COBRA premiums will be subject to a two percent (2.0%) administrative fee and as allowed by law retained by the State to offset the administrative costs. Based on CMS guidance, the two percent administrative fee will not be assessed on any PDP.

II.A.13. Administrative Procedures

Each contracting vendor shall furnish EBD and EGID with accurate up-to-date information as requested for an administrative reference manual to enable EBD staff to refer to the same when member questions arise about the vendors operations, coverage, and grievance procedure or provider networks. Specific information for the administrative reference manual will include updates of provider networks and other material as requested by EBD and shall be delivered to EBD within fifteen (15) business days of its request, prior to January 1, 2017**.** HMOs will receive specific instructions regarding this Manual material after award of contract by EBD one (1) copy of the administrative reference manual will be provided to EBD. Vendors shall provide the administrative reference manuals during the annual Readiness Review.

II.A.14. Additional Requirements for Any Medicare Supplement that Includes a Medicare Part D Prescription Drug Plan (PDP)

Pursuant to CMS' group enrollment procedures, EGID will process and transmit enrollments and disenrollments to the PDP in the same manner as described for all HMO plans. Any vendor offering a Medicare supplement plan whose pharmacy benefits are through a PDP must provide EGID with the following, with respect to that Plan:

- The PDP shall provide EGID, no later than August 10, 2016, with the LIS amount to be subtracted from the monthly premium for the following year if a member is eligible for a 100% percent low income premium subsidy. EGID will set up rates to properly bill for members who qualify for the 100% percent, 75% percent, 50% percent, or 25% percent premium subsidy based on the amount provided by the PDP. This requirement may be waived if an alternative method is established and approved by EGID to pass along the LIS savings to the member.

- The PDP must send a weekly report listing any enrollments rejected by CMS, as well as any disenrollments not initiated at EGID (i.e. member calls 1-800-Medicare to disenroll). In addition, the weekly report must list the proper LIS level for any member who is LIS eligible or where a change in LIS level was reported on the previous Transaction Reply Report (TRR). Required fields for this report are listed in Appendix L.

- The PDP must provide a monthly full file showing everyone covered in the PDP. Required fields for this report are listed in Appendix L.

As an employer group, EGID does not charge a Part D late enrollment penalty (LEP) to any of its members. The premium billed to the member and remitted to the plan will not include

an LEP. If an LEP exists, the PDP may include the penalty in the reconciliation process described in Section II.A.9 and EGID will reimburse the PDP for the penalty amount.

II.B. Administrative Requirements and Standards

II.B.1. Licensure

For purposes of this RFP, a bidding HMO vendor must be a health maintenance organization which meets the operational licensure requirements of 36 O.S. § 6901 et seq.

II.B.2. Operating Staff

The HMO must have sufficient operating staff to comply with all requirements and standards described in this RFP. At a minimum, the HMO vendor must be able to identify qualified staff in the following areas:

- Executive management with clear oversight authority for all other functions
- Medical director's office
- Accounting and budgeting function
- Member services function
- Provider services function
- Medical management function, including quality assurance and utilization review
- Internal complaint resolution function
- Claims processing function
- Management information system

The vendor may combine functions (e.g., Member services and internal complaint resolution) as long as it is able to demonstrate that all necessary tasks are being performed. The vendor may also use management contractors or administrative service firms to perform any or all of the above functions. Specific standards for certain of these functions follow in Section II.C.

II.B.3. Financial Solvency

The vendor shall remain in compliance with all requirements of the Oklahoma Insurance Department, including those that pertain to financial solvency. In the event of a failure to remain in compliance, vendor shall inform EBD as soon as such failure is known.

EBD may reject a vendor's proposal based upon the financial condition of the vendor's company or organization as evidenced by any fact or statement of financial condition including, but not limited to, financial statements that raise doubt about the vendor's ability to continue as a "going concern", or some similar concern or qualification. The vendor shall demonstrate its ability to be financially viable during the contract period. This demonstration shall be provided in the Executive Summary as specified in Section III.A.

II.B.4. Reinsurance

The vendor must have adequate reinsurance or adequate risk based capital to protect against catastrophic financial loss due to unusually high medical claims in accordance with the requirements of the Oklahoma State Insurance Department or another agency of the State of Oklahoma with regulatory authority over the vendor.

II.B.5. Contingency Plan

The vendor must submit with its proposal a contingency plan which illustrates its ability to respond to the following:

- Rapid increase in enrollment;
- Rapid decrease in enrollment;
- Loss of one or more facilities;
- Voluntary provider termination;
- Work stoppage;
- Financial insolvency;
- Loss of license or contract revocation;
- Disaster Recovery Plan; and
- Pandemic Health Emergency.

II.B.6. Cost Utilization Reporting

The HMO vendor shall provide EBD with quarterly reports containing information that is pertinent to the ongoing operation and success of the program for covered members. The quarterly reports are deemed proprietary and shall be held confidential in accordance with the *Oklahoma State Employees Benefits Act, 74 O.S.2001 § 1365,* (A) (13). The quarterly reports shall be labeled "Confidential" and shall provide a review of the quarter's experience, members' utilization of services and member service summaries that provide a clear picture of the overall working relationship between the HMO vendor and EBD.

Provide an example of your detailed quarterly management report as defined in this RFP. The quarterly reports shall include, at a minimum:

- Executive summary of findings;
- Utilization summary (including a glossary of applicable terms);
- Per member per month (broken down by health and separate for pharmacy);
- Utilizing members (broken down by health and separate for pharmacy);
- Quarter to quarter comparisons (broken down by health and separate for pharmacy);
- Top fifteen (15) medications ranked by dollars paid;
- Top fifteen (15) medications ranked by utilization;
- Therapeutic Category analysis to identify top five (5) medications in each category;
- Experience by covered health service (i.e., appendectomy, cataract surgery, oxygen, etc.);

- Experience by top ten (10) health providers by dollars paid and by utilization (i.e., separate for hospital, physician, etc.);
- Experience by top ten (10) diagnoses by dollars paid and by utilization.
- Member Services summary;
- Provider network status;
- Results of member surveys; and
- Observations and recommendations for enhancements and improvements.

Each quarterly report shall be provided not later than sixty (60) days following the close of the calendar quarter and shall include the monthly performance reports for that quarter. The quarterly report for the period ending December 31 should also include an annual summary for the plan year with a comparison to the previous plan year. The report shall be mailed to the attention of Jimmy Trotter, Director of Benefits and Contracts, 2401 N. Lincoln Blvd., Suite 106, Oklahoma City, Oklahoma, 73105.

During the term of the contract resulting from this RFP, the vendor agrees to submit complete reports of the standardized performance measures covered by the most current version of HEDIS data collection and reporting guidelines or an updated HEDIS version at the vendor's option.

II.B.7. Operational and Network Performance Reporting

The vendor shall provide EBD with monthly reports containing information that is essential to the proper delivery of health care to the vendor's members. These monthly reports shall include, at a minimum, the following information for the reporting period:

- An indication of the month of the reporting period, (e.g. January, February, etc.);
- The date the report was created;
- The percentage of primary care physicians accepting new patients during the reporting period;
- A list of primary care physicians, hospitals, and specialists in the HMOs network for that month's reporting period;
- A summary of the changes in the vendors Primary Care Physician network, hospital network, and specialist network from the previous month. and
- The percentage of customer service calls answered within in 30 seconds or less;
- The average hold time for customer service calls in seconds; and
- The vendors average call abandonment rate for customer service calls.

EBD has provided a format for reporting in Appendix G. No emailed reports will be accepted. Each quarterly report shall include the monthly performance report and a hard copy of both reports must be received at the following address:

Mr. Jimmy Trotter, Director
Benefits and Contracts
Employee Benefits Department of Human Capital Management

II.B.8. Privacy Protections for Health Information

The acronym "HIPAA" as used in this section refers to the *Health Insurance Portability and Accountability Act* of 1996 and includes any regulations promulgated pursuant thereto. Vendor agrees to comply with HIPAA and to assume the responsibilities of the "Covered Entity" as that term is defined by HIPAA with regard to the State of Oklahoma's Flexible Benefits Plan and all the employees and dependents who enroll and participate in vendor's insurance plan(s). The vendor is solely responsible for the consequences of any act or omission on its part not in compliance with HIPAA. EBD may terminate the contract in whole or in part in accordance with Section I.I.6 of this RFP if EBD determines vendor is not in compliance with HIPAA.

II.C. Operational Standards and Requirements

II.C.1. Marketing and Communications

Each vendor must review its marketing and communications plan with EBD and EGID **prior to distribution** to employees. All requests for any marketing and communication by the vendors must be submitted to EBD and EGID at least ten (10) business days in advance of the scheduled advertising date using the Advertising Approval Form in Appendix F. EBD and EGID reserve the right to have the vendors amend or modify such information to meet its requirements.

No direct marketing or "sales" marketing approaches will be permitted. Restricted advertising includes but is not limited to advertising directed specifically to the individual prospective member using direct mail, direct selling, and direct-action advertising by phone (such as telemarketing), mail or personal visit. Mass quantity promotions, not in an advertising medium, that are issued from the carrier by mail or personal distribution to prospects by way of folders, leaflets, throwaways, letters and delivered by mail, salespeople, or dealers are prohibited (with the exception of materials handed out at health fairs and employer-sponsored employee meetings and events). Use of marketing inducements directed to individual prospective members (such as paid lunches, pizza parties, and other non-employer sponsored events is not permitted).

Mass media advertising (newspapers, outdoor advertising, transit advertising, radio and broadcast television), is permitted only if the vendor has filed the appropriate request using the Advertising Approval Form referenced above, and has received written approval for publication of the material by EBD and EGID. Attendance at health fairs and employer-sponsored meetings throughout the year is strongly encouraged. Post-election enrollment follow-ups are allowed.

In the event that a change in name of the vendor or vendor plan design occurs, the change must be communicated to EBD and EGID by the designated print deadlines to be included in the Option Period print materials for the specified plan year.

Each HMO must participate in preparation or review of materials in the format specified for the Option Period. All Option Period marketing shall be conducted in accordance with policies and procedures approved and established by EBD in connection with the Annual Option Period. This is the only HMO marketing which should occur for participating members administered by the Employee Benefits Department.

HMOs will not be allowed to make presentations during employee meetings for State active employees unless pre-approved by EBD and as permitted by law; however, carriers may participate in education, county, and local government employee scheduled and organized meetings as directed by EGID.

If requested by EBD, the HMO will provide a representative to assist benefits coordinators in understanding the HMO benefit plan structure, particularly during designated training sessions or as requested by EBD for special employee benefit education sessions.

Changes in the network and updates of providers will be communicated at least once each plan year quarter to affected members, to EBD and to EGID at the HMOs expense. All updates to an HMO provider network must be submitted timely to EBD and to EGID for reference and informational purposes. Those same changes/updates must also be made current and available on the HMOs website to which EBD and EGID will provide links for member access.

Oklahoma State Ethics Commission Administrative Rules, Section 257:20-1-9 (c) (2) states the following: "Except for an elective officer, no state officer, state employee or an immediate family member of such state officer or state employee shall, directly or indirectly, ask, demand, exact , solicit , seek, accept , assign receive or agree to receive things of value in a calendar year which, in the aggregate, are valued at more than one hundred dollars ($100)." HMOs should refrain from offering items of value to members or prospective members that are greater than twenty-five dollars ($25.00) in value, in an effort to keep annual aggregate gift values for employees at the required minimum.

II.C.2. Member Services

Telephone assistance by HMO customer service representatives regarding plan benefits and network service problem resolution will be provided by the HMO through a toll-free telephone number during normal business hours. The HMOs customer service telephone response performance must meet or exceed the following standards for each month of each Plan Year:

- The HMO shall answer at least eighty percent (80%) of all calls in thirty (30) seconds or less;
- The average hold time shall be no more than thirty (30) seconds; and
- The average call abandonment rate shall not exceed five percent (5%).

The HMO must report its performance under the aforementioned requirements in accordance with Section II.B.7. of this RFP.

HMO customer service representatives must be trained and familiar with all aspects of the program covered by this RFP. The HMO must have written policies and procedures, specific to the enrollments covered under this RFP, in place for the use of its member services staff prior to the opening of each Option Period**.**

Member service telephone numbers for each contracting HMO will be printed in all enrollment materials. Potential and current members may call the HMO directly and request that a provider directory be sent to them. It is expected that the HMO will provide forty-eight (48) hour turnaround on these mailings.

During the contract period, the HMO will respond to EGID's inquiries through the web with EGID's software that tracks and reports member issues. The software that EGID utilizes for the process is called "WorkFlow" and was developed by ViTech, the EGID's premium accounting and eligibility system. WorkFlow is user friendly, and would require that the HMO have access to the web, and would not have to purchase any software for this process.

II.C.3. Comprehensive Member Handbook

Each HMO must develop a comprehensive member handbook, which shall be mailed to the member's home address no later than January 1, 2017 and must include the HMOs current prescription drug formulary. Copies of the HMOs current drug formulary must be made available for the annual Option Period. The member handbook must be specific to the program and benefits covered in this RFP. Such handbook should also include a provider directory for the covered services. Those physicians accepting new enrollees must be clearly identified.

Members should also receive an up-to-date listing of all physician and provider facilities at least once each quarter, or more frequently if needed. These handbooks and listings will also be provided to coordinators for those employees seeking additional information about an individual HMO. **All materials will be reviewed by EBD before distribution.** The development, printing, and delivery expenses will be the sole responsibility of the HMO and materials must be delivered to EBD and EGID and/or sites designated by EBD and EGID.

II.C.4. Member Identification Cards and Creditable Coverage

Member ID cards will be mailed at the HMOs expense directly to each member's home so that the same is received no later than December 31, 2016, or no more than two weeks following delivery of new member enrollment data from EBD and EGID.
The HMO is required to provide a written status report regarding the distribution of ID cards to Jimmy Trotter, Director and Administrator of Benefits and Contracts no later than Wednesday, December 10, 2016. ID cards are to reflect accurate information and shall NOT contain the member's social security number unless the number has been encrypted in an "alpha" or "numerical" method so it is not readily decipherable. The HMO must provide written notice of creditable prescription drug coverage to EGID per CMS definition and guidelines (pass the actuarial equivalency test) by December 31st of each year for the next plan year.

II.C.5. Pharmacy Network Download

Vendors must have a process for Option Period data to be downloaded to all pharmacy networks no later than December 31, 2016**.** Ongoing new enrollments must be transferred from EBD and EGID's respective weekly enrollment update into the HMOs pharmacy network within seventy-two (72) hours of receipt.

II.C.6. Three (3) Day Supply

If eligibility of a member cannot be confirmed with the HMO, the HMO must provide in good faith a three-day (3) supply of the prescription. Copays are not to be collected until the balance of the prescription is filled.

II.C.7. Network Composition

The HMO shall have a provider network sufficient in size and scope to furnish all covered health benefits listed in Section IV, Appendix B. No less than fifty percent (50%) of the primary care physicians (PCP) in the HMO network must be accepting new patients at any point during each plan year. Any vendor quoting a value based network must demonstrate that its network has adequate capacity to service its members. The HMOs must include State of Oklahoma licensed practitioners performing within their legal scope of practice sufficient to meet its members' needs. The HMOs must comply with all gatekeeper requirements as outlined in the Patient Protection and Affordable Care Act of 2010, PL 111-148 as amended by The Health Care and Education Reconciliation Act of 2010, PL 111-152. The network must provide access to PCP services, specialty physician services, and emergency care and tertiary care services.

II.C.8. Provider Contracting

Where the HMO contracts with health care practitioners to render services, such contracting arrangements must promote quality and cost effective care by ensuring that:

- Every enrollee has a PCP and that the PCP coordinates all of the enrollee's comprehensive health care; and,
- Practitioners' agreements require them to observe the plan's practice guide and/or to share the plan's financial risk.

Covered services may also be rendered by non-contracting providers through reimbursements to members who receive and pay for these services, provided such services are used only to supplement the plan's primary mode of health care delivery through its network of contracting providers.

The HMO must warrant and agree that there will be no provisions in the HMOs provider contracts that prohibit providers from discussing any treatment options and/or reimbursements with members in their provider contracts.

II.C.9. Primary Care Physicians

Each member must have a PCP from one of the following practice areas: family practice, general practice, internal medicine, general pediatrics (for children), and Ob/Gyn (for women, at the option of the HMO). Established patients must be assured acceptance by the existing provider in a new plan year unless that provider is no longer in the HMOs network of providers. The **HMO must comply with all gatekeeper requirements as outlined in The Patient Protection and Affordable Care Act of 2010, PL 111-148 as amended by The Health Care and Education Reconciliation Act of 2010, PL 111-152.**

II.C.10. Specialist Physicians/Other Providers

Each HMO must have sufficient numbers of contracted specialists to adequately provide the entire range of benefits covered in this RFP to all its enrolled members. Specialists shall not be included in the Provider Spreadsheet in Section IV, Appendix D. Such specialty services, such as laboratory and/or minor surgery must be available within a reasonable geographic area. Any changes in the benefit provisions must be reviewed by EBD: Attention, Jimmy Trotter, Director and Administrator of Benefits and Contracts.

II.C.11. Malpractice Liability

EBD requires all network providers to maintain malpractice liability limits equal to or greater than the State of Oklahoma requirement for licensure. By submitting a proposal, the HMO agrees these limits of coverage shall be maintained during the term of the contract.

II.C.12. Quality Assurance

EBD requires contracting HMOs to demonstrate a commitment to providing high quality health care. The HMO should follow a rigorous process by which medical providers are selected and monitored. In addition, strong quality assurance programs, procedures, and mechanisms must be in place and strictly followed. Description of the HMOs programs must be submitted.

The HMO must annually submit the results of quality evaluations, including formal reports to EBD. The HMO must have implemented a program of utilization review, which includes procedures to develop, compile, evaluate, and report statistics, which relate to health services information.

II.C.13. Internal Grievance Procedures

The HMO must establish and operate an internal member grievance procedure pursuant to the requirements of the Oklahoma Insurance Department or another agency of the State of Oklahoma with regulatory authority over the HMO.

The HMO must provide EBD with quarterly reports documenting the number and types of complaints and grievances registered by members and providers and the status or disposition of complaints/grievances. EBD will release formats for these reports prior to

program implementation. Reports must be submitted no later than thirty (30) days after close of the quarter to which they apply. Reports must be submitted to:

Mr. Jimmy Trotter, Director
Administrator of Benefits and Contracts
Employee Benefits Department of Human Capital Management
Will Rogers Building
2401 N. Lincoln Blvd, Suite 106
Oklahoma City, Oklahoma 73105

II.C.14. Member Satisfaction Surveys

The HMO must conduct membership satisfaction surveys of members covered under this RFP at least annually to assess quality of service and the "necessities" of care, such as after-hours care, office appointment waiting times, satisfaction with providers, and plan administration. The HMO must submit copies of sample surveys and survey results to EBD during the contract year. It is the intention of the State to work with the HMOs and the Department of Health to adopt a standardized survey format and methodology for the State populations.

II.C.15. State Wellness Program

The State Wellness Program of HCM Employee Benefits Department (EBD) was created in 1994 through legislation for the purpose of promoting the health and well-being of all State employees and to contribute to a healthy and safe workplace. The mission of the State Wellness Program is to provide support, resources, coordination, and development of wellness programs in State government. The State Wellness Program shall encourage the participation in wellness programs by State employees. Such health education and promotion programs will be designed to foster knowledge, attitudes, and behavioral skills necessary to improve the overall health status of all State employees, dependents, and their communities. The State Wellness Program sponsors many wellness programs to promote health education among State employees.

Through improved health, OK Health participants will experience less health care utilization and a reduction in health care-related expenses. As a result, the State's overall employee population should experience lower health insurance premiums.

The State Wellness Program Subject to HIPAA Privacy & Security

EBD main business function is as plan sponsor of the flexible benefit plans offered to employees of the State of Oklahoma and their dependents. As a plan sponsor, EBD does not use or disclose *protected health information* as defined by privacy regulations of the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA). However, EBD has designated itself as a *hybrid entity* under HIPAA, meaning the EBD business activities include both covered and non-covered functions under HIPAA. (See 45 C.F.R. § 164.504) As a *hybrid entity*, EBD has designated the following *healthcare components* as functions covered under HIPAA and its regulations:

- All operations of the State Wellness Program; and
- All operations of EBD HealthCare Reimbursement Accounts.

II.C.16. Prohibition on Direct Member Billing

The HMO must have procedures in place which prevent direct member billing (balanced billing) for covered services during the plan year of this Agreement.

II.C.17. Utilization Management Decisions

The HMO must make utilization decisions in a timely manner to minimize any disruption in the provision of health care. For non-urgent pre-service decisions, the HMO must make the decision and notify the member of the same within fifteen (15) calendar days of the receipt of the request. For urgent pre-service decisions, the HMO must make the decision and notify the member of the same within seventy-two (72) hours of receipt of the request.

SECTION III
PROPOSAL FORMAT

III.A. Proposal Submission Format

Vendor(s) must submit its proposal strictly according to the following format and all instructions and requirements contained in this RFP. Vendor(s) must submit one (1) original proposal (hardcopy) and two (2) exact copies on CD. Proposals should be neatly bound and clearly marked. Vendor(s) must also submit its provider networks, in the spreadsheet formats specified on a CD with the RFP. **Vendors are cautioned not to include confidential quoted rates and copays anywhere within the Vendors proposal binder.** The sealed envelope shall be labeled confidential in accordance with the format specified in Appendix D. Although vendors are required to submit an original hard copy and two (2) copies of the proposal on CD, only one confidential original rate sheet shall be submitted **(Do not include on CD)**. **Vendors are cautioned not to include or reference confidential quoted rates and copays anywhere within the vendor's proposal binder or on CDs.** The qualified actuary certification and adequate supporting information shall be attached to the vendor's rate sheet. For accounting purposes, any cents quoted in the vendor's rates shall be divisible by two.

In order to be considered for evaluation and selection, all proposals must adhere to the required outline and format:

- **Chapter One: Questionnaire and Attachments**

This chapter of the proposal shall include all questions listed herein and all narrative answers the vendor is required to give as described in Section III.B. All necessary attachments and additional documentation will be included in this chapter following the questions and narrative answers. All such attachments should be clearly identified with the appropriate question number(s) and clearly marked by tabs.

- **Chapter Two: Provider Network**

Vendor shall include both a printed copy and disk of all required provider network spreadsheets in the order and format presented in Section IV, Appendix C. Vendor shall also include all provider location/employee correlation maps specified in Section III.C.

- **Chapter Three: Premium Rates**

Chapter Three shall reference the confidential rates submitted separate from the vendor's proposals; i.e., "Chapter Three: Premium Rates. The quoted premium rates are confidential and are submitted separate from this proposal in the example provided in Appendix D." In setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, HMOs shall set the monthly premium for active employees to be equal to the premium for retirees under sixty-five (65) years of age. The rate charts provided in Section III.D.1 must be completed for all covered population groups. For accounting purposes, any cents quoted in the vendor's rates shall be divisible by two.

III.B. Questionnaire

Vendor must provide thorough narrative answers to the following questionnaire, including all necessary explanatory material and requested attachments. Vendor shall print the questions in order and numbered as they are presented herein, with each answer immediately following the appropriate question. All attachments to the narrative answers shall be appended to the questionnaire and marked with tabs. Vendor's provider network spreadsheets shall be included in the written copies of the proposal as Chapter 2, immediately following the questionnaire attachments. Vendor must also submit all provider network spreadsheets on CD, in the identical format given to them with the RFP.

GENERAL/ADMINISTRATIVE

1. Identify the model or type of HMO: Staff, Group, Network, IPA, Other. If the HMO is a mixed model, describe and include percentage of participation in each type.

2. Attach a complete organizational chart for the HMO, including all departments/functions listed in Section II.B.2, as well as lines of authority, and relationships among the HMOs Board of Directors, administration, medical services, and other functions. If expansions or changes are anticipated show as much detail as possible reflecting the changes.

3. Provide copies of signed audited financial statements covering a period subsequent to the latest financial period submitted in response to vendor registration for Plan Year 2014.

4. Describe in detail any pending litigation involving the HMO, which could materially affect its solvency.

5. Describe in detail, the HMOs contingency plan in the event of each of the following:

- Rapid increase in enrollment;
- Rapid decrease in enrollment;
- Loss of one or more facilities;
- Voluntary physician termination;
- Work stoppage;
- Financial insolvency;
- Loss of license or contract revocation;
- Pandemic Health Emergency;
- HIPAA Violation; and
- Ability to provide timely and accurate 6055 reporting

6. List and describe any current malpractice suits filed against the HMO or a provider in your network.

7. Provide a copy of the Vendor detailed disaster recovery plan.

8. Provide an example of the Vendor's detailed quarterly management report as defined in this RFP.

Operational/Provider Contracting

NOTE: If you are quoting multiple network offerings, please be sure to differentiate your responses between the networks.

9. Describe the HMO's hospital reimbursement mechanism or mechanisms, differentiating between acute and psychiatric, and include the mix (percentages of each) for the following methods: fee for service, discounted fee schedule, per diem, DRG, capitation, other.

10. Describe the HMO's physician reimbursement mechanism or mechanisms, differentiating between PCPs and specialists, and include the mix (percentages of each) for the following methods: salary, fee for service, discounted fee schedule, capitation, other.

11. How many providers, by region and location, have been sanctioned and/or removed from the Vendor's managed care networks within the last year?

12. List the HMOs current ratio of PCPs to members (total block of business in Oklahoma).

	Number of PCPs	Number of Members	Ratio
Section IV, Appendix A			

13. Percentage of your PCPs retained based on length of contract.

Over 3 years	_____%
2 to 3 years	_____%
Less than 2 years	_____%

14. How many PCPs and specialists have terminated contracts with the vendor in the last year (at the physician's request)? State the reason(s) for the termination.

15. What has been the turnover rate of PCPs in the vendor's network during the last year (due to all reasons)? Express as a percent of total PCPs. Separate turnovers by voluntary and involuntary.

16. Describe the vendor's pharmacy retail network capabilities in all service areas proposed, including point-of-service capabilities, mail order, and/or delivery methods used.

17. Describe in detail the vendor's pharmacy network arrangements. If the Vendor subcontracts these services, please provide complete information about the pharmacy benefit manager (name, contractual relationship, ownership interest (if applicable), etc.

18. Describe in detail the retail network (number of pharmacies) and provide a directory of pharmacies as of June 1, 2015. Also provide the location of the customer service center and toll free number for member inquiries.

19. Describe in detail the mail order pharmacy program, including location of mail order prescription fill center(s), and customer service center, with toll-free number for member inquiries. Also provide information on methods of requesting refills (i.e., telephone, internet, mail, etc.)

20. Describe in detail any pharmacy health care management programs, outreach, consumer education, and health promotion programs that apply to the membership covered by this RFP.

21. Identify each provider that is a part of the vendor's centers of excellence program.

22. Eligible dependents residing at an address different from the employee's address may select a primary care physician (PCP) in the service area covering the dependent's address. The HMOs may provide all eligible services outside the State of Oklahoma for covered dependents. Does the HMO offer eligible services outside the State of Oklahoma to eligible dependents residing at an address different from the employee's address? If so, please provide details of those services; i.e., location, limitations, etc.

23. The vendor must verify and commit that during the length of the contract, it shall provide no less than thirty (30) days' notice to EBD and EGID prior to performing changes, fixes, modifications and enhancements that may impact the exchange of eligibility or any other shared business process. The vendor must also include a test plan and provide resources to EBD and EGID to verify changes are valid and will not disrupt business processes. Changes will not be implemented until all parties mutually agree the changes are ready to be put into production.

All operational data, including but not limited to email messages, EPHI (electronic protected health information), batch eligibility files, reports and pre-edits, shall be encrypted when transmitted in any manner outside of the protected (trusted) network. Data must remain encrypted when at rest in a publicly accessible manner, to include FTP servers and portable media such as flash drives, CD, and DVD media. Does the vendor agree to this requirement?

24. The vendor shall use appropriate security and encryption to protect the confidentiality of EGID's data. EGID currently uses Pretty Good Privacy (PGP) as its standard data file encryption application. Data file transmissions will be performed utilizing the SFTP (Secure FTP) protocol. Does the vendor agree to this requirement? Describe the vendor's security and encryption standards and preferred method. Provide the vendor's network specialist to serve as liaison and the liaison's title, relevant skills and years of experience.

25. Confirm your company is in strict compliance with all HIPAA regulations? Provide the contact information for your HIPAA Compliance Officer including name, title, address, telephone number, and email address. The HMO shall use appropriate security and encryption to protect the confidentiality of EBD and EGID's data. EGID currently

uses Pretty Good Privacy (PGP) as its standard data file encryption application. Data file transmissions will be performed utilizing the SFTP (Secure FTP) protocol. Does the HMO agree to this requirement? Describe the HMO's security and encryption standards and preferred method.

Operational/Medical Management

26. Describe the HMO's procedures to ensure that every member has a PCP and that the PCP coordinates all of the member's medical care.

27. Describe in detail the HMO's procedures for after-hours care and emergencies in the service area and outside the service area.

28. Provide the following HMO contact person for the State's Employee Assistance Program: name, address, telephone number, email address, and brief clinical/professional description.

29. Describe in detail the care management initiatives the HMO will be administering in the contract year. This pertains to a program of pro-active outreach to all members to ensure that appropriate detection, prevention, acute, and chronic care is delivered.

30. Describe in detail how you will educate members about their health and actively involve them in treatment decisions.

Operational/Quality Assurance

31. Describe in detail the HMOs quality assurance program and address the following component activities:

- Chart review;
- Focused studies;
- Facility inspection;
- Social service intervention;
- Discharge planning; and
- Frequency of QA activities (e.g., how often QA committee meets, number and frequency of focused studies, etc.)

32. Does the HMO maintain a Quality Assurance Committee? Include the names and credentials of those involved.

33. Describe in detail the systems in place to ensure follow-up and correction of identified problem areas found as a result of the QA activities.

34. Describe in detail how the HMO monitors and detects underutilization or overutilization of services by providers, including follow-up actions.

35. Describe in detail the utilization review programs you use. If you do not utilize these programs, explain why. Address: peer review, pre-admission certification, second surgical opinion, concurrent review, discharge planning, standards of care/profile analysis, quality review, mental health/substance abuse utilization review, and other.

36. Described in detail any quality assurance (QA)/utilization review (UR) service, and identify each subcontractor and describe its services.

37. Describe in detail the internal grievance procedure for members and providers. All contracting HMOs must include a description of the grievance procedures in their member handbooks.

38. Describe the frequency and methodology of the HMOs member satisfaction surveys. What is the overall member satisfaction rate from the most recent survey? Attach a copy of the most recent survey instrument completed and a summary of the results.

Operational/Credentialing and Peer Review

39. Which criteria for physician credentialing do you actively monitor on an ongoing basis.

- State Licensure
- Board Certification
- DEA License
- Verification of Medical Education and Training
- Admitting Privileges at Network Hospitals
- Office Hours
- Proof of Malpractice Insurance
- Reputation
- Malpractice History
- On-site Audit before Contracting
- Other: Describe.

Operational/Communications and Marketing

40. Describe in detail the methods which will be used by the HMO (at HCM Benefits Department's and/or EGID's request) to educate and communicate the proper use of the plan to members? Describe all that apply, including:

- Enrollment Meetings
- Mass Mailings
- Provider Directories
- Interactive Phone
- Marketing Brochures
- Website
- Welcome calls to new members
- Other

41. Furnish copies of the following materials:

- Membership I.D. card (Cannot contain employee's Social Security number, unless encrypted in an alpha or numerical method so that it is not distinguishable)
- Membership materials, including a marketing document describing the benefits offered to enrollees in a format described under separate communications cover by EBD and as requested by EGID not to exceed two (2) 8-1/2 x 11 pages for inclusion in the enrollment guides.

Operational/Member Services

42. Provide the standards that the HMO Member Services staff achieved during the last 12 months in the following categories.

- Telephone Answer Time
- Telephone Hold Time
- Average Length of Call
- Average Calls per Month
- Abandoned calls (hang ups)
- Other

43. Describe your quality assurance program for member services. What are your internal performance standards for accuracy, responsiveness and courtesy and how are they measured for each customer service representative? What measures are taken for poor or unacceptable performance? What number of customer service representatives have you dedicated to this contract?

44. Describe how the HMO will interface with EGID's Workflow process to track and report member issues through the web.

45. Describe how EBD and EGID staff can have read-only access to eligibility files for participating state, education and local government members.

Operational/Claims Administration

46. Is your managed medical care claims system fully integrated and automated for in-network and out-of-network claims processing? Does it have procedures that prevent direct member billing (balanced billing)? If so, describe the procedures. If not, how will the HMO ensure members are not billed inappropriately for covered services?

47. Describe in detail your claim cost-control program. How do you detect overcharges for medically unnecessary care or provider abuses? What program have you developed to address special areas of concern? Who performs these functions?

48. Describe in detail the HMOs fraud prevention capabilities/ claims auditing.

49. Does the HMO routinely send out EOBs or only upon member request?

50. Does the HMO track member out-of-pocket maximums or is this left up to the member to notify the HMO when the maximum is met?

51. What is the average turnaround time for payment of claims, those that originate both inside and outside the service area? Be specific regarding types of claims and any differences in turnaround times.

Benefits/Service Enhancements

52. Describe in detail the service enhancements (from the list in Section II.A.4) to be offered by the HMO.

53. Describe in detail the Zip code areas, provider networks, and plan of benefits that would be available to participants that live outside the State of Oklahoma.

(end of questionnaire)

III.C. Provider Network

III.C.1. Complete the provider spreadsheets in Appendix C on CD in an Excel (PC) format. Each spreadsheet must be completed exactly as it appears on the disk. Any deviation from this format may result in the HMOs disqualification. Attach printed copies of each spreadsheet, as well as submitting the completed spreadsheets on CD.

Provider Spreadsheets (each to be completed by service area)

- Primary Care Physicians
- Specialist Physicians/Other Practitioners
- Pharmacy Network
- Hospitals
- Urgent Care After Hours Centers

III.C.2. Provide maps for all service areas proposed and show each provider type by address/location. Follow the provider type list shown above in Section III.C.1, in order, for these maps.

III.C.3. Match employee data to providers and present the results in a map and in numerical format (by service area, county, and Zip code). The HMO will be provided employee counts by Zip code that should be used for mapping.

III.C.4. If applicable, provide maps for all service areas that would be available to participants that live outside the State of Oklahoma.

III.D. Premium Quotes

Complete the following Premium Rate for Table 1 for the benefits specified in Appendix B (Active and Non-Medicare Retiree) and Appendix K (Medicare Supplement) for all covered populations and at all levels of coverage as outlined in Section II.A.6. **Vendors shall provide any other information as requested by EBD, including but not limited to**

confidential rate development methodology and plan design, as required for use by EBD during the procurement process.

In setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, the HMOs shall set the monthly premium for active employees to be equal to the premium for retirees under sixty-five (65) years of age. This RFP must be accompanied by a signed statement by the HMOs actuary, certifying that the methodology used in developing these rates is sound according to accepted actuarial principles.

All proposed confidential rates and copays shall be submitted in a sealed envelope separate from the vendor's proposal binder (Do not include on CD). The sealed envelope shall be labeled confidential in accordance with the format specified in Appendix D. The vendor is required to submit one (1) original and two (2) CD copies of the proposal, but only one original rate sheet shall be submitted. **Vendor is cautioned not to include confidential quoted rates and copays anywhere within the vendor's proposal binder or CDs.** The qualified actuary certification and adequate supporting information shall be attached to the vendor's rate sheet. For accounting purposes, any cents quoted in the vendor's rates shall be divisible by two. Vendors must provide one state-wide premium quote for all service areas. Vendors may provide an explanation of the service areas covered by the premium quote.

III.D.1. Premium Quote Tables

TABLE 1 –Premium Quote

(Renewal Rates: No Benefit Changes)

Active and Non-Medicare Retiree Blended Rate
(January 1, 2017 through December 31, 2017)

TIERS OF ENROLLMENT	MONTHLY RATE FOR MEMBERS
Active Employee Only	$
Spouse	$
One Child	$
Two or More Children	$

III.D.2. Rate Tables for the Medicare Supplement Plans Described in Appendix K.

TABLE 2 – Medicare Plan Premium Quotes
(January 1, 2017 through December 31, 2017)

Classification of Medicare Eligible Participants	Monthly Rate for Medicare Plan Participants
Employee	$
Spouse	$
One Child	$
Two or More Children	$

APPENDIX A
STANDARDIZED SERVICE AREAS
HMO RFP #H0020

Service Areas Offered for Plan Year 2017
Note: Please Review Section II.A.5 Before Completing This Section.

Please indicate all the areas in which you will provide service.

Zip	Zip / County / City

APPENDIX A
STANDARDIZED SERVICE AREAS
HMO RFP #H0020

APPENDIX B
Current HMO Plan Design- Please Populate

HCM is currently is requesting that all incumbent HMOs quote the current plan design being offered in PY 2017.

Type of Benefit	HMO Current	HMO Plan Year 2017
ANNUAL OUT OF POCKET MAXIMUM (Individual/Family) **ANNUAL DEDUCTIBLE** **PREVENTIVE HEALTH SERVICES** Hearing Screening (One (1) visit per year) Must conform the USPTF preventive care guidelines		
PROFESSIONAL SERVICES • PCP (per visit) • Specialist (per visit with authorization)		
HOSPITAL Inpatient (per admission) Outpatient (per visit)		
EMERGENCY HEALTH CARE SERVICES (waived if hospitalized)		
AFTER-HOURS URGENT HEALTH CARE SERVICES		
MEDICAL TRANSPORTATION SERVICES		
X-RAY AND LABORATORY SERVICES		
PRESCRIPTION DRUGS: The HMO is required to provide a definition for each of the three (3) tier categories based on the HMOs pharmaceutical formulary plan design. The definition for each of the three (3) tier categories as defined by the HMOs pharmaceutical formulary plan design shall remain unchanged and consistent throughout the term of the Plan Year. However, the HMO can change the formulary if such a change results in a less expensive copayment to members. HMOs are strictly prohibited from amending the definition of the three (3) tier categories at any time during the term of the contract. The HMO can design its formulary to provide drugs to members at no cost during the Plan Year. The HMOs current pharmaceutical formulary must be provided with the HMOs proposal. Additional distribution of the pharmaceutical formulary must be provided pursuant to the requirements specified in Section II.C.3 of this RFP. If the cost of the prescribed medication(s) is less than the copayment, the HMO is prohibited from charging the member more than the cost of the prescribed medication(s).		
PHYSICAL AND MANIPULATIVE THERAPY Physical, Occupational or Speech Therapy (limited to sixty (60) treatment days per course of therapy) • Inpatient • Outpatient Chiropractic or Manipulative Therapy (15 visits/year)		
MENTAL HEALTH **NOTE:** The HMO is responsible for providing a benefit that conforms with Mental Health Parity regulations. Inpatient Outpatient		
SUBSTANCE ABUSE **NOTE:** The HMO is responsible for providing a benefit that conforms with Mental Health Parity regulations. Inpatient Outpatient		
ALLERGY TREATMENT AND TESTING Testing per series. Serum and shots, including a six (6) week supply of Antigen and administration.		
DURABLE MEDICAL EQUIPMENT (DME) (initial device/repair		

and replacement)		
MATERNITY (initial visit only/per admission)		
INFERTILITY SERVICES - includes diagnosis and some treatment including drug treatment		
HOME HEALTH SERVICES		
HOSPICE		
SKILLED NURSE FACILITY		
TMD (lifetime non-surgical maximum of $1,500. Surgery is under medical)		
TRANSPLANTS		
BLOOD AND BLOOD PRODUCTS		
DESCRIPTION OF ANY NETWORK VARIATION		

PLAN DESIGN DESCRIPTION OF SCOPE

ANNUAL DEDUCTIBLE

The Bidder's HMO Plan cannot impose any type of an annual deductible.

PREVENTIVE HEALTH SERVICES

The Bidder must provide for preventative health services that are compliant with a non-grandfathered health plan as defined by PPACA.

PROFESSIONAL SERVICES

The Bidder must provide medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Coverage must include surgery, assistant surgery and anesthesia (inpatient or outpatient); non-dental related oral surgery; inpatient hospital and skilled nursing facility visits; professional office visits including visits for radiation therapy, chemotherapy, dialysis treatment, and home visits when medically necessary.

HOSPITAL

The Bidder must provide for inpatient and outpatient hospital services as defined below.

Inpatient: General hospital services, in a semi-private room, meals (including special diets as medically necessary), and general nursing care. Includes all medically necessary ancillary services such as use of operating room and related facilities; intensive care unit and services; prescribed drugs, medications, and biologicals; anesthesia and oxygen; diagnostic, laboratory and x-ray services; special duty nursing as medically necessary; respiratory therapy; radiation therapy; perfusion, delivery; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.

Includes inpatient hospital services in connection with dental procedures when hospitalization is required due to an underlying medical condition and clinical status or because of the severity of the dental procedure.

Outpatient: Services performed at a hospital or outpatient facility which shall include hospital services that can reasonably be provided on an ambulatory basis; and related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the individual's stay at the facility.

Includes outpatient services in connection with dental procedures when the use of a hospital or outpatient facility is required due to an underlying medical condition and clinical status or because of the severity of the dental procedure.

EMERGENCY HEALTH CARE SERVICES

The Bidder must provide coverage for twenty-four hour emergency department screening and care to achieve stabilization as needed for conditions that reasonably appear to constitute a life or limb threatening emergency based on the presenting symptoms of the patient for both in and out of service area.

MEDICAL TRANSPORTATION SERVICES

The Bidder must provide emergency air or land ambulance transportation in connection with emergency services to the first hospital or urgent care center which actually accepts the individual for emergency care.

Subject to prior authorization, ambulance transportation for the transfer of an individual from a hospital to another hospital or facility or home when medically necessary and approved by the medical plan.

Excludes transportation in the form of public conveyance such as airplane, passenger car, or taxi.

DIAGNOSTIC X-RAY AND LABORATORY SERVICES

The Bidder must provide medically necessary diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services subject to plan protocols and preauthorization.

PRESCRIPTION DRUGS

Medically necessary drugs which are prescribed by a physician or dentist. Includes injectable medication, injectable and oral insulin, needles, ostomy bags, ostomy wafers, syringes necessary for the administration of the covered injectable medication, blood glucose testing strips and lancets, and oral contraceptives. Also includes prenatal vitamins and vitamins with fluoride which require a physician's prescription.

Medically necessary drugs administered while member is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when provided through a participating pharmacy unless these charges are covered under the plan's hospital or medical benefit.

*Excludes experimental or investigational drugs**, unless required by law**; accepted for use by the standards of the medical community; drugs or medications for cosmetic purposes; patent or over-the-counter medicines, or medicines not requiring a written prescription order; and dietary supplements, appetite suppressants or any other diet drugs or medications.*

PHYSICAL AND MANIPULATIVE THERAPY

The Bidder must provide physical, occupational, or speech therapy benefits provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or patient's home. Benefits must also include chiropractic and manipulative therapy.

MENTAL HEALTH

The Bidder must provide benefits for the inpatient and outpatient treatment of mental illness. Benefits for the treatment of severe mental illness must also be included. The HMO is responsible for providing a benefit that conforms with Mental Health Parity regulations.

SUBSTANCE ABUSE

The Bidder must provide benefits for the treatment of substance abuse for both inpatient and outpatient settings. The HMO is responsible for providing a benefit that conforms with Mental Health Parity regulations.

ALLERGY TREATMENT AND TESTING

The Bidder must provide benefits for intradermal and percutaneous allergy testing including serum and allergy shots.

DURABLE MEDICAL EQUIPMENT (DME)

The Bidder must provide benefits for durable medical equipment.

MATERNITY

The Bidder must provide for medically necessary professional and hospital services related to maternity care including pre-natal and post-natal care, complications of pregnancy, and delivery. Includes any professional or hospital services related to a newborn adoption as required by law. Services for birth mother of newborn adoption are not covered unless the birth mother is a member of the plan.

INFERTILITY SERVICES

The Bidder must provide coverage for the diagnosis and some treatment for infertility.

HOME HEALTH SERVICES

The Bidder must provide coverage for home health services.

HOSPICE

The Bidder must provide for hospice care.

SKILLED NURSING CARE

The Bidder must provide for services prescribed by a plan physician and provided in a licensed skilled nursing facility when medically necessary.

TRANSPLANTS

The Bidder must provide coverage for medically necessary organ, tissue and bone marrow transplants which are not experimental or investigational in nature.

APPENDIX C
HMO PROVIDER CHARTS

Provider Network Format

Each HMO should provide an Excel file containing only additions, deletions, and changes to their original Provider Directory List submitted during the first quarter of 2017. Please see the attached spreadsheet for the requested format. Do not send a full file.

Please complete the following charts by noting the number of providers in your network in each cell below. Reporting should be provided as demonstrated in the exhibit below. Information should be provided in both hard copy and CD disk format, utilizing the excel file provided entitled – Appendix D. The CD disk must be separate from any other CD disk requested in this RFP and with the following specifications:

Microsoft Office 2003 Excel or later
Send on CD Disk labeled as: Appendix C – Provider Charts

The fields must appear in order presented.

Please provide an additional Excel spreadsheet containing the Specialists that will be in the HMO offering. The file layout will be the same.

PRIMARY CARE PROVIDER (PCP)

Carrier Code	Record Status	Zip Code	County	Last Name	First Name	Practice Type	Provider Type	Participation	Provider ID	License Number	Gate Keeper
ABC	C	73069	CLEVELAND	SMITH	JOHN	PE	DO	E	0123456789	00000	N
ABC	C	73071	CLEVELAND	SMITH	JOHN	PE	DO	E	0123456789	00000	N
ABC	C	73072	CLEVELAND	SMITH	JOHN	PE	DO	E	0123456789	00000	N

Please note that the examples listed above are in the appropriate format. All characters must be in UPPERCASE. List only the information requested. Names should be listed as they appear on their medical licenses. Punctuation marks should **NOT** be used.

Denote any change by an A for Add, D for Deletions and C for Changes in the Record Status field of the layout.

For the PCP list, use the following abbreviations for "PARTICIPATION":

Accepting New Enrollments	A
Accepting Established Patients Only	E
Not Accepting Enrollments	N

Please note the access coding must be determined as accurately as possible, i.e., A--Accepting New Enrollments, E--Accepting Established Patients Only, N--Not Accepting

Enrollment. All carriers are reminded that they must conform to the definition of "Established Patients" as follows:

> "Established patients" indicate members treated by that provider under the same plan. Establishment must be with the **provider and the plan,** not just with the provider.

For the PCP list, use the following abbreviation for "TYPE OF PRACTICE":

Family Practice	FP
General Practice	GP
Internal Medicine	IM
Pediatrician	PE
Obstetric and Gynecology	OB

(*Do not list OB-GYN providers unless they will be utilized as primary care physicians as referenced in Section II.C.9 of the RFP.)*

HOSPITAL AFFILIATION LIST

COUNTY	HOSPITAL
ATOKA	ATOKA MEMORIAL HOSPITAL
GARFIELD	ST MARYS MERCY HOSPITAL
GREER	MANGUM CITY HOSPITAL
KIOWA	ELKVIEW GENER HOSPITAL

Please provide present and former names of each hospital. Do not indicate the plan has a contractual hospital affiliation unless there are a reasonable number of contracted providers available to treat our members effective January 1, 2017.

APPENDIX D
(Name of HMO)

Confidential Rates/Plan Design Envelope

HMO RFP #H0020

****Important Notice****

This sealed envelope contains original confidential Rates/Plan Design charts.

APPENDIX E
Human Capital Management, a division of the Office of Management and Enterprise Services

Advertising Approval Request Form

■ This form must accompany all ads submitted to Human Capital Management for approval at least ten (10) business days in advance of the scheduled advertising date. The information provided in the advertisement must be accurate and not misleading.

Carrier Name: _____

Contact Name: _____

Telephone: _____

Fax: _____

Email Address: _____

Today's Date: _____

■ Type of Advertising (please circle):

Newspaper Magazine Radio Television Outdoor/Billboard
In/On Public Transport Poster Cinema Facebook
Twitter

Other (please specify) _____

■ Please provide a complete description of the item or promotion and attach a copy if applicable:

_____
_____
_____
_____
_____
_____

- Ad Schedule: (List all publications, locations and/or radio/TV stations and corresponding dates that ads are scheduled to run).

Date: _____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Approval Requested By: _____ Date: _____

Additional Disclosures Required if Any:

Send this form and the proposed advertisement to the following contact for consideration:

HCM/Benefits Department
Jimmy Trotter, Director, Benefits & Contracts
2401 N. Lincoln Blvd, Suite 106
Oklahoma City, OK 73105
(405) 522-1180
(405) 522-1120 Fax
jimmy.trotter@omes.ok.gov

EGID
Cassie Waters, Group Mgmt Mgr
3545 N.W. 58th Street, Ste 110
Oklahoma City, OK 73112
(405) 717-8759
(405) 717-8922 Fax
cassie.waters@omes.ok.gov

HCM/Benefits Department Approval

_____
Signature

_____
Date

EGID Approval

_____
Signature

_____
Date

APPENDIX F

Performance Reporting Template for PY 2017

Plan Name_____

Month	PCPs Accepting new patients	Count of PCPs in the network list for the month	Count of Hospitals in the network for the month	Count of Specialists in the network for the month	Count of Pharmacies in the network for the month	Net Changes in PCP Network*	Net Changes in Hospital Network*	Net Changes in Specialist Network*	Net Changes in Pharmacy Network*	Customer service calls within 30 sec. or less	Average hold time for customer service calls in seconds	Average abandonment rate for customer service calls
Example	86.00%	883	35	2,214	791	-2	0	7	0	72.00%	45.2	3.00%
January												
February												
March												
Ist QTR												
April												
May												
June												
2nd QTR												
July												
August												
September												
3rd QTR												
October												
November												
December												
4th QTR												

*Net changes are the difference between Terminations and New Providers.

APPENDIX G
Administrative Rules

of the

Employee Benefits Department

The official administrative rules that govern the Employee Benefits Department can be found on file at the offices of the Oklahoma Secretary of State, Oklahoma State Capitol, 2300 N. Lincoln Boulevard, Ste. 101, Oklahoma City, OK 73105.

An electronic version of the rules can be found at **http://www.sos.ok.gov/oar/default.aspx**. Once at the preceding URL, select "**Administrative Rules**" from the menu near the top of the screen. Then select "**View Code**." Finally, select "**Title 260**" from the list of titles in the middle of the screen. At this point, select Chapter 40. For the purposes of this RFP, special emphasis should be directed to Subchapter 37, Competitive Bidding Criteria and Procedures for Contracts Awarded to Flexible Benefits Plans.

An electronic version of the Employee Group Insurance Department rules can be found at www.ok.gov/sib/documents/EGIDAdminRules.pdf

APPENDIX H

Demographic and Census Data

CD Disks

Export Overview

I. *Business Overview*

This export file will contain eligibility data for members and dependents enrolled in HMOs and DMOs. A weekly incremental file will be sent to each HMO and DMO. A reconciliation Active file will be sent quarterly if requested.

This export file will contain eligibility data for members and dependents enrolled in VMOs, also. A weekly Active file will be sent to each VMO.

File layout: Fixed length 1500
Save as options: Text File
 # Of Files Generated: 1 File –For each carrier based on the Fund plan combination
# of records per member*:* Multiple
Data formatting:
Alphanumeric – left justified and padded with trailing spaces
Dates – YYYYMMDD format
Numeric fields – should be right justified and padded with leading spaces

General:
Fields without values must be left blank and space filled should not contain zeros

Selection Criteria:

General:

1. Each eligible member and dependent will have its own record. Fields with demographic information should be specific to the member or dependent, i.e. the dependent record will contain the dependent name, address, date of birth and gender.

2. Each Export Parameter Carrier file should only contain the covered person for that Carrier. For example, if a member is on Health HMO-Senior and the spouse is on Health HMO-High, then the Health HMO-Senior file will contain only the member record and the Health HMO file will contain only the dependent.

For Each Export Parameter:

1. *For Export Parameter type of file = Active File*
   - The file must include all ACTIVE members and their elected dependents as of the date of the export. ACTIVE is defined as Members and elected dependents whose enrollment termination date is > the export as of date or blank and whose billing_entity.billing_group <> 'EBC' (Non-EBC groups only). (The full file will contain future enrollment. For example, if member is enrolled 1/1/2009 – 12/31/2009 and 1/1/2010 – open. On the export file of 11/1/2009, both records will be included.) Only members and elected legal dependents enrolled in each listed plans should be included. One active file for each plan should be created based on the export parameter.

2. *For Export Parameter type of file = Incremental*
   - Get all new members and dependents who have been added to the selected parameter Carrier between the last export and 'as of date' of the export and whose billing_entity.billing_group <> 'EBC' (Non-EBC groups only).

1) Get the Export Parameter Carrier Name and Export Date and follow steps 2 – 6 for each Carrier.

2) **If Member or Dependent indicative information is changed with enrollment change,**

   Send current indicative information for the affected individual. Send changed eligibility information and any subsequent eligibility information.

3) **If Member or Dependent indicative information (name, address, phone, dep ssn etc.) is changed without enrollment change,**

   Send current indicative information for the affected individual. Send any current and future eligibility information.
   Effective date on file = effective date of coverage.

4) **If Current Coverage is terminated and New Coverage is created,**

   Coverage terminates and new coverage for this carrier does not start the day following the termination, a type 3 record is sent with the termination date.

   If new coverage starts the following day, then send a type 3 record with new coverage and a start date for that coverage.

   Retro change – Send eligibility changes and any subsequent eligibility data for the affected individual.

   Dependent is added – Tier Code Change – Send entire family record.
   Dependent is added – No Tier Code Change – Send the added individual
   Coverage change – Tier Code – Send entire family record
   Coverage Level – Send entire family record

Status – Send entire family record

5) **Member Custom/Dependent Custom Change**
If Export Parameter Carrier is in Health Fund or Dental Fund, then include if the Primary Care Physician and Primary Dental Provider updated date or inserted date > last export date. Custom field will be null after export is ran.
NOTE: If PCP/PCD is populated, then it will be sent on the file. Carrier should only load the data if the person is a new add or a reinstate to their plan.

6) **Delete Coverage or opt-out dependent (Data entry error or correction)**
If Period is deleted, benefit is deleted or dependent is opted out within a period, the record should be transmitted as a record type 3 where the termination date is one day less than the effective date. For example, effective date = 1/1/2010 termination date = 12/31/2009

II. *Export Sections and Sequence*

Records must be sorted in ascending order by SSN, opt out records (if any), then by person code, then by effective date. However, Vision plans have the effective date sorted descending.

Seq #	Record Type	Description/Selection Logic	Optional / Required
1	Header	Uniquely identifies the export	R
2	Detail	Person eligibility data	R
3	Trailer	Tracking and verification information for the export	R

III. *Export Parameters*

Label	Type	Description (include default value)	Format
As of Date	Date	Date of the export – default to today's date for incremental file	MM/DD/YYYY
File Type	Varchar2	Indicate whether to send changes only, All Active members and dependents, or Full historical members, dependents, and active members, dependents. Values = 'I', 'A', 'F'	
Fund/Plan	Varchar2	Indicate which fund/plan export is to be created. Values = Fund Plan Health CommunityCare HMO Health GlobalHealth HMO Health UnitedHealthcare HMO Health UnitedHealthcare Senior Supp Senior CommunityCare Senior Generations Senior UnitedHealthcare Group Medicare Advantage Dental Assurant Heritage Plus (Prepaid) Dental Assurant Freedom Preferred Dental Assurant Heritage Secure (PrePaid) Dental Cigna Dental Care Plan (Prepaid) Dental Delta Dental PPO - Choice Dental Delta Dental PPO Dental Delta Dental Premier Vision EE VSP Vision EE UnitedHealthcare Specialty Benefits Vision Vision EE Superior Vision Vision EE Primary Vision Care Vision EE Humana/CompBenefits	

IV. *Steps to create export:*

Step #	Description
1	Execute oseegib.pkg_eligibility.p_export_carrier('carrier name', 'filename',as_of_date,'file-type');

V. *Record Layouts*

Header

Start Position	Stop Position	Field Name	Length	Data Type	Required	Format	Value/Default	Description
1	1	Record type		A/N	Y		1	Indicates header file
2	10	Carrier		A/N	Y		9010	Indicates this file is from OSEEGIB
11	35	Address1		A/N	N			3545 NW 58th Street
36	60	Address2		A/N	N			Suite 110
61	80	City		A/N				Oklahoma City
81	82	State		A/N	N			OK
83	92	Zip		A/N	N			73112
93	102	Phone		A/N	N			405-717-8888
103	110	Creation Date		N	Y	YYYYMMDD		Creation date of this file.
111	111	File Type		A	Y			The file type. A = Active I = Incremental F = Full
112	1500	Filler						

Detail

Start Position	Stop Position	Field Name	Length	Data Type	Required	Format	Value/Default	Description
1	1	Record type	1	A/N	Y		2, 3, 4, or A for Active file	Indicate if the record type is an add record or a change record.
2	10	Carrier	9	A/N	Y		9010	9010 Hard coded for every record, stands for OSEEGIB

11	20	Account	10	A/N	Y		ST – State ED – Education LG – Local Govt	Populated for Vision Carriers only
21	30	Group	10	A/N	Y			Group Number
31	39	Member_SSN	9	A/N	Y			Member SSN
40	41	Person Code	2	A/N	Y			Member or dependent custom field
42	43	Relationship	2	A/N	Y			Relationship of this person to the member. Ex: S-spouse, C-child
44	93	Last Name	50	A/N	N			The last name of this person record.
94	143	First Name	50	A/N	N			The first name of this person record.
144	144	Middle Initial	1	A/N	N			The middle initial of this person record.
145	145	Sex	1	A/N	Y			The sex of this person record.
146	153	Date of Birth	8	N	Y	YYYYMMDD		The birth date of this person record.
154	161	Effective Date	8	N	Y	YYYYMMDD		The effective date for this person's coverage
162	169	Termination Date	8	N	Y	YYYYMMDD		The termination date for this person's coverage
170	229	Mailing Address1	60	A/N	Y			Address_Line1 of this person record, if it doesn't exist then use the Member Address_Line1. Address Type = 'R'
230	259	Mailing Address2	30	A/N	Y			Address_Line2 of this person record, if it doesn't exist then use the Member Address_Line2. Address Type = 'R'
260	309	Mailing City	50	A/N	Y			City of this person record, if it doesn't exist then use the Member City Address Type = 'R'
310	311	Mailing State	2	A/N	Y			State of this person record, if it doesn't exist then use the Member State Address Type = 'R'
312	321	Mailing Zip	10	A/N	Y			Zip of this person record, if it doesn't exist then use the Member Zip Address Type = 'R'
322	331	Phone	10	A/N	N			(Home) Phone of this

								person record, if it doesn't exist then use the Member phone Address Type = 'R' If not supplied: Null or '0000000000'
332	332	Alt Ins Indicator	1	A/N	N			Not Used
333	342	Alt Ins Code	10	A/N	N			Not Used
343	360	Alt Ins ID	18	A/N	N			Not Used
361	371	Filler	11					For Future Additions
372	381	Status	10	A/N	N			Member or dependents status code. For example, Active, Medicare, Cobra etc.
382	391	Plan	10	A/N	N			Selected benefit level, elected by the member. Examples Healthchoice Hi option, Healthchoice Low option etc. Enrollment_type_id
392	399	Plan Eff Date	8	N	N			Not used
400	400	New card Flag	1	A/N	Y			Not used
401	402	Martial Status	2	A/N	Y		M = Married N = Single U = Undefined	Member/dependents marital status. If not supplied: Null
403	412	Alt Phone	10	A/N	N			Member/dependents alternate (work) phone. If not supplied: Null or '0000000000'
413	420	Hire Date	8	N	N	YYYYMMDD		Not Used
421	429	Dependent Social	9	A/N	Y			For member record leave blank, For dependent record put dependents SSN. If dependent SSN is not available leave blank. DO NOT PUT MEMBER SSN
430	430	ID Handicap Code	1	A/N	N			If dependent is handicapped, just a Y or N or blank, Only applies to dependents. (Incapacitated Child)
431	431	Student Code	1	A/N	N			Not Used
432	441	Tier code	10	A/N	Y			Coverage level – such as Member, member and spouse etc

442	451	Division	10	A/N	Y			Division Number
452	459	Alt Ins From Date	8	N	N			Not used
460	467	Alt Ins Thru Date	8	N	N			Not used
468	468	Pen Claim	1	A/N	N		Y or N	Not used
469	469	Pre Ex	1	A/N	N		Y or N	Not used
470	480	HICN	11	A/N	N			HCIN Number, SSN+ 1 or 2 special code to ID Medicare person. Member Custom
481	490	Disenrollment Code	10	A/N	N			Disenrollment Code This is for MAPD/PDP plans
491	500	Signature Date	10	A/N	N	MMDDYYYY		Signature Date on MAPD/PDP enrollment form
501	509	From Member SSN	9	A/N	N			Old Member SSN
510	511	From Person_ Code	2	A/N	N			Old Person Code
512	519	Original Eff Date	8	N	N	YYYYMMDD		Not used
520	527	Dental Penalty	8	N	N	YYYYMMDD		Not used
528	535	Life Insurance Amt	8	N	N	999999.99		Not used
536	550	Country	15	A/N	N			Country of Address. Populate the country
551	553	Reason	3		N		Y or N	Change Type: 1st Position – Eligibility, 2nd Position – Address, 3rd Position – Indicative
554	561	Date of Death	8	N	N	YYYYMMDD		The death date of this person record
562	571	Member_Code	10	A/N	Y			Unique Member Number Right Justified
572	621	Employer Name	50	A/N	N			Employer Name
622	681	Permanent Address_1	60	A/N	Y			Address_Line1 of this person record, if it doesn't exist then use the Member Address_Line1. Address Type = 'C' If 'C' is null, use 'R'
682	711	Permanent Address_2	30	A/N	Y			Address_Line2 of this person record, if it doesn't exist then use the Member Address_Line2. Address Type = 'C' If 'C' is null, use 'R'

712	761	Permanent City	50	A/N	Y			City of this person record, if it doesn't exist then use the Member City Address Type = 'C' If 'C' is null, use 'R'
762	763	Permanent State	2	A/N	Y			State of this person record, if it doesn't exist then use the Member State Address Type = 'C' If 'C' is null, use 'R'
764	773	Permanent Zip	10	A/N	Y			Zip of this person record, if it doesn't exist then use the Member Zip Address Type = 'C' If 'C' is null, use 'R'
774	798	County	25	A/N	N			County of Permanent Residence of this person record Member Medicare Info Datasheet
799	848	Email	50	A/N	N			Email Address of this person record Address Type = 'R'
849	849	Plan Premium Payment Option	1	A/N	Y		1	1=OSEEGIB will bill the member
850	850	ESRD	1	A/N	Y		Y=Yes N=Blank	Member is ESRD Medicare Info Datasheet
851	851	Request Materials in Language Other Than English	1	A/N	Y		Y=Yes N-No	Default=N or <Blank> Language preference or another format other than English MAPD will contact the Beneficiary if the box on the enrollment form is marked 'Yes' Medicare Info Datasheet
852	852	Language Preference and Alternative Formats	1	A/N	Y		N=No	Default=N NOT USED

853	853	Beneficiary Signature and/or Authorized Representative Signature	1	A/N	Y		Y=Yes	Form is signed. Default to Y since no enrollments will be sent if form is not signed.
854	903	Authorized Representative Last Name	50	A/N	Y			1) Medicare Info Datasheet 2) Person record is dependent child – use Primary Member's Indicative Info 3) <blank>
904	953	Authorized Representative First Name	50	A/N	Y			1) Medicare Info Datasheet 2) Person record is dependent child – use Primary Member's Indicative Info 3) <blank>
954	954	Authorized Representative Middle Initial	1	A/N	Y			1) Medicare Info Datasheet 2) Person record is dependent child – use Primary Member's Indicative Info 3) <blank>
955	1014	Authorized Representative Address1	60	A/N	Y			1) Medicare Info Datasheet 2) Person record is dependent child – use Primary Member's Indicative Info 3) <blank>
1015	1044	Authorized Representative Address2	30	A/N	N			1) Medicare Info Datasheet 2) Person record is dependent child – use Primary Member's Indicative Info 3) <blank>
1045	1094	Authorized Representative City	50	A/N	Y			1) Medicare Info Datasheet 2) Person record is dependent child – use Primary Member's Indicative Info 3) <blank>
1095	1096	Authorized Representative State	2	A/N	Y			1) Medicare Info Datasheet 2) Person record is dependent child – use Primary Member's Indicative Info 3) <blank>
1097	1106	Authorized Representative Zip	10	A/N	Y			1) Medicare Info Datasheet 2) Person record is dependent child – use

								Primary Member's Indicative Info 3) <blank>
1107	1116	Authorized Representative Phone	10	A/N	N			1) Medicare Info Datasheet 2) Person record is dependent child – use Primary Member's Indicative Info 3) <blank> NOT USED
1117	1124	Employer or Union Name	8	A/N	Y		OSEEGIB	
1125	1128	Employer or Union Group Number	4	A/N	Y		9010	
1129	1129	Plan Change?	1	A/N	Y		Y=Yes N=Blank	Yes=info is completed on form. Used when changing from one plan to another under same carrier. NOT USED
1130	1130	Info Provided Under "Please Read and Sign Below"?	1	A/N	Y		Y=Yes N=No	Default is Y because info is on the form and member signed the form
1131	1131	Release of Information Elements Provided?	1	A/N	Y		Y=Yes N=No	Default is Y because info is on the form and member signed the form
1132	1132	PCP/PCD Status	1	A/N				PCP/PCD Patient Status: N = New C = Current If the Fund is Health then populate Primary Care Provider. If the Fund is Dental then populate Dental Provider.
1133	1182	PCP/PCD First Name	50	A/N				PCP/PCD Provider First Name If the Fund is Health then populate Primary Care Provider. If the Fund is Dental then populate Dental Provider.
1183	1232	PCP/PCD Last Name	50	A/N				PCP/PCD Provider Last Name If the Fund is Health then populate Primary Care Provider. If the Fund is

								Dental then populate Dental Provider.
1233	1258	RX OGI	26	A/N				Other Group Insurance Plan Name
1259	1278	RX ID# For OGI	20	A/N				Other Group Insurance Member ID#
1279	1293	RX Group# For OGI	15	A/N				Other Group Insurance Group #
1294	1500	Filler	207					For Future Additions

Note 1:

To identify the record type is 2 or 3

All member and dependent records need to be identified as record type 2 (add record) or record type 3 (change record).

A member or dependent that is enrolled in a given plan for the *first* time is an ADD record and should be indicated as a record type 2. For example, a member/dependent is active in Health Healthchoice from 1/1/2008 to 12/31/2009. On 1/1/2010 they move to Health Pacificare then the member record should be identified as record type 2.

To identify the record type 4.

For record type 4 only the following fields will be populated

i. Carrier
ii. Member SSN
iii. From Member SSN
iv. Effective Date
v. Person Code

Record Type 4 is created for following events:

a) When a dependent becomes a primary member

The Carrier, Member SSN, and Person Code will contain the Dependents data and the From Member SSN and Person Code will contain primary member's data under which this person was a dependent.

b) Primary member becomes dependent

The Carrier, Member SSN, and Person Code will contain the new member's data under whom this person has become dependent and the From Member SSN and Person Code will contain the primary member's data under which this person was a member.

c) When a dependent moves from one member to another member

The Carrier, Member SSN, and Person Code will contain the primary Member's data and the From Member SSN and Person Code will contain the old member's data under which this person was a dependent.

d) When the SSN of member is changed

The Carrier, Member SSN, and Person Code will contain the new SSN information and the From SSN and Person Code will indicate the old SSN from which they moved. All the other fields for the record type 4 should be blank.

Trailer

Start Position	Stop Position	Field Name	Length	Data Type	Required	Format	Value/ Default	Description
1	1	Record Type	1	A/N			9	Indicates trailer record
2	10	Carrier	9	A/N				
11	19	Total records	9	N				Do NOT include header and trailer = Adds+ Changes+ Total count of records on the file
20	28	Total Adds	9	N				Total Number of Add Records. Total count of record type 2
29	37	Total Changes	9	N				Total Number of Change Records. Total count of record type 3
38	46	Total Move History	9	N				Total Number of Move Records. Total count of record type 4.
47	1500	Filler						

VI. *Contact Information*

Name	Phone	E-Mail
Shuqin Li	405-717-8992	Shuqin.Li@omes.ok.gov
Todd Marney	405-717-8827	Todd.Marney@omes.ok.gov

VII. *Open Issues*

#	Author	Date Opened	Issue	Resolution	Date Closed

VIII. *Assumptions*

#	Author	Assumptions

IX. *Document Change Log*

Date of change	Author	Change Description
8/18/2004	Patti Claxton	Document Created w/New Logic
8/25/2005	Patti Claxton	Updated Fund/Plan for new HMOs
9/7/2005	Patti Claxton	Removed language – Record Type 4 d
6/17/2008	Patti Claxton	Remove Tricare. Add New DMO
9/25/2009	Patti Claxton	Update Fund/Plan for Name Changes
3/24/2010	Patti Claxton	Update language throughout layout and update Fund/Plan for Name Changes
6/9/2011	Patti Claxton	Updated Fund/Plan for Name Changes
12/20/2011	Patti Claxton	Updated Fund/Plan for Name Changes
3/14/2012	Patti Claxton	Updated Fund/Plan & added field names (Disenrollment Code & Signature Date)
6/12/2012	Patti Claxton	Added additional length to file; add Permanent Address fields, other Medicare required fields and update changes to PCP/PCD field(s)
7/11/2012	Patti Claxton	Added additional new fields; RxOGI, RX ID# for OGI, and RX Group# for OGI.
7/20/2012	Patti Claxton	Removed 'LTC' field, Updated Plan Premium Payment Option field, Updated Request Materials in Language Other Than English field, and Updated Language Perference and Alternative Formats field.
8/19/2012	Patti Claxton	Update verbage for Language Preference in Description
4/15/2015	Todd Marney	Updated the following: - Expected value/default codes for field name 'Account'; - Description for field name 'Phone'; - Expected value/default codes & description for field name 'Martial Status'; - Description for field name 'Alt Phone'; - Updated details under the section 'Contact Information'

X. *Sign-off*

Reviewed by: _____ *Date:* _____

Approved by: _____ *Date:* _____

Summary of HealthChoice High and Low Option Medicare Supplement Plans

Medicare Part A (Hospitalization) Services
All Benefits are Based on Medicare-Approved Amounts

Services or Items	Description	Medicare Part A Pays	HealthChoice Pays	You Pay
Hospitalization Semiprivate room, meals, drugs as part of your inpatient treatment, and other hospital services and supplies	First 60 days	All except the Part A deductible	100% of the Part A deductible	0%
	Days 61 through 90	All except the coinsurance per day	Coinsurance per day	0%
	Days 91 and after while using Medicare's 60 lifetime reserve days	All except the coinsurance per day	Coinsurance per day	0%
	Once Medicare's lifetime reserve days are used, HealthChoice provides additional lifetime reserve days Limited to 365 days	0%	100% of Medicare eligible expenses Certification by HealthChoice is required	0%
	Beyond the 365 HealthChoice lifetime reserve days	0%	0%	100%
Skilled Nurse Facility Care Must meet Medicare requirements, including inpatient hospitalization for at least 3 days and entering a Medicare-approved facility within 30 days of leaving the hospital. Limited to 100 days per calendar year	First 20 days	All approved amounts	0%	0%
	Days 21 through 100	All except the coinsurance per day	Coinsurance per day	0%
	Days 101 and after	0%	0%	100%

Medicare Part A (Hospitalization) Services
All Benefits are Based on Medicare-Approved Amounts

Services or Items	Description	Medicare Part A Pays	HealthChoice Pays	You Pay
Hospice Care Your doctor and hospice provider must certify you are terminally ill and you elect hospice	Physical care, counseling, equipment, supplies, respite care, inpatient care and drugs for pain and symptom control	All but very limited coinsurance for outpatient drugs and inpatient respite care	0%	Up to $5 per palliative drugs or biologicals; 5% of Medicare amount for inpatient respite care
Blood	Limited to the first 3 pints unless you or someone else donates blood to replace what you use	0%	100%	0%

Medicare Part B (Medical) Services
All Benefits are Based on Medicare-Approved Amounts

Services or Items	Description	Medicare Part B Pays	HealthChoice Pays	You Pay
Medical Expenses Medically necessary outpatient services and supplies	Doctor's visits, out-patient hospital treatment, surgical services, physical and speech therapy and diagnostic tests	80% after the Part B deductible	20% after the Part B deductible	Part B deductible
Clinical Diagnostic Laboratory Services	Blood tests, urinalysis and tissue pathology	100%	0%	0%
Home Health Care Medicare-approved services	Intermittent skilled care and medical supplies	100%	0%	0%
Durable Medical Equipment	Items such as nebulizers, wheelchairs and walkers	80% after the Part B deductible	20% after the Part B deductible	Part B deductible

Medicare Part B (Medical) Services
All Benefits are Based on Medicare-Approved Amounts

Services or Items	Description	Medicare Part B Pays	HealthChoice Pays	You Pay
Diabetes Monitoring Supplies Includes coverage for glucose monitors, test strips and lancets	All Medicare beneficiaries with diabetes – must be requested by your doctor	80% after the Part B deductible	20% after the Part B deductible	0%
Ostomy Supplies Ostomy bags, wafers and other ostomy supplies	All Medicare beneficiaries who have a need based on their condition	80% after the Part B deductible	20% after the Part B deductible	Part B deductible
Blood	Amounts in addition to the coverage under Part A unless you or someone else donates blood to replace what you use	80% after the Part B deductible	20% after the Part B deductible	Part B deductible
Outpatient Prescription	Infused, oral end-stage renal disease and some cancer and transplant drugs	80% after the Part B deductible	20% after the Part B deductible	Part B deductible

Medicare Part B (Preventive) Services
All Benefits are Based on Medicare-Approved Amounts

Preventive Services	Who is Covered	Medicare Part B Pays	HealthChoice Pays	You Pay
One-time Initial Wellness Physical Exam One time "Welcome to Medicare Visit"	All Medicare beneficiaries during the first 12 months of Part B enrollment	100%	0%	0%
Annual Wellness Visit Once every 12 months	All Medicare beneficiaries who have had Part B longer than 12 months	100%	0%	0%

Medicare Part B (Preventive) Services
All Benefits are Based on Medicare-Approved Amounts

Preventive Services	Who is Covered	Medicare Part B Pays	HealthChoice Pays	You Pay
Screening Mammogram Once every 12 months	All female Medicare beneficiaries ages 40 and older	100%	0%	0%
Screening Blood Tests for Early Detection of Cardiovascular (Heart) Disease	All Medicare beneficiaries	100%	0%	0%
Pap Test and Pelvic Exam Once every 24 months; includes a clinical breast exam Once every 12 months if high risk/abnormal Pap test in preceding 36 months	All female Medicare beneficiaries	Pap Test, 100% No Part B deductible For all other exams, 80% No Part B deductible	0% For all other exams, 20% No Part B deductible	0%
Bone Mass Measurements Once every 24 months for qualified individuals	All Medicare beneficiaries at risk for losing bone mass	100%	0%	0%
Glaucoma Screening Once every 12 months; must be performed or supervised by an eye doctor who is authorized to do this within the scope of their practice	Medicare beneficiaries at high risk or a family history of glaucoma	80% after the Part B deductible	20% after the Part B deductible	Part B deductible

Medicare Part B (Preventive) Services
All Benefits are Based on Medicare-Approved Amounts

Preventive Services	Who is Covered	Medicare Part B Pays	HealthChoice Pays	You Pay
Colorectal Cancer Screening **Fecal Occult Blood Test** Limited to once every 12 months	All Medicare beneficiaries ages 50 and older	For the fecal occult blood test, 100% No Part B deductible	0% for the fecal occult blood test	0%
Flexible Sigmoidoscopy Limited to once every 48 months for ages 50 and older; for those not at high risk, 10 years after a previous screening		For all other tests, 80% after the Part B deductible	For all other tests, 20% after the Part B deductible	0%
Colonoscopy Limited to once every 24 months if you are at high risk for colon cancer; if not, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy	There is no minimum age for having a colonoscopy			
Barium Enema Doctor can substitute for sigmoidoscopy or colonoscopy	**Note:** For a flexible sigmoidoscopy or screening colonoscopy in an outpatient hospital setting or an ambulatory surgical center, you pay 25% of the Medicare-approved amount			
Prostate Cancer Screening **Digital Rectal Exam** Once every 12 months	All male Medicare beneficiaries ages 50 and older	For the digital rectal exam, 80% after the Part B deductible	For the digital rectal exam, 20% after the Part B deductible	0%
Prostate Specific Antigen Test (PSA) Once every 12 months		For the PSA test, 100% No Part B deductible	For the PSA test, 0%	
Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 15% above the Medicare-approved amount.				

High Option Medicare Supplement Plans With and Without Part D

Pharmacy Copay Structure for Network Benefits

There is no annual deductible and no Coverage Gap. There is an annual out-of-pocket maximum. A **50%** discount applies to the copay for brand-name drugs after **$3,310.00** in total drug spend.

Prescription Medications	30-Day Supply	31- to 90-Day Supply
Generic (Tier 1) Drugs	Up to $10 copay	Up to $25 copay
Preferred (Tier 2) Drugs	Up to $45 copay	Up to $90 copay
Non-Preferred (Tier 3) Drugs	Up to $75 copay	Up to $150 copay
Specialty (Tier 4) Drugs	Up to $100 copay	Specialty drugs are available only in a 30-day supply
Preferred (Tier 5) Tobacco Cessation Drugs	$0 copay	$0 copay

The Pharmacy Out-of-Pocket Maximum

Out-of-Pocket Maximum	After Out-of-Pocket Maximum is Met
The annual out-of-pocket maximum is **$4,850.00**. Only copays for covered prescription drugs purchased at Network Pharmacies count toward the out-of-pocket maximum. Refer to the chart above for copay amounts.	After your pharmacy out-of-pocket costs reach **$4,850.00**, HealthChoice pays 100% of Allowed Charges for covered prescription drugs purchased at Network Pharmacies for the remainder of the calendar year.

Pharmacy benefits generally cover up to a 30- or 90-day supply. Specific therapeutic categories, medications and/or dosage forms may have more restrictive quantity and/or duration of therapy limitations.

Low Option Medicare Supplement Plans With and Without Part D

Pharmacy Cost Structure for Network Benefits

Pharmacy Deductible Stage $360.00	Initial Coverage Limit Stage $2,950.00	Coverage Gap Stage $3,752.50	100% Benefit Stage $4,850.00
You pay 100% of **$360.00**	After the deductible, you and HealthChoice share the costs of the next **$2,950.00** of prescription drug costs. You pay 25% **($737.50)** and HealthChoice pays 75% **($2,212.50)**	You pay 100% of the next **$3,752.50** of prescription drug costs*	After you spend **$4,850.00** out-of-pocket, HealthChoice pays 100% of Allowed Charges for covered prescription drugs for the remainder of the calendar year

Reaching the Annual Out-of-Pocket Maximum of $4,850.00

$ 360.00	Deductible
$ 737.50	25% of the Initial Coverage Limit of **$2,950.00**
$3,752.50	Coverage Gap – you pay 100% of costs for prescription drugs*
$4,850.00	Your total annual out-of-pocket for covered prescription drugs

Your Costs for Covered Medications

You Pay	HealthChoice Pays
Annual deductible of **$360**	$0
$737.50 (25%) of the next **$2,950.00** of prescription drug costs, the Initial Coverage Limit	**$2,212.50** (75%) of the next **$2,950.00**
*During the Coverage Gap, you are responsible for the next **$3,752.50** of prescription drug costs; however, you receive a **58%** discount on the cost of brand-name drugs and a **42%** discount on the cost of generic drugs	HealthChoice pays the **42%** discount on the cost of generic drugs and **8%** of the **58%** discount on the cost of brand-name drugs during the Coverage Gap
$0 after you have spent **$4,850.00** out-of-pocket for prescription drugs	100% of Allowed Charges for covered drugs for the remainder of the calendar year

Pharmacy benefits generally cover up to a 30- or 90-day supply. Specific therapeutic categories, medications and/or dosage forms may have more restrictive quantity and/or duration of therapy limitations.

APPENDIX K

II.A.13. Additional Requirements for Medicare Supplement that includes a Medicare Part D PDP

Weekly File

Name
SSN
HICN
Effective Date
Term Date
LIS Level (100%, 75%, 50%, or 25%)
LIS Effective Date
LIS Term Date
Plan Level (high vs. low - if applicable)

Monthly File

Name
HICN
LIS Level
Plan Level (high vs. low - if applicable)

Appendix M

HMO RFP #H0020 - Plan Year 2017

HMO Utilization/Experience Data and Underwriting Request - Assume no plan design changes at this time

Note: Information requested on a per member per month (pmpm) basis should reflect the total membership applicable.

Experience Data/Information	Illustrative 2015 Rate Development			
	Medical	Rx	Capitation	Total
I. Financial Data				
A. Total Subscriber				
a) EBD				
b) EGID				
B. Total Members				
a) EBD				
b) EGID				
C. Age Factor/ Sex Factor EBD				
Age Factor/ Sex Factor EGID				
D. Total Premium				
E. Total Paid Claims				
H. Paid Loss Ratio				
II. Claims Forecast				
A. Incurred Claims (12 / 15)				
B. Less: Rx Rebates (1)				
C. Less Pooled Claims				
a) Pooling Level Used				
D. Pooling Charge				
E. IBNR				
F. PPACA Plan Design Changes				
G. Estimated Incurred Claims				
H. Exposure Units - Member Months				
I. Estimated Incurred Claims PMPM				
Trend Factor				
Annual Trend % Used:				
J. Expected Claims PMPM				
K. Retention PMPM				
L. Retention - EGID @ 1% PMPM				
M. Retention - EBD @ 1.15% PMPM				
N. PPACA - PCORI PMPM				
O. PPACA - Transitional Reinsurance Fee PMPM				
P. PPACA - Health Insurer Fee PMPM				
Q. State Taxes PMPM				
R. Projected Premium PMPM				
S. Current Premium PMPM				
T. Percentage Increase				
III. Current Enrollment				
A. Employee Only				
B. Spouse				
C. Child				
D. Child(ren)				
E. Spouse + Child				
F. Spouse + Children				
IV. Current Premium				
A. Employee Only				
B. Spouse				
C. Child				
D. Children				
E. Total Premium				

(1) If your organization does not provide a direct credit for claims, please provide a supplemental explanation (signed by an Actuary) detailing how, and in what amounts, rebates are accounted for in your methodology.

Appendix N

HMO RFP #H0020 - Plan Year 2017

Aggregate Utilization/Experience Data - EBD

Instructions on providing the experience segments:
- Experience **Segment 1**: Provide requested information for the Oklahoma **EBD** Employees (Active)

Experience Segment 1 - January 2014 through December 2014	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	July 2014	August 2014	September 2014	October 2014	November 2014	December 2014	Total 2014
1. Total Premium Received (In Dollars)													
2. Total Medical Paid Claims: non-capitated (In Dollars)													
3. Total Rx Paid Claims (In Dollars)													
4. Total Capitated Paid Claims (In Dollars)													
5. Total Rx Rebates (Client Specific in Dollars)													
6. Total Subscribers Covered													
7. Total Members Covered													
8. Total Admissions													
9. Total Inpatient Days													
10. Total Non-Specialty Prescriptions													
11. Total Specialty Prescriptions													

Experience Segment 2 - January 2015 through December 2015	January 2015	February 2015	March 2015	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	Total 2015
1. Total Premium Received (In Dollars)													
2. Total Medical Paid Claims: non-capitated (In Dollars)													
3. Total Rx Paid Claims (In Dollars)													
4. Total Capitated Paid Claims (In Dollars)													
5. Total Rx Rebates (Client Specific in Dollars)													
6. Total Subscribers Covered													
7. Total Members Covered													
8. Total Admissions													
9. Total Inpatient Days													
10. Total Non-Specialty Prescriptions													
11. Total Specialty Prescriptions													

Experience Segment 3 - January 2016 through April 2016	January 2016	February 2016	March 2016	April 2016	Total 2016 YTD
1. Total Premium Received (In Dollars)					
2. Total Medical Paid Claims: non-capitated (In Dollars)					
3. Total Rx Paid Claims (In Dollars)					
4. Total Capitated Paid Claims (In Dollars)					
5. Total Rx Rebates (Client Specific in Dollars)					
6. Total Subscribers Covered					
7. Total Members Covered					
8. Total Admissions					
9. Total Inpatient Days					
10. Total Non-Specialty Prescriptions					
11. Total Specialty Prescriptions					

Note: A 24 month medical and Rx claims triangle (separated) through April 2016 with EBD and EGID combined is required. Please attach each as separate documents.

Appendix O

HMO RFP #H0020 - Plan Year 2017

Aggregate Utilization/Experience Data - EGID

Instructions on providing the experience segments:
- Experience **Segment 2**: Provide requested information for the Oklahoma **EGID** Employees (Active)

Experience Segment 1 - January 2014 through December 2014	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	July 2014	August 2014	September 2014	October 2014	November 2014	December 2014	Total 2014
1. Total Premium Received (In Dollars)													
2. Total Medical Paid Claims: non-capitated (In Dollars)													
3. Total Rx Paid Claims (In Dollars)													
4. Total Capitated Paid Claims (In Dollars)													
5. Total Rx Rebates (Client Specific in Dollars)													
6. Total Subscribers Covered													
7. Total Members Covered													
8. Total Admissions													
9. Total Inpatient Days													
10. Total Non-Specialty Prescriptions													
11. Total Specialty Prescriptions													

Experience Segment 2 - January 2015 through December 2015	January 2015	February 2015	March 2015	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	Total 2015
1. Total Premium Received (In Dollars)													
2. Total Medical Paid Claims: non-capitated (In Dollars)													
3. Total Rx Paid Claims (In Dollars)													
4. Total Capitated Paid Claims (In Dollars)													
5. Total Rx Rebates (Client Specific in Dollars)													
6. Total Subscribers Covered													
7. Total Members Covered													
8. Total Admissions													
9. Total Inpatient Days													
10. Total Non-Specialty Prescriptions													
11. Total Specialty Prescriptions													

Experience Segment 3 - January 2016 through April 2016	January 2016	February 2016	March 2016	April 2016	Total 2016 YTD
1. Total Premium Received (In Dollars)					
2. Total Medical Paid Claims: non-capitated (In Dollars)					
3. Total Rx Paid Claims (In Dollars)					
4. Total Capitated Paid Claims (In Dollars)					
5. Total Rx Rebates (Client Specific in Dollars)					
6. Total Subscribers Covered					
7. Total Members Covered					
8. Total Admissions					
9. Total Inpatient Days					
10. Total Non-Specialty Prescriptions					
11. Total Specialty Prescriptions					

Note: A 24 month medical and Rx claims triangle (separated) through April 2016 with EBD and EGID combined is required. Please attach each as separate documents.

Appendix P

HMO RFP #H0020 - Plan Year 2017

Aggregate Utilization/Experience Data - Early Retirees

Instructions on providing the experience segments:
- Experience **Segment 3**: Provide requested information for the Oklahoma **Early Retirees**

Experience Segment 1 - January 2014 through December 2014	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	July 2014	August 2014	September 2014	October 2014	November 2014	December 2014	Total 2014
1. Total Premium Received (In Dollars)													
2. Total Medical Paid Claims: non-capitated (In Dollars)													
3. Total Rx Paid Claims (In Dollars)													
4. Total Capitated Paid Claims (In Dollars)													
5. Total Rx Rebates (Client Specific in Dollars)													
6. Total Subscribers Covered													
7. Total Members Covered													
8. Total Admissions													
9. Total Inpatient Days													
10. Total Non-Specialty Prescriptions													
11. Total Specialty Prescriptions													

Experience Segment 2 - January 2015 through December 2015	January 2015	February 2015	March 2015	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	Total 2015
1. Total Premium Received (In Dollars)													
2. Total Medical Paid Claims: non-capitated (In Dollars)													
3. Total Rx Paid Claims (In Dollars)													
4. Total Capitated Paid Claims (In Dollars)													
5. Total Rx Rebates (Client Specific in Dollars)													
6. Total Subscribers Covered													
7. Total Members Covered													
8. Total Admissions													
9. Total Inpatient Days													
10. Total Non-Specialty Prescriptions													
11. Total Specialty Prescriptions													

Experience Segment 3 - January 2016 through April 2016	January 2016	February 2016	March 2016	April 2016	Total 2016 YTD
1. Total Premium Received (In Dollars)					
2. Total Medical Paid Claims: non-capitated (In Dollars)					
3. Total Rx Paid Claims (In Dollars)					
4. Total Capitated Paid Claims (In Dollars)					
5. Total Rx Rebates (Client Specific in Dollars)					
6. Total Subscribers Covered					
7. Total Members Covered					
8. Total Admissions					
9. Total Inpatient Days					
10. Total Non-Specialty Prescriptions					
11. Total Specialty Prescriptions					

Note: A 24 month medical and Rx claims triangle (separated) through April 2016 with EBD and EGID combined is required. Please attach each as separate documents.

Appendix Q - Aggregate Utilization/Experience Data - EBD, EGID, and Early

HMO RFP #H0020 - Plan Year 2017

Aggregate Utilization/Experience Data - EBD, EGID, and Early Retiree

Instructions on providing the experience segments:
- Provide de-identified large claim data information requested below (dollars and diagnosis)
- Provide information for any claimant over $150,000 in aggregate claims (both medical and pharmacy)
- Data must be provided in the below worksheet - do not refer to a separate document
- Provide information for 12 months ending December 2014 on an INCURRED basis (12 / 24)

	Claimant	Diagnosis	Group	Amount
Example	*Claimant 1*	*Some Condition*	*EBD*	*$150,000*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
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Attachment R (Large Claims 12 mo ending December 2015)

HMO RFP #H0020 - Plan Year 2017

Aggregate Utilization/Experience Data - EBD, EGID, and Early Retiree

Instructions on providing the experience segments:
- Provide de-identified large claim data information requested below (dollars and diagnosis)
- Provide information for any claimant over $150,000 in aggregate claims (both medical and pharmacy)
- Data must be provided in the below worksheet - do not refer to a separate document
- Provide information for 12 months ending December 2015 on an INCURRED basis (12 / 16)

	Claimant	Diagnosis	Group	Amount
Example	*Claimant 1*	*Some Condition*	*EBD*	*$150,000*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
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11.				
12.				
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Appendix S

HMO RFP #H0020 - Plan Year 2017

Other Information

Instructions on providing the experience segments:
- Experience **Segment 1**: Provide requested information for the Oklahoma Book of Business on Non-Value Based Networks
- Experience **Segment 2**: Provide requested information for the Oklahoma Book of Business on Value Based Networks

Note: In absence of actual data, please provide anticipated / expected information

Experience Segment 1 - May 2016 through April 2016	**Oklahoma City**	**Tulsa**	**Statewide**
1. Total Premium Received (In Dollars)			
2. Total Medical Paid Claims: non-capitated (In Dollars)			
3. Total Rx Paid Claims (In Dollars)			
4. Total Capitated Paid Claims (In Dollars)			
5. Total Rx Rebates (Client Specific in Dollars)			
6. Total Subscribers Covered			
7. Total Members Covered			
8. Age/Sex Factor			
9. Total Admissions			
10. Total Inpatient Days			
11. Total Prescriptions			
12. Total Primary Care Providers			
13. Total Specialists			
14. Total Hospitals			

Experience Segment 2 - May 2015 through April 2016	**Oklahoma City**	**Tulsa**	**Statewide**
Is your data illustrative or actual?	**??**	**??**	**??**
1. Total Premium Received (In Dollars)			
2. Total Medical Paid Claims: non-capitated (In Dollars)			
3. Total Rx Paid Claims (In Dollars)			
4. Total Capitated Paid Claims (In Dollars)			
5. Total Rx Rebates (Client Specific in Dollars)			
6. Total Subscribers Covered			
7. Total Members Covered			
8. Age/Sex Factor			
9. Total Admissions			
10. Total Inpatient Days			
11. Total Prescriptions			
12. Total Primary Care Providers			
13. Total Specialists			
14. Total Hospitals			