Solicitation Cover Page

1. Solicitation #: 0900000264 **2. Solicitation Issue Date:** 05/16/17

3. Brief Description of Requirement:

The OMES/CP, on behalf of EGID, intends to solicit competitive proposals on a non-exclusive basis with one or more qualified Health Maintenance Organizations (HMOs), Medicare Supplements, and Medicare Advantage Prescription Drug (MAPD) health plans to offer managed care benefits to eligible OEIBA Program participants.

Attachment 22 is not included in the solicitation packet but is included as an attachment.

Solicitation Notice: Please note that on a Request for Proposal (RFP), no pricing shall be released at the time of opening. Should a public opening be requested the only information to be released will be a list of bidders without pricing.

All questions regarding this solicitation must be submitted in writing and are to be emailed **no later than May 22, 2017 at 3:00 p.m.** Central Standard Time. Questions are to be emailed to Richard.Williams@omes.ok.gov. Questions received after this date will not be answered. If any questions are received, an amendment to this solicitation will be posted on our website after this deadline listing all questions received and their answers.

4. Response Due Date[1]: 6/12/17 **Time**: 3:00 PM CST/CDT

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

U.S. Postal Delivery Address: 5005 N. Lincoln Ste 300
Oklahoma City, OK 73105

Common Carrier Delivery Address: 5005 N. Lincoln Ste 300
Oklahoma City, OK 73105

Electronic Submission Address: N/A

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

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

7. Contracting Officer:

Name: Richard Williams
Phone: 405-522-1040
Email: Richard.Williams@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 #** 0900000264

2. **Bidder General Information:**

FEI / SSN : _____ Supplier 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 – Attach an explanation of exemption

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.*

Agency Name: *OMES Employees Group Insurance Division* Agency Number: *090*

Solicitation or Purchase Order #: 0900000264

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	

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A. GENERAL PROVISIONS

A.1. Definitions

As used herein, the following terms shall have the following meaning unless the context clearly indicates otherwise:

A.1.1. "Acquisition" means items, products, materials, supplies, services, and equipment a state agency acquires by purchase, lease purchase, lease with option to purchase, or rental pursuant to the Oklahoma Central Purchasing Act;

A.1.2. “Addendum” means a written restatement of or modification to a Contract Document executed by the Supplier and State.

A.1.3. ”Bid” means an offer in the form of a bid, proposal, or quote a bidder submits in response to a solicitation;

A.1.4. "Bidder" means an individual or business entity that submits a bid in response to a solicitation;

A.1.5. "Solicitation" means a request or invitation by the State Purchasing Director or a state agency for a supplier to submit a priced offer to sell acquisitions to the state. A solicitation may be an invitation to bid, request for proposal, or a request for quotation; and

A.1.6. ”Supplier” or “vendor” means an individual or business entity that sells or desires to sell acquisitions to state agencies.

A.2. Bid Submission

A.2.1. Submitted bids shall be in strict conformity with the instructions to bidders and shall be submitted with a completed Responding Bidder Information, OMES-FORM-CP-076, and any other forms required by the solicitation.

A.2.2. Bids shall be submitted to the Central Purchasing Division in a single envelope, package, or container and shall be sealed, unless otherwise detailed in the solicitation. The name and address of the bidder shall be inserted in the upper left corner of the single envelope, package, or container. SOLICITATION NUMBER AND SOLICITATION RESPONSE DUE DATE AND TIME MUST APPEAR ON THE FACE OF THE SINGLE ENVELOPE, PACKAGE, OR CONTAINER.

A.2.3. The required certification statement, "Certification for Competitive Bid and/or Contract (Non-Collusion Certification)", OMES-FORM-CP-004, must be made out in the name of the bidder and must be properly executed by an authorized person, with full knowledge and acceptance of all its provisions.

A.2.4. All bids shall be legible and completed in ink or with electronic printer or other similar office equipment. Any corrections to bids shall be identified and initialed in ink by the bidder. Penciled bids and penciled corrections shall NOT be accepted and will be rejected as non-responsive. In addition to a hard copy submittal, the bidder will also be required to submit an electronic copy. Electronic responses must be submitted in the identical format contained in the solicitation (for example Microsoft Word, Microsoft Excel, but not Adobe PDF). In the event the hard copy of the price worksheets and electronic copy of the price worksheets do not agree, the electronic copy will prevail.

A.2.5. All bids submitted shall be subject to the Oklahoma Central Purchasing Act, Central Purchasing Rules, and other statutory regulations as applicable, these General Provisions, any Special Provisions, solicitation specifications, required certification statement, and all other terms and conditions listed or attached herein—all of which are made part of this solicitation.

A.3. Solicitation Amendments

A.3.1. If an ”Amendment of Solicitation”, OMES-FORM-CP-011, is issued, the bidder shall acknowledge receipt of any/all amendment(s) to solicitations by signing and returning the solicitation amendment(s). Amendment acknowledgement(s) may be submitted with the bid or may be forwarded separately. If forwarded separately, amendment acknowledgement(s) must contain the solicitation number and response due date and time on the front of the envelope. The Central

Purchasing Division must receive the amendment acknowledgement(s) by the response due date and time specified for receipt of bids for the bid to be deemed responsive. Failure to acknowledge solicitation amendments may be grounds for rejection.

A.3.2. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in the solicitation. All amendments to the solicitation shall be made in writing by the Central Purchasing Division.

A.3.3. It is the bidder's responsibility to check the OMES/Central Purchasing Division website frequently for any possible amendments that may be issued. The Central Purchasing Division is not responsible for a bidder's failure to download any amendment documents required to complete a solicitation.

A.4. Bid Change

If the bidder needs to change a bid prior to the solicitation response due date, a new bid shall be submitted to the Central Purchasing Division with the following statement "This bid supersedes the bid previously submitted" in a single envelope, package, or container and shall be sealed, unless otherwise detailed in the solicitation. The name and address of the bidder shall be inserted in the upper left corner of the single envelope, package, or container. SOLICITATION NUMBER AND SOLICITATION RESPONSE DUE DATE AND TIME MUST APPEAR ON THE FACE OF THE SINGLE ENVELOPE, PACKAGE, OR CONTAINER.

A.5. Certification Regarding Debarment, Suspension, and Other Responsibility Matters

By submitting a response to this solicitation:

A.5.1. The prospective primary participant and any subcontractor certifies to the best of their knowledge and belief, that they and their principals or participants:

A.5.1.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal, State or local department or agency;

A.5.1.2. Have not within a three-year period preceding this proposal been convicted of or pled guilty or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) contract; or for violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

A.5.1.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph A.5.1.2. of this certification; and

A.5.1.4. Have not within a three-year period preceding this application/proposal had one or more public (Federal, State, or local) contracts terminated for cause or default.

A.5.2. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to its solicitation response.

A.6. Bid Opening

Sealed bids shall be opened by the Central Purchasing Division at 5005 N. Lincoln Blvd. Suite 300, Oklahoma City, Oklahoma, 73105 at the time and date specified in the solicitation as Response Due Date and Time.

A.7. Open Bid / Open Record

Pursuant to the Oklahoma Public Open Records Act, a public bid opening does not make the bid(s) immediately accessible to the public. The procurement or contracting agency shall keep the bid(s) confidential, and provide prompt and reasonable access to the records only after a contract is awarded or the solicitation is cancelled. This practice protects the integrity of the competitive bid process and prevents excessive disruption to the procurement process. The interest of achieving the best value for the State of Oklahoma outweighs the interest of vendors immediately knowing the contents of competitor's bids. [51 O.S. § 24A.5(5)]

Additionally, financial or proprietary information submitted by a bidder may be designated by the Purchasing Director as confidential and the procurement entity may reject all requests to disclose information designated as confidential pursuant to 62 O.S. (2012) § 34.11.1(H)(2) and 74 O.S. (2011) § 85.10. Bidders claiming any portion of their bid as proprietary or confidential must specifically identify what documents or portions of documents they

consider confidential and identify applicable law supporting their claim of confidentiality. The State Purchasing Director shall make the final decision as to whether the documentation or information is confidential pursuant to 74 O.S. § 85.10. Otherwise, documents and information a bidder submits as part of or in connection with a bid are public records and subject to disclosure after contract award or the solicitation is cancelled.

A.8. Late Bids

Bids received by the Central Purchasing Division after the response due date and time shall be deemed non-responsive and shall NOT be considered for any resultant award.

A.9. Legal Contract

A.9.1. Submitted bids are rendered as a legal offer and any bid, when accepted by the Central Purchasing Division, shall constitute a contract.

A.9.2. The Contract resulting from this solicitation may consist of the following documents in the following order of precedence:

A.9.2.1. Any Addendum to the Contract;

A.9.2.2. Purchase order, as amended by Change Order (if applicable);

A.9.2.3. Solicitation, as amended (if applicable); and

A.9.2.4. Successful bid (including required certifications), to the extent the bid does not conflict with the requirements of the solicitation or applicable law.

A.9.3. Any contract(s) awarded pursuant to the solicitation shall be legibly written or typed.

A.10. Pricing

A.10.1. Bids shall remain firm for a minimum of sixty (60) days from the solicitation closing date.

A.10.2. Bidders guarantee unit prices to be correct.

A.10.3. In accordance with 74 O.S. §85.40, ALL travel expenses to be incurred by the supplier in performance of the Contract shall be included in the total bid price/contract amount.

A.11. Manufacturers' Name and Approved Equivalents

Unless otherwise specified in the solicitation, manufacturers' names, brand names, information and/or catalog numbers listed in a specification are for information and not intended to limit competition. Bidder may offer any brand for which they are an authorized representative, and which meets or exceeds the specification for any item(s). However, if bids are based on equivalent products, indicate on the bid form the manufacturer's name and number. Bidder shall submit sketches, descriptive literature, and/or complete specifications with their bid. Reference to literature submitted with a previous bid will not satisfy this provision. The bidder shall also explain in detail the reason(s) why the proposed equivalent will meet the specifications and not be considered an exception thereto. Bids that do not comply with these requirements are subject to rejection.

A.12. Clarification of Solicitation

A.12.1. Clarification pertaining to the contents of this solicitation shall be directed in writing to the Central Purchasing Contracting Officer specified in the solicitation, and must be prior to the closing date of the solicitation.

A.12.2. If a bidder fails to notify the State of an error, ambiguity, conflict, discrepancy, omission or other error in the SOLICITATION, known to the bidder, or that reasonably should have been known by the bidder, the bidder shall submit a bid at its own risk; and if awarded the contract, the bidder shall not be entitled to additional compensation, relief, or time, by reason of the error or its later correction. If a bidder takes exception to any requirement or specification contained in the SOLICITATION, these exceptions must be clearly and prominently stated in their response.

A.12.3. Bidders who believe proposal requirements or specifications are unnecessarily restrictive or limit competition may submit a written request for administrative review

to the contracting officer listed on the solicitation. This request must be made prior to the closing date of the solicitation.

A.13 Negotiations

A.13.1. In accordance with Title 74 §85.5, the State of Oklahoma reserves the right to negotiate with one, selected, all or none of the vendors responding to this solicitation to obtain the best value for the State. Negotiations could entail discussions on products, services, pricing, contract terminology or any other issue that may mitigate the State's risks. The State shall consider all issues negotiable and not artificially constrained by internal corporate policies. Negotiation may be with one or more vendors, for any and all items in the vendor's offer.

A.13.2. Firms that contend that they lack flexibility because of their corporate policy on a particular negotiation item shall face a significant disadvantage and may not be considered. If such negotiations are conducted, the following conditions shall apply:

A.13.3. Negotiations may be conducted in person, in writing, or by telephone.

A.13.4. Negotiations shall only be conducted with potentially acceptable offers. The State reserves the right to limit negotiations to those offers that received the highest rankings during the initial evaluation phase.

A.13.5. Terms, conditions, prices, methodology, or other features of the bidders offer may be subject to negotiations and subsequent revision. As part of the negotiations, the bidder may be required to submit supporting financial, pricing, and other data in order to allow a detailed evaluation of the feasibility, reasonableness, and acceptability of the offer.

A.13.6. The requirements of the Request for Proposal shall not be negotiable and shall remain unchanged unless the State determines that a change in such requirements is in the best interest of the State Of Oklahoma.

A.14. Rejection of Bid

The State reserves the right to reject any bids that do not comply with the requirements and specifications of the solicitation. A bid may be rejected when the bidder imposes terms or conditions that would modify requirements of the solicitation or limit the bidder's liability to the State. Other possible reasons for rejection of bids are listed in OAC 260:115-7-32.

A.15. Award of Contract

A.15.1. The State Purchasing Director may award the Contract to more than one bidder by awarding the Contract(s) by item or groups of items, or may award the Contract on an ALL OR NONE basis, whichever is deemed by the State Purchasing Director to be in the best interest of the State of Oklahoma.

A.15.2. Contract awards will be made to the lowest and best bidder(s) unless the solicitation specifies that best value criteria is being used.

A.15.3. In order to receive an award or payments from the State of Oklahoma, suppliers must be registered. The vendor registration process can be completed electronically through the OMES website at the following link: https://www.ok.gov/dcs/vendors/index.php .

A.16. Contract Modification

A.16.1. The Contract is issued under the authority of the State Purchasing Director who signs the Contract. The Contract may be modified only through a written Addendum, signed by the State Purchasing Director and the supplier .

A.16.2. Any change to the Contract, including but not limited to the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by a person who is not specifically authorized by the Central Purchasing Division in writing, or made unilaterally by the supplier, is a breach of the Contract. Unless otherwise specified by applicable law or rules, such changes, including unauthorized written Addendums, shall be void and without effect, and the supplier shall not be entitled to any claim under this Contract based on those changes. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in the resultant Contract.

A.17. Delivery, Inspection and Acceptance

A.17.1. Unless otherwise specified in the solicitation or awarding documents, all deliveries shall be F.O.B. Destination. The supplier(s) awarded the Contract shall prepay all packaging, handling, shipping and delivery charges and firm prices quoted in the bid shall include all such charges. All products and/or services to be delivered pursuant to the Contract shall be subject to final inspection and acceptance by the State at destination. "Destination" shall mean delivered to the receiving dock or other point specified in the purchase order. The State assumes no responsibility for goods until accepted by the State at the receiving point in good condition. Title and risk of loss or damage to all items shall be the responsibility of the supplier until accepted by the receiving agency. The supplier(s) awarded the Contract shall be responsible for filing, processing, and collecting any and all damage claims accruing prior to acceptance.

A.17.2. Supplier(s) awarded the Contract shall be required to deliver products and services as bid on or before the required date. Deviations, substitutions or changes in products and services shall not be made unless expressly authorized in writing by the Central Purchasing Division.

A.18. Invoicing and Payment

A.18.1. Pursuant to 74 O.S. §85.44(B), invoices will be paid in arrears after products have been delivered or services provided.

A.18.2. Payment terms will be net 45.

A.18.3. Additional terms which provide discounts for earlier payment will be evaluated when making an award. Additional terms shall be no less than ten (10) days increasing in five (5) day increments up to thirty (30) days. Discounts offered must be in half or whole percent increments. The date from which the discount time is calculated shall be the date of a valid invoice. An invoice is considered valid if sent to the proper recipient and goods or services have been received.

A.19. Tax Exemption

State agency acquisitions are exempt from sales taxes and federal excise taxes. Bidders shall not include these taxes in price quotes.

A.20. Audit and Records Clause

A.20.1. As used in this clause, “records" includes books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form. In accepting any Contract with the State, the successful bidder(s) agree any pertinent State or Federal agency will have the right to examine and audit all records relevant to execution and performance of the resultant Contract.

A.20.2. The successful supplier(s) awarded the Contract(s) is required to retain records relative to the Contract for the duration of the Contract and for a period of seven (7) years following completion and/or termination of the Contract. If an audit, litigation, or other action involving such records is started before the end of the seven (7) year period, the records are required to be maintained for two (2) years from the date that all issues arising out of the action are resolved, or until the end of the seven (7) year retention period, whichever is later.

A.21. Non-Appropriation Clause

The terms of any Contract resulting from the solicitation and any Purchase Order issued for multiple years under the Contract are contingent upon sufficient appropriations being made by the Legislature or other appropriate government entity. Notwithstanding any language to the contrary in the solicitation, purchase order, or any other Contract document, the procuring agency may terminate its obligations under the Contract if sufficient appropriations are not made by the Legislature or other appropriate governing entity to pay amounts due for multiple year agreements. The Requesting (procuring) Agency's decisions as to whether sufficient appropriations are available shall be accepted by the supplier and shall be final and binding.

A.22. Choice of Law

Any claims, disputes, or litigation relating to the solicitation, or the execution, interpretation, performance, or enforcement of the Contract shall be governed by the laws of the State of Oklahoma.

A.23. Choice of Venue

Venue for any action, claim, dispute or litigation relating in any way to the Contract shall be in Oklahoma County, Oklahoma.

A.24. Termination for Cause

A.24.1. The supplier may terminate the Contract for default or other just cause with a 30-day written request and upon written approval from the Central Purchasing Division. The State may terminate the Contract for default or any other just cause upon a 30-day written notification to the supplier.

A.24.2. The State may terminate the Contract immediately, without a 30-day written notice to the supplier, when violations are found to be an impediment to the function of an agency and detrimental to its cause, when conditions preclude the 30-day notice, or when the State Purchasing Director determines that an administrative error occurred prior to Contract performance.

A.24.3. If the Contract is terminated, the State shall be liable only for payment for products and/or services delivered and accepted.

A.25. Termination for Convenience

A.25.1. The State may terminate the Contract, in whole or in part, for convenience if the State Purchasing Director determines that termination is in the State's best interest. The State Purchasing Director shall terminate the Contract by delivering to the supplier a Notice of Termination for Convenience specifying the terms and effective date of Contract termination. The Contract termination date shall be a minimum of 60 days from the date the Notice of Termination for Convenience is issued by the State Purchasing Director.

A.25.2. If the Contract is terminated, the State shall be liable only for products and/or services delivered and accepted, and for costs and expenses (exclusive of profit) reasonably incurred prior to the date upon which the Notice of Termination for Convenience was received by the supplier.

A.26. Insurance

The successful supplier(s) awarded the Contract shall obtain and retain insurance, including workers' compensation, automobile insurance, medical malpractice, and general liability, as applicable, or as required by State or Federal law, prior to commencement of any work in connection with the Contract. The supplier awarded the Contract shall timely renew the policies to be carried pursuant to this section throughout the term of the Contract and shall provide the Central Purchasing Division and the procuring agency with evidence of such insurance and renewals.

A.27. Employment Relationship

The Contract does not create an employment relationship. Individuals performing services required by this Contract are not employees of the State of Oklahoma or the procuring agency. The supplier's employees shall not be considered employees of the State of Oklahoma nor of the procuring agency for any purpose, and accordingly shall not be eligible for rights or benefits accruing to state employees.

A.28. Compliance with the Oklahoma Taxpayer and Citizen Protection Act of 2007

By submitting a bid for services, the bidder certifies that they, and any proposed subcontractors, are in compliance with 25 O.S.
§1313 and participate in the Status Verification System. The Status Verification System is defined in 25 O.S. §1312 and includes but is not limited to the free Employment Verification Program (E-Verify) through the Department of Homeland Security and available at www.dhs.gov/E-Verify .

A.29. Compliance with Applicable Laws

The products and services supplied under the Contract shall comply with all applicable Federal, State, and local laws, and the supplier shall maintain all applicable licenses and permit requirements.

A.30. Special Provisions

Special Provisions set forth in SECTION B apply with the same force and effect as these General Provisions. However, conflicts or inconsistencies shall be resolved in favor of the Special Provisions.

B. SPECIAL PROVISIONS

B.1. Contract Period

Contract Period is January 1, 2018 through December 31, 2018**.** The awarded contract agreement binds the Supplier as of the date of award to provide services, as awarded, for Plan Year 2018 (January 1, 2018 through December 31, 2018).

B.2. Definitions

B.2.1. "Business Associate" shall have the meaning given to Business Associate under the Privacy Rule, including, but not limited to, 45 CFR § 160.103.

B.2.2. "Business Associate Agreement" is the contract between an entity covered under HIPAA and its Business Associate as required under the Privacy Rule, including (but not limited to) 45 CFR § 164.502(e)(2).

B.2.3. "Contract" shall mean the definition of contract as defined in Section A9.

B.2.4. "CMS" shall mean Centers for Medicare and Medicaid Services.

B.2.5. "EGID" means Employees Group Insurance Division of the Office of Management and Enterprise Services. It shall also have the meaning given to the term 'Covered Entity' under the Privacy Rule, including, but not limited to, 45 CFR § 160.103 for purposes of this Business Associate Agreement only and to the extent required by law.

B.2.6. "HIPAA" refers to the Health Insurance Portability and Accountability Act of 1996 and includes any regulations promulgated pursuant thereto.

B.2.7. "HMO" means Health Maintenance Organization.

B.2.8. "MA-PD" means Medicare Advantage Prescription Drug plan.

B.2.9. "OEIBA" means the Oklahoma Employees Insurance and Benefits Act, 74 O. S. (2011) §1301, et seq.

B.2.10. "OEIBA Program" means those benefits available to eligible participants through the OEIBA.

B.2.11. "OEIBB" means the Oklahoma Employees Insurance and Benefits Board, established by the OEIBA.

B.2.12. "OMES" means the Office of Management and Enterprise Services.

B.2.13. "OMES/CP" means the Office of Management and Enterprise Services, Central Purchasing.

B.2.14. "PGP" means Pretty Good Privacy.

B.3. Contract Defined

B.3.1. This solicitation together with the Supplier's response, exhibits, written questions and clarifications, amendments or revisions signed by both parties and presented to OMES/CP and the purchase, and any Addendum to the contract constitute the entire and final agreement between EGID and the Supplier relating to the rights granted and the obligations assumed by the parties and is the Contract, when OMES/CP awards the Contract to the successful Supplier(s). This clause supplements section A.9. Any Addendum to the contract or revisions signed by both parties and presented to OMES/CP shall take precedence over other contract documents.

B.3.2. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this solicitation and the Supplier's response thereto, not expressly set forth, are of no force or effect.

B.4. Acceptance of Offer

B.4.1. The submission of a solicitation shall constitute a binding offer to perform those services described within the RFP.

B.4.2. By submitting a solicitation response, the Supplier(s) agrees that it waives its rights to claims for damages against the Office of Management Enterprise Services Group Insurance Department (EGID) because of any misunderstanding or misrepresentation of the specifications in the RFP or because of any misinformation or lack of information in the RFP.

B.4.3. The provider(s) must affirm their understanding of all contractual provisions and agree to those provisions for the duration of the contract.

B.5. Termination

B.5.1. EGID may terminate the contract in whole or in part, whenever it determines that a Supplier or its subcontractors has failed to maintain the quality of its services provided for by this Contract to the satisfaction of EGID.

B.5.2. EGID may terminate this Contract for cause upon giving the Supplier sixty (60) days' notice prior to the date of termination. EGID shall provide the Supplier with a thirty (30) day written notification of termination.

B.5.3. The State may terminate the Contract immediately, without a 30-day written notice to the Supplier, when a violation(s) is found to be an impediment to the State.

B.5.4. Following the effective date of termination, this Contract shall be of no further force and effect, except that each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to the effective date of termination of this Contract.

B.5.5. The contract shall not be cancelled by any Supplier for any reason during the contract period. This supersedes Section A.24.1.

B.5.6. These terminations clauses are in addition to Sections A.24 and A.25.

B.6. Costs Incurred

OMES/CP and EGID specifically assumes no responsibility for expenses incurred by the Supplier in the submission or review of any proposal in response to this RFP, in making an oral presentation, in providing a demonstration, or in performing any other related activities. All such costs shall be the Supplier's responsibility, whether or not a contract is awarded.

B.7. Appropriated Funds

The parties understand and agree that none of the sums to be paid under this Contract are appropriated funds. Should there be a revenue shortfall, EGID shall not seek appropriations and shall not use appropriated funds to pay for this obligation. The most recent financial statement of EGID is posted on EGID's website: www.ok.gov/sib/ (go to "About EGID", then 2015 Annual Report Statement).

B.8. Records

The Provider shall maintain records, according to Federal laws relating to the services it is performing under this contract. OMES/CP and EGID shall have the right at any time to review and copy such records upon request. OMES/CP and EGID understands the Provider will not release confidential protected member information. The Provider agrees to provide OMES/CP and EGID, upon request, de-identified summary health information, information related to the member's enrollment or disenrollment, or records regarding compliance and policy matters. This is in addition to Section A.20.

B.9. Electronic and Information Technology Accessibility (EITA) Standards

B.9.1. Supplier shall comply with federal and State laws, rules and regulations related to information technology accessibility, as applicable, including but not limited to Oklahoma Information Technology Accessibility Standards ("Standards") set forth at http://www.ok.gov/cio/documents/isd_itas.pdf. and shall provide a Voluntary Product Accessibility Template ("VPAT") describing such compliance, which may be provided via a URL linking to the VPAT.

B.9.2. If Products require development or customization, additional requirements and documentation may be required and compliance shall be necessary by Supplier. Such requirements may be stated in appropriate documents including but not limited to a statement of work, riders, agreement, purchase order or Addendum. Accordingly, in each statement of work or similar document issued pursuant to the Addendum, Supplier shall describe such compliance and identify, if and as applicable, (i) which exception to the Standards applies or (ii) a description of the tasks and estimated cost to make the proposed products and/or services compliant with applicable Standards.

B.9.3. The Supplier shall indemnify and hold harmless the State of Oklahoma and any Oklahoma governmental entity purchasing the product, system or application developed and/or customized by the Supplier from any claim arising out of the Supplier's failure to comply with the aforementioned requirements.

B.10. Confidentiality and HIPAA Compliance

B.10.1. Supplier agrees to comply with HIPAA regulations and assumes the responsibilities of a "Covered Entity" as defined by HIPAA with regard to the State of Oklahoma and all the employees and dependents who enroll and participate in Supplier's insurance plan(s).

B.10.2. Supplier is solely responsible for the consequences of any act or omission on its part not in compliance with HIPAA.

B.10.3. Supplier shall dedicate an experienced networking specialist to serve as a liaison to EGID for network related issues.

B.10.4. Electronic Protected Health Information (EPHI) which could include eligibility files, reports, pre-edits and other transactional data shall be encrypted when transmitted in any manner outside of the EGID protected (trusted) network.

B.10.5. EGID utilizes Pretty Good Privacy (PGP) as its standard data file encryption methodology with both public and private keys. Data file transmissions will be performed utilizing the SFTP (FTP over SSH) protocol. Transmissions can occur over ports that are both standard or non-standard.

B.10.6. Data files prepared for transmission to and from EGID must remain encrypted at rest. This includes files stored on FTP servers and portable media (ex: flash drives, CD, and DVD media).

B.10.7. All email shall be encrypted using the TLS protocol between email servers unless an encrypted VPN tunnel has been established.

B.11. Ownership of Data

B.11.1. Although EGID is subject to the Oklahoma Open Records Act, 51 O.S. (2011) § 24A.1, EGID maintains documents and information that are considered confidential by law, 74 O.S. (2011) §§ 1322 and 3113.1. In connection with this Contract, the Supplier will have access to information that is considered confidential.

B.11.2. The Supplier warrants and represents that such confidential information shall not be sold, assigned, conveyed, provided, released, disseminated or otherwise disclosed by the Supplier, its employees, officers, directors, subsidiaries, affiliates, agents, representatives, assignees, subcontractors, independent contractors, successors, or any other persons or entities without EGID's express written permission. The Supplier shall instruct its agents, representatives, subcontractors and/or independent contractors that they shall not use or disclose such confidential information to any other person or entity without the express written permission of EGID, except as absolutely necessary for Provider to render services under this Contract or as required by law. The Provider warrants and represents that it has a tested and proven system in effect to protect all confidential information as defined herein.

B.11.3. The Supplier agrees that EGID possesses exclusive property rights to the records and data designated herein as confidential information on behalf of EGID members. EGID "Confidential Information" includes the records and resulting data generated from the confidential information of all EGID members, retirees, and beneficiaries in any plan administered by EGID and all other related information that is subject to protection from disclosure pursuant to Oklahoma or federal law, including, without limitation all privacy protections as provided in and in the "Privacy Rule" adopted pursuant to HIPAA.

B.11.4. The Supplier shall immediately report to EGID any and all unauthorized use, appropriation, sale, assignment, conveyance, provision, release, access, acquisition, disclosure or other dissemination of any confidential information of which it or its subsidiaries, affiliates, employees, officers, directors, assignees, agents, representatives, independent contractors, and subcontractors is aware or have knowledge or reasonable should have knowledge. The Provider shall also promptly furnish to EGID full details of the unauthorized use, appropriate, sale, assignment, conveyance, provision, release, access, acquisition, disclosure or other dissemination, or attempt thereof, and use its best efforts to assist EGID in investigating or preventing the reoccurrence of such event in the future. The Provider shall cooperate with EGID in connection with any litigation and investigation deemed necessary by EGID to protect any confidential information and shall bear all costs associated with the investigation, response and recovery in connection with any breach of confidential information including but not limited to credit monitoring services with a term of at least three (3) years, all notice-related costs and toll free telephone call center services. The Provider further agrees to promptly prevent a reoccurrence of any unauthorized use, appropriation, sale, assignment, conveyance, provision, release, access, acquisition, disclosure or other dissemination of confidential information.

B.11.5. The Provider acknowledges that any improper use, appropriation, sale, assignment, conveyance, provision, release, access, acquisition, disclosure or other dissemination of any confidential information to others may cause immediate and irreparable harm to EGID and/or HealthChoice members and may violate state or federal laws and regulations. If the Provider or its affiliates, subsidiaries, employees, officers, directors, assignees, agents, representatives, independent contractors, and subcontractors improperly use, appropriate, sell, assign, convey, provide, release, access, acquire, disclose or otherwise disseminate such confidential information to any person or entity in violation of the Contract, EGID will immediately be entitled to injunctive relief and/or any other rights or remedies available to EGID under this Contract, at equity or pursuant to applicable statutory, regulatory, and common law without a cure period.

B.11.6. During the term of this Contract, the Supplier agrees that EGID is granted access to all EGID Confidential Information in the possession of the Supplier and upon EGID request, the Supplier shall deliver to EGID a copy of any specified EGID confidential information and data that the Supplier prepared, developed and/or stored by the Supplier as part of this contract.

B.11.7. Prior to the expiration, or upon the earlier termination of this Contract, the Supplier shall provide EGID all confidential information and data as defined herein within the Supplier's possession in the form of hard copy and/or electronic storage media. This paragraph does not apply to the Supplier's proprietary formats or systems that contain the confidential information or proprietary documents pertaining to the operation of the Supplier's business. The Supplier may retain copies of those records or documents that it considers necessary for proof of performance.

B.11.8. This entire Section shall survive any termination, renewal, extension or amendment of this Contract.

B.12. License

To be eligible to submit a proposal under this RFP, an organization must meet all legal requirements for doing business in the State of Oklahoma. The Supplier must provide a copy of its administrator's license issued by the Insurance Commissioner for the State of Oklahoma.

B.13. Fiduciary

The Supplier shall become a fiduciary to EGID as defined at 74 O. S. (2011) §1305.2.

B.14. Hold Harmless

The Supplier shall be responsible for the work, direction, and compensation of Supplier employees, agents and subcontractors. Neither the Supplier nor the State of Oklahoma shall be liable, directly or indirectly, for the work and direction of the Supplier employees, agents or subcontractors. The Supplier agrees to indemnify and hold harmless EGID, its employees and agents, and the State of Oklahoma from damages, loss, or liability to persons or property arising from claims of any kind, including, but not limited to compensation by the Supplier employees, agents, and subcontractors of the Supplier against the Supplier; negligent or willful acts of the Supplier its employees or agents in performance of this contract; acts, omissions or liabilities of the Supplier acting in any capacity that relate to the contract; and damages, costs, fines or penalties arising from HIPAA violations committed by the Supplier employees, agents or subcontractors. The State of Oklahoma does not waive compromise, concede, surrender, or relinquish any rights, privileges, immunities, or remedies that the State of Oklahoma and its employees possess under State or Federal law.

B.15. Contract Obligations and Enforcement

The Supplier 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. Suppliers who fail to so perform are hereby notified that EGID reserves the right to undertake all measures, including legal proceedings, to protect the interests of the parties to and the beneficiaries under this agreement.

B.16. EGID Designation of Personnel

EGID may designate EGID personnel to administer any of the terms or conditions of this contract and any and all duties or acts required of EGID.

B.17. Severability

The terms and provisions of this Contract shall be deemed to be severable one from the other, and any determination at law or in a court of equity that one term or provision is unenforceable, shall have no effect on the remaining terms and provisions of this Contract, or any one of them, in accordance with the intent and purposes of the parties.

B.18. Notices Required by Contract

B.18.1. Any notice required by the terms of this Contract, shall be provided in writing and (1) mailed by the United States Postal Service (USPS), postage prepaid, certified mail, return receipt requested; or, (2) delivered by an overnight delivery company with written delivery confirmation, or, (3) hand delivered with written delivery confirmation. Notices shall be addressed to EGID Director of Benefit Contracting, 3545 N.W. 58th Street, Suite 110, Oklahoma City, OK 73112, or the Supplier at the address listed on the purchase order.

B.18.2. 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.

B.19. Evidence of Compliance with Oklahoma Insurance Department Requirements

The Supplier shall furnish evidence that it complies with all requirements imposed by the Oklahoma Insurance Department necessary for it to provide the services herein.

B.20. Force Majeure

Neither party shall be liable for any delay or failure of performance under this contract due to an act of God, or due to war mobilization, insurrection, rebellion, riot, sabotage, explosion, fire, flood or storm.

B.21. Assignments

This contract shall not be assigned in whole or in part without prior written approval by OMES/CP and EGID.

B.22. Federal Exclusion List

The Supplier affirms and agrees that it complies with the federal statutes and regulations concerning persons who are listed on the Excluded Parties List System maintained by the General Services Administration, or excluded from receiving payment from federal government programs by the Department of Health and Human Services, Office of Inspector General.

B.23. Subcontractors

B.23.1. In the event a proposal is jointly submitted by more than one Supplier, one of the organizations must be designated as the Plan Prime Contractor. All other entities should be designated as subcontractors. Any planned or proposed use of subcontractors must be clearly documented in the proposal. The prime contractor shall be completely responsible for all contract services to be performed. Prime contractors must demonstrate that all aspects of system integration have been carefully and completely considered.

B.23.2. Additionally, MAPDs utilizing subcontractors for this RFP should name the subcontractor, define the relationship, the services to be performed by the subcontractor, and clearly state the years of experience. The Supplier shall document procedures implemented allowing the Supplier to fully interface with its subcontractors. Failure to adequately demonstrate the ability to timely integrate systems shall result in the elimination of the proposal.

B.24. Notice for Changes that Impact Shared Business Processes

The Supplier 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 Supplier 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.

B.25. Actuary Certification

Suppliers are required to submit a statement from a qualified HMO actuary certifying that the Supplier's information submitted in response to Attachments 13 through 17 is true, complete, and accurately reflects the experience of this account. The qualified HMO's actuary certification shall be submitted as part of the Supplier'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 Supplier shall be ineligible for award of contract for Plan Year 2018.

B.26. Supplier Utilization Experience Data

Suppliers meeting the requirements outlined in 36 O.S. 6901 et seq. are required to submit HMO Utilization Experience Data as specified within this RFP. The specification made in prior years shall not serve as precedent for specifications that may be specified in this RFP.

B.27. Benefits and Reporting Required by Law

In addition to the benefits specified within this RFP, Suppliers must provide any benefits and reporting (such as IRS 6055) otherwise required by state or federal law.

B.28. No Commissions

B.28.1. The Provider shall agree that absolutely no commissions or finder's fees shall be paid to anyone or any organization resulting from the State of Oklahoma's contract, either arising from an agreement to pay a commission or finder's fee prior to or during the term of this Contract; and,

B.28.2. To provide a statement as part of its response to this RFP that absolutely no commissions or finder's fees are to be paid to any subcontractor, broker, agent or other individual, organization or entity in connection with an award of the contract to offer Provider services.

B.29. Conflict

The Provider shall disclose any apparent or potential conflict of interest with any state employee and shall not cause a state employee to violate 74 O.S. 2011 §85.3. The Provider shall not engage in conduct that violates or induces others to violate provisions of any state or federal law regarding the conduct of public employees. See: The Anti-Kickback Act of 1974 at 74 O. S. 2001 §3401 et seq. and the Conflict of Interest provision in the Oklahoma Central Purchasing Act at 74 O. S. 2011 §85.3.

B.30. Lawsuits and Litigation

B.30.1. The Provider must disclose, unless prohibited by securities law, any prior lawsuits and litigation involving alleged or actual violations of administrative rules and hearings, or any lawsuits, litigation, or administrative proceedings, threatened or pending, involving the Provider and any person or entity, the State of Oklahoma or any political subdivisions, and/or any state officer and/or any state employee acting in the capacity of a state employee arising from services rendered that are the same or similar to the work defined in the Solicitation Specifications in this RFP, and any settlements, compromises (if confidential, a statement of that fact) or Judgments of Record resulting from the foregoing described litigation or administrative proceedings for the past five (5) years or affirm there are none.

B.30.2. The Provider shall list and disclose Contract cancellations or negligent causes of action that arose from work performed that is the same or similar to work identified in the Solicitation Specifications in this RFP that was initiated by persons or entities against the Provider that resulted in a settlement with or judgment against the Provider in any jurisdiction in the United States in an amount of One Hundred Thousand Dollars ($100,000.00) or more within the previous five (5) years, or affirm there are none.

B.30.3. The Provider shall disclose any data security breaches and specifically HIPAA security breaches that required notification to affected persons or a regulatory authority.

B.31. Fraud, Waste & Abuse Compliance Program

The Provider must acknowledge EGID's Fraud, Waste & Abuse Compliance Program. The compliance program can be viewed at http://www.ok.gov/sib/ (Go to About EGID, click on Fraud, Waste and Abuse, then Compliance Plan.). The Provider must include in its Fraud, Waste & Abuse training efforts at least one hour annually of training for applicable Provider employees.

B.32. Supremacy of State Statutes

This Contract is subject to all applicable Oklahoma State Statutes, EGID Rules and Administrative Directives. The Provider shall comply with the American Disabilities Act. Any provision of this Contract that 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 Contract provisions shall be resolved in accordance with the laws of the State of Oklahoma. Jurisdiction for and any litigation between EGID and the Provider

shall occur in either a State or Federal court in Oklahoma County, Oklahoma. However, federal laws, regulations and CMS rules applicable to the OEIBA Program preempt all State laws and regulations, except for State licensing laws and State laws relating to plan solvency.

B.33. 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 Suppliers.

B.34. Public Bid Opening

Upon request for a public bid opening, only the name(s) of the qualified Supplier(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 and EGID.

B.35. Notification of Award

Notification shall be made to the successful Suppliers by issuance of a purchase order. Public information releases pertaining to this project shall not be made without prior written approval by EGID.

B.36. Information from One Supplier Concerning Another Is Prohibited

Suppliers are advised that EGID is not interested in, nor shall it consider, allegations of lack of qualification or of impropriety made or initiated by any Supplier concerning another Supplier at any point during the solicitation process. Inclusion of such information in the RFP response or communication of such information to any state officials, state staff or its Suppliers after RFP submission may be grounds for disqualification. This clause in no way limits the right to file a protest or appeal under the laws or rules governing the State of Oklahoma.

B.37. Cancellation of Procurement

EGID 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.

B.38. Withdrawal

Before the opening date and time of this solicitation, a submitted response may be withdrawn by a written request signed by the proposer to the Contracting Officer listed on the front page of the solicitation packet.

B.39. Revisions to the RFP

EGID may at any time hereafter modify this RFP for purposes of enumerating, defining, and clarifying services, duties and functions, but not to add new services, duties or functions.

B.40. Conflict of Interest

The Supplier shall disclose any apparent or potential conflict of interest with any state employee and shall not cause a state employee to violate 74 O.S. 2011 §85.3. The Supplier shall not engage in conduct that violates or induces others to violate provisions of any state or federal law regarding the conduct of public employees. See: The Anti-Kickback Act of 1974 at 74 O. S. 2001 §3401 et seq. and the Conflict of Interest provision in the Oklahoma Central Purchasing Act at 74 O. S. 2011 §85.3.

B.41. Minimum Requirements

B.41.1. The Supplier must provide a copy of its administrator's license issued by the Insurance Commissioner of the State of Oklahoma (Section B.12.)

B.41.2. The Supplier must provide a CMS Certification for MAPD submissions (Section C.1.2.)

B.41.3. Supplier's submission must meet the RFP's bid requirements (74 O.S. § 1371)

B.41.4. Supplier's submission must not contain an excessive benefit price (74 O.S. § 1371)

C. SOLICITATION SPECIFICATIONS

C.1. Statement of Purpose

C.1.1. The OMES/CP, on behalf of EGID, intends to solicit competitive proposals on a non-exclusive basis with one or more qualified Health Maintenance Organizations (HMOs), Medicare Supplements, and Medicare Advantage Prescription Drug (MAPD) health plans to offer managed care benefits to eligible OEIBA Program participants. All proposals must be submitted in accordance with the policies, procedures, requirements, and dates set forth below.

C.1.2. The Supplier's MAPD plan must be qualified by the Centers for Medicaid Services, hereinafter "CMS". The Supplier or its related HMO and/or PPO must be qualified and accepted according to the OMES/EGID Supplier's process to offer these services to eligible participants.

C.1.3. To participate, Suppliers must offer an HMO option meeting the Solicitation Specifications. If the Supplier additionally offers a Medicare Supplement benefit to any other population than the one within the OEIBA Program, then it must also offer a Medicare Supplement benefit within this Program in accordance with the Solicitation Specifications. In addition to the Medicare Supplement benefit, the Supplier may also offer an MAPD option. **Suppliers may not offer a MAPD or a Medicare Supplement on a standalone basis for this RFP.**

C.2. Objectives

EGID intends to offer cost effective managed care service alternatives to the OEIBA Program's covered population statewide, and provide improvements and initiatives in health care benefits that are available in Oklahoma while maintaining a cost efficient program and a rising level of quality health care services.

C.3. Identification of EGID

C.3.1. EGID was established by, and operates pursuant to, the OEIBA.

C.3.2. OMES has declared itself a HIPAA hybrid entity in accordance with 45 C.F.R. §§164.103 and 164.105, and EGID is a "covered component" subject to HIPAA.

C.3.3. Pursuant to legislative authority, EGID adopts Rules that set forth the eligibility, type of participation and benefit guidelines for all participating employers. A copy of the official agency Rules is on file with the Office of the Secretary of State beginning at 260:45-1-1, or the Rules may be found on EGID's website at http://www.ok.gov/sib/, under "About EGID" then click on "Administrative Rules".

C.4. Identification of the Program

EGID is responsible for administering the OEIBA and the benefit contracting elements of the Oklahoma State Employees Benefits Act. 74 O.S. § 1361 et seq. As such, EGID must provide for health benefit choices for the eligible participating population.

C.5. Identification of OEIBA Program Participants

Health benefits are available to current and former state and education employees, employees of other state governmental entities and quasi-state governmental entities authorized by the OEIBA to participate in the OEIBA Program.

As of January 31, 2017 the OEIBA Program included:

Category	Total Lives	Primary	Dependents
Medicare	39,000	34,349	4,651
Current employees	176,306	106,007	70,299
Pre-Medicare former employees	10,148	8,212	1,936

C.6. Specifications Applying to All Proposals (HMO, Medicare Supplement, MAPD)

Eligibility Transmission

C.6.1.1. EGID will maintain individual eligibility records. EGID will communicate all eligibility data and remit all premium dollars to carriers. At a minimum, eligibility transmissions shall be on a weekly basis.

C.6.1.2. The Supplier must accept EGID's eligibility file layout as described in Attachment 9 Carrier Eligibility Export. The following is a list of various eligibility transactions included in a typical incremental file. The listing is provided for informational purposes and should not be considered an all-inclusive list of eligibility transactions. Any of the following could have future or retroactive dates.

C.6.1.2.1. New member/dependent enrollment

C.6.1.2.2. Member/dependent termination/disenrollment

C.6.1.2.3. Member/dependent adding and/or dropping various benefits

C.6.1.2.4. Member moves between participating employer groups

C.6.1.2.5. Dependent moves from participating primary member to another primary member

C.6.1.2.6. Member/dependent status changes from active to pre-Medicare or COBRA status

C.6.1.2.7. Member/dependent becomes eligible for Medicare

C.6.1.2.8. A lapse is added to a member/dependent coverage

C.6.1.2.9. Member address changes

C.6.1.3. 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 it wasn't processed.

C.6.1.4. The Supplier will be required to maintain its eligibility records from the data provided in a timely and accurate manner.

C.6.1.5. Eligibility information sent as "urgent" must be processed and confirmed within (24) twenty-four hours.

C.6.1.6. Information on eligibility reconciliation will also be furnished on a quarterly basis.

C.6.2. Premium Accounting

C.6.2.1. EGID will communicate all eligibility data and remit all premium dollars to carriers. EGID remits premiums to Suppliers based on enrolled members.

C.6.2.2. EGID forwards premiums to the Supplier on the 20th of the month following the premium month or the first business day thereafter.

C.6.2.3. Because of eligibility provisions within the Act, retroactive adjustments may occur to eligibility of individual participants. If, due to retroactive adjustments, premiums must be refunded to a member or participating entity, EGID will recover those premiums from a future Supplier remittance. In these situations, premiums must be refunded to a member or participating entity and EGID will recover those premiums from a future Supplier remittance.

C.6.2.4. Premium Reports. The Supplier shall provide EGID premium reporting as required in Attachment 20. A verification procedure will be used for compliance.

C.6.2.4.1. Monthly discrepancy reports received by EGID should not go back further than the month being reconciled.

C.6.2.4.2. Discrepancies older than those indicated above will not be reconciled and EGID will not assume financial responsibility for a Supplier's failure to comply with reconciliation efforts. Please note that no member coverage will be affected by a Supplier's failure to comply with above.

C.6.3. Reporting

C.6.3.1. The statistical information contained throughout this RFP is believed to be accurate for the date specified but is not intended as, and must not be considered, an express or implied warranty by EGID. EGID and the State shall not be liable for any damages resulting from inaccuracies contained in statistical information.

C.6.3.2. The Supplier shall deliver all reports listed in Attachment 20 Minimum Required Reporting in the format, frequency, timeframe and to the intended recipient noted in the list or as otherwise required by EGID. The reports shall include subgroups, which at a minimum are active employees, COBRA, retirees not eligible for Medicare, and retirees eligible for Medicare.

C.6.3.3. The OEIBB is interested in increased OEIBA Program transparency to the public. Please indicate (by report number in Attachment 20 Minimum Required Reporting which of the reports the Supplier already makes public in some form or to which the Supplier agrees to allow the OEIBB to make summary data public at its quarterly Board meetings.

C.6.4. Significant Events

C.6.4.1. The Supplier shall immediately notify EGID of any current or prospective "significant event" on an ongoing basis. All notifications shall be submitted in writing to EGID Director of Benefits Contracting Administrator. As used in this provision, a "significant event" is any current or future occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon the Supplier's ability to meet its contractual obligations to EGID. Significant events may include but not be limited to the following:

C.6.4.1.1. Disposal of major assets

C.6.4.1.2. Any major computer software conversion, enhancement or modification to the operating systems, security systems, and application software, used in the performance of this contract

C.6.4.1.3. Termination or addition of provider contracts

C.6.4.1.4. The Supplier's 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

C.6.4.1.5. 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 Supplier's facilities or of other facilities used by the Supplier in the performance of this contract

C.6.4.1.6. Reorganization, reduction and/or relocation in key personnel such as, but not limited to, customer service representatives or claims adjusters

C.6.4.1.7. Known or anticipated merger or acquisition

C.6.4.1.8. Known, planned or anticipated stock sales

C.6.4.1.9. Any litigation filed by a member against the Supplier

C.6.4.1.10. Any sale or merger

C.6.4.1.11. Significant changes in market share or product focus

C.6.4.1.12. HIPAA violation

C.6.4.1.13. 6055 IRS reporting deficiencies

C.6.4.2. The Supplier shall confirm its understanding and its agreement to the above notification requirements.

C.6.5. Workflow and Web Interfacing

C.6.5.1. During the contract period, the Supplier 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 only requires that the Supplier have access to the web. No software purchase is required by the Supplier for this process.

C.6.5.2. During the contract period, the Supplier will also utilize EGID's Web Eligibility Application to resolve eligibility issues and payment discrepancies. Suppliers agree to regularly log in to both applications in order to keep access from being terminated due to inactivity.

C.6.5.3. Describe how the Supplier will interface with EGID's Web Eligibility and Workflow process to track and report member issues through the web.

C.6.6. Fraud and Abuse Investigations

C.6.6.1. The Supplier shall aggressively monitor for fraud and abuse, and provide EGID with a quarterly report of fraud and fraud-prevention activities and discoveries relating to the OEIBA Program. The Supplier shall investigate any fraudulent or suspicious activity relating to the OEIBA Program whenever detected or brought to the Supplier's attention by EGID or others. Describe how the Supplier will accomplish this.

C.6.7. Participant Eligibility

C.6.7.1. An individual's eligibility to participate is subject to all federal and state laws governing the Program. EGID has the responsibility and authority to decide all questions of eligibility within the OEIBA Program. Highlights of eligibility include:

C.6.7.1.1. There is an annual option period which historically begins in mid-September and runs through early December. Elections made during this option period are effective January 1st of the following year.

C.6.7.1.2. 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.

C.6.7.1.3. 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.

C.6.7.1.4. 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. EGID will handle the premium billing, collection and termination procedures for all COBRA participants, while the Supplier shall provide the health coverage services for those enrolled in the Supplier's OEIBA plans. Qualified COBRA beneficiaries will have the option of changing enrollment elections during any Option Period, which occurs during the term of their coverage continuation.

C.6.7.2. 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. Service areas shall be limited to those ZIP Codes approved by relevant licensure as of May 1, 2017.

C.6.7.3. 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 Supplier, unless agreed to in writing by EGID, is not allowed except in the event of relocation of service area.

C.6.7.4. Additional eligibility/enrollment requirements apply to plans for Medicare-eligible participants. These include:

C.6.7.4.1. Eligibility for MAPD is limited to EGID/Medicare eligible former employees and their eligible dependents. Eligible EGID former members shall have an Option Period (historically November – December) to elect one of the MAPDs to be effective January 1, 2018. Former employees may enroll in coverage the first day of the month following termination of active employment. The former employee also has thirty (30) days after acquiring a new dependent in which to add that dependent. Former members or dependents not enrolled when initially eligible or within thirty (30) days of a midyear qualifying event, cannot add coverage. Former employees can change health coverage at Option Period but they cannot add health coverage that was not elected at separation from active employment.

C.6.7.4.2. Continuous health insurance coverage through EGID or qualified HMOs and/or PPO must begin or continue within thirty (30) days of termination from active employment.

C.6.7.4.3. Members of a family who are Medicare eligible and those who are not Medicare eligible must participate in the same carrier plans offered through the current HMO and/or PPO.

C.6.7.4.4. Members in an HMO and/or PPO plan that also offers an MAPD option may enroll in the MAPD upon turning age 65 or attaining early eligibility for Medicare.

C.6.7.4.5. A change from one insurance carrier to another is limited to the option period unless the Member moves from an authorized service area. Plan enrollments or changes by the Member shall not be allowed during the same plan year, except as required by changes in service areas or in accordance with CMS requirements or when CMS approves the change.

C.6.7.4.6. As required by CMS and applicable federal regulations, the MAPD shall provide Prescription Drug Benefit Creditable Coverage Notices to all of its MAPD participants and affected persons.

C.6.7.5. The Supplier shall confirm its understanding and its agreement to the above notification requirements.

C.6.8. Failure to Abide by Marketing and Communications Guidelines. The Supplier must affirm its understanding and agreement that failure to abide by marketing and communication guidelines may result in one or more of the following consequences:

C.6.8.1. the Supplier being barred from accepting new enrollees for the balance of this contract

C.6.8.2. the Supplier being barred from accepting new enrollees for the contract immediately succeeding this contract,

C.6.8.3. the Supplier being deemed ineligible from bidding in subsequent RFPs for the OEIBA Program

C.6.9. Guidelines for Required Marketing and Communications Activities.

C.6.9.1. Each Supplier must receive approval for its marketing and communications plan with EGID **prior to distribution** to employees. EGID reserve the right to have the Suppliers amend or modify such information to meet its requirements. All requests for any marketing and communication by the Suppliers must be submitted to EGID at least ten (10) business days in advance of the scheduled advertising date using the Advertising Approval Form in Attachment 6. Mass media advertising (newspapers, outdoor advertising, transit advertising, radio and broadcast television) is permitted only if the Supplier has filed the appropriate request using the Advertising Approval Form referenced above, and has received written approval for publication of the material by EGID.

C.6.9.2. In the event that a change in name of the Supplier or Supplier's plan design occurs, the change must be communicated to EGID by the designated print deadlines to be included in the Option Period print materials for the specified plan year.

C.6.9.3. Each Supplier 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 EGID in connection with the Annual Option Period. This is the only marketing that will be allowed for participating members administered by the EGID. Changes in

the network and updates of providers must be communicated to affected members and to EGID at the Supplier's expense. All updates to a Supplier's provider network must be submitted to EGID for reference and informational purposes per required reports. Those same changes/updates must also be made current and available on the Supplier's website to which EGID will provide links for member access. Suppliers are to describe how they will provide notification to members as required.

C.6.9.4. If requested by EGID, the Supplier will provide a representative to assist employer insurance and benefit coordinators in understanding the benefit plan structure, particularly during designated training sessions or as requested by EGID for special employee benefit education sessions.

C.6.10. Guidelines on Prohibited Marketing and Communications Activities. The following is not permitted:

C.6.10.1. Direct marketing or "sales marketing approaches

C.6.10.2. Use of marketing inducements (such as paid lunches, pizza parties, and other non-employer sponsored events) directed to individual prospective members or to employer personnel, which includes Benefit/Insurance Coordinators.

C.6.10.3. Solicitations or attempts by the Supplier or any affiliate or subsidiary to induce an employer participating in the OEIBA Program to enter into an agreement for any type of health insurance coverage other than that provided under this contract. The Supplier must not use any information obtained as a result of this contract, including information about participating employers, employees, dependents, and claim experience, for any purpose other than processing claims and providing such other services as are required under this contract. In the event the Supplier or any affiliate or subsidiary receives from a participating employer a request for a proposal and/or a request for claim information for coverage of the type being provided under this contract, the Supplier must advise the EGID Director of Benefit Contracting of the request. Claim information will only be released with EGID approval. Suppliers should not attend, create, or hold any meetings with employer groups without prior EGID approval.

C.6.10.4. 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.

C.6.10.5. 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).

C.6.10.6. Suppliers will not be allowed to make presentations during employee meetings for active employees unless pre-approved by EGID and as permitted by law; however, carriers may participate in education, county, and local government employee scheduled and organized meetings as directed by EGID.

C.6.10.7. Oklahoma State Ethics Commission Administrative Rules, 74 O.S. Chapter 62, App. 1, Rule 4.10 states the following: Except as permitted by these Rules, no state officer or employee shall accept any gift for himself or herself or for his or her family member from any person or entity or agent of any person or entity that is regulated or licensed by the state officer or employee's agency; provided, however, this prohibition shall not apply to gifts that are made by the employer of the state officer or employee or his or her family member under circumstances that make it clear that the gift is not motivated by the state officer or employee's status as a state officer or employee.

C.6.11. Encouraged Marketing and Communications Activities. The following is encouraged:

C.6.11.1. Attendance at health fairs and employer sponsored meetings throughout the year is strongly encouraged.

C.6.11.2. Post-election enrollment follow-ups are allowed.

C.6.12. Malpractice Liability

C.6.12.1. EGID 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 Supplier agrees these limits of coverage shall be maintained during the term of the contract.

C.6.13. Provider Discussion of Treatment Options and Reimbursements

C.6.13.1. The Supplier must warrant and agree that there will be no provisions in the Supplier's provider contracts that prohibit providers from discussing any treatment options and/or reimbursements with members in their provider contracts

C.6.14. Prohibited Limitations and Exclusions

C.6.14.1. The Supplier agrees to waive all pre-existing condition limitations and evidence of insurability requirements for all beneficiaries covered under the OEIBA Program.

C.6.15. Reinsurance

C.6.15.1. The Supplier 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 Supplier.

C.6.16. Internal Grievance Procedures

C.6.16.1. The Supplier 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 Supplier.

C.6.17. Affordable Care Act Rebate Issues

C.6.17.1. The Supplier must notify EGID if the Supplier'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 EGID.

C.6.18. Dependents Residing at a Different Address

C.6.18.1. 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.

C.6.19. Certificates of Coverage

C.6.19.1. The Supplier shall provide Certificates of Coverage for members or dependents when requested.

C.6.20. Prohibition on Direct Member Billing

C.6.20.1. The Supplier must have procedures in place which prevent direct member billing (balance billing) for covered services during the plan year of this Agreement.

C.6.21. Member Materials

C.6.21.1. The Supplier shall be responsible for the following:

C.6.21.1.1. Each Supplier must develop a comprehensive member handbook, which shall be available no later than January 1, 2018 and must include the Supplier's current prescription drug formulary. Copies of the Supplier's 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.

C.6.21.1.2. Suppliers shall provide an online directory of network providers, which shall be updated at least weekly and made available to plan participants 24 hours a day, 7 days a week. Suppliers shall also mail provider directories to plan participants upon request. Those physicians accepting new enrollees must be clearly identified. The development, printing, and delivery expenses will be the sole responsibility of the Supplier.

C.6.21.1.3. Member identification cards will be mailed at the Supplier's expense directly to each member's home so that the same is received no later than December 31, 2017, or no more than two weeks following delivery of new member enrollment data from EGID**. 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 Supplier is required to provide a written status report regarding the distribution of ID cards to EGID Director of Benefits Contracts no later than Wednesday, December 13, 2017.**

C.6.21.1.4. Summary of Benefits and Coverage for approved benefit plan(s) due to EGID no later than 5:00 p.m. Central Time, Monday, August 28, 2017.

C.6.22. Supplier Affirmation

C.6.22.1. Supplier is to affirm and agree to all requirements in all of Section C.6. Any exceptions must be stated per the applicable section. Please reference Section E for submission requirements. Any exceptions taken may make the Supplier's response non-responsive.

C.7. HMO Proposal (excluding Medicare Supplement or MAPD lines of business)

C.7.1. Supplier Identification. Provide a response to each requested item below:

C.7.1.1. Supplier's legal name.

C.7.1.2. Address (including city, state, and zip code).

C.7.1.3. Office location responsible for this account, if different than C.7.1.2 above. If this office will be located

outside of Oklahoma, explain the Supplier's plans to interact closely with EGID.

C.7.1.4. Web address.

C.7.1.5. Trade name that the Supplier intends to use for marketing purposes, if different from the name used for contracting purposes.

C.7.1.6. The name and contact information for the Account Manager that will be assigned to the OEIBA Program. Include years of experience, number of other clients, and the size and industry of said clients.

C.7.1.7. The name and contact information for the highest ranking office with direct involvement with the OEIBA Program's account.

C.7.1.8. The name and contact information for the Supplier's designated personnel authorized to enter into BAFO competitive negotiations. In the event the Supplier's designated personnel changes, the Supplier's shall notify OMES/CP immediately in writing.

C.7.2. Supplier Eligibility

C.7.2.1. The Supplier must be a registered Supplier with OMES/CP and must meet all legal requirements for doing business in the State of Oklahoma and all EGID requirements for a State defined Supplier as specified in the laws of Oklahoma and the rules of the Oklahoma Insurance Department. Provide a copy of the Supplier's relevant licensure for the programs it intends to bid.

C.7.3. Supplier Operating Staff

C.7.3.1. The Supplier must have sufficient operating staff to comply with all requirements and standards described in this RFP. At a minimum, the Supplier must be able to identify qualified staff in the following areas:

C.7.3.1.1. Executive management with clear oversight authority for all other functions

C.7.3.1.2. Medical director's office

C.7.3.1.3. Accounting and budgeting function

C.7.3.1.4. Member services function

C.7.3.1.5. Provider services function

C.7.3.1.6. Medical management function, including quality assurance and utilization review

C.7.3.1.7. Internal complaint resolution function

C.7.3.1.8. Claims processing function

C.7.3.1.9. Management information system

C.7.3.1.10. The Supplier 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 Supplier may also use management contractors or administrative service firms to perform any or all of the above functions.

C.7.3.2. Attach a complete organizational chart for the Supplier, including all departments/functions listed above, as well as lines of authority, and relationships among the Supplier's Board of Directors, administration, medical services, and other functions. If expansions or changes are anticipated, show as much detail as possible reflecting the changes

C.7.4. Financial Stability

C.7.4.1. EGID may reject a Supplier's proposal based upon the financial condition of the Supplier'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 Supplier's ability to continue as a "going concern", or some similar concern or qualification. The Supplier shall demonstrate its ability to be financially viable during the contract period.

C.7.4.1.1. Provide copies of audited financial statements for the Supplier's last three (3) fiscal years immediately preceding the date of its response. The financial statements should include, but not limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders' Equity, Statement of Cash Flows, and Notes to the Financial Statements. The Supplier further agrees to be available for reasonable inquiry by EGID regarding these financial statements.

C.7.4.1.2. Identify the Supplier's independent auditor.

C.7.4.2. If applicable, specify the name and address of any sponsoring or parent corporation or others who provide financial support to the Supplier, or affirm there are none.

C.7.4.2.1. Describe any understandings, legal relationships or financial agreements with respect to sponsorship or other financial support of the Supplier with any other entity, i.e., guarantees, letters of credit, etc. What are maximum limits of additional financial support?

C.7.4.2.2. Provide a copy of the sponsoring organization's most recent audited financial statement if any such entity provides financial support to the Supplier. The financial statements should include, but not limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders' Equity, Statement of Cash Flows, and Notes to the Financial Statements.

C.7.4.2.3. Identify the independent auditor for the Supplier's sponsoring organization.

C.7.4.3. Does the Supplier warrant and represent that it is in good financial standing, not in any form of bankruptcy or the zone of insolvency, and is current in the payment of all taxes and fees?

C.7.4.4. Does the Supplier agree to the following: The Supplier 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, Supplier shall inform EGID as soon as such failure is known.

C.7.5. Lawsuits and Litigation

C.7.5.1. Disclose, unless prohibited by securities law, any prior lawsuits and litigation involving alleged or actual violations of administrative rules and hearings, or any lawsuits, litigation, or administrative proceedings, threatened or pending, involving the Supplier and any person or entity, the State of Oklahoma or any political subdivisions, and/or any state officer and/or any state employee acting in the capacity of a state employee arising from services rendered that are the same or similar to the work defined in this RFP, and any settlements, compromises (if confidential, a statement of that fact) or Judgments of Record resulting from the foregoing described litigation or administrative proceedings for the past five (5) years or affirm there are none.

C.7.5.2. List and disclose contract cancellations or negligent causes of action that arose from work performed that is the same or similar to work identified in the specifications listed in this RFP that was initiated by persons or entities against the Supplier that resulted in a settlement with or judgment against the Supplier in any jurisdiction in the United States in an amount of One Hundred Thousand Dollars ($100,000.00) or more within the previous five (5) years, or affirm there are none.

C.7.5.3. Disclose any data security breaches and specifically HIPAA security breaches that required notification to affected persons or a regulatory authority.

C.7.5.4. List and describe any current malpractice suits filed against the Supplier or a provider in your network.

C.7.6. Acquisitions or Mergers

C.7.6.1. Summarize any mergers with or acquisitions of other organizations completed in the past 24 months and summarize these actions directly impact this solicitation.

C.7.6.2. Describe, to the best of Supplier's knowledge, any acquisitions or mergers in which the Supplier is expected to be involved within the next twelve (12) months.

C.7.7. Supplier Profile

Provide a profile of the Supplier's HMO insurance business for each of the latest three calendar years (2014, 2015, 2016):

	Calendar Year 2014	**Calendar Year 2015**	**Calendar Year 2016**
Total number of clients (employer groups, state programs, etc.)			
Total number of enrollees covered			
Number of public sector clients			
Average number of public sector enrollees			
Number of plans terminated			
Average number of members in terminated plans			

C.7.8. Member Services Telephone Assistance

C.7.8.1. Telephone assistance by customer service representatives regarding plan benefits and network service problem resolution will be provided by the Supplier through a toll-free telephone number during normal business hours. Provide the hours that this service will be available.

C.7.8.2. The Supplier's customer service telephone response performance must meet or exceed the following standards for each month of each Plan Year:

C.7.8.2.1. The Supplier shall answer at least eighty percent (80%) of all calls in thirty (30) seconds or less;

C.7.8.2.2. The average hold time shall be no more than thirty (30) seconds; and

C.7.8.2.3. The average call abandonment rate shall not exceed five percent (5%).

C.7.8.3. The Supplier's customer service representatives must be trained and familiar with all aspects of the program covered by this RFP. The Supplier 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.

C.7.8.4. Member service telephone numbers for each contracting Supplier will be printed in all enrollment materials. Potential and current members may call the Supplier directly and request that a provider directory be sent to them. The Supplier is expected to provide forty-eight (48) hour turnaround on these mailings.

C.7.8.5. Call Center Performance

C.7.8.5.1. Provide the standards that the HMO Member Services staff achieved during the last 12 months in the following categories.

C.7.8.5.1.1. Average telephone answer time (in seconds)

C.7.8.5.1.2. Average telephone hold time (in seconds)

C.7.8.5.1.3. Average length of call (in minutes)

C.7.8.5.1.4. Average calls per month

C.7.8.5.1.5. Abandoned calls (hang ups, average per month)

C.7.8.5.1.6. First Call Resolution Rate. (First Call Resolution rate is the percentage of telephone inquiries completely resolved within a "window period" of time. A call is considered "resolved" when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call).

C.7.8.6. Member Service Quality Assurance

C.7.8.6.1. What is the Supplier's internal performance standards for accuracy, responsiveness and courtesy and how are they measured for each customer service representative? Describe any other measures and standards used in the Supplier's Customer Service Representative Audit Scores at its customer service facility.

C.7.8.6.2. What measures are taken for poor or unacceptable performance?

C.7.8.6.3. What is the ratio of full-time customer service representatives to covered members?

C.7.8.6.4. What number of customer service representatives has the Supplier dedicated to this contract?

C.7.9. Systems and Eligibility.

C.7.9.1. Identify the systems the Supplier will use to in the performance of this RFP. This includes, but is not limited to, eligibility and claims processing systems.

C.7.9.2. Describe how these systems will integrate to administer these services?

C.7.9.3. Identify any changes to systems that the Supplier make in order to fulfill this RFP.

C.7.10. Benefit Plans for Participants Living Out of State

C.7.10.1. The Supplier may provide a plan of benefits for those participants that live outside the State of Oklahoma. A census report is available as Attachment 22 which identifies participants by age, sex, and zip code. The premium for coverage to participants outside the State of Oklahoma must be the same as quoted for participants within the State of Oklahoma.

C.7.10.1.1. 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.

C.7.11. Provider Contracting

C.7.11.1. Identify any use of sub-contracted or "leased" network(s)

C.7.11.2. Describe the Supplier'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.

C.7.11.3. Describe the Supplier'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.

C.7.11.4. How many providers, by region and location, have been sanctioned and/or removed from your managed care networks within the last three (3) years?

C.7.11.5. List the Supplier's current ratio of PCPs to member on Attachment 21.

C.7.11.6. Percentage of your PCPs retained based on length of contract.

C.7.11.6.1. Over 3 years (%)

C.7.11.6.2. 2 to 3 years (%)

C.7.11.6.3. Less than 2 Years (%)

C.7.11.7. How many PCPs and specialists have terminated contracts with the Supplier in the last year (at the physician's request)? State the reason(s) for the termination.

C.7.11.8. What has been the turnover rate of PCPs in the Supplier's network during the last year (due to all reasons)? Express as a percent of total PCPs. Separate turnovers by voluntary and involuntary.

C.7.11.9. Describe the Supplier's pharmacy retail network capabilities in all service areas proposed, including point-of-service capabilities, mail order, and/or delivery methods used.

C.7.11.10. Describe in detail the Supplier's pharmacy network arrangements. If the Supplier subcontracts these services, please provide complete information about the pharmacy benefit manager (name, contractual relationship, ownership interest (if applicable), etc.

C.7.11.11. Describe any financial incentive programs (such as bonuses, penalties, or other) for PCPs.

C.7.11.12. Describe in detail the retail network (number of pharmacies) and provide a directory of pharmacies as of January 1, 2018. Also provide the location of the customer service center and toll free number for member inquiries.

C.7.11.13. 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.)

C.7.11.14. 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. Describe specialty pharmacy program details separately.

C.7.11.15. Identify each provider that is a part of the Supplier's centers of excellence program, the nature of illnesses/conditions treated, and the criteria used in selecting these facilities..

C.7.11.16. 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 Suppliers may provide all eligible services outside the State of Oklahoma for covered dependents. Does the Supplier 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.

C.7.11.17. The Supplier must verify and commit that during the length of the contract, it shall provide no less than thirty (30) days' notice to EGID prior to performing changes, fixes, modifications and enhancements that may impact the exchange of eligibility or any other shared business process. The Supplier 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 all parties mutually agree the changes are ready to be put into production.

C.7.11.18. Briefly describe all service areas covered by the Supplier's response. Include a map showing boundaries of all service areas by ZIP Code covered in this solicitation including areas available to participants that live outside the State of Oklahoma. Suppliers may also elect to include separately any areas being considered for future expansion. Also, attach a CD with Excel file for zip code list including a list of every ZIP Code that is part of your service area.

C.7.11.19. What is your standard advanced notice Period before terminating a network location (facility) or a provider?

C.7.11.20. What changes have been made in your service area in the past year? Include a map showing the changes.

C.7.11.21. 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.

C.7.11.22. Complete the provider spreadsheets in Attachment 5 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.

C.7.11.23. Match employee data to providers and present the results in a map and in numerical format (by service area, county, and Zip code). The census report (Attachment 22) is to be used for mapping.

C.7.12. Section 125.

C.7.12.1. An Internal Revenue Code, Section 125 Cafeteria plan with a Flexible Spending Account (FSA) for medical reimbursement is offered to Oklahoma State active employees. Within the FSA, a debit card program allows a participating member to use a pre-loaded debit card that works like any other debit MasterCard or debit Visa Card, except that it is charged only against the cardholder's personal FSA balance, not against a general bank balance. OMES requests that the Supplier shall interface with the debit card company and provide paid claims utilization on a weekly basis. Attachment 11 is the file format required by the current debit card company.

C.7.12.1.1. Does the Supplier agree to provide information, where available, to assist in verifying purchases made through State sponsored FSAs?

C.7.13. Provider Network. The Supplier shall confirm its understanding and its agreement to the following regarding the Supplier's provider network:

C.7.13.1. The Suppliers 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.

C.7.13.2. The network must provide access to PCP services, specialty physician services, and emergency care and tertiary care services. It shall be sufficient in size and scope to furnish all covered health benefits listed in Attachment 4. No less than fifty percent (50%) of the primary care physicians (PCP) in the Supplier's network must be accepting new patients at any point during each plan year. Any Supplier quoting a value based network must demonstrate that its network has adequate capacity to service its members. The Suppliers must include State of Oklahoma licensed practitioners performing within their legal scope of practice sufficient to meet its members' needs.

C.7.13.3. 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 Supplier). Established patients must be assured acceptance by the existing provider in a new plan year unless that provider is no longer in the Supplier's network of providers.

C.7.13.4. Each Supplier 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 Attachment 5. 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 the EGID Director of Benefit Contracts.

C.7.13.5. Where the Supplier contracts with health care practitioners to render services, such contracting arrangements must promote quality and cost effective care by ensuring that:

C.7.13.5.1.1. Every enrollee has a PCP and that the PCP coordinates all of the enrollee's comprehensive health care; and,

C.7.13.5.1.2. Practitioners' agreements require them to observe the plan's practice guide and/or to share the plan's financial risk.

C.7.13.6. 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.

C.7.13.7. 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.

C.7.14. Standardized Service Areas and Access Standards.

C.7.14.1. EGID has a standardized geographic service area that includes every zip code within the geographic borders of the State of Oklahoma. Suppliers are encouraged to provide services in the standardized geographic service area; however, Suppliers are not required to offer enrollment in every service area. Access standards for the standardized service area and those areas which fall outside the standardized service area offered by the Supplier shall meet the minimum requirements of the Oklahoma Insurance Department.

C.7.14.2. Suppliers should clearly identify the zip codes of all areas in which it will offer services in on Attachment 3.

C.7.14.3. The Supplier shall provide a Geo Access report to show the network access strength.

C.7.15. Claims Administration

C.7.15.1. Is the Supplier's 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?

C.7.15.2. 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?

C.7.15.3. Describe in detail the HMOs fraud prevention capabilities/ claims auditing.

C.7.15.4. Does the HMO routinely send out EOBs or only upon member request?

C.7.15.5. 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?

C.7.15.6. Claims Processing. Please provide the following information:

C.7.15.6.1. Turnaround time (Turnaround time is measured from the date a paper claim, or an electronic claim submission is received by the administrator, or by a subcontracted Supplier responsible for the initial receipt of claims, to the date the claims are resolved).

C.7.15.6.2. Financial accuracy rate (Financial Accuracy is the absolute dollar value of all claim payment errors in an audit sample, subtracted from the total benefits paid in the same audit sample. The result is then divided by the total medical benefits paid in the audit sample).

C.7.15.6.3. Overall accuracy (Overall Accuracy is the total number of claims within an audit sample processed without any type of error, divided by the total number of claims within the audit sample).

C.7.16. Contingency Plan. Provide a copy of the Supplier's contingency plans that illustrate its ability to respond to the following:

C.7.16.1. Rapid increase in enrollment;

C.7.16.2. Rapid decrease in enrollment;

C.7.16.3. Loss of one or more facilities;

C.7.16.4. Voluntary provider termination;

C.7.16.5. Work stoppage;

C.7.16.6. Financial insolvency;

C.7.16.7. Loss of license or contract revocation; and

C.7.16.8. Pandemic Health Emergency

C.7.17. Disaster Recovery Plan

C.7.17.1. Describe the disaster recovery protocols, procedures and backup systems in place, including the ability to rapidly shift phone service and claims processing to alternative sites.

C.7.18. Credentialing and Peer Review

C.7.18.1. Identify which physician credentialing criteria the Supplier actively monitors on an ongoing basis.

C.7.18.1.1. State Licensure

C.7.18.1.2. Board Certification

C.7.18.1.3. DEA License

C.7.18.1.4. Verification of Medical Education and Training

C.7.18.1.5. Admitting Privileges at Network Hospitals

C.7.18.1.6. Office Hours

C.7.18.1.7. Proof of Malpractice Insurance

C.7.18.1.8. Reputation

C.7.18.1.9. Malpractice History

C.7.18.1.10. On-site Audit before Contracting

C.7.18.1.11. Other: Describe

C.7.18.1.12. How frequently does the Supplier re-credential providers?

C.7.19. Medical Management

C.7.19.1. Describe the Supplier's procedures to ensure that every member has a PCP and that the PCP coordinates all of the member's medical care.

C.7.19.2. Describe in detail the HMO's procedures for after-hours care and emergencies in the service area and outside the service area.

C.7.19.3. Provide the following HMO contact person for the State's Employee Assistance Program: name, address, telephone number, email address, and brief clinical/professional description.

C.7.19.4. 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.

C.7.19.5. Describe in detail how you will educate members about their health and actively involve them in treatment decisions.

C.7.19.6. Do you offer a 24-hour Nurseline service? If so, describe the program and utilization results.

C.7.19.7. Provide the following statistics for the Supplier's utilization management programs for year 2016.

C.7.19.7.1. Number of admission requests

C.7.19.7.2. Number of denials

C.7.19.7.3. Admission denial rate

C.7.19.7.4. Admissions per 1,000 covered lives

C.7.19.7.5. Average length of stay (days)

C.7.19.7.6. Inpatient days per 1,000 covered lives

C.7.20. Medical Quality Assurance

C.7.20.1. Describe in detail the Supplier's quality assurance program and address the following component activities:

C.7.20.1.1. Chart review;

C.7.20.1.2. Focused studies;

C.7.20.1.3. Facility inspection;

C.7.20.1.4. Social service intervention;

C.7.20.1.5. Discharge planning; and

C.7.20.1.6. Frequency of QA activities (e.g., how often QA committee meets, number and frequency of focused studies, etc.)

C.7.20.2. Does the Supplier maintain a Quality Assurance Committee? Include the names and credentials of those involved. Describe the programs used to monitor, evaluate, and emphasize quality health care.

C.7.20.3. 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.

C.7.20.4. Describe in detail how the Supplier monitors and detects underutilization or overutilization of services by providers, including follow-up actions.

C.7.20.5. 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.

C.7.20.6. Described in detail any quality assurance (QA)/utilization review (UR) service, and identify each subcontractor and describe its services.

C.7.20.7. Describe in detail the internal grievance procedure for members and providers. All contracting Suppliers must include a description of the grievance procedures in their member handbooks.

C.7.20.8. Member Satisfaction Surveys

C.7.20.8.1. Describe the frequency and methodology of the Supplier's member satisfaction surveys.

C.7.20.8.2. What is the overall member satisfaction rate from the most recent survey?

C.7.20.8.3. Attach a copy of the most recent survey instrument completed and a summary of the results.

C.7.20.8.4. If current surveys do not include items such as satisfaction with afterhours care, office appointment waiting times, providers and plan administration, will the Supplier include these items surveys covering the 2018 period?

C.7.20.8.5. Does the Supplier survey its members regarding their satisfaction with its customer service and claims processing? If so, what are the book of business results for this survey?

C.7.20.9. What continuous quality improvement process is the Supplier utilizing in enrollment procedures, appointment scheduling, and other member services operations?

C.7.20.10. What type of care management initiatives does the Supplier intend to implement 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.

C.7.20.11. What percent of a network provider's case volume is reviewed for quality and appropriateness each year?

C.7.21. Service Enhancements. Suppliers may offer enhancements in an effort to make their plans more attractive and competitive. The enhancements must be clearly identified and consolidated into one page in the Supplier's response to this RFP and in any material submitted to EGID to be disseminated to members, including, but not limited to: 24-Hour Toll-Free Nurse Line; Well Woman Self-Referral; Wellness/Health Education; Health and Fitness Discounts; Healthy Pregnancy Program; or Vision.

C.7.21.1. Describe in detail the service enhancements to be offered by the Supplier, or affirm that there are none.

C.7.22. Compliance and Privacy Procedures and Standards. The Supplier shall describe its compliance procedures in general and specifically, but not limited to, explaining how it will comply with the privacy and security standards and describing how it will electronically and operationally interface with its business associates according to HIPAA security and X12 standards for electronic transmissions. The Supplier shall describe how it will interface with EGID as a Plan Sponsor and maintain confidentiality/privacy of members' health information.

C.7.23. Member Education

C.7.23.1. Describe in detail the methods which will be used by the Supplier to educate and communicate the proper use of the plan to members. Describe all that apply, including:

C.7.23.1.1. Enrollment Meetings

C.7.23.1.2. Mass Mailings

C.7.23.1.3. Mass media

C.7.23.1.4. Provider Directories

C.7.23.1.5. Interactive Phone

C.7.23.1.6. Marketing Brochures

C.7.23.1.7. Website

C.7.23.1.8. Welcome calls to new members

C.7.23.1.9. Other

C.7.24. Member Materials. Furnish copies of the following materials:

C.7.24.1. Membership I.D. card. The card cannot contain employee's Social Security number, unless encrypted in an alpha or numerical method so that it is not distinguishable)

C.7.24.2. Membership materials, including a marketing document describing the benefits offered to enrollees in a format not to exceed two (2) 8-1/2 x 11 pages for inclusion in the enrollment guides

C.7.25. HMO Offering

C.7.25.1. Suppliers offering options to the pre-Medicare population are required to meet and offer the benefits and copayments as outlined in Attachment 4. EGID may also request additional plans such as a Point of Service, Value Based Networks, or Accountable Care Organization option. Suppliers must also provide a Medicare plan as described in Attachment 10 if the Supplier offers a Medicare supplement product to other entities within Oklahoma.

C.7.25.2. Claims Experience. Suppliers who are currently under contract with the State for Plan Year 2017 must complete Attachment 12, Attachment 13, Attachment 14, Attachment 15, Attachment 16, and Attachment 17. Information contained in Attachment 13, Attachment 14, Attachment 15, and Attachment 16 may 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 2017 must provide the information contained in Attachment 17 for their Oklahoma book of business. Compliance with this 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 RFP.

C.8. Medicare Supplement Plan Proposal

C.8.1. Suppliers must provide a Medicare supplement plan as described in Attachment 10 only if the Supplier offers a Medicare supplement product to other entities within Oklahoma and has offered a pre-Medicare proposal. Suppliers must meet or exceed the Medicare plan as specified in Attachment 10. Terms relating to Medicare plans are not negotiable. The Supplier must complete a copy of Attachment 19 (Medicare Supplement and MAPD PPO Plans) listing the benefits provided under this plan.

C.8.2. If the Medicare Supplement incudes a Medicare Part D Prescription Drug Plan (PDP) it is also subject to the following:

C.8.2.1. The PDP shall provide 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.

C.8.2.2. 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 Minimum Required Reporting, Attachment 20.

C.8.2.3. The PDP must provide a monthly full file showing everyone covered in the PDP. Required fields for this report are listed in Minimum Required Reporting, Attachment 20.

C.8.2.4. 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 and EGID will reimburse the PDP for the penalty amount.

C.8.3. Networks.

C.8.3.1. Identify any networks that may be involved (Medicare Select).

C.9. MAPD Proposal

C.9.1. Supplier Identification. Provide a response to each requested items below:

C.9.1.1. Supplier's legal name.

C.9.1.2. Address (including city, state, and zip code).

C.9.1.3. Office location responsible for this account, if different than C.9.1.2 above. If this office will be located outside of Oklahoma, explain the Supplier's plans to interact closely with EGID.

C.9.1.4. Web address.

C.9.1.5. Trade name that the Supplier intends to use for marketing purposes, if different from the name used for contracting purposes.

C.9.1.6. The name and contact information for the Account Manager that will be assigned to the OEIBA Program.

C.9.1.7. The name and contact information for the highest ranking office with direct involvement with the OEIBA Program's account.

C.9.1.8. The name and contact information for the Supplier's designated personnel authorized to enter into BAFO competitive negotiations. In the event the Supplier's designated personnel changes, the Supplier's shall notify OMES/CP immediately in writing.

C.9.2. Supplier Eligibility

C.9.2.1. The Supplier must be a registered Supplier with OMES/CP and must meet all legal requirements for doing business in the State of Oklahoma and all EGID requirements for a State defined Supplier as specified in the laws of Oklahoma and the rules of the Oklahoma Insurance Department. In addition, a MAPD must be qualified by the Centers for Medicare and Medicaid Services, hereinafter "CMS". Provide a copy of the Supplier's relevant licensure for the programs it intends to bid.

C.9.3. Supplier Operating Staff. The Supplier must have sufficient operating staff to comply with all requirements and standards described in this RFP. At a minimum, the Supplier must be able to identify qualified staff in the following areas:

C.9.3.1.1. Executive management with clear oversight authority for all other functions

C.9.3.1.2. Medical director's office

C.9.3.1.3. Accounting and budgeting function

C.9.3.1.4. Member services function

C.9.3.1.5. Provider services function

C.9.3.1.6. Medical management function, including quality assurance and utilization review

C.9.3.1.7. Internal complaint resolution function

C.9.3.1.8. Claims processing function

C.9.3.1.9. Management information system

C.9.3.2. The Supplier 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 Supplier may also use management contractors or administrative service firms to perform any or all of the above functions.

C.9.3.3. Attach a complete organizational chart for the Supplier, including all departments/functions listed above, as well as lines of authority, and relationships among the Supplier's Board of Directors, administration,

medical services, and other functions. If expansions or changes are anticipated, show as much detail as possible reflecting the changes.

C.9.4. Financial Stability

C.9.4.1. EGID may reject a Supplier's proposal based upon the financial condition of the Supplier'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 Supplier's ability to continue as a "going concern", or some similar concern or qualification. The Supplier shall demonstrate its ability to be financially viable during the contract period.

C.9.4.1.1. Provide copies of audited financial statements for the Supplier's last three (3) fiscal years immediately preceding the date of its response. The financial statements should include, but not limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders' Equity, Statement of Cash Flows, and Notes to the Financial Statements. The Supplier further agrees to be available for reasonable inquiry by EGID regarding these financial statements.

C.9.4.1.2. Identify the Supplier's independent auditor.

C.9.4.2. Sponsoring or Parent Organizations. If applicable, specify the name and address of any sponsoring or parent corporation or others who provide financial support to the Supplier, or affirm there are none.

C.9.4.2.1. Describe any understandings, legal relationships or financial agreements with respect to sponsorship or other financial support of the Supplier with any other entity, i.e., guarantees, letters of credit, etc. What are maximum limits of additional financial support?

C.9.4.2.2. Provide a copy of the sponsoring organization's most recent audited financial statement if any such entity provides financial support to the Supplier. The financial statements should include, but not limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders' Equity, Statement of Cash Flows, and Notes to the Financial Statements.

C.9.4.2.3. Identify the independent auditor for the Supplier's sponsoring organization.

C.9.4.3. Financial Standing.

C.9.4.3.1. Does the Supplier warrant and represent that it is in good financial standing, not in any form of bankruptcy or the zone of insolvency, and is current in the payment of all taxes and fees?

C.9.4.3.2. The Supplier shall acknowledge and agree to the following: The Supplier 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, the Supplier shall inform EGID as soon as such failure is known.

C.9.5. MAPD Networks

C.9.5.1. Identify any use of subcontracted or "leased" network(s).

C.9.5.2. How many providers, by region and location, have been sanctioned and/or removed from the MAPD's managed care networks within the last three (3) years?

C.9.5.3. List the MAPD's current ratio of PCPs to members:

C.9.5.3.1. Tulsa

C.9.5.3.1.1. Number of PCPs

C.9.5.3.1.2. Number of Members

C.9.5.3.1.3. Ratio

C.9.5.3.2. Oklahoma City

C.9.5.3.2.1. Number of PCPs

C.9.5.3.2.2. Number of Members

C.9.5.3.2.3. Ratio

C.9.5.3.3. All Other/Rural

C.9.5.3.3.1. Number of PCPs

C.9.5.3.3.2. Number of Members

C.9.5.3.3.3. Ratio

C.9.5.4. Percentage of MAPD's PCPs retained based on length of contract.

C.9.5.4.1. Over 5 Years (%)

C.9.5.4.2. 3 to 5 Years (%)

C.9.5.4.3. 2 to 3 Years (%)

C.9.5.4.4. Less than 2 Years (%)

C.9.5.5. How many PCPs and Specialists have terminated contracts with the MAPD in the last two (2) years (at the physician's request)?

C.9.5.6. What has been the turnover rate of PCPs in the MAPD network during the last two (2) years (due to all reasons)? Express as a percent of total PCPs.

C.9.5.7. Describe the termination procedures contained in the MAPD's provider contracts, including the length of notice a PCP must give to terminate its contract with the MAPD. Attach a sample copy (or copies, if more than one form is used) of the MAPD's contracts with its PCPs.

C.9.5.8. Describe any financial incentive programs (such as bonuses, penalties, or other) for PCPs. Specify between individual and group incentives, and address the MAPD's experience and use of withholds and risk pools.

C.9.5.9. Describe the MAPD's pharmacy retail network capabilities in all service areas proposed, including point-of-service capabilities, mail order, and/or delivery methods used. Describe the pharmacy program that will be offered to the members, specifically the actuarial equivalence and CMS certification of a Medicare Part D Prescription Drug Plan offered to Medicare eligible members.

C.9.5.10. Provide the name, address and contact name for the Pharmacy Benefit Manager (PBM) who handles the MAPD's pharmacy plan of benefits.

C.9.5.11. Describe the MAPD's procedures to ensure that every member has a PCP and that he/she coordinates all of the member's medical care.

C.9.5.12. Briefly describe all service areas covered by the MAPD Supplier's response. Include a map showing boundaries of all service areas by ZIP Code covered in this solicitation. Suppliers may also elect to include separately any areas being considered for future expansion. Also, attach a CD with Excel file for zip code list including a list of every ZIP Code that is part of your service area.

C.9.5.13. What changes have been made in your service area in the past year? Include a map showing the changes.

C.9.5.14. What are the MAPD Supplier's procedures for after-hours care and emergencies in the service area and outside the service area?

C.9.5.15. Based upon the OK Medicare retiree census data (Attachment 22), identify any counties of the state in which the Supplier is filed to operate where its provider network may not have adequate capacity to meet the potential Oklahoma demand.

C.9.5.16. Does the Supplier foresee any significant provider contracts coming up for negotiation in the next 3 years based on the Oklahoma Retirees locations?

C.9.5.17. Provide a listing of all acute care Oklahoma hospitals that are considered out-of-network hospitals in the Supplier's Medicare Advantage PPO plans.

C.9.5.18. Describe the Supplier's MA network growth and development plans

C.9.5.19. Describe the Supplier's approach for selecting and recruiting providers to participate in its MA networks.

C.9.5.20. Describe the Supplier's process for collaborating with employers and key providers to address provider acceptance issues that may surface over time.

C.9.5.21. Complete a pharmacy disruption of the top utilized Oklahoma pharmacies

C.9.6. MAPD HMO versus PPO. The MAPD may submit either an HMO or a PPO response to this RFP but not both.

C.9.6.1. The MAPD shall complete Attachment 18 MAPD HMO Benefit Summary MAPD Benefits Summary that indicates the level of benefits that the MAPD will be providing under this Contract. For benefits requiring a mixture of fixed dollar and percentage copayments, indicate the fixed dollar amounts first. All maximums should clearly specify if they are based on copayments or on benefit charges

C.9.6.2. An MAPD PPO plan is required to have a level of benefits that are equivalent to or exceed the HealthChoice SilverScript High Option Medicare Supplement plan benefits (Attachment 10). The HealthChoice plan is comparable to the Medicare Plan G with two enhancements. The enhancements provide coverage for Hospice Care and Foreign Travel. The MAPD PPO pharmacy plan must be actuarially equivalent to the HealthChoice SilverScript High Option Medicare Supplement Plan which is an Employer Group Waiver Plan (EGWP) with a Wrap setup. The Supplier must complete a copy of Attachment 19 (Medicare Supplement and MAPD PPO Plans) listing the benefits provided under this plan.

C.9.7. Additional Marketing Guidelines Specific to MAPD Plans. The following additional marketing guidelines are specific to MAPD plans:

C.9.7.1. The MAPD shall be in compliance with CMS Medicare Marketing Guidelines for Medicare Advantage Organization (MA) (also referred to as Plan), Medicare Prescription Drug Plan (PDP) (also referred to as Part D Sponsor), and except where otherwise specified 1876 cost contract (also referred to as Plans) rules, (i.e., Title 42 of the Code of Federal Regulations, Parts 422, 423, and 417) regarding marketing materials, promotional activities, advertising, social networking sites, and Call Center cost requirements.

C.9.7.2. Successful MAPDs must develop a single marketing package including age-in information that, following approval by EGID, is to be submitted to CMS for final approval. The marketing package shall include notifications required by CMS.

C.9.7.3. The MAPD must schedule representatives (from one to three) to attend all option period meetings for service areas of member base and provide at said meetings new member materials for the upcoming Plan Year, provided these have been approved by CMS.

C.9.7.4. The MAPD shall provide EGID with a training outline and timeframes for training of MAPD Customer Service Representatives (CSR) prior to the enrollment period and include EGID enrollment deadlines, eligibility, and rules as they pertain to the Medicare population. Also, the MAPD shall include in the solicitation response contact information (name and phone) of a customer service supervisor.

C.9.8. Medicare Experience

C.9.8.1. Supplier is to provide their total Medicare enrollment for 2015 and 2016.

C.9.8.2. Describe the Supplier's experience participating in Medicare as a private plan option. Include the number of years that Supplier has participated in Medicare and a brief history of key developments over this time, such as when Supplier's first group Medicare plan was offered.

C.9.8.3. Has Supplier been sanctioned by CMS in the past 5 years?

C.9.8.4. Describe the Supplier's strategy and key initiatives to assure that Medicare Advantage will offer the Plan a sustainable value proposition.

C.9.9. Member Services Telephone Assistance

C.9.9.1. Telephone assistance by customer service representatives regarding plan benefits and network service problem resolution will be provided by the Supplier through a toll-free telephone number during normal business hours. Provide the hours that this service will be available.

C.9.9.2. The Supplier's customer service telephone response performance must meet or exceed the following standards for each month of each Plan Year:

C.9.9.2.1. The Supplier shall answer at least eighty percent (80%) of all calls in thirty (30) seconds or less;

C.9.9.2.2. The average hold time shall be no more than thirty (30) seconds; and

C.9.9.2.3. The average call abandonment rate shall not exceed five percent (5%).

C.9.9.3. The Supplier's customer service representatives must be trained and familiar with all aspects of the program covered by this RFP. The Supplier 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.

C.9.9.4. Member service telephone numbers for each contracting Supplier will be printed in all enrollment materials. Potential and current members may call the Supplier directly and request that a provider directory be sent to them. The Supplier is expected to provide forty-eight (48) hour turnaround on these mailings.

C.9.9.5. Call Center Performance

C.9.9.5.1. Provide the standards that the HMO Member Services staff achieved during the last 12 months in the following categories.

C.9.9.5.1.1. Average Telephone answer time (in seconds)

C.9.9.5.1.2. Average Telephone hold time (in seconds) Average length of call (in minutes)

C.9.9.5.1.3. Average calls per month

C.9.9.5.1.4. Abandoned calls (hang ups, average per month)

C.9.9.5.1.5. First Call Resolution Rate. (First Call Resolution rate is the percentage of telephone inquiries completely resolved within a "window period" of time. A call is considered "resolved" when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.

C.9.9.6. Member Service Quality Assurance

C.9.9.6.1. What is the Supplier's internal performance standards for accuracy, responsiveness and courtesy and how are they measured for each customer service representative? Describe any other measures and standards used in the Supplier's Customer Service Representative Audit Scores at its customer service facility.

C.9.9.6.2. What measures are taken for poor or unacceptable performance?

C.9.9.6.3. What is the ratio of full-time customer service representatives to covered members?

C.9.9.6.4. What number of customer service representatives has the Supplier dedicated to this contract?

C.9.10. Medical Management/Staff

C.9.10.1. Does the Medicare Advantage include a 24-hour nurse support call line that would be available to members under this contract?

C.9.10.2. Provide details on which medical management programs in place now (either retiree or active population) that would be most effective for a retiree-only population.

C.9.10.3. Describe the Supplier's medical management experience with groups that have significant retiree population.

C.9.10.4. Describe how the Supplier's medical management program design enhances quality of care, including improvements in health status and clinical outcomes.

C.9.10.5. How does the Supplier's approach differ in its MA products vs. its commercial plans?

C.9.11. CMS Stars Quality

C.9.11.1. Describe the Supplier's commitment to the Stars quality rating program

C.9.11.2. Briefly describe the Supplier's CMS Stars quality rating enhancement strategy and timeline. Include a description of the continuous quality improvement initiatives included in this strategy.

C.9.11.3. Describe how the Supplier's Stars enhancement strategy fits with its overall Medicare Advantage strategy.

C.9.12. Customer Service Experience

C.9.12.1. What methods/service support do you have in place to ensure consistency of experience for retirees?

C.9.12.2. Describe required CSR training, with emphasis on any retiree-sensitivity training.

C.9.12.3. Provide any additional customer service differentiators for your proposed MA plans.

C.9.12.4. Describe how you differentiate your service from that of your competitors.

C.9.12.5. On an ongoing basis, what are your standards in assuring transition of care for new members to your Medicare Advantage PPO?

C.9.13. Pharmacy

C.9.13.1. Does your Medicare Advantage PPO plan utilize a drug formulary beyond the drugs covered and reimbursed under traditional Medicare?

C.9.13.2. Describe under what circumstances prior authorization of a drug is required.

C.9.13.3. For the MAPD plan, will you issue a combined ID card for medical care and PBM services?

C.9.14. Organizational Infrastructure

C.9.14.1. Describe your organizational infrastructure responsible for administering a Group Medicare Advantage program.

C.10. Implementation

C.10.1. LIS Amounts for MAPD Plans. MAPDs shall provide the LIS amount to be subtracted from the monthly premium for the following year if a member is eligible for a 100% low income premium subsidy. EGID will set up rates to properly bill for members who qualify for the 100%, 75%, 50%, or 25% premium subsidy based on the amount provided by the MAPD. This requirement may be waived if an alternative method is established and approved by EGID to pass along the LIS savings to the member.

C.10.2. Transition Meetings. Upon award of this Contract, Suppliers are required to meet with EGID following option period to ensure smooth transition for the upcoming plan year.

C.10.3. Creditable Coverage. The Supplier 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.

C.10.4. Administrative Procedures Reference Manual. The Supplier shall furnish EGID with accurate up-to-date information as requested for an administrative reference manual to enable staff to refer to the same when member questions arise about the Suppliers 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 EGID and shall be delivered to EGID within fifteen (15) business days of its request, prior to January 1, 2018. Suppliers will receive specific instructions regarding this Manual material after award of contract by EGID. One (1) copy of the administrative reference manual will be provided to EGID.

C.10.5. Pharmacy Network Download. Suppliers must have a process for Option Period data to be downloaded to all pharmacy networks no later than December 31, 2017.

C.10.6. Readiness Reviews. OMES/CP and EGID may conduct scheduled meetings to the Supplier for purposes of testing the readiness of the Supplier.

C.10.6.1. Submission of a proposal in response to this RFP commits the bidding Supplier to cooperate and participate in these reviews, as required by EGID.

C.10.6.2. These reviews will take no more than one (1) day each. EGID 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.

C.10.6.3. Details of the schedules, agendas, and content of the readiness reviews will be distributed to the contracting Suppliers in a timely manner.

C.10.6.4. Prior to the Readiness Review meetings, OMES/CP and EGID may submit a written list of questions to the Supplier. These questions should be completed by the Supplier and returned to EGID no later than the time scheduled for the Supplier's meeting.

D. EVALUATION

D.1. Evaluation Process

The *Oklahoma State Employees Benefits Act*, 74 O.S. § 1371(C) states that all plans offered by Supplier(s) meeting the proposal requirements as determined by EGID shall be accepted. Bids may be rejected or enrollment restricted for which the benefit price is determined to be excessive. The determination of compliance with proposal requirements shall be made by OMES/CP and EGID. EGID shall be responsible and have the final decision regarding compliance with administrative rules and regulations.

D.2. Evaluation Criteria

D.2.1. Minimum Requirements (Section B.41)

D.2.2. Response to Section B – Special Provisions Including Required Attachments

D.2.3. Response to Section C – Specifications Including Required Attachments

D.2.4. Response to Section H – Price and Cost Including Required Attachments

E. INSTRUCTIONS TO BIDDER

E.1. Proposal Response Format

EGID seeks an accurate and concise description of the Supplier's compliance with all standards and requirements in this RFP. Proposals should not require extra review because of irrelevant or redundant material.

It is requested that proposals be prepared in the format described below and marked with tabs. Proposals that are not prepared in the requested format may be declared non-responsive.

E.1.1. The Supplier is required to restate the service, requirement, or question and then follow with its response.

E.1.2. Exhibits should follow in sequential order. Any other information thought to be relevant, but not applicable to the prescribed format, should be provided as appendices to the solicitation and marked with tabs. If a Supplier provides a publication to respond to a requirement, the Supplier should include references to the publication and page number. Supplier proposals received without this reference may be considered to have no reference materials included.

E.1.3. Supplier(s) must submit its proposal strictly per the following format and all instructions and requirements contained in this RFP.

E.1.3.1. Supplier(s) are to submit two (2) complete copies of their response on TWO (2) separate CDs or DVDs (one copy on each Disc) which includes the completed proposal, including the scanned images of the OMES signed forms. Disc must be an unprotected document. Original hard copies are not required or preferred. This overrides hard copy submittal requirements of A.2.4. Please ensure that your Discs are marked clearly with the RFP Number.

E.1.3.2. PDF is an acceptable format for solicitation responses except for the required documents that need to be submitted in Excel and/or Word format..

E.1.3.3. All proposed HMO and Medicare Supplement confidential rates and copays shall be submitted in a single envelope, package, or container and shall be sealed, under separate cover separate from the Supplier's proposal and is NOT to be included on the CD. The qualified actuary certification and adequate supporting information shall be attached to the Supplier's rate sheet. It shall be clearly marked as CONFIDENTIAL – RATES AND CO-PAYS. <u>The name and address of the bidder shall be inserted in the upper left corner of the single envelope, package, or container. SOLICITATION NUMBER AND SOLICITATION RESPONSE DUE DATE AND TIME MUST APPEAR ON THE FACE OF THE SINGLE ENVELOPE, PACKAGE, OR CONTAINER</u>. This is in addition to Section A.2 and A.7.

E.1.3.4. For MAPD plans, confidential rates and copays shall be submitted in a single envelope, package, or container and shall be sealed under separate cover separate from the Supplier's proposal and is NOT to be included on the CD. Because MAPD rates are dependent on federal rates, the MAPD rates may be submitted separately to the Contracting Officer listed on the front of the solicitation no later than July 25, 2017. It shall be clearly marked as CONFIDENTIAL – RATES AND CO-PAYS. <u>The name and address of the bidder shall be inserted in the upper left corner of the single envelope, package, or container. SOLICITATION NUMBER AND SOLICITATION RESPONSE DUE DATE AND TIME MUST APPEAR ON THE FACE OF THE SINGLE ENVELOPE, PACKAGE, OR CONTAINER</u>. This is in addition to Section A.2 and A.7.

F. CHECKLIST

F.1. Proposal Checklist

Listed below is a checklist of items that are to be completed and returned with the proposal. This is not an all-inclusive list and it is the Supplier's responsibility to ensure that they submit all required/requested documentation:

F.1.1. _____OMES Form 076 – Responding Bidder Information

F.1.2. _____OMES Form CP 004 – Certification for Competitive Bid and/or Contract

F.1.3. _____Response to Section B

F.1.4. _____Response to Section C

F.1.5. _____All Amendments signed (if any)

F.1.6. _____Attachment 1: Business Associate Agreement

F.1.7. _____Attachment 2: Statement of Compliance

F.1.8. _____Attachment 3: Standardized Service Areas

F.1.9. _____Attachment 4: Current HMO Plan Design

F.1.10. _____Attachment 5: HMO Provider Charts

F.1.11. _____Attachment 7: Performance Reporting Template

F.1.12. _____Attachment 8: Premium Tables 1 and 2

F.1.13. _____Attachment 12: HMO Utilization/Experience Data and Underwriting Request

F.1.14. _____Attachment 13: Aggregate Utilization/Experience Data – Active – By Month

F.1.15. _____Attachment 14: Aggregate Utilization/Experience Data – Early Retirees – By Month

F.1.16. _____Attachment 15: Aggregate Utilization/Experience Data – Active and Early Retiree 2015

F.1.17. _____Attachment 16: Aggregate Utilization/Experience Data – Active and Early Retiree 2016

F.1.18. _____Attachment 17: Aggregate Utilization/Experience Data – Early Retirees

F.1.19. _____Attachment 18: MAPD HMO Benefit Summary

F.1.20. _____Attachment 19: Coverage for the PPO Plans – Medicare Supplement and MAPD PPO Plans

F.1.21. _____Attachment 21: HMO Ratio of PCPs to Members

F.1.22. _____Electronic copies as outlined in Section E

F.1.23. _____Administrator's license issued by the Insurance Commissioner for the State of Oklahoma (Section B.12)

F.1.24. _____CMS Certification (Section C.1.2)

G. OTHER

G.1. Questions

G.1.1. All questions regarding this solicitation must be submitted in writing and are to be submitted to no later than Monday, 05/22/17 at 3:00 P.M. CST. Questions are to be emailed to: Richard.Williams@omes.ok.gov. Questions received after this date will not be answered. An Amendment will be posted regarding the questions which must be signed, dated and returned with your response.

G.2. Attachments

G.2.1. Attachment 1: Business Associate Agreement

G.2.2. Attachment 2: Statement of Compliance

G.2.3. Attachment 3: Standardized Service Areas

G.2.4. Attachment 4: Current HMO Plan Design

G.2.5. Attachment 5: HMO Provider Charts

G.2.6. Attachment 6: Advertising Approval Request Form

G.2.7. Attachment 7: Performance Reporting Template

G.2.8. Attachment 8: Premium Tables 1 and 2

G.2.9. Attachment 9: Carrier Eligibility Export

G.2.10. Attachment 10: Summary of HealthChoice High and Low Option Medicare Supplement Plans

G.2.11. Attachment 11: Section 125 Debit Card file format

G.2.12. Attachment 12: HMO Utilization/Experience Data and Underwriting Request

G.2.13. Attachment 13: Aggregate Utilization/Experience Data – Active – By Month

G.2.14. Attachment 14: Aggregate Utilization/Experience Data – Early Retirees – By Month

G.2.15. Attachment 15: Aggregate Utilization/Experience Data – Active and Early Retiree 2015

G.2.16. Attachment 16: Aggregate Utilization/Experience Data – Active and Early Retiree 2016

G.2.17. Attachment 17: Aggregate Utilization/Experience Data – Early Retirees

G.2.18. Attachment 18: MAPD HMO Benefit Summary

G.2.19. Attachment 19: Coverage for the PPO Plans – Medicare Supplement and MAPD PPO Plans

G.2.20. Attachment 20: Minimum Required Reporting

G.2.21. Attachment 21: HMO Ratio of PCPs to Members

G.2.22. Attachment 22: Census

G.3. Negotiation Meetings (In addition to Section A.13)

G.3.1. Any negotiation meetings held in person shall be conducted individually and privately with qualified HMO Supplier(s) and may be tape recorded by EGID. OMES/CP and EGID shall hold all tape recordings, transcripts and notes of discussion(s) confidential.

G.3.2. Negotiation Meetings are tentatively set for July 12 – 13, 2017. Please note that these dates are tentative and may be adjusted. Additionally, negotiation meetings are at the discretion of EGID and may or may not be held.

G.4. Best and Final Offer (BAFO) (In addition to Section A.13)

G.4.1. Best and Final Offer (BAFO) Process

G.4.1.1. It is at the sole discretion of EGID if BAFO's will be requested.

G.4.1.2. In the event a BAFO is requested, further information will be provided to all qualified Suppliers at that time.

G.4.1.3. OMES/CP and EGID shall retain as confidential information contained in the initial proposals submitted by qualified Supplier(s) as well as any subsequent bid offers made by qualified Suppliers(s) prior to final contract award as part of the BAFO negotiation process. Information clearly designated in the RFP as proprietary shall be held confidential pursuant to 74 O.S. § 1304.1(M)(12).

G.4.1.4. For Suppliers offering an MAPD product, the Supplier should not expect that the state will ask for best and finals to give the MAPD an opportunity to enhance its proposal. Therefore, the MAPD should submit its best offer based on the terms and conditions set forth in this solicitation.

H. PRICE AND COST

H.1. Coverage Tiers

H.1.1. **Pre-Medicare and Medicare Supplement Plans**. The State of Oklahoma offers four coverage tiers 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 Supplier will be required to describe the methodology for developing the rates. The four levels of coverage are as follows:

H.1.1.1. Employee Only

H.1.1.2. Spouse

H.1.1.3. One Child

H.1.1.4. Two or More Children

H.1.2. **MAPDs.** In accordance with federal requirements, MAPDs rates are based upon per-covered individual.

H.1.3. **Family Units with combined Medicare/non-Medicare Coverage.** If a Supplier must provide a Medicare plan, such Supplier 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.

H.2. Risk Adjustments

H.2.1. 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.

H.2.2. 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.

H.2.3. 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.

H.2.4. 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, EGID will be available to discuss this methodology during the Best and Final Offer process if any a health care choice has any questions.

H.3. Administrative Assessment

The quoted rates shall include an administrative cost adjustment to reimburse EGID for administrative activities including, but not limited to, enrollment, record keeping, accounting, and employee communication functions. The amount of this adjustment for 2018 shall be $4.624 Per Member Per Month (PMPM) rate collected by EGID. This fee is determined annually by EGID and is subject to change either up or down in pricing.

H.4. Consolidated Omnibus Budget Reconciliation Act (COBRA)

The monthly rates which eligible participants under COBRA are charged for plan 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.

H.5. Premium Quotes

H.5.1. Each Supplier 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.

H.5.2. Suppliers must provide one state-wide premium quote for all service areas.

H.5.3. The premium rates shall not be excessive, inadequate or unfairly discriminatory.

H.5.4. This rate sheet must be accompanied by a signed statement by the Supplier's qualified actuary, certifying that the methodology used in developing these rates is sound according to accepted actuarial principles. 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. This documentation shall be attached to the rate sheet.

H.5.5. Suppliers may provide an explanation of the service areas covered by the premium quote.

H.5.6. Suppliers shall provide any other information as requested by EGID, including but not limited to confidential rate development methodology and plan design, as required for use by EGID during the procurement process.

H.5.7. Submission of confidential proposed rates must be handled in accordance with procedures stated in Section E of this RFP.

H.5.8. Active and Non-Medicare Retiree Quotes

H.5.8.1. Each Supplier must bid on all categories, including both eligible current and former eligible employees and their eligible dependents.

H.5.8.2. The benefits shall be those specified in Attachment 4 (Active and Non-Medicare Retiree).

H.5.8.3. In setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, the Suppliers shall set the monthly premium for active employees to be equal to the premium for retirees under sixty-five (65) years of age.

H.5.8.4. For accounting purposes related to biweekly payrolls, any cents quoted in the Supplier's rates shall be divisible by two.

H.5.8.5. The rates shall be submitted in the "Table 1 – Premium Quote" format shown in Attachment 8.

H.5.9. Medicare Supplement Quotes

H.5.9.1. The benefits shall be those specified in Attachment 10 (Medicare Supplement).

H.5.9.2. The rates shall be submitted in the "Table 2 – Premium Quote" format shown in Attachment 8. Submission of confidential proposed rates must be handled in accordance with procedures stated in Section E of this RFP. The submitted rates and accompanying documentation for Table 2 should be submitted in the same envelope as Table 1 (Active and Non-Medicare Retiree).

H.5.10. Premium Quotes – MAPD only

H.5.10.1. The rate sheet shall include the plan name and the per-covered individual per month premium.

H.5.10.2. The MAPD shall submit rates on a per-covered individual per month basis for the Plan Year January 1, 2018 through December 31, 2018.

H.5.10.3. All rates set forth shall be for Medicare-eligible members only.

H.5.10.4. Confidential premium rates must be sent in a separate envelope marked "confidential" by the proposer on or before July 25, 2017 by 10:00 a.m. and will be considered a part of this RFP. These rates should be submitted to: Contracting Officer listed on the front page of the solicitation packet.

Attachment 1

BUSINESS ASSOCIATE AGREEMENT BETWEEN THE OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES EMPLOYEES GROUP INSURANCE DIVISION (COVERED ENTITY) AND _____ (BUSINESS ASSOCIATE)

Definitions

Catch-all definitions:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean _____.

(b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean the Oklahoma **Office of Management and Enterprise Services Employees Group Insurance Division**.

(c) HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by this Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by this Agreement;

(c) Report to Covered Entity any use or disclosure of protected health information not provided for by this Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware, provided however that Business Associate shall not be required to report any routine unsuccessful attempts to access, modify or destroy electronic data, or to interfere with an electronic date system, such as "pings" or other broadcast attacks on a firewall, port scans, routine unsuccessful log-on attempts, or denial of service attacks; breaches involving 100 or more affected individuals shall be reported within ten (10) days of discovery, and breaches involving less than 100 affected individuals shall be reported within thirty (30) days of discovery; Business Associate shall provide Covered Entity

with information regarding the nature and extent of the improper use or disclosure and any additional information Covered Entity may reasonably request;

(d) Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement;

(e) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information;

(f) In accordance with 45 CFR 164.514(d)(3), only request, use and disclose the minimum amount of protected health information necessary to accomplish the purpose of the request, use or disclosure;

(g) Make available protected health information in a designated record set to the individual or the individual's designee as necessary to satisfy Covered Entity's obligations under 45 CFR 164.524;

(h) Provide access, at the request of Covered Entity and during normal business hours, to Protected Health Information in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR §164.524, provided that Covered Entity delivers to Business Associate a written notice at least five (5) business days in advance of requesting such access. This provision does not apply if Business Associate and its employees, subcontractors and agents have no Protected Health Information in a Designated Record Set of Covered Entity;

(i) Make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR §164.526, at the request of Covered Entity or an Individual. This provision does not apply if Business Associate and its employees, subcontractors and agents have no Protected Health Information from a Designated Record Set of Covered Entity;

(j) Maintain and make available the information required to provide an accounting of disclosures to the individual as necessary to satisfy Covered Entity's obligations under 45 CFR 164.528;

(k) Unless otherwise protected or prohibited from discovery or disclosure by law, Business Associate agrees to make internal practices, books, and records, including policies and procedures, relating to the use or disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, available to the Covered Entity or to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule or Security Rule. Business Associate shall have a reasonable time within which to comply with requests for such access and in no case shall access be required in less than five (5) business days after Business Associate's receipt of such request, unless otherwise designated by the Secretary;

(l) To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s); and (m) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

Permitted Uses and Disclosures by Business Associate

(a) Except as otherwise limited by this Agreement, Business Associate may make any uses and disclosures of Protected Health Information necessary to perform its services to Covered Entity and otherwise meet its obligations under this Agreement, if such use or disclosure would not violate the Privacy Rule if done by Covered Entity. All other uses or disclosures by Business Associate not authorized by this Agreement or by specific instruction of Covered Entity are prohibited.

(b) Business Associate may use or disclose protected health information as required by law.

(c) Business Associate agrees to make uses and disclosures and requests for protected health information
consistent with the minimum necessary policies and procedures of the HIPAA Rules.

(d) Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by Covered Entity.

(e) Business Associate may disclose protected health information for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(f) Business Associate may provide data aggregation services relating to the health care operations of the Covered Entity.

Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

(a) Covered Entity shall notify Business Associate of any limitation(s) in the notice of privacy practices of Covered Entity under 45 CFR 164.520, to the extent that such limitation may affect Business Associate’s use or disclosure of protected health information.

(b) Covered Entity shall notify Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect Business Associate’s use or disclosure of protected health information.

(c) Covered Entity shall notify Business Associate of any restriction on the use or disclosure of protected health information that Covered Entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of protected health information.

Indemnification

Business Associate will indemnify, defend and hold harmless Covered Entity and its respective employees, directors, officers, subcontractors, agents and affiliates from and against all claims, actions, damages, losses, liabilities, fines, penalties, costs or expenses (including without limitation

reasonable attorneys' fees) suffered by Covered Entity arising from or in connection with any breach of this Agreement, or any negligent or wrongful acts or omissions in connection with this Agreement, by Business Associate or by its employees, directors, officers, subcontractors, or agents. Notwithstanding the foregoing, the Business Associate shall not be responsible or liable for following Covered Entity's instructions with regard to the protected health and/or confidential information or from and to the extent of any breach of contract or negligent actions or omissions by the Covered Entity. No person or entity is to be considered a third-party beneficiary under the agreement, nor shall any third party have any rights as a result of the agreement.

Term and Termination

(a) Term. This agreement shall be effective upon execution by both parties and will continue until terminated by either party for any reason with a written notice of 30 days, or on the date Covered Entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall give Business Associate written notice of such breach and provide reasonable opportunity for Business Associate to cure the breach or end the violation. Covered Entity may terminate this Agreement, and Business Associate agrees to such termination, if Business Associate has breached a material term of this Agreement and does not cure the breach or cure is not possible.

(c) Obligations of Business Associate Upon Termination.

Upon termination of this Agreement for any reason, at the option of Covered Entity, Business Associate shall do one or more of the following: 1) return all protected health information to Covered Entity, 2) transmit the protected health information to another business associate of the Covered Entity, and/or, 3) destroy all protected health information received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity. Business Associate and its subcontractors shall retain no copies of the protected health information.

Miscellaneous

(a) Assignment. The Parties will not sublicense or assign this Agreement or any right or interest hereunder without prior written consent, and any attempted sublicense or assignment without such consent will be void. Subject to the foregoing restriction, this Agreement will bind and benefit the parties and their respective successors and assigns.

(b) Governing law; Severability. Except as preempted by federal law, this Agreement will be interpreted, construed and enforced in all respects in accordance with the laws of the State of Oklahoma, without giving effect to its principles of conflict of laws. If any provision of this Agreement is determined to be invalid to any extent or in any context, such provision will be enforced to the extent and in the contexts in which it is valid, and the remaining provisions are severable and will not be affected by any such determination of invalidity.

(c) Entire Agreement. This Agreement sets forth the entire agreement, and supersedes any and all prior agreements, of the Parties with respect to the subject matter hereof. No amendment of this Agreement will be valid unless set forth in a writing signed by both Parties. No waiver will be binding unless signed by the party to be bound.

(d) Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

(e) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

(f) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

(g) No Third-Party Beneficiaries. Nothing express or implied in the PBM Agreement or in this Business Associate Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the parties, any rights, remedies, obligations or liabilities whatsoever.

(h) Notices. Any notices pertaining to this Agreement shall be given in writing and shall be deemed duly given when personally delivered to a Party or a Party's authorized representative as listed below or sent by means of a reputable overnight carrier, or sent by means of certified mail, return receipt requested, postage prepaid. A notice sent by certified mail shall be deemed given on the date of receipt or refusal of receipt. All notices shall be addressed to the appropriate Party as follows:

If to Covered Entity:

First Point of Contact:
Title: OMES Privacy Officer/HealthChoice Chief Compliance Officer
Name: Paul King
Address: 3545 N.W.58th Street, Suite 110
Oklahoma City, OK 73112
Telephone: 405-717-8880
Fax: 405-717-8609
Email: Paul.King@omes.ok.gov

Second Point of Contact:
Title: HealthChoice Deputy Compliance Officer
Name: Lori Baer
Address: 3545 N.W.58th Street, Suite 110
Oklahoma City, OK 73112
Telephone: 405-717-8809
Fax: 405-717-8609
Email: Lori.Baer@omes.ok.gov

Website URL https://www.ok.gov/sib

If to Business Associate:

First Point of Contact:
Title: _____
Name: _____
Address: _____
_____
_____
Telephone: _____
Fax: _____
Email: _____

Second Point of Contact:
Title: _____
Name: _____
Address: _____
_____
_____
Telephone: _____
Fax: _____
Email: _____

Website URL _____

Agreed and Accepted

COVERED ENTITY - The Office of Management and Enterprise Services Employees Group Insurance Division

By: _____

Printed Name: Frank Wilson

Title: Administrator

Date Signed: _____

BUSINESS ASSOCIATE - _____

By: _____

Printed Name: _____

Title: _____

Date Signed: _____

ATTACHMENT 2

STATEMENT OF COMPLIANCE

Statement of Compliance

A. Certain conditions may preclude the Provider's strict compliance with a term specified in this Request for Proposal (RFP). The Provider shall describe its method of compliance to accomplish the requirements of the specific term and EGID reserves its unrestricted discretion to determine, whether an alternative method offered by the Provider is acceptable to EGID.

B. Any alternative method or exceptions to terms, conditions or other requirements in any part of the RFP must be clearly described in both the appropriate section of the solicitation and listed as an attachment to the Statement of Compliance and shall be made a part of this RFP. Otherwise, EGID shall consider that all items offered are in strict compliance with the RFP and the Provider shall be responsible for compliance. EGID shall specify at the time of the awarding of the contract what, if any, optional, alternative methods are accepted.

C. Notwithstanding anything to the contrary, EGID maintains the unrestricted discretion to make any decision as to suitability, competency, ability to perform, conflicts of interest or the appearance thereof, responsiveness of the Provider's proposal, acceptability of such proposal, or other decisions concerning qualifications.

D. Each Provider shall be required to submit a response to this RFP as it is written. Any Provider who wishes to propose exceptions or alternatives to any term, condition, or requirement of this RFP must specify the exception and/or alternative and submit a response for each deviation. If a Statement of Compliance is not returned to EGID with the Provider's original bid, the response shall be excluded from further consideration. If a Statement of Compliance is submitted with deviations, EGID will consider such exceptions and/or alternatives in the evaluation process or such exception and/or alternative may constitute grounds for rejection of the proposal.

☐ The solicitation submitted to EGID is in strict compliance with this RFP, and if selected as a Provider, the Provider will be responsible for meeting all requirements of this RFP.

☐ The solicitation submitted to EGID contains deviations from the specifications of this RFP. The deviations are attached.

Name: _____ Company: _____

Signature: _____ Address: _____

Title: _____ _____

Phone: _____ Fax: _____

ATTACHMENT 3

STANDARDIZED SERVICE AREAS

Service Areas Offered for Plan Year 2018

Note: Please Review Section C.7.14. Before Completing This Section.

Zip	Zip / County / City

ATTACHMENT 4

Current HMO Plan Design– Please Populate

EGID is currently is requesting that all incumbent HMOs quote the current plan design being offered in PY 2018.

Type of Benefit	**HMO Current**	**HMO Plan Year 2018**
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: See Plan Design Description Of Scope – Prescription Drugs		
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 Supplier's HMO Plan cannot impose any type of an annual deductible.

Does the Supplier affirm agreement with this condition?

PREVENTIVE HEALTH SERVICES

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

Does the Supplier affirm agreement with this condition?

PROFESSIONAL SERVICES

The Supplier 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.

Does the Supplier affirm agreement with these conditions?

HOSPITAL

The Supplier 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.

Does the Supplier affirm agreement with these conditions?

EMERGENCY HEALTH CARE SERVICES

The Supplier 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.

Does the Supplier affirm agreement with this condition?

MEDICAL TRANSPORTATION SERVICES

The Supplier 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.

Does the Supplier affirm agreement with these conditions?

DIAGNOSTIC X-RAY AND LABORATORY SERVICES

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

Does the Supplier affirm agreement with this condition?

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.*

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 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).

Does the Supplier affirm agreement with these conditions?

PHYSICAL AND MANIPULATIVE THERAPY

The Supplier 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.

Does the Supplier affirm agreement with this condition?

MENTAL HEALTH

The Supplier 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.

Does the Supplier affirm agreement with this condition?

SUBSTANCE ABUSE

The Supplier 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.

Does the Supplier affirm agreement with this condition?

ALLERGY TREATMENT AND TESTING

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

Does the Supplier affirm agreement with this condition?

DURABLE MEDICAL EQUIPMENT (DME)

The Supplier must provide benefits for durable medical equipment.

Does the Supplier affirm agreement with this condition?

MATERNITY

The Supplier 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.

Does the Supplier affirm agreement with this condition?

INFERTILITY SERVICES

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

Does the Supplier affirm agreement with this condition?

HOME HEALTH SERVICES

The Supplier must provide coverage for home health services.

Does the Supplier affirm agreement with this condition?

HOSPICE

The Supplier must provide for hospice care.

Does the Supplier affirm agreement with this condition?

SKILLED NURSING CARE

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

Does the Supplier affirm agreement with this condition?

TRANSPLANTS

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

Does the Supplier affirm agreement with this condition?

ATTACHMENT 5

HMO PROVIDER CHARTS
PROVIDER NETWORK FORMAT

Provide a Microsoft Excel file (version 2010 or later) listing the Supplier's Provider Network of Primary Care Providers (PCPs), Specialists, Hospitals, and Pharmacies. These should appear on separate tabs, each labeled appropriately.

PCPs and Specialists

Use the following format for PCPs and Specialists (the fields must appear in the order presented).

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.

Instructions Specific to PCP List

1. "Participation"
    a. Use the following coding
        i. For "Accepting New Enrollments", use "A"
        ii. For "Accepting Established Patients Only", use "E"
        iii. For "Not Accepting Enrollments", use "N"
    b. "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.
2. "Type of Practice"
    a. Use the following coding:
        i. Family Practice = FP
        ii. General Practice = GP
        iii. Internal Medicine = IM
        iv. Pediatrician = PE
        v. Obstetrics and Gynecology = OB
    b. Do not list OB-GYN providers unless they will be utilized as primary care physicians.

Hospitals

Use the following format for Hospitals (the fields must appear in the order presented).

Name	Primary Address	City	Zip

Pharmacies

Use the following format for Network Pharmacies (the fields must appear in the order presented).

NABP	Pharmacy	Address	City	State	Zip	Phone	FedTax

ATTACHMENT 6

Office of Management and Enterprise Services
Employees Group Insurance Division
Advertising Approval Request Form

- This form must accompany all ads submitted to the Employees Group Insurance Division 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:

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

EGID:
Scott Boughton, Deputy General Counsel
3545 NW 58th, Suite 110
OKC, OK 73102
Phone (405) 717-8809
Fax (405) 717-8609
Scott.Boughton@omes.ok.gov

EGID Approval

_____
Signature

_____

Date

ATTACHMENT 7

Performance Reporting Template for PY 2018

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*	Name_____ 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												
1st 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.

ATTACHMENT 8

Premium Quote Tables

TABLE 1 –Premium Quote
(Renewal Rates: No Benefit Changes)

Active and Non-Medicare Retiree Blended Rate
(January 1, 2018 through December 31, 2018)

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

TABLE 2 – Medicare Plan Premium Quotes
(January 1, 2018 through December 31, 2018)

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

Frank Wilson
Administrator
Employees Group Insurance Department

Preston L. Doerflinger
Director
Secretary of Finance, Administration
and Information Technology

ATTACHMENT 9

CARRIER ELIGIBILITY EXPORT

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.

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Director
Secretary of Finance, Administration
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1) **FOR 2015 and BEFORE**: 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).

2) **FOR 2016 and AFTER**: ACTIVE is defined as Members and elected dependents whose enrollment termination date is > the export as of date or blank.

   (The full file will contain future enrollment. For example, if member is enrolled 1/1/2016 – 12/31/2016 and 1/1/2017 – open. On the export file of 11/1/2016, 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*

- **FOR 2015 and BEFORE**: 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).

- **FOR 2016 and AFTER**: 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

  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,**

     A type 3 record for the termination will be sent for the terminated coverage and a type 3 record will be sent for the new coverage with that coverage's start date. The records will be sent with the current indicative information for the affected individual(s).

  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,**

     If 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 where changes were made to the plan, then a type 3 record will be sent with the termination date and a type 3 record will be sent for the new coverage with that coverage's start date.

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

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, alter coverage dates or opt-out dependent in period (Data entry error or correction)**

If Period is deleted, benefit is deleted or dependent is opted out within the current 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 = 1/1/2016 termination date = 12/31/2015.

If a benefit is changed within the same plan but to a different option, the old plan option will be sent with a termination date. The new plan option will be sent with the new effective date.

If a dependent is opted in within the current period then only the dependent will be transmitted with the original effective date of coverage with the new tier code if affected – if not affected the original tier code will be sent.

If the date for a termination is adjusted then the file will transmit the original effective date along with the new adjusted terminated date.

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

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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 — AetnaHMO Health — CommunityCare HMO Health — GlobalHealth HMO Senior — Aetna Medicare Senior — CommunityCare Senior — Generations Dental — Assurant Freedom Preferred Dental — Assurant Heritage Plus (Prepaid) Dental — Assurant Heritage Secure (PrePaid) Dental — Cigna Dental Care Plan (Prepaid) Dental — Delta Dental PPO Dental — Delta Dental PPO - Choice Dental — Delta Dental PPO Plus Premier Dental — MetLife Classic Dental — MetLife MAC Dental — MetLife PDP Vision EE — Primary Vision Care Vision EE — Superior Vision Vision EE — Vision Care Direct Vision EE — VSP	

IV. *Steps to create export:*

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

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V. *Record Layouts*

Header

Field Number	Start Position	Stop Position	Field Name	Length	Data Type	Required	Format	Value/Default	Description
1	1	1	Record type		A/N	Y		1	Indicates header file
2	2	10	Carrier		A/N	Y		9010	Indicates this file is from EGID
3	11	35	Address1		A/N	N			3545 NW 58th Street
4	36	60	Address2		A/N	N			Suite 110
5	61	80	City		A/N				Oklahoma City
6	81	82	State		A/N	N			OK
7	83	92	Zip		A/N	N			73112
8	93	102	Phone		A/N	N			405-717-8888
9	103	110	Creation Date		N	Y	YYYYMMDD		Creation date of this file.
10	111	111	File Type		A	Y			The file type. A = Active I = Incremental F = Full
11	112	1500	Filler						

Detail

Field Number	Start Position	Stop Position	Field Name	Length	Data Type	Required	Format	Value/Default	Description
1	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	2	10	Carrier	9	A/N	Y		9010	9010 Hard coded for every record, stands for EGID
3	11	20	Account	10	A/N	Y		ST – State ED – Education LG – Local Govt	Populated for Vision Carriers only
4	21	30	Group	10	A/N	Y			Group Number
5	31	39	Member_SSN	9	A/N	Y			Member SSN
6	40	41	Person Code	2	A/N	Y			Member or dependent custom field
7	42	43	Relationship	2	A/N	Y			Relationship of this person to the member. Ex: S-spouse, C-child

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8	44	93	Last Name	50	A/N	N			The last name of this person record.
9	94	143	First Name	50	A/N	N			The first name of this person record.
10	144	144	Middle Initial	1	A/N	N			The middle initial of this person record.
11	145	145	Sex	1	A/N	Y			The sex of this person record.
12	146	153	Date of Birth	8	N	Y	YYYYMMDD		The birth date of this person record.
13	154	161	Effective Date	8	N	Y	YYYYMMDD		The effective date for this person's coverage
14	162	169	Termination Date	8	N	Y	YYYYMMDD		The termination date for this person's coverage
15	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'
16	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'
17	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'
18	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'
19	312	321	Mailing Zip	10	A/N **See Description*	Y			Zip of this person record, if it doesn't exist then use the Member Zip Address Type = 'R' ***Zip code will be right justified and padded with leading spaces.***
20	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'
21	332	332	Alt Ins Indicator	1	A/N	N			Not Used
22	333	342	Alt Ins Code	10	A/N	N			Not Used
23	343	360	Alt Ins ID	18	A/N	N			Not Used
24	361	371	Filler	11					For Future Additions
25	372	381	Status	10	A/N	N			Member or dependents status code. For example, Active, Medicare, Cobra etc.
26	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
27	392	399	Plan Eff Date	8	N	N			Not used
28	400	400	New card Flag	1	A/N	Y			Not used
29	401	402	Marital Status	2	A/N	Y		M = Married N = Single U = Undefined	Member/dependents marital status. If not supplied: Null
30	403	412	Alt Phone	10	A/N	N			Member/dependents alternate (work) phone. If not supplied: Null or '0000000000'
31	413	420	Hire Date	8	N	N	YYYYMMDD		Not Used
32	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
33	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)
34	431	431	Student Code	1	A/N	N			Not Used
35	432	441	Tier code	10	A/N	Y			Coverage level – such as Member, member and spouse etc.
36	442	451	Division	10	A/N	Y			Division Number
37	452	459	Alt Ins From Date	8	N	N			Not used

38	460	467	Alt Ins Thru Date	8	N	N			Not used
39	468	468	Pen Claim	1	A/N	N		Y or N	Not used
40	469	469	Pre Ex	1	A/N	N		Y or N	Not used
41	470	480	HICN	11	A/N	N			HCIN Number, SSN+ 1 or 2 special code to ID Medicare person. Member Custom
42	481	490	Disenrollment Code	10	A/N	N			Disenrollment Code This is for MAPD/PDP plans
43	491	500	Signature Date	10	A/N	N	MMDDYYYY		Signature Date on MAPD/PDP enrollment form
44	501	509	From Member SSN	9	A/N	N			Old Member SSN
45	510	511	From Person_ Code	2	A/N	N			Old Person Code
46	512	519	Original Eff Date	8	N	N	YYYYMMDD		Not used
47	520	527	Dental Penalty	8	N	N	YYYYMMDD		Not used
48	528	535	Life Insurance Amt	8	N	N	999999.99		Not used
49	536	550	Country	15	A/N	N			Country of Address. Populate the country
50	551	553	Reason	3		N		Y or N	Change Type: 1st Position – Eligibility, 2nd Position – Address, 3rd Position – Indicative
51	554	561	Date of Death	8	N	N	YYYYMMDD		The death date of this person record
52	562	571	Member_Code	10	A/N	Y			Unique Member Number Right Justified
53	572	621	Employer Name	50	A/N	N			Employer Name
54	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'
55	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'
56	712	761	Permanent City	50	A/N	Y			City of this person record, if it doesn't exist then use the Member

Frank Wilson
Administrator
Employees Group Insurance Department

Preston L. Doerflinger
Director
Secretary of Finance, Administration
and Information Technology

									City Address Type = 'C' If 'C' is null, use 'R'
57	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'
58	764	773	Permanent Zip	10	A/N *See Description*	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' **Zip code will be right justified and padded with leading spaces.*
59	774	798	County	25	A/N	N			County of Permanent Residence of this person record Member Medicare Info Datasheet
60	799	848	Email	50	A/N	N			Email Address of this person record Address Type = 'R'
61	849	849	Plan Premium Payment Option	1	A/N	Y		1	1=EGID will bill the member
62	850	850	ESRD	1	A/N	Y		Y=Yes N=Blank	Member is ESRD Medicare Info Datasheet
63	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
64	852	852	Language Preference and Alternative Formats	1	A/N	Y		N=No	Default=N NOT USED

65	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.
66	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>
67	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>
68	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>
69	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>
70	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>
71	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>
72	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>
73	1097	1106	Authorized Representative Zip	10	A/N *See Description*	Y			1) Medicare Info Datasheet 2) Person record is dependent child – use Primary Member's Indicative Info 3) <blank> **Zip code will be right justified and padded with leading spaces.*
74	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
75	1117	1124	Employer or Union Name	8	A/N	Y		OSEEGIB	
76	1125	1128	Employer or Union Group Number	4	A/N	Y		9010	
77	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
78	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
79	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
80	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.
81	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.
82	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.
83	1233	1258	RX OGI	26	A/N				Other Group Insurance Plan Name
84	1259	1278	RX ID# For OGI	20	A/N				Other Group Insurance Member ID#
85	1279	1293	RX Group# For OGI	15	A/N				Other Group Insurance Group #
86	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 1/1/2015 to 12/31/2016. On 1/1/2017 they move to HealthCare X 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

Field Number	Start Position	Stop Position	Field Name	Length	Data Type	Required	Format	Value/ Default	Description
1	1	1	Record Type	1	A/N			9	Indicates trailer record
2	2	10	Carrier	9	A/N				
3	11	19	Total records	9	N				Do NOT include header and trailer = Adds+ Changes+ Total count of records on the file
4	20	28	Total Adds	9	N				Total Number of Add Records. Total count of record type 2
5	29	37	Total Changes	9	N				Total Number of Change Records. Total count of record type 3
6	38	46	Total Move History	9	N				Total Number of Move Records. Total count of record type 4.
7	47	1500	Filler						

VI. *Contact Information*

Name	Phone	E-Mail
OMES ISD Service Desk	405-521-2444 or 866-521-2444	ServiceDesk@omes.ok.gov
**Do not send PHI/PII or other sensitive information electronically to the Service Desk. Thank you!*		

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 Preference 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'
9/2/2015	Todd Marney	Updated to include EBC members for files created 2016 and after.
10/12/2015	Todd Marney	Added 'Field Number' column.
11/23/2015	Todd Marney	Modified the following Incremental bullet points due to V3 Browser differences: - If Current Coverage is terminated and New Coverage is created - Delete Coverage, alter coverage dates or opt-out dependent in period (Data entry error or correction)
1/19/2016	Todd Marney	Modified the 'Description' and 'Data Type' for fields #19, #58 and

		#73 to include: '*See Description*' and '**Zip code will be right justified and padded with leading spaces.'*
1/31/2017	Todd Marney	- Updated examples from 2008/2009/2010 to 2015/2016/2017 - Updated contact information to OMES ISD Helpdesk - Updated Fund/Plan

IX. *Sign-off*

Reviewed by: _____ *Date:* _____

Approved by: _____ *Date:* _____

ATTACHMENT 10

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, outpatient 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	All female Medicare beneficiaries	Pap Test, 100% No Part B deductible For all	0% For all other	0%

Once every 12 months if high risk/abnormal Pap test in preceding 36 months		other exams, 80% No Part B deductible	exams, 20% No Part B deductible	
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 **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 **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 **Barium Enema** Doctor can substitute for sigmoidoscopy or colonoscopy	All Medicare beneficiaries ages 50 and older There is no minimum age for having a colonoscopy	For the fecal occult blood test, 100% No Part B deductible For all other tests, 80% after the Part B deductible	0% for the fecal occult blood test For all other tests, 20% after the Part B deductible	0% 0%
	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 **Prostate Specific Antigen Test (PSA)** 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 PSA test, 100% No Part B deductible	For the digital rectal exam, 20% after the Part B deductible For the PSA test, 0%	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.

ATTACHMENT 11
Section 125 Debit Card File Format

HealthCare Transaction File Layout

Version: 1.51 **Last Updated Date:** 5/12/2017 4:32:00 PM

Description: WEX Health Standard File layout for HealthCare transaction data
Format: ASCII; Carriage return and line feed terminations
Record Length: 250 bytes (followed by CRLF terminations, including the trailer record)

HEADER

Minimum Occurrences = 1; Maximum Occurrences = 1

Field Name	Start POS	End POS	Required	Format	Description
Record Type	1	1	Yes	X(1)	Always equal to “H”
File Date	2	9	Yes	9(8) CCYYMMDD	File Transmission Date
File Time	10	15	Yes	9(6) HHMMSS	Time File created (military clock)
TPA ID	16	21	Yes	X(6)	E1 TPA ID - Provided by Evolution
Filler	22	250	Yes	X(229)	Space Filler

DETAIL

Minimum Occurrences = 0; Maximum Occurrences = Many

Field Name	Start POS	End POS	Required	Format	Description
Record Type	1	1	Yes	X(1)	Always equal to “D”
Participant ID	2	31	Yes	X(30)	Contract Holder Member ID (left justify)
Client ID	32	56	Yes	X(25)	E1 Client Identifier – Provided by Evolution (left justify)
Carrier Claim Number	57	81	Yes	X(25)	The Carrier Claim Number of the original transactions must be Unique.(left justify)
Patient Responsibility CoPay Amount	82	91	Yes	9(10)	Original Transaction Patient copay Responsibility Amount or (*Adjustment Amount that will be added to the original amount) (right justify, zero filled, two implied decimals)
Transaction Code	92	94	Yes	X(3)	“MED”,“DEN”,”PHA”,”VIS”
Process Date	95	102	Yes	9(8) CCYYMMDD	Payment Adjudication date
Carrier ID	103	112	Yes	9(10)	E1 Carrier ID - Provided by Evolution (right justify)
*Adjustment Flag	113	113	Yes	X(1)	‘Y’ – Adjustment to a previous transaction ‘N’ – Original transaction
Patient Responsibility Deductible Amount	114	123	Yes	9(10)	Original Transaction Patient Deductible Responsibility Amount or (*Adjustment Amount that will be added to the original amount) (right justify, zero filled, two implied decimals)
Patient Responsibility Coinsurance	124	133	Yes	9(10)	Original Transaction Patient Coinsurance Responsibility Amount or (*Adjustment Amount that will be added to the original

Amount					amount) (right justify, zero filled, two implied decimals)
Date of Service	134	141	Yes	9(8) CCYYMMDD	The Date service was provided
Filler	142	250	Yes	X(109)	Space filler

TRAILER

Minimum Occurrences = 1; Maximum Occurrences = 1

Field Name	Start POS	End POS	Required	Format	Description
Record Type	1	1	Yes	X(1)	Always equal to “T”
Total Record	2	21	Yes	9(20)	Total number of service lines on file (right justify, zero filled)
Filler	22	250	Yes	X(229)	Space Filler

NOTES

***Adjustments**

The adjustment flag indicates the type of transaction per a record. If there is to be an adjustment, two records are expected which are identical, with the exception of the Patient Responsibility Amounts and the Adjustment Flag. All original (non-adjustment) records will have the value of ‘N’ for the Adjustment Flag; Adjustments will have the value of ‘Y’. If no value is found in the Adjustment flag field the implied default value is ‘N’.

If the adjustment flag value = ‘Y’ then the Patient Responsibility Amounts within that record will be added to the Patient Responsibility Amounts associated to the original Carrier Claim Number. If the adjustment is to reduce the original transactions Patient Responsibility Amounts, a negative (-) amount should be sent in the adjustment records Patient Responsibility Amount fields. If the adjustment is to increase the original transaction Patient Responsibility Amounts, a positive amount should be sent in the adjustment records Patient Responsibility Amount fields. The carrier claim number field is used to associate an adjustment record to an original transaction record.

ATTACHMENT 12

Plan Year 2018

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	Rate Development			
	Medical	Rx	Capitation	Total
I. Financial Data				
A Total Subscriber				
B Total Members				
C Age Factor/ Sex Factor				
D Total Premium				
E. Total Paid Claims/Net of Rebates				
H Paid Loss Ratio				
II. Claims Forecast				
A Incurred Claims (12/16)				
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 @ $4.624 PMPM				
M PPACA - PCORI PMPM				
N PPACA - Health Insurer Fee PMPM				
O State Taxes PMPM				
P Projected Premium PMPM				
Q Current Premium PMPM				
R 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.

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ATTACHMENT 13

Plan Year 2018

Aggregate Utilization/Experience Data – Active Employees

Instructions on providing the experience segments:
- Experience Segment 1: Provide requested information for the Oklahoma Active Employees.
- This attachment and Attachment 12 should reconcile.

Experience Segment 1 - January 2015 through December 2015	January	February	March	April	May	June	July	August	September	October	November	December
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 2016 through December 2016	January	February	March	April	May	June	July	August	September	October	November	December
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 2017 through April 2017	January	February	March	April	Total 2017 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 2017. Please attach each as separate documents.

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ATTACHMENT 14

Plan Year 2018

Aggregate Utilization/Experience Data - Early Retirees

Instructions on providing the experience segments:
- Experience Segment 1: Provide requested information for the Oklahoma Early Retirees

Experience Segment 1 - January 2015 through December 2015	January	February	March	April	May	June	July	August	September	October	November	December
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 2016 through December 2016	January	February	March	April	May	June	July	August	September	October	November	December
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 2017 through April 2017	January	February	March	April	Total 2017 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 2017. Please attach each as separate documents.

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ATTACHMENT 15 - (Large Claims 12 mo. ending December 2015)

Plan Year 2018

Aggregate Utilization/Experience Data - Active 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 $100.000 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 the 12 months ending December 2015 on an INCURRED basis (12/24)**

	Claimant	Diagnosis	Status	Medical	Pharmacy	Amount
Example	*Claimant 1*	*Some Condition*	*Active*	*$82,300*	*$27,500*	*$109,800*
1.						
2.						
3.						
4.						
5.						
6.						
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8.						
9.						
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ATTACHMENT 16 - (Large Claims 12 mo. ending December 2016)

Plan Year 2018

Aggregate Utilization/Experience Data - Active 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 $100.000 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 the 12 months ending December 2016 on an INCURRED basis (12/16)**

	Claimant	Diagnosis	Status	Medical	Pharmacy	Amount
Example	*Claimant 1*	*Some Condition*	*Active*	*$82,300*	*$27,500*	*$109,800*
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ATTACHMENT 17

Plan Year 2018

Aggregate Utilization/Experience Data - Early Retirees

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 2017	**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 2016 through April 2017	**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	

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ATTACHMENT 18

MAPD HMO Benefits Summary

THIS ATTACHMENT MUST BE COMPLETED FOR EACH PLAN OFFERED.

All pharmacy coverage descriptions and benefits listed must reflect compliance with CMS benefit guidance for MAPD plans and meet the Creditable Coverage definition.

Please note if changes have been made since previous year with *.**

COVERAGE FOR INPATIENT SERVICES

Service	MAPD HMO Benefit
HOSPITALIZATION Semi-private room (private if medically necessary)	
Nursing Services	
All meals, including special diets	
Drugs and medication	
Laboratory tests	
X-rays and other radiology services	
Inpatient physician and surgical services, including anesthesia	
Necessary medical supplies and appliances	
Blood and its administration	
Special care units	
Operating room	
Rehabilitation services	
Use of appliances, such as wheelchairs	
ORGAN TRANSPLANTS AT A MEDICARE-APPROVED TRANSPLANT FACILITY	
SKILLED NURSING FACILITY CARE Semi-private room	
Regular nursing services (except private-duty nurse)	
All meals, including special diets	
Physical, occupational, and speech therapy	
Drugs furnished by the facility	
Necessary medical equipment and supplies	
Blood and its administration	
Inpatient radiology and pathology	
Use of appliances such as a wheelchair	

COVERAGE FOR EMERGENCY AND URGENTLY NEEDED SERVICES

Service	MAPD HMO Benefit
OUT-OF-AREA URGENT CARE SERVICES Urgently needed services worldwide (during a temporary absence from the service area)	
EMERGENCY SERVICES Emergency services needed worldwide	

COVERAGE FOR EMERGENCY AND URGENTLY NEEDED SERVICES

(continued from previous page)

Service	MAPD HMO Benefit
IN-AREA URGENT CARE SERVICES **AMBULANCE SERVICES** (when medically necessary)	

COVERAGE FOR OUTPATIENT AND PHYSICIAN SERVICES

Service	MAPD HMO Benefit
PROFESSIONAL SERVICES Office Visits	
Consultation, diagnosis, and treatment by specialist	
Medical and surgical care	
Allergy tests and treatment (serum)	
Diagnostic tests and treatments	
Medical supplies including casts, dressings and splints	
PHYSICAL AND OCCUPATIONAL THERAPY AND SPEECH THERAPY SERVICES	
HEARING EXAMINATION Examination	
IMMUNIZATIONS Includes flu injections and all Medicare-approved immunizations	
LABORATORY SERVICES	
PHYSICAL EXAM Examination	
WELL FEMALE EXAM	
Examination	
Pap Smear	
X-RAY SERVICES Including annual mammography screening, if medically indicated.	

ATTACHMENT 19

Coverage for High Option
Medicare Supplement and MAPD PPO Plans
Medicare Part A (Hospitalization) Services
All Benefits are Based on Medicare-Approved Amounts

Indicate Type of Plan:

- ☐ **Medicare Supplement**
- ☐ **MAPD PPO**

Part A Network Services	Supplier's Plan Pays	HealthChoice Pays
HOSPITALIZATION Includes semiprivate room, meals, drugs as part of your inpatient treatment, and other hospital services and supplies First sixty 60 days		100% of the Part A deductible
Days 61 through 90		Coinsurance per day
Days 91 and after while using Medicare's 60 lifetime reserve days		Coinsurance per day
Once Medicare's lifetime reserve days are used, the plan provides additional lifetime reserve days		100% of Medicare eligible expenses Limited to 365 days
Beyond the plan's lifetime reserve days		0%
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		0% (Medicare pays all approved amounts)
Days 21 through 100		Coinsurance per day
Days 101 and after		0%
HOSPICE CARE Your doctor and hospice provider must certify you are terminally ill and you elect hospice Includes physical care, counseling, equipment, supplies, respite care, inpatient care and drugs for pain and symptom control		0% (Medicare pays all but very limited coinsurance for outpatient palliative drugs or biologics and inpatient respite care)

BLOOD Limited to the first 3 pints unless you or someone else donates blood to replace what you use		100%

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount.

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

Part B Network Services	Supplier's Plan Pays	HealthChoice Pays
MEDICAL EXPENSES Medically necessary outpatient services and supplies Includes doctor's visits, out-patient hospital treatment, surgical services, physical and speech therapy and diagnostic tests		20% after the Part B deductible
CLINICAL DIAGNOSTIC LABORATORY SERVICES		
Includes blood tests, urinalysis and tissue pathology		0% (Medicare pays 100%)
HOME HEALTH CARE Includes intermittent skilled care and medical supplies		0% (Medicare pays 100%)
DURABLE MEDICAL EQUIPMENT Includes items such as nebulizers, wheelchairs and walkers		20% after the Part B deductible
DIABETES MONITORING SUPPLIES Includes coverage for glucose monitors, test strips and lancets for those with diabetes Must be requested by your doctor		20% after the Part B deductible
OSTOMY SUPPLIES Includes ostomy bags, wafers and other ostomy supplies for those who have a need based on their condition		20% after the Part B deductible
BLOOD Includes amounts in addition to the coverage under Part A unless you or someone else donates blood to replace what you use		20% after the Part B deductible
OUTPATIENT PRESCRIPTIONS Includes infused, oral end-stage renal disease drugs and some cancer and transplant drugs		20% after the Part B deductible

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount.

Medicare Part B (Preventative) ServicesAll Benefits are Based on Medicare-Approved Amounts

Part B Network Services	Supplier's Plan Pays	HealthChoice Pays
INITIAL PREVENTIVE PHYSICAL EXAM		

Includes a onetime “Welcome to Medicare Visit” for Medicare beneficiaries during the first 12 months of Part B coverage		0% (Medicare pays 100%)
ANNUAL WELLNESS VISIT Includes one visit every 12 months for Medicare beneficiaries who have been enrolled in Part B for more than 12 months		0% (Medicare pays 100%)
SCREENING MAMMOGRAM Once every 12 months for female Medicare beneficiaries ages 40 and older		0% (Medicare pays 100%)
CARDIOVASUCLAR DISEASE SCREENING Once every five years for all Medicare beneficiaries		0% (Medicare pays 100%)
PAP TEST AND PELVIC EXAM Once every 24 months; includes a clinical breast exam Once every 12 months if high risk or abnormal Pap test in preceding 36 months		0% (Medicare pays 100%)
BONE MASS MEASUREMENTS Once every 24 months for all Medicare beneficiaries at risk of losing bone mass		0% (Medicare pays 100%)
GLAUCOMA SCREENING Once every 12 months for Medicare beneficiaries at high risk or a family history of glaucoma Must be performed or supervised by an optometrist or ophthalmologist		20% after the Part B deductible
COLORECTAL CANCER SCREENING For all Medicare beneficiaries ages 50 and older **FECAL OCCULT BLOOD TEST** Once every 12 months **FLEXIBLE SIGNOIDOSCOPY** Once every 4 years for those at high risk for colorectal cancer For those at normal risk, once every 4 years, or 119 months after a previous screening colonoscopy **COLONOSCOPY** Once every 2 years for those at high risk for colorectal cancer For those at normal risk, once every 10 years, or 47 months after a previous flexible sigmoidoscopy		0% (Medicare pays 100%)
BARIUM ENEMA Doctor can substitute this test for a sigmoidoscopy or colonoscopy Procedure must be performed in an outpatient hospital setting or an ambulatory surgical center		20% coinsurance
PROSTATE CANCER SCREENING For all male Medicare beneficiaries ages 50 and older **DIGITAL RECTAL EXAM** Once every 12 months		20% after the Part B deductible

PROSTATE SPECIFIC ANTIGEN TEST (PSA) Once every 12 months		0% (Medicare pays 100%)

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount.

Preventive Services - Vaccinations

Medicare covers the vaccine and administration at 100% if the provider accepts Medicare assignment.

Vaccination	Supplier's Plan Pays	HealthChoice Pays
Flu Vaccination One per flu season		0%
Pneumonia Vaccination One time vaccination		0%
Hepatitis B Vaccination Medicare beneficiaries at medium to high risk for Hepatitis B		0%

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount.

Coverage for Additional Medical Services

Service	Supplier's Plan Pays	HealthChoice Pays
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.		80% after you pay the first $250 each calendar year. $50,000 lifetime maximum

Pharmacy Copay Structure for Network Benefits

General Information	Supplier's Plan Pays	HealthChoice SilverScript High Option
These plans use a formulary		No annual deductible and no Coverage Gap. There is an annual out-of-pocket maximum of $4,850.
Mandatory generic and formulary medications you get at a Network Pharmacy	**30- Day Supply**	
Some drugs require prior authorization		**Generic (Tier 1) Drugs** Up to $10 copay

Quantity limits apply to certain drugs Only copays for covered drugs purchased at Network Pharmacies count toward out-of-pocket maximums Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before any changes are made to your plan's formulary		**Preferred (Tier 2) Drugs** Up to $45 copay
		Non-Preferred (Tier 3) Drugs Up to $75 copay
		Specialty (Tier 4) Drugs Up to $100 copay
		Preferred Tobacco Cessation (Tier 5) Drugs $0 copay
	31- to 90-Day Supply	
		Generic (Tier 1) Drugs Up to $25 copay
		Preferred (Tier 2) Drugs Up to a $90 copay
		Non-Preferred (Tier 3) Drugs Up to $150 copay
		Specialty (Tier 4) Drugs Specialty drugs are available in only a 30-day supply
		Preferred Tobacco Cessation (Tier 5) Drugs $0 copay
		Once the out-of-pocket maximum of $4,850 is reached, you pay 0% of Allowable Fees for covered prescription drugs purchased at Network Pharmacies for the remainder of the calendar year.

ATTACHMENT 20

Minimum Required Reporting

Notes:

1. Separate reports are required for HMO/Medicare Supplement and MAPD lines of business.
2. Unless indicated otherwise, all reports should be submitted electronically.
3. DBC is EGID's Director of Benefits Contracting. Send by secure email to paul.king@omes.ok.gov
4. Recon should be sent to: wednesday.shafer@omes.ok.gov by secure email or enforced TLS.

Frequency	Report Number	Report Name	Due Date	Format	Recipient
Daily					
Weekly	1	MAPD Disenrollment and changes	Wednesday following the week being reported	Electronic file or spreadsheet indicating disenrollments and changes processed in the MAPD's system along with any change in the low income premium subsidy. Minimum fields required are: 1. Name: Covered person's First Name, Middle Name, Last Name; 2. Effective Date: For New Enrollments, the date coverage begins; 3. Term Date: For Disenrollment, the date coverage ends; 4. HICN: Medicare Claim Number; 5. Plan Option: For MAPDs that have two or more different plans (e.g., High or Low); 6. LIS% (100%, 75%, 50% or 25%): Low Income Subsidy Percentage as established by CMS (if applicable); 7. LIS Effective Date: Date LIS begins. 8. LIS Term Date 9. Member ID	ftp.sib.ok.gov
Monthly	2	Member Services Telephone Assistance	20th of following month	1. Telephone Answer Time 2. Telephone Hold Time 3. Average Length of Call 4. Calls per Month 5. Abandoned calls (hang ups)	DBC
	3	Summary of operational and network performance	20th of following month	1. Month being reported; 2. Date the report was created; 3. Percentage of primary care physicians accepting new patients during the reporting period; 4. Summary of changes in the Supplier's Primary Care Physician network, hospital network, and specialist network from the previous month; 5. Percentage of customer service calls answered within in 30 seconds or less; 6. Average hold time for customer service calls in seconds; and 7. Average call abandonment rate for customer service calls	DBC
	4	Provider Lists	20th of following month	1. Month being reported 2. List of primary care physicians, hospitals, and specialists in the Supplier's network	DBC
	5	MAPD full file	10th of same month	Listing all members enrolled in the MAPD as of the first of the month	ftp.sib.ok.gov

				Required fields: 1. Name 2. Member ID 3. HICN 4. LIS Level 5. Plan Level (high vs. low – if applicable)	
	6	MAPD Monthly premium discrepancy	30 days after the premium remittance	Excel spreadsheet containing the following five fields in this order: 1. Member ID 2. Last Name 3. First Name 4. Amount of premium discrepancy 5. Supplier comments Showing any discrepancy between the premium remittance and the MAPD's eligibility records	Recon
	7	HMO/MSP Monthly premium discrepancy	60 days after the premium remittance	Excel spreadsheet containing the following five fields in this order: 1. Member ID 2. Last Name 3. First Name 4. Amount of premium discrepancy 5. Supplier comments Showing any discrepancy between the premium remittance and the MAPD's eligibility records	Recon
Quarterly	8	Grievance Report	45 days following the close of the calendar quarter	Number and types of complaints and grievances per month registered by members and providers	DBC
	9	MAPD Grievance Report	45 days following the close of the calendar quarter	Number and types of complaints and grievances per month registered by members and providers	DBC
	10	Fraud and fraud prevention activities related to OEIBA Program	60 days following the close of the calendar quarter	As related to the OEIBA Account: 1. Details of complaints made regarding suspicious provider billing practices and activities and outcomes by Supplier in investigating complaints. 2. Summary details of fraud prevention activities undertaken during quarter related to the OEIBA account.	DBC
	11	Cost utilization reporting	60 days following the close of the calendar quarter	1. Executive summary of findings; 2. Utilization summary (including a glossary of applicable terms); 3. Per member per month (broken down by health and separate for pharmacy); 4. Utilizing members (broken down by health and separate for pharmacy); 5. Quarter to quarter comparisons (broken down by health and separate for pharmacy); 6. Top fifteen (15) medications ranked by dollars paid; 7. Top fifteen (15) medications ranked by utilization; 8. Therapeutic Category analysis to identify top five (5) medications in each category; 9. Experience by covered health service (i.e., appendectomy, cataract surgery, oxygen, etc.); 10. Experience by top ten (10) health providers by dollars paid and by utilization (i.e., separate for hospital, physician, etc.); 11. Experience by top ten (10) diagnoses by dollars paid and by utilization. 12. Member Services summary; 13. Provider network status;	DBC

				14. Results of member surveys; and 15. Observations and recommendations for enhancements and improvements.	
	12	Paid Claim Summary	60 days following the close of the calendar quarter	All claims paid in the quarter along with a rolling prior twelve months of past paid claims, including the past quarter, separated by employee type (current, pre-Medicare retired, Medicare) and payment type (i.e. medical claim, capitation payment, prescription drug claim)	DBC
	13	Quarterly Summary of operational and network performance	20th of month after quarter ends	1. Month being reported; 2. Date the report was created; 3. Percentage of primary care physicians accepting new patients during the reporting period; 4. Summary of changes in the Supplier's Primary Care Physician network, hospital network, and specialist network from the previous month; 5. Percentage of customer service calls answered within in 30 seconds or less; 6. Average hold time for customer service calls in seconds; and 7. Average call abandonment rate for customer service calls	DBC
Annual	14	Annual Cost Utilization Summary	60 days following the close of the calendar year	Annual summary with a comparison to the previous plan year containing: 1. Executive summary of findings; 2. Utilization summary (including a glossary of applicable terms); 3. Per member per month (broken down by health and separate for pharmacy); 4. Utilizing members (broken down by health and separate for pharmacy); 5. Quarter to quarter comparisons (broken down by health and separate for pharmacy); 6. Top fifteen (15) medications ranked by dollars paid; 7. Top fifteen (15) medications ranked by utilization; 8. Therapeutic Category analysis to identify top five (5) medications in each category; 9. Experience by covered health service (i.e., appendectomy, cataract surgery, oxygen, etc.); 10. Experience by top ten (10) health providers by dollars paid and by utilization (i.e., separate for hospital, physician, etc.); 11. Experience by top ten (10) diagnoses by dollars paid and by utilization. 12. Member Services summary; 13. Provider network status; 14. Results of member surveys; and 15. Observations and recommendations for enhancements and improvements.	DBC
	15	Member Satisfaction Survey Results	60 days following close of calendar year	Assess quality of service and the "necessities" of care, such as afterhours care, office appointment waiting times, satisfaction with providers, and plan administration.	DBC
	16	Quality Evaluations	60 days following close of calendar year	The Suppliers must annually submit the results of quality evaluations, including formal reports to EGID. The Supplier must have implemented a program of utilization review, which includes procedures to develop, compile, evaluate, and report statistics, which relate to health services information.	DBC

ATTACHMENT 21

Plan Year 2018

List the Plan's Current Ratio of PCPs to Members (total block of business in Oklahoma).

Zip Code	Number of PCPs	Number of Members	Ratio