



STATE OF OKLAHOMA CONTRACT WITH HUMANA INSURANCE COMPANY

This State of Oklahoma Contract is entered into between the State of Oklahoma by and through the Employees Group Insurance Division of the Oklahoma Health Care Authority and Humana Insurance Company (“Supplier”) and is effective as of the effective date set forth on a properly issued purchase order or, if no effective date is listed, the date of last signature (“Effective date”). The term of the Contract is 1 year with the option to renew for 2 additional years.

Purpose

The State is awarding the Contract to Supplier for the provision of qualified HMOs, Medicare Supplements, and Medicare Advantage Prescription Drug health plans to offer managed care benefits to eligible OEIBA Program participants who live in the state of Oklahoma., as more particularly described in certain Contract Documents. Supplier submitted a proposal containing exceptions to the Solicitation and Supplier requested confidential matters to be considered This Contract Document memorializes the agreement of the parties with respect to terms of the Contract that is being awarded to Supplier.

Now, therefore, in consideration of the foregoing and the mutual promises set forth herein, the receipt and sufficiency of which are hereby acknowledged the parties agree as follows:

1. The parties agree that Supplier has not yet begun performance of work under the Contract. Issuance of a purchase order is required prior to payment to a Supplier.
2. The following Contract Documents are attached hereto and incorporated herein:
 - 2.1. Solicitation EV00000681, Attachment A;
 - 2.2. General Terms, Attachment B;
 - 2.3. Reserved, Attachment C;
 - 2.4. IT Terms, Attachment D;
 - 2.5. Response to Specifications, Attachment E;
 - 2.6. BAFO (MAPD Benefits Summary, and MAPD Premium Rate and LIS Quote), Attachment E-1
 - 2.7. BAFO Rate Sheet, Attachment E-2
 - 2.8. BAFO Plan Design Exhibits, Attachment E-3
3. The parties additionally agree:
 - 3.1. Except for Attachment E Sections A.10.1 Exhibit 11, Humana Rate Methodology Buildup, D.2.12, List of Vendors, D.7.1, Humana Medicare Enrollment, D.9 Call Center

Performance, D.10 Member Service Quality Assurance, D.11.2 Process for Providers, and Call Center Staff, D16.2, Prior Authorization, Security Assessment, Humana Vendor Security Assessment Section 7.7e, Third Party Supplier Information Section 7.12 and Exhibit 20 and other information deemed confidential by the State pursuant to applicable law, rule, regulation or policy, the parties agree Contract terms and information are not confidential and are disclosable without further approval of or notice to Supplier.

- 3.2. To the extent any term or condition in any Contract Document, including via a hyperlink or uniform resource locator, conflicts with an applicable Oklahoma and/or United States law or regulation, such term or condition is void and unenforceable. By executing any Contract Document which contains a conflicting term or condition, the State or Customer makes no representation or warranty regarding the enforceability of such term or condition and the State or Customer does not waive the applicable Oklahoma and/or United States law or regulation which conflicts with the term or condition.
- 3.3. In Exhibit E-1, Supplier included two plan designs for MAPD. The alternative plan titled With Proposed Plan Changes is the plan approved.
- 4. The undersigned Agency hereby attests that any required terms and conditions based on a Federal Award applicable to this Contract are included herein.
- 5. Any reference to a Contract Document refers to such Contract Document as it may have been amended. If and to the extent any provision is in multiple documents and addresses the same or substantially the same subject matter but does not create an actual conflict, the more recent provision is deemed to supersede earlier versions.

SIGNATURES

The undersigned represent and warrant that they are authorized, as representatives of the party on whose behalf they are signing, to sign this Agreement and to bind their respective party thereto.

**STATE OF OKLAHOMA
by and through the EMPLOYEES GROUP
INSURANCE DIVISION OF THE
OKLAHOMA HEALTH CARE AUTHORITY:**

By: *Gary Beebe*
Gary Beebe (Oct 29, 2025 15:56:39 CDT)

Name: Gary Beebe

Title: EGID Administrator

Date: Oct 29, 2025

HUMANA INSURANCE COMPANY

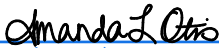
By: *Jill Tobin*

Name: Jill Tobin

Title: SVP - Group Medicare

Date: 10/21/2025

The State Purchasing Director is signing solely to ensure state agency compliance with provisions of the Oklahoma Central Purchasing Act pursuant to 74 O.S., 85.5 concerning acquisitions by state agencies.

By: 
Amanda Otis (Oct 29, 2025 16:05:27 CDT)

Name: Amanda Otis

Title: State Purchasing Director

Date: Oct 29, 2025

ATTACHMENT A

SOLICITATION NO. EV00000681

PLAN YEAR 2026 HEALTH

This Solicitation is a Contract Document and is a request for proposal in connection with the Contract awarded by and through the Office of Management and Enterprise Services on behalf of the Oklahoma Health Care Authority Employees Group Insurance Division (EGID) as more particularly described below. Any defined term used herein but not defined herein shall have the meaning ascribed in the General Terms or other Contract Document.

PURPOSE

The Contract is awarded on behalf of the Oklahoma Health Care Authority Employees Group Insurance Division (EGID) for qualified HMOs, Medicare Supplements, and Medicare Advantage Prescription Drug health plans to offer managed care benefits to eligible OEIBA Program participants who live in the state of Oklahoma. OMES/CP, on behalf of EGID intends to also solicit a standalone MAPD proposal on an exclusive basis with only one national MAPD to be primarily offered as an alternative for retired OEIBA Program members living outside the state of Oklahoma.

BACKGROUND

Identification of EGID

EGID was established by, and operates pursuant to, the Oklahoma Employees Insurance and Benefits Act (OEIBA), 74 O.S. § 1301, et seq., hereinafter (Act). The Act was established for the benefit of state and education employees, employees of other state governmental entities and quasi-state governmental entities authorized by the Act to participate in the insurance plans offered by EGID.

EGID is a covered entity subject to HIPAA. 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 at <https://www.rules.ok.gov/home>.

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. Currently, there are approximately 900 participating employer groups, each with unique Section 125 plans.

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. For most employees, insurance coverage is optional.

Identification of OEIBA Program Census Data (as of February 28, 2025):

Category	Total Lives	Primary	Dependents
Medicare	34,570	31,085	3,485
Current Employees	176,142	114,737	61,405
Pre-Medicare Former Employees	5,478	4,252	1,226
TOTAL	216,190	150,074	66,116

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.

A. CONTRACT TERM AND RENEWAL OPTIONS

- A.1. The initial Contract term is January 1, 2026, through December 31, 2026, and there are two one-year options to renew the Contract.
- A.2. For each contract renewal, Supplier shall offer the plan in place at the time of the renewal request if it is still an option in the solicitation, plus it may offer an alternative plan design. OEIBA Program may request updated documentation found in this Solicitation to review for purposes of the renewal.

B. SOLICITATION CRITERION

- B.1. **The Bid will be evaluated using a best value criterion, based on the following:**
 - B.1.1. Technical Response
 - B.1.2. Pricing Proposal
 - B.1.3. Past Performance
- B.2. **The Bid response shall show the ability of the Bidder to meet or exceed the following mandatory specifications based on the plan combination:**
 - B.2.1. Attachment A Section C.2.
 - B.2.2. Attachment A Section C.4.1.
 - B.2.3. Attachment A Section C.7.
 - B.2.4. Attachment E Section A.11

C. REQUIREMENTS AND LIMITATIONS ON THE PLAN(S) TO BE OFFERED UNDER THIS SOLICITATION

- C.1. Per Oklahoma State Employees Benefits Act, 74 O.S. § 1371(C), bids involving current employee coverage may be rejected or enrollment restricted for which the benefit price is determined to be excessive. Standalone MAPD plans will be evaluated by Best Value evaluation criteria. If a Bidder submits an HMO and an MAPD plan, and the HMO plan is rejected, then the entire bid combination will be rejected. 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.
- C.2. **Bidder shall offer only one of the following bid combinations:**
 - C.2.1. HMO and Medicare Supplement
 - C.2.2. HMO and MAPD
 - C.2.3. HMO and Medicare Supplement and MAPD
 - C.2.4. Standalone national MAPD
- C.3. Bidders with current contracts with the OEIBA Program are required to offer the current plan design for this solicitation. In addition, they may offer an alternative plan design. Only one plan design will be selected.
- C.4. For all plans offered to pre-Medicare employees, excessive pricing shall result in rejection of the bid combination. A rejection of a Bidder's HMO plan shall result in the elimination of the entire bid combination.

- C.4.1. For purposes of evaluating “**excessive pricing**”, refer to Exhibit 26.
- C.5. Bidder shall offer only one single bid combination. If a Bidder offers more than one bid combination for this Solicitation, all of the Bidder’s bid combinations will be automatically rejected.
- C.6. To participate, Bidders must offer an HMO option meeting the Solicitation Specifications, unless the Bidder submits the bid as a standalone MAPD offer.
- C.7. Bidders may offer a commercial plan for current and pre-Medicare employees and a Medicare Advantage plan for retirees. **Bidders shall not offer an HMO or a Medicare Supplement on a standalone basis for this RFP.**
 - C.7.1. To participate, Bidders must offer an HMO option that meets the Solicitation Specifications unless the Bidder submits the bid as a standalone national MAPD offer.
 - C.7.2. MAPD plans must be qualified by the Centers for Medicaid Services, hereinafter “CMS” and must be qualified and accepted according to the OMES/EGID Supplier’s process to offer these services to eligible participants.
 - C.7.3. Bidder may submit either an MAPD HMO or an MAPD PPO response to this RFP, but not both.
 - C.7.4. In accordance with State law under 74 O.S. §1366.1, if the Bidder additionally offers a Medicare Supplement benefit to any population within the State of Oklahoma other than the one within the OEIBA Program, it must also offer a Medicare Supplement benefit within this Program in accordance with the Solicitation Specifications.
- C.8. Bidder affirms their understanding of all contractual provisions and agrees to those provisions for the duration of the contract.
- C.9. Bidder shall furnish evidence that it complies with all requirements imposed by the Oklahoma Insurance Department necessary for it to provide the services herein.
- C.10. **Minor Deficiencies.** The State Purchasing Director has the right to waive minor deficiencies or informalities in a proposal provided that the State’s best interest would be served without prejudice to the rights of the other Bidders.

D. SCOPE AND DESCRIPTIONS

SPECIFICATIONS APPLYING TO ALL PROPOSALS

(HMO, MEDICARE SUPPLEMENT, MAPD)

- D.1. **Eligibility Transmission.**
 - D.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. Suppliers should only accept eligibility from EGID, not from employers or other sources.
 - D.1.2. The Supplier must accept EGID's eligibility file layout as described in Exhibit 25. 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.
 - D.1.2.1. New member/dependent enrollment
 - D.1.2.2. Member/dependent termination/disenrollment
 - D.1.2.3. Member/dependent adding and/or dropping various benefits
 - D.1.2.4. Eligibility changes due to ESRD determinations
 - D.1.2.5. Member moves between participating employer groups
 - D.1.2.6. Dependent moves from participating primary member to another primary member

D.1.2.7. Member/dependent status changes from current to pre-Medicare or COBRA status

D.1.2.8. Member/dependent becomes eligible for Medicare

D.1.2.9. A lapse is added to a member/dependent coverage

D.1.2.10. Member address changes

D.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.

D.1.4. The Supplier will be required to maintain its eligibility records from the data provided in a timely and accurate manner.

D.1.5. Eligibility information sent by EGID as "urgent" must be processed and confirmed within two (2) business hours. Supplier must fully process "non-urgent" requests within two (2) business days. EGID's business hours are 7:30 AM CT – 4:30 PM CT, Monday – Friday.

D.1.5.1. Response time: Urgent Workflow issues should be resolved within two (2) business hours of receipt. If the issue cannot be resolved within two (2) business hours, the workflow should be noted within two (2) business hours of receipt as to the action that is being taken to resolve the issue.

D.1.5.2. Response time: Non-urgent Workflow issues should be resolved within two (2) business days of receipt.

D.1.5.3. Urgent issues will be identified with a "high" priority and non-urgent issues will be identified as "medium" priority. Both urgent and non-urgent issues are tracked and routed back and forth between EGID and the Supplier through the Workflow Application.

D.1.6. For the categories Medicare Retiree and Pre-Medicare-Retiree, the retirement system contribution ranges from \$100 to \$105 per month for the primary member only. The contribution applies to health coverage only. For employees, contribution levels vary widely. In the majority of cases, the employer contribution for the employee will be at least equal to the HealthChoice High Option Premium. In the majority of cases, there is no employer contribution towards the cost of dependent coverage.

D.1.7. Information on eligibility reconciliation will also be furnished on a quarterly basis upon request of Supplier.

D.1.8. PCP information is only transmitted on the basis of the PCP name. No other code or identifier is available. Note that not all OEIBA Program members supply this information at the time of plan selection.

D.1.8.1. The status of the patient with the PCP will be included in the transmission as either "N" for New Patient or "C" for Current Patient if the information is supplied to EGID.

D.1.8.2. If awarded the contract, Suppliers will receive enrollment information for members as early as Option Period and should work directly with new members to confirm the member's selection of the PCP.

D.2. Premium Accounting.

D.2.1. EGID will communicate all eligibility data and remit all premium dollars to carriers. EGID remits premiums to Suppliers based on enrolled members.

D.2.2. EGID forwards premiums to the supplier on the 20th of the month (or the first business day thereafter) following the month of coverage (aka premium month). Example: Premiums due for the month of January are paid on February 20th. Payment and retroactivity detail files are sent by SFTP to the plan on the 21st.

D.2.3. Retroactive adjustments may occur to eligibility of individual participants because of eligibility provisions within the Act. In these circumstances, premiums must be refunded to a member or participating entity and EGID will recover those premiums from a future supplier remittance.

- D.2.4. EGID shall provide the Supplier with a premium report each month. A verification procedure will be used for compliance.
- D.2.5. Monthly discrepancy reports received by EGID should not go back further than the month being reconciled. Discrepancies older than sixty (60) calendar days from premium remittance date for HMO or MSP or thirty (30) calendar days from premium remittance date for MAPD will not be reconciled and EGID will not assume financial responsibility for a Supplier's failure to comply with reconciliation efforts. Note: no member coverage will be affected by a Supplier's failure to comply with above. Refer to Exhibit 29.

D.3. Significant Events.

D.3.1. The Supplier shall immediately notify EGID and OMES of any current or prospective "significant event" on an ongoing basis. All notifications shall be submitted in writing to EGID Director of Compliance at EGIDVendorReporting@omes.ok.gov and the State Purchasing Director. As used in this provision, a "significant event" is any current or future occurrence or anticipated occurrence that might 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:

D.3.1.1. Disposal of major assets

D.3.1.2. Any major computer software conversion, enhancement or modification to the operating systems, security systems, and application software, used in the performance of this contract

D.3.1.3. Termination or addition of provider contracts

D.3.1.4. 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

D.3.1.5. 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

D.3.1.6. Reorganization, reduction and/or relocation of key personnel such as, but not limited to, customer service representatives or claims adjusters

D.3.1.7. Known or anticipated merger or acquisition

D.3.1.8. Known, planned or anticipated stock sales

D.3.1.9. Any litigation filed by a member against the Supplier

D.3.1.10. Any sale or merger

D.3.1.11. Significant changes in market share or product focus

D.3.1.12. HIPAA violation

D.3.1.13. 6055 IRS reporting deficiencies

D.4. Workflow and Web Interfacing.

D.4.1. During the contract period, the Supplier will respond to EGID's inquiries using EGID's web-based application that tracks and reports member issues. This application is called "WorkFlow" and was developed by ViTech, creator of EGID's premium accounting and eligibility system. There is no software to purchase, and it only requires a connection to the Internet using a Microsoft Internet Explorer or compatible browser.

D.4.2. During the contract period, the Supplier will also utilize EGID's Web Eligibility Application to resolve eligibility issues and payment discrepancies. Suppliers agree to log in to both applications every sixty (60) days. Inactivity will result in termination of access. Send eligibility issues by email to the Member Research and Resolution unit at MemberAccountsResearch&Resolution@omes.ok.gov.

- D.4.2.1. Failure to log into Workflow and the Web Eligibility Application every sixty (60) days will lead to termination due to inactivity and will require new security forms to be completed and approved for reinstatement.
- D.4.2.2. The Supplier will respond to EGID's quarterly Vitech Security Verifications by reviewing and confirming current Supplier staff users of the web workflow and eligibility systems. The Supplier will notify EGID of employees no longer utilizing the system to terminate their access. New users will complete applications for access as needed.

D.5. Fraud and Abuse Investigations.

- D.5.1. 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.

D.6. Participant Eligibility.

- D.6.1. An individual's eligibility to participate is subject to all federal and state laws governing the OEIBA Program. EGID has the responsibility and authority to decide all questions of eligibility within the Program. Highlights of eligibility include:
 - D.6.1.1. 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.
 - D.6.1.2. Current employees may enroll in coverage the first day of the month following the month of employment or the date he/she 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 thirty (30) 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.
 - D.6.1.3. Coverage for newborn dependents will be effective the first of the birth month. The member may enroll 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. For members who choose not to add the newborn within thirty (30) days of the birth event, the Supplier will handle expenses of the newborn limited coverage in accordance with State law.
 - D.6.1.4. 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 administration of eligibility, 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.
- D.6.2. 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 preceding the Plan Year to which the service area applies.
- D.6.3. 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.
- D.6.4. Additional eligibility/enrollment requirements apply to plans for Medicare-eligible participants. These include:

- D.6.4.1. Eligibility for MAPD is limited to EGID/Medicare eligible former employees and their eligible dependents.
- D.6.4.2. Eligible EGID former employees with their covered dependents:
 - D.6.4.2.1. 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. Failure to maintain continuous health insurance coverage through the OEIBA Program shall result in permanent loss of eligibility for coverage under the Program.
 - D.6.4.2.2. Those who are not enrolled when initially eligible or within thirty (30) days of a mid-year qualifying event cannot add coverage.
 - D.6.4.2.3. Cannot add health coverage that was not elected at separation from active employment.
- D.6.4.3. Members must enroll in an OEIBA Program Medicare plan upon turning age sixty-five (65) or attaining early eligibility for Medicare, as permitted by federal guidelines.
- D.6.4.4. **Split Coverage.** When there is a retiree situation where the primary and the dependent(s) are not both Medicare eligible:
 - D.6.4.4.1. So long as there is a dependent relationship, both individuals must be on plans offered through the same Supplier through the OEIBA Program.
 - D.6.4.4.2. The Medicare eligible member is enrolled in the Supplier's MAPD/Medicare Supplement and the other covered individual is enrolled in the commercial offering from the same Supplier with the appropriate non-Medicare rate applied.
- D.6.4.5. A change from one insurance carrier to another may be permitted in the following circumstances:
 - D.6.4.5.1. During Option Period elections (historically October 15 to December 7) to be effective January 1 of the proximate Plan Year.
 - D.6.4.5.2. Changes in service areas.
 - D.6.4.5.3. At the time an individual becomes Medicare primary in accordance with CMS requirements or when CMS approves the change. This does not apply to a spouse or dependent becoming Medicare eligible after the primary member has enrolled in Medicare coverage. Refer to OEIBA Program materials for more detailed eligibility at <https://oklahoma.gov/omes/divisions/employees-group-insurance-division.html>.

Exception: split coverage rules apply.
- D.6.4.6. As required by CMS and applicable federal regulations, the MAPD shall provide Prescription Drug Benefit Creditable Coverage Notices to all its MAPD participants and affected persons.

D.7. Annual Deficiency Report.

- D.7.1. At its discretion, EGID may draft and issue a periodic report to Central Purchasing detailing instances of each of the HMO, MAPD and MSP Commercial Carriers failing to uphold their contractual responsibilities.

D.8. Marketing and Communications Guidelines.

- D.8.1. **Failure to abide by marketing and communication guidelines may result in one (1) or more of the following consequences:**
 - D.8.1.1. The Supplier being barred from accepting new enrollees for the balance of this contract.
 - D.8.1.2. The Supplier being barred from accepting new enrollees for the contract immediately succeeding this contract.
 - D.8.1.3. The Supplier being deemed ineligible from bidding in subsequent RFPs for the OEIBA Program.

- D.8.2. Approval.** Each Supplier must receive approval for its marketing and communications plan with EGID **prior to distribution** to employees. EGID reserves 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 Exhibit 38. 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. Suppliers must request and receive advertising approval each Plan Year.
- D.8.3. Name Change.** In the event that a change in name of the Supplier occurs, the change must be communicated to EGID by the designated print deadlines (typically at the end of August preceding the Plan Year to which the plan design applies) to be included in the Option Period print materials for the specified plan year. Plan design name changes are not allowed for the duration of the contract.
- D.8.4. Option Period Activities.** 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. This does not prohibit plans from sending materials to its current members.
- D.8.5. Network Changes.** 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.
- D.8.6. Training of Coordinators.** 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 or Annual Option Period Meetings. All those meetings shall be specified and authorized by EGID or otherwise specified in this RFP.
- D.8.7. Encouraged Marketing and Communications Activities.** The following is encouraged:
- D.8.7.1.** Attendance at health fairs and employer sponsored meetings throughout the year is strongly encouraged.
 - D.8.7.2.** Post-election enrollment follow-ups are allowed.
- D.8.8. Prohibited Marketing and Communications Activities.** The following is not permitted:
- D.8.8.1.** 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. Plan benefit information for members and giveaway items of nominal value (such as eyeglass cleaning cloths, etc.) may be made available for distribution at EGID-sponsored events with/without the company representative present.
 - D.8.8.2.** 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 Compliance of the request. Claim information will only be released with EGID approval. Suppliers should not attend, create, or hold any meetings

with employer groups unless invited by EGID or approval has been received from the EGID Director of Compliance.

- D.8.8.3.** 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.
- D.8.8.4.** 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. This does not include materials handed out at health fairs and employer-sponsored employee meetings and events.
- D.8.8.5.** Presentations by Suppliers during employee meetings for current state, education, county and local government employees unless pre-approved by EGID and as permitted by law.
- D.8.8.6.** 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."

D.8.9. Member Materials. Supplier shall be responsible for the following:

- D.8.9.1.** Each Supplier must develop a comprehensive member handbook, which shall be available no later than January 1 of the Plan Year. 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 OEIBA Program and benefits covered in this RFP.
- D.8.9.2.** Suppliers shall provide an online listing of network providers which shall be updated at least weekly and made available to plan participants twenty-four (24) hours a day, seven (7) days a week. Those physicians accepting new enrollees must be clearly identified.
- D.8.9.3.** Member identification cards will be mailed at the Supplier's expense directly to each member's home so that the card(s) is received no later than December 31 preceding the Plan Year to which the card applies, or no more than two (2) weeks following delivery of new member enrollment data from EGID. ID cards are to reflect accurate information and cannot contain the member's Social Security number (SSN) unless the number has been encrypted in an alpha and/or numerical method so it is not distinguishable. The member's account number should not be the same as their SSN in the Supplier's system.
- D.8.9.4.** The Supplier is required to provide a written status report regarding the distribution of ID cards to the Director of Compliance no later than December 15 of each Plan Year. Status information includes but is not limited to Supplier name, number of member ID cards generated, beginning and ending dates for mailing of cards, and the latest date expected for members to receive cards.
- D.8.9.5.** Summary of Benefits and Coverage for the Supplier's approved HMO plan is due to EGID no later than 5:00 p.m. Central Time, October 1 preceding the Plan Year to which the benefits apply.

D.9. Malpractice Liability.

- D.9.1.** 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.

D.10. Provider Discussion of Treatment Options and Reimbursements.

- D.10.1.** 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.

D.11. Prohibited Limitations and Exclusions.

D.11.1. The Supplier agrees to waive all pre-existing condition limitations and evidence of insurability requirements for all beneficiaries covered under the OEIBA Program.

D.12. Reinsurance.

D.12.1. 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 other agencies of the State of Oklahoma with regulatory authority over the Supplier.

D.13. Internal Grievance Procedures.

D.13.1. The Supplier must establish and operate an internal member grievance procedure pursuant to the requirements of the Oklahoma Insurance Department as appropriate.

D.14. Affordable Care Act Rebate Issues.

D.14.1. 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.

D.15. Dependents Residing at a Different Address.

D.15.1. 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.

D.16. Family Units with combined Medicare/non-Medicare Coverage.

D.16.1. Excluding the one national MAPD standalone plan, if a Bidder provides a Medicare plan, such Bidder must be able to provide service to members and dependents when the primary member is eligible for Medicare but the dependent 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.

D.17. Consolidated Omnibus Budget Reconciliation Act (COBRA).

D.17.1. The monthly rates for which eligible participants under COBRA are charged for plan coverage will include the various loadings (e.g., administrative, reserves, etc.) also charged current 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 (2%) administrative fee will not be assessed on any PDP.

D.18. Supplier Operating Staff.

D.18.1. The Bidder must have sufficient operating staff to comply with all requirements and standards described in this RFP. At a minimum, the Bidder must identify qualified staff in the following areas.

D.18.1.1. Executive management with clear oversight authority for all other functions

D.18.1.2. Medical director's office

D.18.1.3. Accounting and budgeting function

D.18.1.4. Member services function

D.18.1.5. Provider services function

D.18.1.6. Medical management function, including quality assurance and utilization review

D.18.1.7. Internal complaint resolution function

D.18.1.8. Claims processing function

D.18.1.9. Management information system. This can be addressed in various methods such as how technology is utilized to ensure and monitor healthcare compliance, methods of targeting services areas, etc.

D.18.1.10. 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.

D.19. Systems and Eligibility.

D.19.1. During the length of the contract, the Bidder agrees it shall provide no less than thirty (30) days' notice to EGID prior to performing changes, fixes, modifications and enhancements that may affect the exchange of eligibility or any other shared business process. The Bidder 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.

D.20. Service Enhancements.

D.20.1. Bidders 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 Bidder'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; Dental; or Vision.

D.21. Claims Experience.

D.21.1. Bidders who are currently under contract with the State for Plan Year 2025 must complete Exhibits 6-8 and Exhibit 16. Bidders who are not under contract with the State for Plan Year 2025 must provide the information contained in Exhibit 15 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 Bidder shall be ineligible to bid on this RFP.

D.22. Reporting.

D.22.1. 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.

D.22.2. The Supplier shall deliver all reports listed in Exhibit 27 in the exact format, frequency, timeframe and to the intended recipient noted in the list or as otherwise instructed by EGID. The reports shall include subgroups, which at a minimum are current employees, COBRA, retirees not eligible for Medicare, and retirees eligible for Medicare. A verification procedure will be used for compliance

D.22.3. The OEIBB is interested in increased OEIBA Program transparency to the public. Supplier agrees to allow the OEIBB to make HMO and Medicare **aggregate summary** claims data public at its quarterly Board meetings. This information is not identifiable by Supplier.

D.22.4. The Supplier shall deliver Exhibit 37B upon request for individual employer data requests, on an incurred basis. Refer to Exhibit 37A for detailed instructions. Data will be provided to the employer in aggregate so the individual health plan will not be identified. The template represents the maximum amount of information that will be requested. In all cases, the Supplier will only be asked for the minimum amount of data necessary to meet the employer's request. Often, this will be no more than the "Medical and Pharmacy" section of the tab labeled "Experience" along with the same year section of the tab labeled "Request #1a".

D.22.5. Failure to Abide by Reporting Guidelines.

D.22.5.1. Suppliers meeting the requirements outlined in 36 O.S. 6901 et seq. are required to submit the minimum reporting requirements as specified within this RFP (Exhibit 27). The specifications

made in prior years shall not serve as precedent for specifications that may be specified in this RFP. Failure to abide by reporting guidelines may result in one or more of the following consequences.

- D.22.5.1.1. The Supplier being barred from accepting new enrollees for the balance of this contract.
- D.22.5.1.2. The Supplier being barred from accepting new enrollees for the contract immediately succeeding this contract.
- D.22.5.1.3. The Supplier being deemed ineligible from bidding in subsequent RFPs for the OEIBA Program.
- D.22.5.2. In addition to the benefits specified within this RFP, Suppliers must provide any benefits and reporting otherwise required by state or federal law.

D.23. Implementation.

- D.23.1. Suppliers may be required to meet with EGID to ensure smooth transition for the upcoming plan year.
- D.23.2. 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 of the Plan Year to which the Supplier's plan(s) applies. Suppliers will receive specific instructions regarding this manual material after the award of contract by EGID. One (1) electronic copy of the administrative reference manual will be provided to EGID.
- D.23.3. Pharmacy Network Download. Suppliers must have a process for Option Period data to be downloaded to all pharmacy networks no later than December 31 preceding the Plan Year for which the network applies. This process could include downloading pharmacy benefit information to a Supplier's pharmacy benefits manager.
- D.23.4. Readiness Reviews. OMES/CP and EGID may annually conduct scheduled meetings to the Supplier for purposes of testing the readiness of the Supplier.
 - D.23.4.1. Submission of a proposal in response to this RFP commits the bidding Supplier to cooperate and participate in these reviews, as required by EGID.
 - D.23.4.2. These reviews will take no more than one (1) business 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.
 - D.23.4.3. Details of the schedules, agendas, and content of the readiness review(s) will be distributed to the contracting Suppliers in a timely manner.
 - D.23.4.4. 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.24. Annual Review.

- D.24.1. After the completion of each Calendar Year, the Supplier must be available upon request to meet with OMES/CP and EGID personnel and consultants to review the Plan's claim experience. The review topics may include, but not be limited to, the following:
 - D.24.1.1. Medical management initiatives.
 - D.24.1.2. Summary by reporting division – Displays Claims, CMS Revenue, and Premiums paid by Programs delineated by State, Local Government and Local Education Employers.
 - D.24.1.3. Claimant characteristics (demographics).

- D.24.1.4. Experience by diagnostic grouping, type of service, and claimant cost by age/gender.
- D.24.1.5. Large claims report (>\$25,000).
- D.24.1.6. Plan utilization compared to Supplier's book of business report.
- D.24.2. For each contract renewal, each Supplier shall offer the plan in place at the time of the renewal request, plus it may offer an alternative plan design. Supplier is required to provide OMES/CP and EGID any requested updated documentation found in this Solicitation for purposes of the renewal.

SPECIFICATIONS APPLYING TO HMO PROPOSAL

(EXCLUDING MEDICARE SUPPLEMENT OR MAPD LINES OF BUSINESS)

D.25. Supplier Identification. In the event the Supplier's designated personnel changes, the Supplier shall notify OMES/CP and EGID Director of Compliance immediately in writing.

D.25.1. EGID Director of Compliance contact information:

D.25.1.1. EGID Compliance/HIPAA Privacy Officer

P.O. Box 11137

Oklahoma City, OK 73136

EGIDVendorReporting@omes.ok.gov

D.26. Financial Stability and Standing.

D.26.1. EGID reserves the right to audit (or designate an independent third-party to audit) the selected medical plan at any time during and up to three (3) years following the termination of the Contract/Administrative Agreement (with prior written authorization).

D.26.2. The Supplier agrees to be available for reasonable inquiry by EGID regarding financial statements.

D.26.3. 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.

D.27. Member Services Telephone Assistance.

D.27.1. The Supplier will provide telephone assistance through a toll-free telephone number by customer service representatives regarding plan benefits and network service inquiries/problem resolution during normal business hours.

D.27.2. The Supplier's customer service telephone response performance must meet the below standards for each month of each Plan Year:

D.27.2.1. The Supplier shall answer at least eighty percent (80%) of all calls in thirty (30) seconds or less.

D.27.2.2. The call abandonment rate shall not exceed five percent (5%) of the total number of calls per month.

D.27.3. 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.

D.27.4. Member Service's telephone numbers must be accessible from the Supplier's website. If there is a network specific requirement, there must be an online directory. However, if a potential or current member is unable to access the online directory, Supplier must be able to provide printed material within a (48) forty-eight-hour turnaround via mail at no cost to employees or retirees.

D.28. Member Satisfaction.

D.28.1. Satisfaction Surveys. For Plan Year 2026 and for renewal year, the Supplier shall conduct a member satisfaction survey at least annually that compiles and analyzes its survey results for submission. Refer to Attachment 30. Supplier may leverage existing surveys to address these focus areas so long as all required areas are addressed.

D.29. Benefit Plans for Participants Living Out of State.

D.29.1. The Supplier may provide a plan of benefits for those participants who live outside the State of Oklahoma. A census report is available as Exhibit 24 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.

D.30. Prohibition on Direct Member Billing.

D.30.1. The Supplier must have procedures in place which prevent direct member billing (balance billing) for covered services during the plan year of this solicitation.

D.31. Section 125.

D.31.1. An Internal Revenue Code, Section 125 Cafeteria plan with a Flexible Spending Account (FSA) for medical reimbursement is offered to Oklahoma State education and local government current 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. EGID requests that the Supplier shall interface with the debit card company and provide paid claims utilization on a weekly basis. Exhibit 26 is the file format required by the current debit card company.

D.32. Provider Network Requirements.

D.32.1. 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.

D.32.2. 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 Exhibit 4. No less than fifty percent (50%) of the 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.

D.32.3. 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.

D.32.4. 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. 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 Compliance.

D.32.5. Where the Supplier contracts with health care practitioners to render services, such contracting arrangements must promote quality and cost-effective care by ensuring that:

D.32.5.1. Every enrollee has a PCP, and the PCP coordinates all of the enrollee's comprehensive health care; and

D.32.5.2. Practitioners' agreements require them to observe the plan's practice guide and/or to share the plan's financial risk.

- D.32.6. 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.
- D.32.7. Eligible dependents residing at an address different from the employee's address may select a PCP in the service area covering the dependent's address within the State of Oklahoma. The Supplier will provide all eligible services outside the State of Oklahoma for covered dependents.

D.33. Supplier's Provider Contracting.

- D.33.1. The Supplier must offer eligible services outside the State of Oklahoma to eligible dependents residing at an address different from the employee's address.
- D.33.2. The Supplier 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.
 - D.33.2.1. As part of this process, the Supplier must provide 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.

D.34. Standardized Service Areas and Access Standards.

- D.34.1. 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.

D.35. Medical Quality Assurance.

- D.35.1. All contracting Suppliers must include a description of the grievance procedures in their member handbooks.

D.36. Member Materials.

- D.36.1. **Membership I.D. card.** The card cannot contain employee's Social Security number (SSN), unless encrypted in an alpha and/or numerical method so that it is not distinguishable. The member's account number should not be the same as their SSN in the Supplier's system.
- D.36.2. The Supplier shall furnish membership materials that describe the HMO Plan benefits offered to enrollees in a PowerPoint deck format for Option Period presentation(s) at the request of EGID. (Exhibit 38)
- D.36.3. The Supplier shall furnish membership materials that describe the MSP and/or MAPD Plan benefits offered to enrollees in a PowerPoint deck format for Option Period presentation(s) at the request of EGID. (Exhibit 38)
- D.36.4. Suppliers may use the official EGID logo **on member ID cards only**. Suppliers must request the official logo from EGID; otherwise, member ID cards with any state logo or the State seal will be rejected.

D.37. Suppliers offering options to the pre-Medicare population are required to meet and offer the benefits and copayments as outlined in Exhibit 4.

- D.37.1. Preventive services must conform to federal preventive care guidelines. EGID may also request additional plans such as a Point of Service, Value Based Networks, or Accountable Care Organization option.

SPECIFICATIONS APPLYING TO MEDICARE SUPPLEMENT PLAN PROPOSAL

D.38. Medicare Supplement Requirements.

- D.38.1. In accordance with State of Oklahoma statutes, Suppliers must provide a Medicare Supplement plan (MSP) 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 Exhibit 12. Terms relating to Medicare plans are not negotiable.

- D.38.2.** An MSP is required to have a level of benefits that is equivalent to or exceeds in total Medicare Plan G. It must also include a pharmacy component which is actuarially equivalent to the HealthChoice SilverScript High Option Medicare Supplement Plan which is an Employer Group Waiver Plan (EGWP) with a Wrap setup. In addition, the HealthChoice Medicare Supplement Plan has two (2) enhancements, which are coverage for Hospice Care and Foreign Travel.
- D.38.3.** The Medicare Supplement Plan shall include a Medicare Part D Prescription Drug Plan (PDP), provide creditable coverage and is subject to the following:
 - D.38.3.1.** 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. See Exhibit 13.
 - D.38.3.2.** 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 Exhibit 28.
 - D.38.3.3.** The PDP must provide a monthly full file showing everyone covered in the PDP. Required fields for this report are listed in Exhibit 28.
 - D.38.3.4.** 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.

D.39. Membership Materials.

- D.39.1.** Membership I.D. card. The card cannot contain a member's Social Security number (SSN), unless encrypted in an alpha and/or numerical method so that it is not distinguishable. The member's account number should not be the same as their SSN in the Supplier's system.
- D.39.2.** The Supplier shall furnish membership materials that describe the Medicare supplement plan benefits offered to enrollees in a PowerPoint deck format for Option Period presentation(s) at the request of EGID. Refer to Exhibit 38.

SPECIFICATIONS APPLYING TO MAPD PROPOSAL

D.40. MAPD Requirements.

- D.40.1.** The Bidder may submit an MAPD HMO with an HMO bid. Alternatively, Bidders may submit a standalone national MAPD bid. Bidders may not submit bids for both, and only one standalone national MAPD will be selected.
- D.40.2.** The Bidder shall complete Exhibit 9 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.
- D.40.3.** All MAPD plans shall include a Medicare Part D Prescription Drug Plan (PDP), provide creditable coverage and are subject to the following.

D.40.3.1. 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. Refer to Exhibit 10.

D.40.3.2. 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 Exhibit 28.

D.40.3.3. The PDP must provide a monthly full file showing everyone covered in the PDP. Required fields for this report are listed in Exhibit 28.

D.40.3.4. 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.

D.40.4. 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 functions outlined in the Bidder Instructions.

D.41. Financial Standing. 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.

D.42. Additional Marketing Guidelines Specific to MAPD Plans. The following additional marketing guidelines are specific to MAPD plans:

D.42.1. 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.

D.42.2. 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.

D.42.3. The MAPD must schedule representatives (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.

D.42.4. 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.

D.43. Member Services Telephone Assistance

D.43.1. 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.

D.43.2. The Supplier's customer service telephone response performance must meet or exceed the following standards for each month of each Plan Year:

D.43.2.1. The Supplier shall answer at least eighty percent (80%) of all calls in thirty (30) seconds or less.

D.43.2.2. The call abandonment rate shall not exceed five percent (5%) of the total number of calls per month.

D.43.3. 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.

D.43.4. Member service telephone numbers must be accessible from the Supplier's website. If there is a network specific requirement, there must be an online directory. However, if a potential or current member is unable to access the online directory, Supplier must be able to provide printed material within a forty-eight (48) hour turnaround via mail at no cost to the member.

D.44. Member Materials.

D.44.1. Membership I.D. card. The card cannot contain employee's Social Security number (SSN), unless encrypted in an alpha and/or numerical method so that it is not distinguishable. The member's account number should not be the same as their SSN in the Supplier's system.

D.44.2. Membership materials- The Supplier shall furnish membership materials that describe the MAPD Plan benefits offered to enrollees in a format not to exceed two (2) 8.5" x 11" pages or up to five (5) PowerPoint slides for enrollment guides or Option Period presentation(s) within three (3) business days of a request from EGID. (Exhibit 38).

D.45. Member Satisfaction.

D.45.1. Satisfaction Surveys. For Plan Year 2026 and for renewal year, the Supplier shall conduct a member satisfaction survey at least annually that compiles and analyzes its survey results for submission. Refer to Attachment 30. Supplier may leverage existing surveys to address these focus areas so long as all required areas are addressed.

D.46. MAPD Monthly Premium. All rates set forth shall be for Medicare-eligible members only.

D.47. 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. Refer to Exhibit 10.

PREMIUMS

E. PREMIUM QUOTES

E.1. Exhibits 5, 10 and 13 premium quote sheets must be submitted with the bid response.

E.2. Supplier must submit return renewal rates by the first business day in May preceding the plan year requested.

E.3. The State of Oklahoma offers four (4) coverage tiers for both eligible current and eligible former employees and dependents. Bidder must provide rates for each classification independently of the other classifications; for example, the rate quoted for the spouse should not include the rate quoted for the employee. Rate quotes for coverage levels other than the four (4) levels specified as member, spouse, child, and children will not be considered. (Exhibit 5.)

E.4. Each Bidder 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.

E.5. Bidders must provide one state-wide premium quote for all service areas.

E.6. The premium rates shall not be excessive, inadequate or unfairly discriminatory.

- E.7.** The rate sheet must be accompanied by a signed statement by the Bidder'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.
- E.8.** Bidders may provide an explanation of the service areas covered by the premium quote.
- E.9.** Bidders 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.
- E.10.** Submission of confidential proposed rates must be handled in accordance with procedures stated in Bidder Instructions.

E.11. Current employees and Non-Medicare Retiree Quotes.

E.11.1. Pre-Medicare HMO Plans. The State of Oklahoma offers four (4) coverage tiers for both eligible current and eligible former employees and their eligible dependents. Rates must be quoted for all four (4) levels as specified below. Rate quotes for coverage levels other than the four (4) levels specified below shall not be considered. The Bidder will be required to describe the methodology for developing the rates. The four (4) levels of coverage are as follows:

E.11.1.1. Employee Only

E.11.1.2. Spouse

E.11.1.3. One Child

E.11.1.4. Two (2) or More Children

- E.11.2.** The rates shall be submitted in Exhibit 5. The quotes shall directly correspond to the plan design(s)/benefits specified in Exhibit 4.
- E.11.3.** The rate sheet shall include the plan name and the per-covered individual per month premium (Exhibit 5).
- E.11.4.** Each Bidder must bid on all categories, including both eligible current and eligible former employees and their eligible dependents.
- E.11.5.** In setting health insurance premiums for current employees and for retirees under sixty-five (65) years of age, the Bidders shall set the monthly premium for current employees to be equal to the premium for retirees under sixty-five (65) years of age.
- E.11.6.** For accounting purposes related to biweekly payrolls, any cents quoted in the Bidder's rates shall be divisible by two (2).

E.11.6.1. The rates shall be for the Plan Year 2026 (January 1, 2026 through December 31, 2026).

E.11.6.2. Rates will be reviewed for excessive pricing per Exhibit 26 OEIBB Commercial Carrier Policy.

E.12. Medicare Supplement Quotes.

- E.12.1.** The rate sheet shall include the plan name and the per-covered individual per month premium (Exhibit 13).
- E.12.2.** The MSP rates shall be on a per-covered individual per month basis for the Plan Year 2026 (January 1, 2026 through December 31, 2026).
- E.12.3.** All rates set forth shall be for Medicare-eligible members only.
- E.12.4.** The rates shall be submitted in Exhibit 13. Submission of confidential proposed rates must be handled in accordance with procedures stated in Bidder Instructions of this RFP. The quotes shall directly correspond to the plan design(s)/benefits specified in Exhibit 12.

E.13. MAPD Quotes.

- E.13.1. The rate sheet shall include the plan name and the per-covered individual per month premium (Exhibit 10).
- E.13.2. The MAPD shall submit rates on a per-covered individual per month basis for the Plan Year 2026 (January 1, 2026 through December 31, 2026).
- E.13.3. All rates set forth shall be for Medicare-eligible members only.
- E.13.4. The rates shall be submitted in Exhibit 10. Submission of confidential proposed rates must be handled in accordance with procedures stated in Bidder Instructions of this RFP. The quotes shall directly correspond to the plan design(s)/benefits specified in Exhibit 9.

E.14. Premium Quotes – MAPD and MSP Only.

- E.14.1. In accordance with federal requirements, these rates are based upon per-covered individual.
- E.14.2. The renewal option due date for final MAPD and MSP rates will be the later of:
 - E.14.2.1. August 1 of the year preceding the Plan Year; or
 - E.14.2.2. Two (2) business days following CMS deadlines for rebate allocation calculations based upon the release of the CMS national average monthly bid amounts.

E.15. Risk Adjustments.

- E.15.1. 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.
- E.15.2. This risk adjustment will be calculated for each health care choice available to affected members based on the actual enrollment (active and non-Medicare retirees) as of the first day of the contract year and will remain constant for the entire contract year.
- E.15.3. 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.
- E.15.4. 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. (Refer to Exhibit 26.)

E.16. Administrative Assessment.

- E.16.1. 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 Plan Year 2026 shall be \$4.477 Per Member Per Month (PMPM) rate collected by EGID for each plan. This fee is determined annually by EGID and is subject to change either up or down in pricing.
- E.16.2. This fee is determined annually by EGID and is subject to change either up or down. In the event of renewals, any change in the administrative assessment will be communicated to the Supplier no later than May 1st of the year preceding the following Plan Year.

F. BIDDER RESPONSES

- F.1. All Bidders must submit Attachment E with complete and accurate information with bid response.

G. SOLICITATION EXHIBITS

Reports, Templates and Eligibility Formats to be utilized during the contract period.

- a. Exhibit 1: Standardized Service Areas*
- b. Exhibit 2: Geo-Access Report*
- c. Exhibit 3: Ratio of PCPs to Members*
- d. Exhibit 4: HMO Plan Design*
- e. Exhibit 5: HMO Premium Quote*
- f. Exhibit 6: HMO Rate Development*
- g. Exhibit 7: Rate Development Supporting Data – Active Employees*
- h. Exhibit 8: Rate Development Supporting Data – Early Retiree Employees*
- i. Exhibit 9: MAPD Benefits Summary*
- j. Exhibit 10: MAPD Premium Rate and LIS Quote*
- k. Exhibit 11: MAPD Rate Setting*
- l. Exhibit 12: MSP Benefits Summary*
- m. Exhibit 13: MSP Premium Rate*
- n. Exhibit 14: Bid Submission Network Detailed Reports*
- o. Exhibit 15: New Supplier Only – Aggregate Utilization Experience Data*
- p. Exhibit 16: Large Claims Report for 2023 and 2024*
- q. Exhibit 17: Audited Financial Statements*
- r. Exhibit 18: License(s)*
- s. Exhibit 19: Actuary Certification*
- t. Exhibit 20 Member I.D Card Example*
- u. Exhibit 21 Organizational Chart and Brand Logos*
- v. Exhibit 22: Satisfaction Surveys*
- w. Exhibit 23: CAHPS Survey MAPD*
- x. Exhibit 24: OEIBA Program Census Data
- y. Exhibit 25: Carrier Eligibility Companion Guide
- z. Exhibit 26: OEIBB Commercial Carrier Policy
- aa. Exhibit 27: Minimum Required Reporting List
- bb. Exhibit 28: MAPD File and Changes Reports
- cc. Exhibit 29: Premium Discrepancy Reports
- dd. Exhibit 30: Member Services Reports
- ee. Exhibit 31: HIPAA, FWA, and Grievance Reports
- ff. Exhibit 32: HMO Utilization Reports
- gg. Exhibit 33: Network Changes Summary
- hh. Exhibit 34: Network Detailed Reports
- ii. Exhibit 35: HMO Detailed Utilization Reports
- jj. Exhibit 36: MAPD Detailed Utilization Reports
- kk. Exhibit 37A: Individual Employer Experience Reports Instructions
- ll. Exhibit 37B: Individual Employer Experience Reports
- mm. Exhibit 38: Advertising Approval Request Form

*Required for Bid Submission

STATE OF OKLAHOMA NON-NEGOTIABLE GENERAL TERMS

In addition to other terms contained in an applicable Contract document, Supplier and State agree to the following General Terms:

H. SCOPE AND CONTRACT RENEWAL

- H.1.** Supplier may not add products or services to its offerings under the Contract without the State's prior written approval. Such request may require a competitive bid of the additional products or services. If the need arises for goods or services outside the scope of the Contract, Supplier shall contact the State.
- H.2.** At no time during the performance of the Contract shall the Supplier have the authority to obligate any Customer for payment for any products or services (a) when a corresponding encumbering document is not signed or (b) over and above an awarded Contract amount. Likewise, Supplier is not entitled to compensation for a product or service provided by or on behalf of Supplier that is neither requested nor accepted as satisfactory.
- H.3.** If applicable, prior to any Contract renewal, the State shall subjectively consider the value of the Contract to the State, the Supplier's performance under the Contract, and shall review certain other factors, including but not limited to the: a) terms and conditions of Contract documents to determine validity with current State and other applicable statutes and rules; b) current pricing and discounts offered by Supplier; and c) current products, services and support offered by Supplier. If the State determines changes to the Contract are required as a condition precedent to renewal, the State and Supplier will cooperate in good faith to evidence such required changes in an Amendment. Further, any request for a price increase in connection with a renewal or otherwise will be conditioned on the Supplier providing appropriate documentation supporting the request.
- H.4.** Upon mutual agreement, the Parties may extend the Contract for ninety (90) days beyond a final renewal term. The Parties may to the extent allowable by law, choose to exercise subsequent ninety (90) day extensions.
- H.5.** Supplier understands that supplier registration expires annually and, pursuant to OAC 260:115-3-3, Supplier shall maintain its supplier registration with the State as a precondition to a renewal of the Contract.

I. CONTRACT EFFECTIVENESS

- I.1.** Unless specifically agreed in writing otherwise, the Contract is effective upon the date last signed by the parties. Supplier shall not commence work, commit funds, incur costs, or in any way act to obligate the State until a proper purchase order has been issued.
- I.2.** Any Contract document shall be legibly written in ink or typed. All Contract transactions, and any Contract document related thereto, may be conducted by electronic means pursuant to the Oklahoma Uniform Electronic Transactions Act.

J. MODIFICATION OF CONTRACT TERMS AND CONTRACT DOCUMENTS

- J.1.** The Contract may only be modified, amended, or expanded by an Amendment. Any change to the Contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials made unilaterally by the Supplier, is a material breach of the Contract. Unless otherwise specified by applicable law or rules, such changes, including without limitation, any unauthorized written Contract modification, shall be void and without effect and the Supplier shall not be entitled to any claim under the Contract based on those changes. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in the Contract.
- J.2.** Any additional terms on an ordering document provided by Supplier are of no effect and are void unless mutually executed. OMES bears no liability for performance, payment or failure thereof by the Supplier or by a Customer other than OMES in connection with an Acquisition.

- J.3.** Except for information deemed confidential by the State pursuant to applicable law, rule, regulation, or policy, the parties agree Contract terms are not confidential and are disclosable without further approval of or notice to Supplier.
- J.4.** Unless mutually agreed to in writing by the State of Oklahoma by and through the Office of Management and Enterprise Services, no Contract document or other terms and conditions or clauses, including via a hyperlink or uniform resource locator, shall supersede or conflict with the terms of this Contract or expand the State's or Customer's liability or reduce the rights of Customer or the State.
- J.5.** To the extent any term or condition in any Contract document, including via a hyperlink or uniform resource locator, conflicts with an applicable Oklahoma and/or United States law or regulation, such term or condition is void and unenforceable. By executing any Contract document which contains a conflicting term or condition, the State or Customer makes no representation or warranty regarding the enforceability of such term or condition and the State or Customer does not waive the applicable Oklahoma and/or United States law or regulation which conflicts with the term or condition.

K. PRICING

- K.1.** Pursuant to 68 O.S. §§ 1352, 1356, and 1404, State agencies are exempt from the assessment of State sales, use, and excise taxes. Further, State agencies and political subdivisions of the State are exempt from Federal Excise Taxes pursuant to Title 26 of the United States Code. Any taxes of any nature whatsoever payable by the Supplier shall not be reimbursed.
- K.2.** Pursuant to 74 O.S. §85.40, all travel expenses of Supplier must be included in the total Acquisition price.
- K.3.** The price of a product offered under the Contract shall include and Supplier shall prepay all shipping, packaging, delivery and handling fees. All product deliveries will be free on board Customer's Destination. No additional fees shall be charged by Supplier for standard shipping and handling. If Customer requests expedited or special delivery, Customer may be responsible for any charges for expedited or special delivery
- K.4.** Any product to be delivered pursuant to the Contract shall be subject to final inspection and acceptance by the Customer at Destination. The Customer assumes no responsibility for a product until accepted by the Customer. Title and risk of loss or damage to a product shall be the responsibility of the Supplier until accepted. The Supplier shall be responsible for filing, processing, and collecting any and all damage claims accruing prior to acceptance
- K.5.** Pursuant to OAC 260:115-9-1, payment for an Acquisition does not constitute final acceptance of the Acquisition. If subsequent inspection affirms that the Acquisition does not meet or exceed the specifications of the order or that the Acquisition has a latent defect, the Supplier shall be notified as soon as is reasonably practicable. The Supplier shall retrieve and replace the Acquisition at Supplier's expense or, if unable to replace, shall issue a refund to Customer. Refund under this section shall not be an exclusive remedy.

L. INVOICES AND PAYMENTS

- L.1.** The State requires that payment be made only after products have been provided and accepted or services rendered and accepted.
- L.2.** **SOME SECTIONS INTENTIONALLY OMITTED.**
- L.3.** For additional information regarding payment, refer to Attachment A Section D.2. Premium Accounting.

M. OKLAHOMA OPEN RECORDS ACT

- M.1.** Supplier acknowledges that all State agencies and certain other Customers are subject to the Oklahoma Open Records Act set forth at 51 O.S. §24A-1 et seq. Supplier also acknowledges that compliance with the Oklahoma Open Records Act and all opinions of the Oklahoma Attorney General concerning the Act is required. Customer may be provided access to Supplier Confidential Information. State agencies are subject to the Oklahoma Open Records Act and Supplier acknowledges information marked confidential information will be disclosed to the

extent permitted under the Open Records Act and in accordance with this section. Nothing herein is intended to waive the State Purchasing Director's authority under OAC 260:115-3-9 in connection with Bid information requested to be held confidential by a Bidder. Notwithstanding the foregoing, Supplier Confidential Information shall not include information that: (i) is or becomes generally known or available by public disclosure, commercial use or otherwise and is not in contravention of this Contract; (ii) is known and has been reduced to tangible form by the receiving party before the time of disclosure for the first time under this Contract and without other obligations of confidentiality; (iii) is independently developed without the use of any of Supplier Confidential Information; (iv) is lawfully obtained from a third party (without any confidentiality obligation) who has the right to make such disclosure or (v) pricing provided to the State. In addition, the obligations in this section shall not apply to the extent that the applicable law or regulation requires disclosure of Supplier Confidential Information, provided that the Customer provides reasonable written notice, pursuant to Contract notice provisions, to the Supplier so that the Supplier may promptly seek a protective order or other appropriate remedy.

N. CONFLICT OF INTEREST

N.1. In addition to any requirement of law or of a professional code of ethics or conduct, the Supplier, its employees are required to disclose any outside activity or interest that conflicts or may conflict with the best interest of the State. Prompt disclosure is required under this section if the activity or interest is related, directly or indirectly, to any person or entity currently under contract with or seeking to do business with the State, its employees or any other third-party individual or entity awarded a contract with the State. Further, as long as the Supplier has an obligation under the Contract, any plan, preparation or engagement in any such activity or interest shall not occur without prior written approval of the State. Any conflict of interest shall, at the sole discretion of the State, be grounds for partial or whole termination of the Contract.

O. STATE SHALL NOT INDEMNIFY

O.1. The State of Oklahoma cannot lawfully agree to indemnify a private contractor. The credit of the State shall not be given, pledged, or loaned to any individual, company, corporation, or association, municipality, or political subdivision of the State pursuant to Oklahoma Constitution article 10, Section 15, OAC 260:115-7-32(k)(3)(A) and Attorney General Opinion 2012-18.

P. INDEMNIFICATION COORDINATION OF DEFENSE

P.1. In connection with indemnification obligations under the Contract, when a State agency is a named defendant in any filed or threatened lawsuit, the defense of the State agency shall be coordinated by the Attorney General of Oklahoma, or the Attorney General may authorize the Supplier to control the defense and any related settlement negotiations; provided, however, Supplier shall not agree to any settlement of claims against the State without obtaining advance written concurrence from the Attorney General. If the Attorney General does not authorize sole control of the defense and settlement negotiations to Supplier, Supplier shall have authorization to equally participate in any proceeding related to the indemnity obligation under the Contract and shall remain responsible to indemnify the applicable Indemnified Parties.

Q. TERMINATION FOR FUNDING INSUFFICIENCY

Q.1. Notwithstanding anything to the contrary in any Contract document, the State may terminate the Contract in whole or in part if funds sufficient to pay obligations under the Contract are not appropriated or received from an intended third-party funding source. In the event of such insufficiency, Supplier will be provided at least fifteen (15) calendar days' written notice of termination. Any partial termination of the Contract under this section shall not be construed as a waiver of, and shall not affect, the rights and obligations of any party regarding portions of the Contract that are not terminated. The determination by the State of insufficient funding shall be accepted by, and shall be final and binding on, the Supplier.

- Q.2.** Upon receipt of notice of a termination, Supplier shall immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice. If a purchase order or other payment mechanism has been issued and a product or service has been accepted as satisfactory prior to the effective date of termination, the termination does not relieve an obligation to pay for the product or service but there shall not be any liability for further payments ordinarily due under the Contract or for any damages or other amounts caused by or associated with such termination. Any amount paid to Supplier in the form of prepaid fees that are unused when the Contractor certain obligations are terminated shall be refunded.
- Q.3.** The State's exercise of its right to terminate the Contract under this section shall not be considered a default or breach under the Contract or relieve the Supplier of any liability for claims arising under the Contract.

R. SUSPENSION OF SUPPLIER

- R.1.** Supplier may be subject to Suspension without advance notice and may additionally be suspended from activities under the Contract if Supplier fails to comply with confidentiality, privacy, security, environmental or safety requirements applicable to Supplier's performance or obligations under the Contract.
- R.2.** Upon receipt of a notice pursuant to this section, Supplier shall immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice. If a purchase order or other payment mechanism has been issued and a product or service has been accepted as satisfactory prior to receipt of notice by Supplier, the Suspension does not relieve an obligation to pay for the product or service but there shall not be any liability for further payments ordinarily due under the Contract during a period of Suspension or suspended activity or for any damages or other amounts caused by or associated with such Suspension or suspended activity. A right exercised under this section shall not be an exclusive remedy but shall be in addition to any other rights and remedies provided for by law. Any amount paid to Supplier in the form of prepaid fees attributable to a period of Suspension or suspended activity shall be refunded.
- R.3.** Such Suspension may be removed, or suspended activity may resume, at the earlier of such time as a formal notice is issued that authorizes the resumption of performance under the Contract or at such time as a purchase order or other appropriate encumbrance document is issued. This subsection is not intended to operate as an affirmative statement that such resumption will occur.

S. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS

- S.1.** The certification made by Supplier with respect to Debarment, Suspension, certain indictments, convictions, civil judgments and terminated public contracts is a material representation of fact upon which reliance was placed when entering into the Contract. A determination that Supplier knowingly rendered an erroneous certification, in addition to other available remedies, may result in whole or partial termination of the Contract for Supplier's default. Additionally, Supplier shall promptly provide written notice to the State Purchasing Director if the certification becomes erroneous due to changed circumstances.

T. CERTIFICATION REGARDING STATE EMPLOYEES PROHIBITION FROM FULFILLING SERVICES

- T.1.** Pursuant to 74 O.S. § 85.42, the Supplier certifies that no person involved in any manner in development of the Contract employed by the State shall be employed to fulfill any services provided under the Contract.

U. NOTICES

- U.1.** All notices, approvals or requests allowed or required by the terms of any Contract shall be in writing, reference the Contract with specificity and deemed delivered upon receipt or upon refusal of the intended party to accept receipt of the notice. Notice information may be updated in writing to the other party as necessary.

In addition to other notice requirements in the Contract and the designated Supplier contact provided in a successful Bid (**EGID Director of Compliance must be notified at EGIDVendorReporting@omes.ok.gov**). Refer to Attachment A Section D.3. Significant Events), notices shall be sent to the State at the below addresses:

If sent to the State:

State Purchasing Director
2401 North Lincoln Blvd., Second Floor
Oklahoma City, Oklahoma 73105

With a copy, which shall not constitute notice, to:

Purchasing Division Deputy General Counsel
2401 North Lincoln Blvd., Second Floor
Oklahoma City, Oklahoma 73105

V. MISCELLANEOUS

V.1. Choice of Law and Venue

V.1.1. Any claim, dispute, or litigation relating to the Contract documents, in the singular or in the aggregate, shall be governed by the laws of the State of Oklahoma without regard to application of choice of law principles. Pursuant to 74 O.S. §85.7(F), where Federal awards are involved, applicable federal laws, rules and regulations shall govern to the extent necessary to insure ensure compliance with the terms of the Federal award. Venue for any action, claim, dispute, or litigation relating in any way to the Contract documents, shall be in Oklahoma County, Oklahoma. The State expressly declines any terms that minimize its rights under Oklahoma Law, including but not limited to, Statutes of Limitations.

V.2. Employment Relationship

V.2.1. The Contract does not create an employment relationship. Individuals providing products or performing services pursuant to the Contract are not employees of the State or Customer and, accordingly are not eligible for any rights or benefits whatsoever accruing to such employees.

V.3. Failure to Enforce

V.3.1. Failure by the State or a Customer at any time to enforce a provision of, or exercise a right under, the Contract shall not be construed as a waiver of any such provision. Such failure to enforce or exercise shall not affect the validity of any Contract document, or any part thereof, or the right of the State or a Customer to enforce any provision of, or exercise any right under, the Contract at any time in accordance with its terms. Likewise, a waiver of a breach of any provision of a Contract document shall not affect or waive a subsequent breach of the same provision or a breach of any other provision in the Contract.

V.4. Invalid Term or Condition

V.4.1. To the extent any term or condition in the Contract conflicts with a compulsory applicable State or United States law or regulation, such Contract term or condition is void and unenforceable. By executing any Contract document which contains a conflicting term or condition, no representation or warranty is made regarding the enforceability of such term or condition. Likewise, any applicable State or federal law or regulation which conflicts with the Contract or any non-conflicting applicable State or federal law or regulation is not waived.

V.5. Severability

V.5.1. If any provision of a Contract document, or the application of any term or condition to any party or circumstances, is held invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable and the application of such provision to other parties or circumstances shall remain valid and in full force and effect. If a court finds that any provision of this contract is invalid or

unenforceable, but that by limiting such provision it would become valid and enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.

V.6. Section Headings

V.6.1. The headings used in any Contract document are for convenience only and do not constitute terms of the Contract.

V.7. Sovereign Immunity

V.7.1. Notwithstanding any provision in the Contract, the Contract is entered into subject to the State's Constitution, statutes, common law, regulations, and the doctrine of sovereign immunity, none of which are waived by the State nor any other right or defense available to the State; provided, however, that the parties hereby agree that the doctrine of sovereign immunity does not apply to actions grounded in contract and therefore does not prohibit Supplier from pursuing claims arising under the Contract against the State and Customers.

V.8. Survival

V.8.1. As applicable, performance under all license, subscription, service agreements, statements of work, transition plans and other similar Contract documents entered into between the parties under the terms of the Contract shall survive Contract expiration. Additionally, rights and obligations under the Contract which by their nature should survive including, without limitation, certain payment obligations invoiced prior to expiration or termination; confidentiality obligations; security incident and data breach obligations and indemnification obligations, remain in effect after expiration or termination of the Contract.

V.9. Gratuities

V.9.1. The Contract may be immediately terminated, in whole or in part, by written notice if it is determined that the Supplier, its authorized employee, agent, or another representative acting within the scope of their authority violated any federal, State or local law, rule or ordinance by offering or giving a gratuity to any State employee directly involved in the Contract. In addition, Suspension or Debarment of the Supplier may result from such a violation.

V.10. Import/Export Controls

V.10.1. Neither party will use, distribute, transfer or transmit any equipment, services, software or technical information provided under the Contract (even if incorporated into other products) except in compliance with all applicable import and export laws, conventions and regulations.

ATTACHMENT B

STATE OF OKLAHOMA NEGOTIABLE GENERAL TERMS

This State of Oklahoma General Terms (“General Terms”) is a Contract document in connection with a Contract awarded by the Office of Management and Enterprise Services on behalf of the State of Oklahoma.

In addition to other terms contained in an applicable Contract document, Supplier and State agree to the following General Terms:

1 Contract Order of Priority

1.1 Contract documents shall be read to be consistent and complementary. Any conflict among the Contract documents shall be resolved by giving priority to Contract documents in the following order of precedence:

- A.** any Amendment;
- B.** terms contained in this Contract document.
- C.** any Contract-specific State terms contained in a Contract document including, without limitation, information technology terms and terms specific to a statewide Contract or a State agency Contract;
- D.** any applicable Solicitation;
- E.** any successful Bid as may be amended through negotiation and to the extent the Bid does not otherwise conflict with the Solicitation, Contract or applicable law;
- F.** any statement of work, work order, or other mutually agreed Contract documents.

1.2 If there is a conflict between the terms contained in this Contract document or in Contract-specific terms and an agreement provided by or on behalf of Supplier including but not limited to linked or supplemental documents which alter or diminish the rights of Customer or the State, the conflicting terms provided by Supplier shall not take priority over this Contract document or Acquisition-specific terms. In no event will any linked document alter or override such referenced terms except as specifically agreed in an Amendment.

2 Definitions

In addition to any defined terms set forth elsewhere in the Contract, the Oklahoma Central Purchasing Act and the Oklahoma Administrative Code, Title 260, the parties agree that, when used in the Contract, the following terms are defined as set forth below and may be used in the singular or plural form:

- 2.1 **Acquisition** means items, products, materials, supplies, services and equipment acquired by purchase, lease purchase, lease with option to purchase, value provided or rental under the Contract.
- 2.2 **Amendment** means any mutually executed, written modification to a Contract document or a written change, addition, correction or revision to a Solicitation.
- 2.3 **Bid** means an offer a Bidder submits in response to the Solicitation.
- 2.4 **Bidder** means an individual or business entity that submits a Bid in response to the Solicitation.
- 2.5 **Contract** means the written, mutually agreed and binding legal relationship resulting from the Contract documents and an appropriate encumbering document as may be amended from time to time, which evidences the final agreement between the parties with respect to the subject matter of the Contract.
- 2.6 **Customer** means the entity receiving goods or services contemplated by the Contract.
- 2.7 **Debarment** means action taken by a debarring official under federal or state law or regulations to exclude any business entity from inclusion on the Supplier list; bidding; offering to bid; providing a quote; receiving an award of contract with the State and may also result in cancellation of existing contracts with the State.
- 2.8 **Destination** means delivered to the receiving dock or other point specified in the applicable Contract document.
- 2.9 **Federal award** means the Federal financial assistance that a recipient receives directly from a Federal awarding agency or indirectly from a pass-through entity
- 2.10 **Governmental Entity** means any governmental entity specified as a political subdivision of the State pursuant to the Governmental Tort Claim Act including any associated institution, instrumentality, board, commission, committee, department, or other entity designated to act on behalf of the state.

- 2.11 Indemnified Parties** means the State and Customer and/or its officers, directors, agents, employees, representatives, contractors, assignees and designees thereof.
- 2.12 Inspection** means examining and testing an Acquisition (including, when appropriate, raw materials, components, and intermediate assemblies) to determine whether the Acquisition meets Contract requirements.
- 2.13 Moral Rights** means any and all rights of paternity or integrity of the Work Product and the right to object to any modification, translation or use of the Work Product and any similar rights existing under the judicial or statutory law of any country in the world or under any treaty, regardless of whether or not such right is denominated or referred to as a moral right.
- 2.14 OAC** means the Oklahoma Administrative Code.
- 2.15 OMES** means the Office of Management and Enterprise Services.
- 2.16 Solicitation** means the document inviting Bids for the Acquisition referenced in the Contract and any amendments thereto.
- 2.17 State** means the government of the state of Oklahoma, its employees and authorized representatives, including without limitation any department, agency, or other unit of the government of the state of Oklahoma.
- 2.18 Supplier** means the Bidder with whom the State enters into the Contract awarded pursuant to the Solicitation or the business entity or individual that is a party to the Contract with the State.
- 2.19 Suspension** means action taken by a suspending official under federal or state law or regulations to suspend a Supplier from inclusion on the Supplier list; be eligible to submit Bids to State agencies and be awarded a contract by a State agency subject to the Central Purchasing Act.
- 2.20 Supplier Confidential Information** means certain confidential and proprietary information of Supplier that is clearly marked as confidential and agreed by the State Purchasing Director or Customer, as applicable, but does not include information excluded from confidentiality in provisions of the Contract or the Oklahoma Open Records Act.
- 2.21 Work Product** means any and all deliverables produced by Supplier under a statement of work or similar Contract document issued pursuant to this Contract, including any and all tangible or intangible items or things that have been or will be prepared, created, developed, invented or conceived at any time following the Contract effective date including but not limited to

any (i) works of authorship (such as manuals, instructions, printed material, graphics, artwork, images, illustrations, photographs, computer programs, computer software, scripts, object code, source code or other programming code, HTML code, flow charts, notes, outlines, lists, compilations, manuscripts, writings, pictorial materials, schematics, formulae, processes, algorithms, data, information, multimedia files, text web pages or web sites, other written or machine readable expression of such works fixed in any tangible media, and all other copyrightable works), (ii) trademarks, service marks, trade dress, trade names, logos, or other indicia of source or origin, (iii) ideas, designs, concepts, personality rights, methods, processes, techniques, apparatuses, inventions, formulas, discoveries, or improvements, including any patents, trade secrets and know-how, (iv) domain names, (v) any copies, and similar or derivative works to any of the foregoing, (vi) all documentation and materials related to any of the foregoing, (vii) all other goods, services or deliverables to be provided by or on behalf of Supplier under the Contract and (viii) all Intellectual Property Rights in any of the foregoing, and which are or were created, prepared, developed, invented or conceived for the use of benefit of Customer in connection with this Contract or with funds appropriated by or for Customer or Customer's benefit (a) by any Supplier personnel or Customer personnel or (b) any Customer personnel who then became personnel to Supplier or any of its affiliates or subcontractors, where, although creation or reduction-to-practice is completed while the person is affiliated with Supplier or its personnel, any portion of same was created, invented or conceived by such person while affiliated with Customer. For the avoidance of doubt, the State and Supplier agree that Supplier is not planning to provide Work Product for Customer or the State. Should Supplier and State and/or Customer explicitly agree, in writing, to the acquisition of Work Product, the foregoing definition will apply.

3 Additional Pricing

- 3.1** The price of a product offered under the Contract shall include and Supplier shall prepay all shipping, packaging, delivery and handling fees. All product deliveries will be free on board Customer's Destination. No additional fees shall be charged by Supplier for standard shipping and handling. If Customer requests expedited or special delivery, Customer may be responsible for any charges for expedited or special delivery.
- 3.2** Supplier shall have no right of setoff.
- 3.3** Because funds are typically dedicated to a particular fiscal year, an invoice will be paid only when timely submitted, which shall in no instance be later than six (6) months after the end of the fiscal year in which the goods are provided or services performed.

4 Ordering, Inspection, and Acceptance

- 4.1** Any product or service furnished under the Contract shall be ordered by issuance of a valid purchase order or other appropriate payment mechanism, including a pre-encumbrance, or by use of a valid Purchase Card. All orders and transactions are governed by the terms and conditions of the Contract. Any purchase order or other applicable payment mechanism dated prior to termination or expiration of the Contract shall be performed unless mutually agreed in writing otherwise.
- 4.2** Services will be performed in accordance with industry best practices and are subject to acceptance by the Customer. Notwithstanding any other provision in the Contract, deemed acceptance of a service or associated deliverable shall not apply automatically upon receipt of a deliverable or upon provision of a service.

Supplier warrants and represents that a product or deliverable furnished by or through the Supplier shall individually, and where specified by Supplier to perform as a system, be substantially uninterrupted and error-free in operation and guaranteed against faulty material and workmanship for a warranty period of the greater of ninety (90) days from the date of acceptance or the maximum allowed by the manufacturer. A defect in a product or deliverable furnished by or through the Supplier shall be repaired or replaced by Supplier at no additional cost or expense to the Customer if such defect occurs during the warranty period.

Any product to be delivered pursuant to the Contract shall be subject to final inspection and acceptance by the Customer at Destination. The Customer assumes no responsibility for a product until accepted by the Customer. Title and risk of loss or damage to a product shall be the responsibility of the Supplier until accepted. The Supplier shall be responsible for filing, processing, and collecting any and all damage claims accruing prior to acceptance.

Pursuant to OAC 260:115-9-1, payment for an Acquisition does not constitute final acceptance of the Acquisition. If subsequent inspection affirms that the Acquisition does not meet or exceed the specifications of the order or that the Acquisition has a latent defect, the Supplier shall be notified as soon as is reasonably practicable. The Supplier shall retrieve and replace the Acquisition at Supplier's expense or, if unable to replace, shall issue a refund to Customer. Refund under this section shall not be an exclusive remedy.

- 4.3** Supplier shall deliver products and services on or before the required date specified in a Contract document. Failure to deliver timely may result in liquidated damages as set forth in the applicable Contract document.

Deviations, substitutions, or changes in a product or service, including changes of personnel directly providing services, shall not be made unless expressly authorized in writing by the Customer. Any substitution of personnel directly providing services shall be a person of comparable or greater skills, education and experience for performing the services as the person being replaced. Additionally, Supplier shall provide staff sufficiently experienced and able to perform with respect to any transitional services provided by Supplier in connection with termination or expiration of the Contract.

- 4.4** Product warranty and return policies and terms provided under any Contract document will not be more restrictive or more costly than warranty and return policies and terms for other similarly situated customers for a like product.

5 Maintenance of Insurance, Payment of Taxes, and Workers' Compensation

- 5.1** As a condition of this Contract, Supplier shall procure at its own expense, and provide proof of, insurance coverage with the applicable liability limits set forth below and any approved subcontractor of Supplier shall procure and provide proof of the same coverage. The required insurance shall be underwritten by an insurance carrier with an A.M. Best rating of A- or better or as approved by the State.

Such proof of coverage shall additionally be provided to the Customer if services will be provided by any of Supplier's employees, agents or subcontractors at any Customer premises and/or employer vehicles will be used in connection with performance of Supplier's obligations under the Contract. Supplier may not commence performance hereunder until such proof has been provided. Additionally, Supplier shall ensure each insurance policy includes a notice of cancellation and includes the State and its agencies as certificate holder and shall promptly provide proof to the State of any renewals, additions, or changes to such insurance coverage. Supplier's obligation to maintain insurance coverage under the Contract is a continuing obligation until Supplier has no further obligation under the Contract. Any combination of primary and excess or umbrella insurance may be used to satisfy the limits of coverage for Commercial General Liability, Auto Liability and Employers' Liability. Unless agreed between the parties and approved by the State Purchasing Director, the minimum acceptable insurance limits of liability are as follows:

- A.** Workers' Compensation and Employer's Liability Insurance in accordance with and to the extent required by applicable law;
- B.** Commercial General Liability Insurance covering the risks of personal injury, bodily injury (including death) and property damage, including

coverage for contractual liability, with a limit of liability of not less than \$2,000,000 per occurrence;

- C. Automobile Liability Insurance with limits of liability of not less than \$2,000,000 combined single limit each accident;
- D. If the Supplier will access, process, or store state data, then Security and Privacy Liability insurance, including coverage for failure to protect confidential information and failure of the security of Supplier's computer systems that results in unauthorized access to Customer data with limits \$5,000,000 per occurrence; and
- E. Additional coverage required in writing in connection with a particular Acquisition.

5.2 Supplier shall be entirely responsible during the existence of the Contract for the liability and payment of taxes payable by or assessed to Supplier or its employees, agents and subcontractors of whatever kind, in connection with the Contract. Supplier further agrees to comply with all state and federal laws applicable to any such persons, including laws regarding wages, taxes, insurance, and Workers' Compensation. Neither Customer nor the State shall be liable to the Supplier, its employees, agents, or others for the payment of taxes or the provision of unemployment insurance and/or Workers' Compensation or any benefit available to a State or Customer employee.

5.3 Supplier agrees to indemnify Customer, the State, and its employees, agents, representatives, contractors, and assignees for any and all liability, actions, claims, demands, or suits, and all related costs and expenses (including without limitation reasonable attorneys' fees and costs required to establish the right to indemnification) relating to tax liability, unemployment insurance and/or Workers' Compensation in connection with its performance under the Contract.

6 Compliance with Applicable Laws

6.1 As long as Supplier has an obligation under the terms of the Contract and in connection with performance of its obligations, the Supplier represents its present compliance, and shall have an ongoing obligation to comply, with all applicable federal, State, and local laws, rules, regulations, ordinances, and orders, as amended, including but not limited to the following:

- A. Drug-Free Workplace Act of 1988 set forth at 41 U.S.C. §81.

- B.** Section 306 of the Clean Air Act, Section 508 of the Clean Water Act, Executive Order 11738, and Environmental Protection Agency Regulations which prohibit the use of facilities included on the EPA List of Violating Facilities under nonexempt federal contracts, grants or loans;
- C.** Prospective participant requirements set at 45 C.F.R. part 76 in connection with Debarment, Suspension and other responsibility matters;
- D.** 1964 Civil Rights Act, Title IX of the Education Amendment of 1972, Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act of 1990, and Executive Orders 11246 and 11375;
- E.** Anti-Lobbying Law set forth at 31 U.S.C. §1325 and as implemented at 45 C.F.R. part 93;
- F.** Requirements of Internal Revenue Service Publication 1075 regarding use, access and disclosure of Federal Tax Information (as defined therein);
- G.** Obtaining certified independent audits conducted in accordance with Government Auditing Standards and Office of Management and Budget Uniform Guidance, 2 CFR 200 Subpart F §200.500 et seq. with approval and work paper examination rights of the applicable procuring entity;
- H.** Requirements of the Oklahoma Taxpayer and Citizen Protection Act of 2007, 25 O.S. §1312 and applicable federal immigration laws and regulations and be registered and participate in the Status Verification System. The Status Verification System is defined at 25 O.S. §1312, includes but is not limited to the free Employment Verification Program (E-Verify) through the Department of Homeland Security, and is available at [Home | E-Verify](#);
- I.** Requirements of the Health Insurance Portability and Accountability Act of 1996; Health Information Technology for Economic and Clinical Health Act; Payment Card Industry Security Standards; Criminal Justice Information System Security Policy and Security Addendum; and Family Educational Rights and Privacy Act; and
- J.** Be registered as a business entity licensed to do business in the State, have obtained a sales tax permit, and be current on franchise tax payments to the State, as applicable.

- 6.2** The Supplier's employees, agents and subcontractors shall adhere to applicable Customer policies including, but not limited to acceptable use of Internet and electronic mail, facility and data security, press releases, and public relations. As applicable, the Supplier shall adhere to the State Information Security Policy, Procedures, Guidelines set forth at [Information Security Policy, Procedures, Guidelines \(oklahoma.gov\)](#) Supplier is responsible for reviewing and relaying such policies covering the above to the Supplier's employees, agents and subcontractors.
- 6.3** At no additional cost to Customer, the Supplier shall maintain all applicable licenses and permits required in association with its obligations under the Contract.
- 6.4** In addition to compliance under subsection 6.1 above, Supplier shall have a continuing obligation to comply with applicable Customer-specific mandatory contract provisions required in connection with the receipt of federal funds or other funding source.
- 6.5** The Supplier is responsible to review and inform its employees, agents, and subcontractors who provide a product or perform a service under the Contract of the Supplier's obligations under the Contract and Supplier certifies that its employees and each such subcontractor shall comply with minimum requirements and applicable provisions of the Contract. At the request of the State, Supplier shall promptly provide adequate evidence that such persons are its employees, agents or approved subcontractors and have been informed of their obligations under the Contract.
- 6.6** As applicable, Supplier agrees to comply with the Governor's Executive Orders related to the use of any tobacco product, electronic cigarette or vaping device on any and all properties owned, leased, or contracted for use by the State, including but not limited to all buildings, land and vehicles owned, leased, or contracted for use by agencies or instrumentalities of the State.
- 6.7** The execution, delivery and performance of the Contract and any ancillary documents by Supplier will not, to the best of Supplier's knowledge, violate, conflict with, or result in a breach of any provision of, or constitute a default (or an event which, with notice or lapse of time or both, would constitute a default) under, or result in the termination of, any written contract or other instrument between Supplier and any third party.
- 6.8** Supplier represents that it has the ability to pay its debts when due and it does not anticipate the filing of a voluntary or involuntary bankruptcy petition or appointment of a receiver, liquidator or trustee.

- 6.9** Supplier represents that, to the best of its knowledge, any litigation or claim or any threat thereof involving Supplier has been disclosed in writing to the State and Supplier is not aware of any other litigation, claim or threat thereof.
- 6.10** If services provided by Supplier include delivery of an electronic communication, Supplier shall ensure such communication and any associated support documents are compliant with Section 508 of the Federal Rehabilitation Act and with State standards regarding accessibility. Should any communication or associated support documents be non-compliant, Supplier shall correct and re-deliver such communication immediately upon discovery or notice, at no additional cost to the State. Additionally, as part of compliance with accessibility requirements where documents are only provided in non-electronic format, Supplier shall promptly provide such communication and any associated support documents in an alternate format usable by individuals with disabilities upon request and at no additional cost, which may originate from an intended recipient or from the State.

7 Audits and Records Clause

- 7.1** As used in this clause and pursuant to 67 O.S. §203, “record” includes a document, book, paper, photograph, microfilm, computer tape, disk, record, sound recording, film recording, video record, 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.
- 7.2** Supplier agrees any pertinent federal or State agency or governing entity of a Customer shall have the right to examine and audit, at no additional cost to a Customer, all records relevant to the execution and performance of the Contract except, unless otherwise agreed, costs of Supplier that comprise pricing under the Contract.
- 7.3** The Supplier 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 or termination of an Acquisition unless otherwise indicated in the Contract terms. If a claim, audit, litigation or other action involving such records is started before the end of the seven-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.
- 7.4** Pursuant to 74 O.S. §85.41, if professional services are provided hereunder, all items of the Supplier that relate to the professional services are subject to examination by the State agency, State Auditor and Inspector and the State Purchasing Director.

8 Confidentiality

- 8.1** The Supplier shall maintain strict security of all State and citizen data and records entrusted to it or to which the Supplier gains access, in accordance with and subject to applicable federal and State laws, rules, regulations, and policies and shall use any such data and records only as necessary for Supplier to perform its obligations under the Contract. The Supplier further agrees to evidence such confidentiality obligation in a separate writing if required under such applicable federal or State laws, rules and regulations. The Supplier warrants and represents that such information shall not be sold, assigned, conveyed, provided, released, disseminated or otherwise disclosed by Supplier, its employees, officers, directors, subsidiaries, affiliates, agents, representatives, assigns, subcontractors, independent contractors, successor or any other persons or entities without Customer's prior express written permission. Supplier shall instruct all such persons and entities that the confidential information shall not be disclosed or used without the Customer's prior express written approval except as necessary for Supplier to render services under the Contract. The Supplier further warrants that it has a tested and proven system in effect designed to protect all confidential information.
- 8.2** Supplier shall establish, maintain and enforce agreements with all such persons and entities that have access to State and citizen data and records to fulfill Supplier's duties and obligations under the Contract and to specifically prohibit any sale, assignment, conveyance, provision, release, dissemination or other disclosure of any State or citizen data or records except as required by law or allowed by written prior approval of the Customer.
- 8.3** Supplier shall immediately report to the Customer any and all unauthorized use, appropriation, sale, assignment, conveyance, provision, release, access, acquisition, disclosure or other dissemination of any State or citizen data or records specific to the State of Oklahoma of which it or its parent company, subsidiaries, affiliates, employees, officers, directors, assignees, agents, representatives, independent contractors, and subcontractors is aware or have knowledge or reasonable should have knowledge. The Supplier shall also promptly furnish to Customer full details specific to the State of Oklahoma of the unauthorized use, appropriation, sale, assignment, conveyance, provision, release, access, acquisition, disclosure or other dissemination, or attempt thereof, and use its best efforts to assist the Customer in investigating or preventing the reoccurrence of such event in the future. The Supplier shall cooperate with the Customer in connection with any litigation and investigation specific to the State of Oklahoma deemed necessary by the Customer to protect any State or citizen data and records and shall bear all costs associated with the investigation, response and recovery in connection

with any breach of State or citizen data or records 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.

- 8.4** Supplier further agrees to promptly prevent a reoccurrence of any unauthorized use, appropriation, sale, assignment, conveyance, provision, release, access, acquisition, disclosure or other dissemination of State or citizen data and records.
- 8.5** Supplier acknowledges that any improper use, appropriation, sale, assignment, conveyance, provision, release, access, acquisition, disclosure or other dissemination of any State data or records to others may cause immediate and irreparable harm to the Customer and certain beneficiaries and may violate state or federal laws and regulations. If the Supplier or its affiliates, parent company, 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, the Customer will immediately be entitled to seek injunctive relief and/or any other rights or remedies available under this Contract, at equity or pursuant to applicable statutory, regulatory, and common law without a cure period.
- 8.6** The Supplier shall immediately forward to the State Purchasing Director, and any other applicable person listed in the Notices section(s) of the Contract, any request by a third party for data or records in the possession of the Supplier or any subcontractor or to which the Supplier or subcontractor has access and Supplier shall fully cooperate with all efforts to protect the security and confidentiality of such data or records in response to a third party request.

9 Assignment and Permitted Subcontractors

- 9.1** Supplier's obligations under the Contract may not be assigned or transferred to any other person or entity without the prior written consent of the State which may be withheld at the State's sole discretion. Should Supplier assign its rights to payment, in whole or in part, under the Contract, Supplier shall provide the State and all affected Customers with written notice of the assignment. Such written notice shall be delivered timely and contain details sufficient for affected Customers to perform payment obligations without any delay caused by the assignment.
- 9.2** Notwithstanding the foregoing, the Contract may be assigned by Supplier to any corporation or other entity in connection with a merger, consolidation, sale of all equity interests of the Supplier, or a sale of all or substantially all of the

assets of the Supplier to which the Contract relates. In any such case, said corporation or other entity shall by operation of law or expressly in writing assume all obligations of the Supplier as fully as if it had been originally made a party to the Contract. Supplier shall give the State and all affected Customers prior written notice of said assignment. Any assignment or delegation in violation of this subsection shall be void.

- 9.3** If the Supplier is permitted to utilize subcontractors in support of the Contract, the Supplier shall remain solely responsible for its obligations under the terms of the Contract, for its actions and omissions and those of its agents, employees and subcontractors and for payments to such persons or entities. Prior to a subcontractor being utilized by the Supplier, the Supplier shall obtain written approval of the State of such subcontractor and each employee, as applicable to a particular Acquisition, of such subcontractor proposed for use by the Supplier. Such approval is within the sole discretion of the State. Any proposed subcontractor shall be identified by entity name, and by employee name, if required by the particular Acquisition, in the applicable proposal and shall include the nature of the services to be performed. As part of the approval request, the Supplier shall provide a copy of a written agreement executed by the Supplier and subcontractor setting forth that such subcontractor is bound by and agrees, as applicable, to perform the same covenants and be subject to the same conditions and make identical certifications to the same facts and criteria, as the Supplier under the terms of all applicable Contract documents. Supplier agrees that maintaining such agreement with any subcontractor and obtaining prior written approval by the State of any subcontractor and associated employees shall be a continuing obligation. The State further reserves the right to revoke approval of a subcontractor or an employee thereof in instances of poor performance, misconduct or for other similar reasons.
- 9.4** All payments under the Contract shall be made directly to the Supplier, except as provided in subsection A above regarding the Supplier's assignment of payment. No payment shall be made to the Supplier for performance by unapproved or disapproved employees of the Supplier or a subcontractor.
- 9.5** Rights and obligations of the State or a Customer under the terms of this Contract may be assigned or transferred, at no additional cost, to other Customer entities.

10 Background Checks and Criminal History Investigations

Prior to the commencement of any services, performance of background checks and criminal history investigations of the Supplier's employees and subcontractors who will be providing services may be required. If required, the Supplier agree to provide

the State with a description of the background check process to include any vendor's used to gather information. Supplier will further attest that each employee and subcontractor providing services has passed the back ground check. Supplier's access to facilities, data and information may be withheld prior to completion of background verification acceptable to the State. The costs of additional background checks beyond Supplier's normal hiring practices shall be the responsibility of the Customer unless such additional background checks are required solely because Supplier will not provide verification of results of its otherwise acceptable normal background checks; in such an instance, Supplier shall pay for the additional background checks. Supplier will coordinate with the State and its employees to complete the necessary background checks and criminal history investigations. Should any employee or subcontractor of the Supplier who will be providing services under the Contract not be acceptable as a result of the background check or criminal history investigation, the Customer may require replacement of the employee or subcontractor in question and, if no suitable replacement is made within a reasonable time, terminate the purchase order or other payment mechanism associated with the project or services.

11 Patents and Copyrights

Without exception, a product or deliverable price shall include all royalties or costs owed by the Supplier to any third party arising from the use of a patent, intellectual property, copyright or other property right held by such third party. Should any third party threaten or make a claim that any portion of a product or service provided by Supplier under the Contract infringes that party's patent, intellectual property, copyright or other property right, Supplier shall enable each affected Customer to legally continue to use, or modify for use, the portion of the product or service at issue or replace such potentially infringing product, or re-perform or redeliver in the case of a service, with at least a functional non-infringing equivalent. Supplier's duty under this section shall extend to include any other product or service rendered materially unusable as intended due to replacement or modification of the product or service at issue. If the Supplier determines that none of these alternatives are reasonably available, the State shall return such portion of the product or deliverable at issue to the Supplier, upon written request, in exchange for a refund of the price paid for such returned goods as well as a refund or reimbursement, if applicable, of the cost of any other product or deliverable rendered materially unusable as intended due to removal of the portion of product or deliverable at issue. Any remedy provided under this section is not an exclusive remedy and is not intended to operate as a waiver of legal or equitable remedies because of acceptance of relief provided by Supplier.

12 Indemnification

12.1 Acts or Omissions

- A. Supplier shall defend and indemnify the Indemnified Parties, as applicable, for any and all liability, claims, damages, losses, costs, expenses, demands, suits and actions of third parties (including without limitation reasonable attorneys' fees and costs required to establish the right to indemnification) arising out of, or resulting from any action or claim for bodily injury, death, or property damage brought against any of the Indemnified parties to the extent arising from any negligent act or omission or willful misconduct of the Supplier or its agents, employees, or subcontractors in the execution or performance of the Contract.
- B. To the extent Supplier is found liable for loss, damage, or destruction of any property of Customer due to negligence, misconduct, wrongful act, or omission on the part of the Supplier, its employees, agents, representatives, or subcontractors, the Supplier and Customer shall use best efforts to mutually negotiate an equitable settlement amount to repair or replace the property unless such loss, damage or destruction is of such a magnitude that repair or replacement is not a reasonable option. Such amount shall be invoiced to, and is payable by, Supplier sixty (60) calendar days after the date of Supplier's receipt of an invoice for the negotiated settlement amount.

12.2 Infringement

Supplier shall indemnify the Indemnified Parties, as applicable, for all liability, claims, damages, losses, costs, expenses, demands, suits and actions of third parties (including without limitation reasonable attorneys' fees and costs required to establish the right to indemnification) arising from or in connection with Supplier's breach of its representations and warranties in the Contract or alleged infringement of any patent, intellectual property, copyright or other property right in connection with a product or service provided under the Contract. Supplier's duty under this section is reduced to the extent a claimed infringement results from: (a) a Customer's or user's content; (b) modifications by Customer or third party to a product delivered under the Contract or combinations of the product with any non-Supplier-provided services or products unless Supplier recommended or participated in such modification or combination; (c) use of a product or service by Customer in violation of the Contract unless done so at the direction of Supplier, or (d) a non-Supplier product that has not been provided to the State by, through or on behalf of Supplier as opposed to its combination with products Supplier provides to or develops for the State or a Customer as a system.

12.3 Notice and Cooperation

In connection with indemnification obligations under the Contract, the parties agree to furnish prompt written notice to each other of any third-party claim. Any Customer affected by the claim will reasonably cooperate with Supplier and defense of the claim to the extent its interests are aligned with Supplier. Supplier shall use counsel reasonably experienced in the subject matter at issue and will not settle a claim without the written consent of the party being defended and where applicable the Attorney General of Oklahoma, which consent will not be unreasonably withheld or delayed, except that no consent will be required to settle a claim against Indemnified Parties that are not a State agency, where relief against the Indemnified Parties is limited to monetary damages that are paid by the defending party under indemnification provisions of the Contract.

12.4 Limitation of Liability

- A.** With respect to any claim or cause of action arising under or related to the Contract, neither the State nor any Customer shall be liable to Supplier for lost profits, lost sales or business expenditures, investments, or commitments in connection with any business, loss of any goodwill, or for any other indirect, incidental, punitive, special or consequential damages, even if advised of the possibility of such damages.
- B.** Notwithstanding anything to the contrary in the Contract, no provision shall limit damages, expenses, costs, actions, claims, and liabilities arising from or related to property damage, bodily injury or death caused by Supplier or its employees, agents or subcontractors; indemnity, security or confidentiality obligations under the Contract; the bad faith, negligence, intentional misconduct or other acts for which applicable law does not allow exemption from liability of Supplier or its employees, agents or subcontractors.
- C.** The limitation of liability and disclaimers set forth in the Contract will apply regardless of whether Customer has accepted a product or service. The parties agree that Supplier has set its fees and entered into the Contract in reliance on the disclaimers and limitations set forth herein, that the same reflect an allocation of risk between the parties and form an essential basis of the bargain between the parties. These limitations shall apply notwithstanding any failure of essential purpose of any limited remedy.

13 Termination for Cause

- 13.1** Supplier may terminate the Contract if (i) it has provided the State with written notice of material breach and (ii) the State fails to cure such material breach within thirty (30) days of receipt of written notice. If there is more than one Customer, material breach by a Customer does not give rise to a claim of material breach as grounds for termination by Supplier of the Contract as a whole. The State may terminate the Contract in whole or in part if (i) it has provided Supplier with written notice of material breach, and (ii) Supplier fails to cure such material breach within thirty (30) days of receipt of written notice. Any partial termination of the Contract under this section shall not be construed as a waiver of, and shall not affect, the rights and obligations of any party regarding portions of the Contract that are not terminated.
- 13.2** The State may terminate the Contract in whole or in part immediately without a thirty (30) day written notice to Supplier if (i) Supplier fails to comply with confidentiality, privacy, security, environmental or safety requirements applicable to Supplier's performance or obligations under the Contract; (ii) Supplier's material breach is reasonably determined to be an impediment to the function of the State and detrimental to the State or to cause a condition precluding the thirty (30) day notice or (iii) when the State determines that an administrative error in connection with award of the Contract occurred prior to Contract performance. Notwithstanding the foregoing, to the extent any applicable law requires a modification to the timing of any notices or termination effectuation under this provision, such notice or termination timeframes shall be automatically adjusted to conform with such applicable laws, and such adjusted timeframes shall apply with respect to the Parties.
- 13.3** The State may terminate the Contract if the scope includes PR Vendor services and the Supplier, or Supplier's employee, violate the lobbying clause. PR Vendor services is defined to include a contract for public relations (PR), marketing or communication services. The State may immediately terminate the Contract with no more than 10-day notice under this section. Notwithstanding the foregoing, to the extent any applicable law requires a modification to the timing of any notices or termination effectuation under this provision, such notice or termination timeframes shall be automatically adjusted to conform with such applicable laws, and such adjusted timeframes shall apply with respect to the Parties.
- 13.4** Upon receipt of notice of a termination, Supplier shall immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice. If a purchase order or other payment mechanism has been issued and a product or service has been accepted as satisfactory prior to the effective date of termination, the termination does not relieve an obligation to pay for the product or service but

there shall not be any liability for further payments ordinarily due under the Contract or for any damages or other amounts caused by or associated with such termination. Such termination is not an exclusive remedy but is in addition to any other rights and remedies provided for by law. Any amount paid to Supplier in the form of prepaid fees that are unused when the Contract or certain obligations are terminated shall be refunded. Termination of the Contract under this section, in whole or in part, shall not relieve the Supplier of liability for claims arising under the Contract.

13.5 The Supplier's repeated failure to provide an acceptable product or service; Supplier's unilateral revision of linked or supplemental terms that have a materially adverse impact on a Customer's rights or obligations under the Contract (except as required by a governmental authority); actual or anticipated failure of Supplier to perform its obligations under the Contract; Supplier's inability to pay its debts when due; assignment for the benefit of Supplier's creditors; or voluntary or involuntary appointment of a receiver or filing of bankruptcy of Supplier shall constitute a material breach of the Supplier's obligations, which may result in partial or whole termination of the Contract. This subsection is not intended as an exhaustive list of material breach conditions. Termination may also result from other instances of failure to adhere to the Contract provisions and for other reasons provided for by applicable law, rules or regulations; without limitation, OAC 260:115-9-1 is an example.

14 Termination for Convenience

14.1 The State may terminate the Contract, in whole or in part, for convenience if it is determined that termination is in the State's best interest. In the event of a termination for convenience, Supplier will be provided at least thirty (30) days' written notice of termination. Any partial termination of the Contract shall not be construed as a waiver of, and shall not affect, the rights and obligations of any party regarding portions of the Contract that remain in effect.

14.2 Upon receipt of notice of such termination, Supplier shall immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice. If a purchase order or other payment mechanism has been issued and a product or service has been accepted as satisfactory prior to the effective date of termination, the termination does not relieve an obligation to pay for the product or service but there shall not be any liability for further payments ordinarily due under the Contract or for any damages or other amounts caused by or associated with such termination. Such termination shall not be an exclusive remedy but shall be in addition to any other rights and remedies provided for by law. Any

amount paid to Supplier in the form of prepaid fees that are unused when the Contract or certain obligations are terminated shall be refunded. Termination of the Contract under this section, in whole or in part, shall not relieve the Supplier of liability for claims arising under the Contract.

15 Suspension of Supplier

15.1 Supplier may be subject to Suspension without advance notice and may additionally be suspended from activities under the Contract if Supplier fails to comply with confidentiality, privacy, security, environmental or safety requirements applicable to Supplier's performance or obligations under the Contract.

15.2 Upon receipt of a notice pursuant to this section, Supplier shall immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice. If a purchase order or other payment mechanism has been issued and a product or service has been accepted as satisfactory prior to receipt of notice by Supplier, the Suspension does not relieve an obligation to pay for the product or service but there shall not be any liability for further payments ordinarily due under the Contract during a period of Suspension or suspended activity or for any damages or other amounts caused by or associated with such Suspension or suspended activity. A right exercised under this section shall not be an exclusive remedy but shall be in addition to any other rights and remedies provided for by law. Any amount paid to Supplier in the form of prepaid fees attributable to a period of Suspension or suspended activity shall be refunded.

15.3 Such Suspension may be removed, or suspended activity may resume, at the earlier of such time as a formal notice is issued that authorizes the resumption of performance under the Contract or at such time as a purchase order or other appropriate encumbrance document is issued. This subsection is not intended to operate as an affirmative statement that such resumption will occur.

16 Certification Regarding State Employees Prohibition From Fulfilling Services

Pursuant to 74 O.S. § 85.42, the Supplier certifies that no person involved in any manner in development of the Contract employed by the State shall be employed to fulfill any services provided under the Contract.

17 Force Majeure

17.1 Either party shall be temporarily excused from performance to the extent delayed as a result of unforeseen causes beyond its reasonable control including fire or other similar casualty, act of God, strike or labor dispute, war

or other violence, or any law, order or requirement of any governmental agency or authority provided the party experiencing the force majeure event has prudently and promptly acted to take any and all steps within the party's control to ensure continued performance and to shorten duration of the event. If a party's performance of its obligations is materially hindered as a result of a force majeure event, such party shall promptly notify the other party of its best reasonable assessment of the nature and duration of the force majeure event and steps it is taking, and plans to take, to mitigate the effects of the force majeure event. The party shall use commercially reasonable best efforts to continue performance to the extent possible during such event and resume full performance as soon as reasonably practicable.

17.2 Subject to the conditions set forth above, non-performance as a result of a force majeure event shall not be deemed a default. However, a purchase order or other payment mechanism may be terminated if Supplier cannot cause delivery of a product or service in a timely manner to meet the business needs of Customer. Supplier is not entitled to payment for products or services not received and, therefore, amounts payable to Supplier during the force majeure event shall be equitably adjusted downward.

17.3 Notwithstanding the foregoing or any other provision in the Contract, (i) the following are not a force majeure event under the Contract: (a) shutdowns, disruptions or malfunctions in Supplier's system or any of Supplier's telecommunication or internet services other than as a result of general and widespread internet or telecommunications failures that are not limited to Supplier's systems or (b) the delay or failure of Supplier or subcontractor personnel to perform any obligation of Supplier hereunder unless such delay or failure to perform is itself by reason of a force majeure event and (ii) no force majeure event modifies or excuses Supplier's obligations related to confidentiality, indemnification, data security or breach notification obligations set forth herein.

18 Security of Property and Personnel

In connection with Supplier's performance under the Contract, Supplier may have access to Customer personnel, premises, data, records, equipment and other property. Supplier shall use commercially reasonable best efforts to preserve the safety and security of such personnel, premises, data, records, equipment, and other property of Customer. Supplier shall be responsible for damage to such property to the extent such damage is caused by its employees or subcontractors and shall be responsible for loss of Customer property in its possession, regardless of cause. If Supplier fails to comply with Customer's security requirements, Supplier is subject to immediate suspension

of work as well as termination of the associated purchase order or other payment mechanism.

19 Miscellaneous

19.1 Transition Services

If transition services are needed at the time of Contract expiration or termination, Supplier shall provide such services on a month-to-month basis, at the contract rate or other mutually agreed rate. Supplier shall provide a proposed transition plan, upon request, and cooperate with any successor supplier and with establishing a mutually agreeable transition plan. Failure to cooperate may be documented as poor performance of Supplier.

19.2 Publicity

The existence of the Contract or any Acquisition is in no way an endorsement of Supplier, the products or services and shall not be so construed by Supplier in any advertising or publicity materials. Supplier agrees to submit to the State all advertising, sales, promotion, and other publicity matters relating to the Contract wherein the name of the State or any Customer is mentioned or language used from which, in the State's judgment, an endorsement may be inferred or implied. Supplier further agrees not to publish or use such advertising, sales promotion, or publicity matter or release any informational pamphlets, notices, press releases, research reports, or similar public notices concerning the Contract or any Acquisition hereunder without obtaining the prior written approval of the State.

19.3 Mutual Responsibilities

- A.** No party to the Contract grants the other the right to use any trademarks, trade names, other designations in any promotion or publication without the express written consent by the other party.
- B.** The Contract is a non-exclusive contract and each party is free to enter into similar agreements with others.
- C.** The Customer and Supplier each grant the other only the licenses and rights specified in the Contract and all other rights and interests are expressly reserved.
- D.** The Customer and Supplier shall reasonably cooperate with each other and any Supplier to which the provision of a product and/or service under the Contract may be transitioned after termination or expiration of the Contract.

- E. Except as otherwise set forth herein, where approval, acceptance, consent, or similar action by a party is required under the Contract, such action shall not be unreasonably delayed or withheld.

19.4 Entire Agreement

The Contract documents taken together as a whole constitute the entire agreement between the parties. The Contract documents include this Contract, any Amendments to this Contract, applicable Solicitation, and any successful bid as may be amended or limited through negotiation. No statement, promise, condition, understanding, inducement or representation, oral or written, expressed or implied, which is not contained in a Contract document shall be binding or valid. The Supplier's certifications, including any completed electronically, are incorporated by reference into the Contract.

ATTACHMENT D

STATE OF OKLAHOMA INFORMATION TECHNOLOGY TERMS

The parties further agree to the following terms (“Information Technology Terms”), as applicable, for any Acquisition of products or services with an information technology or telecommunication component. Pursuant to the Oklahoma Information Technology Consolidation and Coordination Act (“The Act” or “Act”), OMES- Information Services (“OMES-IS”) is designated to purchase information technology and telecommunication products and services on behalf of the State. The Act directs OMES-IS to acquire necessary hardware, software and services and to authorize the use by other State agencies. OMES, as the owner of information technology and telecommunication assets and contracts on behalf of the State, allows other State agencies to use the assets while retaining ownership and the right to reassign the assets, at no additional cost, upon written notification to Supplier. OMES-IS is the data custodian for State agency data; however, such data is owned by the respective State agency.

1 DEFINITIONS

- 1.1 **Customer Data** means all data supplied by or on behalf of a Customer in connection with the Contract, excluding any confidential information of Supplier. Customer Data includes both Non-Public Data and Personal Data.
- 1.2 **Data Breach** means the unauthorized access or the reasonable suspicion of unauthorized access, by an unauthorized person that results in the use, destruction, loss, alteration, disclosure, or theft of Customer Data.
- 1.3 **Host** includes the terms Hosted or Hosting and means the accessing, processing or storing of Customer Data.
- 1.4 **Intellectual Property Rights** means the worldwide legal rights or interests evidenced by or embodied in any idea, design, concept, personality right, method, process, technique, apparatus, invention, discovery or improvement including any patents, trade secrets and know-how; any work of authorship including any copyrights, Moral Rights or neighboring rights; any trademark, service mark, trade dress, trade name or other indicia of source or origin; domain name registrations; and any other proprietary or similar rights. Intellectual Property Rights of a party also includes all worldwide legal rights or interests that the party may have acquired by assignment or license with the right to grant sublicenses.
- 1.5 **Non-Public Data** means Customer Data, other than Personal Data, that is not subject to distribution to the public as public information. It is deemed to be sensitive and confidential by Customer because it contains information that is exempt by statute, ordinance or administrative rule from access by the general public as public information. Non-Public Data includes any data deemed confidential pursuant to the Contract, otherwise identified by Customer as Non-Public Data, or that a reasonable person would deem confidential.
- 1.6 **Personal Data** means Customer Data that contains 1) any combination of an individual’s name, social security numbers, driver’s license, state/federal identification number,

account number, credit or debit card number and/or 2) data subject to protection under a federal, state or local law, rule, regulation or ordinance.

- 1.7 Security Incident** means the attempted or successful unauthorized access, use, disclosure, modification, loss, theft, or destruction of information or interference with the Hosted environment used to perform the services.
- 1.8 Supplier** means the Bidder with whom the State enters into the Contract awarded pursuant to the Solicitation or the business entity or individual that is a party to the Contract with the State. A Supplier with whom the State enters into an awarded Contract shall also be known as a Contractor.
- 1.9 Supplier Intellectual Property** means all tangible or intangible items or things, including the Intellectual Property Rights therein, created or developed by Supplier and identified in writing as such (a) prior to providing any services or Work Product to Customer and prior to receiving any documents, materials, information or funding from or on behalf of a Customer relating to the services or Work Product, or (b) after the effective date of the Contract if such tangible or intangible items or things were independently developed by Supplier outside Supplier's provision of services or Work Product for Customer under the Contract and were not created, prepared, developed, invented or conceived by any Customer personnel who then became personnel to Supplier or any of its affiliates or subcontractors, where, although creation or reduction-to-practice is completed while the person is affiliated with Supplier or its personnel, any portion of same was created, invented or conceived by such person while affiliated with Customer.
- 1.10 Third Party Intellectual Property** means the Intellectual Property Rights of any third party that is not a party to the Contract, and that is not directly or indirectly providing any goods or services to a Customer under the Contract.

2 TERMINATION OF MAINTENANCE AND SUPPORT SERVICES

Customer may terminate maintenance or support services without an adjustment charge, provided any of the following circumstances occur:

- 2.1** Customer removes the product for which the services are provided, from productive use; or,
- 2.2** The location at which the services are provided is no longer controlled by Customer (for example, because of statutory or regulatory changes or the sale or closing of a facility).
- 2.3** If Customer chooses to renew maintenance or support after maintenance has lapsed, Customer may choose to pay the additional fee, if any, associated with renewing a license after such maintenance or support has lapsed, or to purchase a new license. Any amount paid to Supplier in the form of prepaid fees that are unused when services under the Contract or purchase order are terminated shall be refunded to Customer.

3 COMPLIANCE AND ELECTRONIC AND INFORMATION TECHNOLOGY ACCESSIBILITY

- 3.1** State procurement of information technology is subject to certain federal and State laws, rules and regulations related to information technology accessibility, including but not limited to Oklahoma Information Technology Accessibility Standards (“Standards”) set forth at [Information and Communication Technology Accessibility Standards \(oklahoma.gov\)](http://Information_and_Communication_Technology_Accessibility_Standards(oklahoma.gov)). Supplier shall provide a Voluntary Product Accessibility Template (“VPAT”) describing accessibility compliance via a URL linking to the VPAT and shall update the VPAT as necessary in order to allow a Customer to obtain current VPAT information as required by State law. 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.

All representations contained in the VPAT provided will be relied upon by the State or a Customer, as applicable, for accessibility compliance purposes.

4 MEDIA OWNERSHIP (Disk Drive and/or Memory Chip Ownership)

- 4.1** Any disk drives and memory cards purchased with or included for use in leased or purchased products under the Contract remain the sole and exclusive property of the Customer.
- 4.2** Personal information may be retained within electronic media devices and components; therefore, electronic media shall not be released either between Customers or for the resale, of refurbished equipment that has been in use by a Customer, by the Supplier to the general public or other entities. This provision applies to replacement devices and components, whether purchased or leased, supplied by Supplier, its agents or subcontractors during the downtime (repair) of products purchased or leased through the Contract. If a device is removed from a location for repairs, the Customer shall have sole discretion, prior to removal, to determine and implement sufficient safeguards (such as a record of hard drive serial numbers) to protect personal information that may be stored within the hard drive or memory of the device.

5 OFFSHORE SERVICES

No offshore services are provided for under the Contract. State data shall not be used or accessed internationally for troubleshooting or any other use not specifically provided for herein without the prior written permission, which may be withheld in the State’s sole discretion, from the appropriate authorized representative of the State. Notwithstanding the above, back office administrative functions of the Supplier may be located offshore and the follow-the-sun support model may be used by the Supplier to the extent allowed by law applicable to any Customer data being accessed or used.

6 COMPLIANCE WITH TECHNOLOGY POLICIES

- 6.1** The Supplier agrees to adhere to the State of Oklahoma “Information Security Policy, Procedures, and Guidelines” available at <https://oklahoma.gov/content/dam/ok/en/omes/documents/InfoSecPPG.pdf>.

Supplier’s employees and subcontractors shall adhere to the applicable State IT

Standards, policies, procedures and architectures as set forth at <https://oklahoma.gov/omes/services/information-services.html> or as otherwise provided by the State.

- 6.2** Supplier shall comply with applicable Federal Information Processing Standards including, without limitation, FIPS 200, FIPS 140-2 or successor standards and all recommendations from the National Institute of Standards and Technology. The confidentiality of Customer Data shall be protected and maintained in accordance with these standards as well as other applicable Customer standards.

7 EMERGING TECHNOLOGIES

The State reserves the right to enter into an Addendum to the Contract at any time to allow for emerging technologies not identified elsewhere in the Contract Documents if there are repeated requests for such emerging technology or the State determines it is warranted to add such technology.

8 EXTENSION RIGHT

In addition to extension rights of the State set forth in the Contract, the State Chief Information Officer reserves the right to extend any Contract at his or her sole option if the State Chief Information Officer determine such extension to be in the best interest of the State.

9 SOURCE CODE ESCROW

Pursuant to 62 O.S. § 34.31, if customized computer software is developed or modified exclusively for a State agency, the Supplier has a continuing obligation to comply with such law and place the source code for such software and any modifications thereto into escrow with an independent third-party escrow agent. Supplier shall pay all fees charged by the escrow agent and enter into an escrow agreement, the terms of which are subject to the prior written approval of the State, including terms that provide the State receives ownership of all escrowed source code upon the occurrence of any of the following:

- 9.1** A bona fide material default of the obligations of the Supplier under the agreement with the applicable Customer;
- 9.2** An assignment by the Supplier for the benefit of its creditors;
- 9.3** A failure by the Supplier to pay, or an admission by the Supplier of its inability to pay, its debts as they mature;
- 9.4** The filing of a petition in bankruptcy by or against the Supplier when such petition is not dismissed within sixty (60) days of the filing date;
- 9.5** The appointment of a receiver, liquidator or trustee appointed for any substantial part of the Supplier's property;
- 9.6** The inability or unwillingness of the Supplier to provide the maintenance and support services in accordance with the agreement with the agency;
- 9.7** Supplier's ceasing of maintenance and support of the software; or

9.8 Such other condition as may be statutorily imposed by the future amendment or enactment of applicable Oklahoma law.

10 COMMERCIAL OFF THE SHELF SOFTWARE OR SUPPLIER TERMS

If Supplier specifies terms and conditions or clauses in an electronic license, subscription, maintenance, support or similar agreement, including via a hyperlink or uniform resource locator address to a site on the internet, that conflict with the terms of this Contract, the additional terms and conditions or conflicting clauses shall not be binding on the State and the provisions of this Contract shall prevail. Further, no such terms and conditions or clauses shall expand the State's or Customer's liability or reduce the rights of Customer or the State.

11 OWNERSHIP RIGHTS

Any software developed, modified, or customized by the Supplier in accordance with a mutually negotiated statement of work pursuant to this Contract is for the sole and exclusive use of the State including but not limited to the right to use, reproduce, re-use, alter, modify, edit, or change the software as it sees fit and for any purpose. The parties mutually agree the State as a licensee of the Supplier does not make a claim of ownership to the existing Intellectual Property of Supplier. Moreover, except with regard to any deliverable based on Supplier Intellectual Property, the State shall be deemed the sole and exclusive owner of all right, title, and interest therein, including but not limited to all source data, information and materials furnished to the State, together with all plans, system analysis, and design specifications and drawings, completed programs and documentation thereof, reports and listing, all data and test procedures and all other items pertaining to the work and services to be performed pursuant to this Contract including all copyright and proprietary rights relating thereto. With respect to Supplier Intellectual Property, the Supplier grants the State, for no additional consideration, a perpetual, irrevocable, royalty-free license, solely for the internal business use of the State, to use, copy, modify, display, perform, transmit and prepare derivative works of Supplier Intellectual Property embodied in or delivered to the State in conjunction with the products.

Except for any Supplier Intellectual Property, all work performed by the Supplier of developing, modifying or customizing software and any related supporting documentation shall be considered as Work for Hire (as defined under the U.S. copyright laws) and, as such, shall be owned by and for the benefit of State.

In the event that it should be determined that any portion of such software or related supporting documentation does not qualify as "Work for Hire", Supplier hereby irrevocably grants to the State, for no additional consideration, a non-exclusive, irrevocable, royalty-free license to use, copy, modify, display, perform, transmit and prepare derivative works of any such software and any Supplier Intellectual Property embodied in or delivered to the State in conjunction with the products.

Supplier shall assist the State and its agents, upon request, in preparing U.S. and foreign copyright, trademark, and/or patent applications covering software developed, modified or customized for the State when made in accordance with a mutually negotiated statement of work pursuant to this Contract. Supplier shall sign any such applications, upon request, and deliver them to the State. The State shall bear all expenses that incurred in connection with such copyright, trademark, and/or patent applications.

If any Acquisition pursuant to this Contract is funded wholly or in part with federal funds, the source code and all associated software and related documentation owned by the State may be shared with other publicly funded agencies at the discretion of the State without permission from or additional compensation to the Supplier.

12 INTELLECTUAL PROPERTY OWNERSHIP TO WORK PRODUCT

The following terms apply to ownership and rights related to Intellectual Property:

- 12.1** As to the Intellectual Property Rights to Work Product between Supplier and Customer, Customer shall be the exclusive owner and not Supplier. Supplier specifically agrees that the Work Product shall be considered “works made for hire” and that the Work Product shall, upon creation, be owned exclusively by Customer. To the extent that the Work Product, under applicable law, may not be considered works made for hire, Supplier agrees that all right, title and interest in and to all ownership rights and all Intellectual Property Rights in the Work Product is effectively transferred, granted, conveyed, assigned, and relinquished exclusively to Customer, without the necessity of any further consideration, and Customer shall be entitled to obtain and hold in its own name all Intellectual Property Rights in and to the Work Product. Supplier acknowledges that Supplier and Customer do not intend Supplier to be a joint author of the Work Product within the meaning of the Copyright Act of 1976. Customer shall have access, during normal business hours (Monday through Friday, 8:00 a.m. to 5:00 p.m.) and upon reasonable prior notice to Supplier, to all Supplier materials, premises and computer files containing the Work Product. Supplier and Customer, as appropriate, will cooperate with one another and execute such other documents as may be reasonably appropriate to achieve the objectives herein. No license or other right is granted under the Contract to any Third-Party Intellectual Property, except as may be incorporated in the Work Product by Supplier.
- 12.2** Supplier, upon request and without further consideration, shall perform any acts that may be deemed reasonably necessary or desirable by Customer to evidence more fully the transfer of ownership and/or registration of all Intellectual Property Rights in all Work Product to Customer to the fullest extent possible including, but not limited to, the execution, acknowledgement and delivery of such further documents in a form determined by Customer. In the event Customer shall be unable to obtain Supplier’s signature due to the dissolution of Supplier or Supplier’s failure to respond to Customer’s repeated requests for such signature on any document reasonably necessary for any purpose set forth in the foregoing sentence, Supplier hereby irrevocably designates and appoints Customer and its duly authorized officers and agents as Supplier’s agent and Supplier’s attorney-in-fact to act for and in Supplier’s behalf and stead to execute and file any such document and to do all other lawfully permitted acts to further any such purpose with the same force and effect as if executed and delivered by Supplier, provided however that no such grant of right to Customer is applicable if Supplier fails to execute any document due to a good faith dispute by Supplier with respect to such document. It is understood that such power is coupled with an interest and is therefore irrevocable. Customer shall have the full and sole power to prosecute such applications and to take all other action concerning the Work Product, and Supplier shall cooperate, at Customer’s sole expense, in the preparation and prosecution of all such applications and in any legal actions and proceedings concerning the Work Product.

- 12.3** Supplier hereby irrevocably and forever waives, and agrees never to assert, any Moral Rights in or to the Work Product which Supplier may now have or which may accrue to Supplier's benefit under U.S. or foreign copyright or other laws and any and all other residual rights and benefits which arise under any other applicable law now in force or hereafter enacted. Supplier acknowledges the receipt of equitable compensation for its assignment and waiver of such Moral Rights.
- 12.4** All documents, information and materials forwarded to Supplier by Customer for use in and preparation of the Work Product shall be deemed the confidential information of Customer, subject to the license granted by Customer to Supplier hereunder. Supplier shall not otherwise use, disclose, or permit any third party to use or obtain the Work Product, or any portion thereof, in any manner without the prior written approval of Customer.
- 12.5** These provisions are intended to protect Customer's proprietary rights pertaining to the Work Product and the Intellectual Property Rights therein and any misuse of such rights would cause substantial and irreparable harm to Customer's business. Therefore, Supplier acknowledges and stipulates that a court of competent jurisdiction may immediately enjoin a material breach of the Supplier's obligations with respect to confidentiality provisions of the Contract and the Work Product and a Customer's Intellectual Property Rights, upon a request by Customer, without requiring proof of irreparable injury, as same is presumed.
- 12.6** Upon the request of Customer, but in any event upon termination or expiration of this Contract or a statement of work, Supplier shall surrender to Customer all documents and things pertaining to the Work Product, generated or developed by Supplier or furnished by Customer to Supplier, including all materials embodying the Work Product, any Customer confidential information and Intellectual Property Rights in such Work Product, regardless of whether complete or incomplete. This section is intended to apply to all Work Product as well as to all documents and things furnished to Supplier by Customer or by anyone else that pertains to the Work Product.
- 12.7** Customer hereby grants to Supplier a non-transferable, non-exclusive, royalty-free, fully paid license to use any Work Product solely as necessary to provide services to Customer. Except as provided in this section, neither Supplier nor any subcontractor shall have the right to use the Work Product in connection with the provision of services to its other customers without the prior written consent of Customer, which consent may be withheld in Customer's sole discretion.
- 12.8** To the extent that any Third Party Intellectual Property is embodied or reflected in the Work Product or is necessary to provide services, Supplier shall obtain from the applicable third party for the Customer's benefit, an irrevocable, perpetual, non-exclusive, worldwide, royalty-free license, solely for Customer's internal business purposes; likewise, with respect to any Supplier Intellectual Property embodied or reflected in the Work Product or necessary to provide services, Supplier grants to Customer an irrevocable, perpetual, non-exclusive, worldwide, royalty-free license, solely for the Customer's internal business purposes. Each such license shall allow the applicable Customer to (i) use, copy, modify, display, perform (by any means), transmit and prepare derivative works of any Third Party Intellectual Property or Supplier Intellectual Property embodied in or delivered to Customer in conjunction with the Work

Product and (ii) authorize others to do any or all of the foregoing. Supplier agrees to notify Customer on delivery of the Work Product or services if such materials include any Third Party Intellectual Property. The foregoing license includes the right to sublicense third parties, solely for the purpose of engaging such third parties to assist or carry out Customer's internal business use of the Work Product. Except for the preceding license, all rights in Supplier Intellectual Property remain in Supplier. On request, Supplier shall provide Customer with documentation indicating a third party's written approval for Supplier to use any Third Party Intellectual Property that may be embodied or reflected in the Work Product.

12.9 Supplier agrees that it shall have written agreement(s) that are consistent with the provisions hereof related to Work Product and Intellectual Property Rights with any employees, agents, consultants, contractors or subcontractors providing services or Work Product pursuant to the Contract, prior to the provision of such services or Work Product and that it shall maintain such written agreements at all times during performance of this Contract which are sufficient to support all performance and grants of rights by Supplier. Copies of such agreements shall be provided to the Customer promptly upon request.

12.10 To the extent not inconsistent with Customer's rights in the Work Product or other provisions, nothing in this Contract shall preclude Supplier from developing for itself, or for others, materials which are competitive with those produced as a result of the services provided under the Contract, provided that no Work Product is utilized, and no Intellectual Property Rights of Customer therein are infringed by such competitive materials. To the extent that Supplier wishes to use the Work Product or acquire licensed rights in certain Intellectual Property Rights of Customer therein in order to offer competitive goods or services to third parties, Supplier and Customer agree to negotiate in good faith regarding an appropriate license and royalty agreement to allow for such.

12.11 If any Acquisition pursuant to the Contract is funded wholly or in part with federal funds, the source code and all associated software and related documentation and materials owned by a Customer may be shared with other publicly funded agencies at the discretion of such Customer without permission from or additional compensation to the Supplier.

13 HOSTING SERVICES

A Supplier shall be responsible for the obligations set forth in in this Contract, including those obligations related to breach reporting and associated costs when a Supplier Hosting Customer Data or providing products or services pursuant to an Acquisition, contributes to, or directly causes a Data Breach or a Security Incident. Likewise, Supplier shall be responsible for the obligations set forth in in this Contract, including those obligations related to breach reporting and associated costs when a Supplier's affiliate or subcontractor contributes to, or directly causes a Data Breach or a Security Incident.

14 CHANGE MANAGEMENT

When a scheduled change is made to products or services provided to a Customer that impacts the Customer's system related to such product or service, Supplier shall provide two (2) weeks' prior written notice of such change. When the change is an emergency change, Supplier shall provide twenty-four (24) hours' prior written notice of the change. Repeated failure to provide such notice may be an evaluation factor (as indicative of Supplier's past performance) upon

renewal or if future bids submitted by Supplier are evaluated by the State.

15 SERVICE LEVEL DEFICIENCY

In addition to other terms of the Contract, in instances of the Supplier's repeated failure to provide an acceptable level of service or meet service level agreement metrics, service credits shall be provided by Supplier and may be used as an offset to payment due.

16 OWNERSHIP OF IT AND TELECOMMUNICATION ASSETS

Notwithstanding any other provision in the Contract and pursuant to the Oklahoma Information Technology Consolidation and Coordination Act, all information technology and telecommunication assets and contracts on behalf of appropriated agencies of the State belong to OMES-IS. OMES-IS allows other State agencies to use the assets while retaining ownership and the right to reassign the assets, at no additional cost, upon written notification to Supplier.

17 CUSTOMER DATA

17.1 The parties agree to the following provisions in connection with any Customer Data accessed, processed transmitted, or stored by or on behalf of the Supplier and the obligations, representations and warranties set forth below shall continue as long as the Supplier has an obligation under the Contract.

17.2 Customer will be responsible for the accuracy and completeness of all Customer Data provided to Supplier by Customer. Customer shall retain exclusive ownership of rights, title, and interest in Customer Data. Non-Public Data and Personal Data shall be deemed to be Customer's confidential information. Supplier shall restrict access to Customer Data to their employees with a need to know (and advise such employees of the confidentiality and non-disclosure obligations assumed herein).

17.3 Supplier shall promptly notify the Customer upon receipt of any requests from unauthorized third parties which in any way might reasonably require access to Customer Data or Customer's use of the Hosted environment. Supplier shall notify the Customer by the fastest means available and also in writing pursuant to Contract notice provisions and the notice provision herein. Except to the extent required by law, Supplier shall not respond to subpoenas, service or process, Freedom of Information Act or other open records requests, and other legal request related to Customer without first notifying the Customer and obtaining the Customer's prior approval, which shall not be unreasonably withheld, of Supplier's proposed responses. Supplier agrees to provide its completed responses to the Customer with adequate time for Customer review, revision and approval.

17.4 Supplier will use commercially reasonable efforts to prevent the loss of or damage to Customer Data in its possession and will maintain commercially reasonable back-up procedures and copies to facilitate the reconstruction of any Customer Data that may be lost or damaged by Supplier. Supplier will promptly notify Customer of any loss, damage to, or unauthorized access of Customer Data. Supplier will use commercially reasonable efforts to reconstruct any Customer Data that has been lost or damaged by Supplier as a result of its negligence or willful misconduct. If Customer Data is lost or damaged for reasons other than as a result of Supplier's negligence or willful misconduct, Supplier, at

the Customer's expense, will, at the request of the State, use commercially reasonable efforts to reconstruct any Customer Data lost or damaged.

18 DATA SECURITY

- 18.1** Supplier will use commercially reasonable efforts, consistent with industry standards, to provide security for the Hosted environment and Customer Data and to protect against both unauthorized access to the Hosting environment, and unauthorized communications between the Hosting environment and the Customer's browser. Supplier shall implement and maintain appropriate administrative, technical and organizational security measures to safeguard against unauthorized access, disclosure or theft of Personal Data and Non-Public Data. Such security measures shall be in accordance with recognized industry practice and not less stringent than the measures the service provider applies to its own personal data and non-public data of similar kind.
- 18.2** All Personal Data and Non-public Data shall be encrypted at rest and in transit with controlled access. Unless otherwise stipulated, the service provider is responsible for encryption of Personal Data. All Personal Data and Non-Public Data shall be subject to controlled access. Any stipulation of responsibilities shall be included in a Statement of Work and will identify specific roles and responsibilities.
- 18.3** Supplier represents and warrants to the Customer that the Hosting equipment and environment will be routinely checked with a commercially available, industry standard software application with up-to-date virus definitions. Supplier will regularly update the virus definitions to ensure that the definitions are as up-to-date as is commercially reasonable. Supplier will promptly purge all viruses discovered during virus checks. If there is a reasonable basis to believe that a virus may have been transmitted to Customer by Supplier, Supplier will promptly notify Customer of such possibility in a writing that states the nature of the virus, the date on which transmission may have occurred, and the means Supplier has used to remediate the virus. Should the virus propagate to Customer's IT infrastructure, Supplier is responsible for costs incurred by Customer for Customer to remediate the virus.
- 18.4** At no time shall any Customer Data or processes – that either belong to or are intended for the use of the State - be copied, disclosed, or retained by Supplier or any party related to Supplier for subsequent use in any transaction that does not include the State unless otherwise agreed to by the State.
- 18.5** Supplier shall provide its services to Customer and its users solely from data centers in the U.S. Storage of Customer Data at rest shall be located solely in data centers in the U.S. Supplier shall not allow its personnel or contractors to store Customer Data on portable devices, including personal computers, except for devices that are used and kept only at its U.S. data centers. Supplier shall permit its personnel and contractors to access Customer Data remotely only as required to fulfill Supplier's obligations under the Contract.
- 18.6** Supplier shall allow the Customer to audit conformance to the Contract terms. The Customer may perform this audit or contract with a third party at its discretion and at Customer's expense.

- 18.7** Supplier shall perform an independent audit of its data centers at least annually at its expense and provide a redacted version of the audit report upon request. Supplier may remove its proprietary information from the redacted version. A Service Organization Control (SOC) 2 audit report or approved equivalent sets the minimum level of a third-party audit.
- 18.8** Any remedies provided are not exclusive and are in addition to other rights and remedies available under the terms of the Contract, at law or in equity.

19 SECURITY ASSESSMENT

- 19.1** The State requires any entity or third-party Supplier Hosting Oklahoma Customer Data to submit to a State Certification and Accreditation Review process to assess initial security risk. Supplier submitted to the review and met the State's minimum security standards at time the Contract was executed. Failure to maintain the State's minimum security standards during the term of the contract, including renewals, constitutes a material breach. Upon request, the Supplier shall provide updated data security information in connection with a potential renewal. If information provided in the security risk assessment changes, Supplier shall promptly notify the State and include in such notification the updated information; provided, however, Supplier shall make no change that results in lessened data protection or increased data security risk. Failure to provide the notice required by this section or maintain the level of security required in the Contract constitutes a material breach by Supplier and may result in a whole or partial termination of the Contract.
- 19.2** Any Hosting entity change must be approved in writing prior to such change. To the extent Supplier requests a different sub-contractor than the third-party Hosting Supplier already approved by the State, the different sub-contractor is subject to the State's approval. Supplier agrees not to migrate State's data or otherwise utilize the different third-party Hosting Supplier in connection with key business functions that are Supplier's obligations under the contract until the State approves the third-party Hosting Supplier's State Certification and Accreditation Review, which approval shall not be unreasonably withheld or delayed. In the event the third-party Hosting Supplier does not meet the State's requirements under the State Certification and Accreditation Review, Supplier acknowledges and agrees it will not utilize the third-party Supplier in connection with key business functions that are Supplier's obligations under the contract, until such third party meets such requirements.

20 SECURITY INCIDENT OR DATA BREACH NOTIFICATION

- 20.1** Supplier shall inform Customer of any Security Incident or Data Breach.
- 20.2** Supplier may need to communicate with outside parties regarding a Security Incident, which may include contacting law enforcement, fielding media inquiries and seeking external expertise as mutually agreed upon, defined by law or contained in the Contract. If a Security Incident involves Customer Data, Supplier will coordinate with Customer prior to any such communication.
- 20.3** Supplier shall report a Security Incident to the Customer identified contact set forth herein within five (5) days of discovery of the Security Incident or within a shorter notice

period required by applicable law or regulation (i.e., HIPAA requires notice to be provided within 24 hours).

- 20.4** Supplier shall maintain processes and procedures to identify, respond to and analyze Security Incidents; (ii) make summary information regarding such procedures available to Customer at Customer's request, (iii) mitigate, to the extent practicable, harmful effects of Security Incidents that are known to Vendor; and (iv) documents all Security Incidents and their outcomes.
- 20.5** If Supplier has reasonable belief or actual knowledge of a Data Breach, Supplier shall (1) promptly notify the appropriate Customer identified contact set forth herein within 24 hours or sooner, unless shorter time is required by applicable law, and (2) take commercially reasonable measures to address the Data Breach in a timely manner.

21 DATA BREACH NOTIFICATION AND RESPONSIBILITIES

This section only applies when a Data Breach occurs with respect to Personal Data or Non-Public Data within the possession or control of Supplier.

- 21.1** Supplier shall (1) cooperate with Customer as reasonably requested by Customer to investigate and resolve the Data Breach, (2) promptly implement necessary remedial measures, if necessary, and (3) document responsive actions taken related to the Data Breach, including any post-incident review of events and actions taken to make changes in business practices in providing the services, if necessary.
- 21.2** Unless otherwise stipulated, if a Data Breach is a direct result of Supplier's breach of its obligation to encrypt Personal Data and Non-Public Data or otherwise prevent its release, Supplier shall bear the costs associated with (1) the investigation and resolution of the Data Breach; (2) notifications to individuals, regulators or others required by state law; (3) credit monitoring services required by state or federal law; (4) a website or toll-free numbers and call center for affected individuals required by state law – all not to exceed the agency per record per person cost calculated for data breaches in the United States on the most recent Cost of Data breach Study: Global Analysis published by the Ponemon Institute at the time of the data breach; and (5) complete all corrective actions as reasonably determined by Supplier based on root cause.
- 21.3** If a Data Breach is a direct result of Supplier's breach of its obligations to encrypt Personal Data and Non-Public Data or otherwise prevent its release, Supplier shall indemnify and hold harmless the Customer against all penalties assessed to Indemnified Parties by governmental authorities in connection with the Data Breach.

22 SUPPLIER REPRESENTATIONS AND WARRANTIES

Supplier represents and warrants the following:

- 22.1** The product and services provided in connection with Hosting services do not infringe a third party's patent or copyright or other intellectual property rights.
- 22.2** Supplier will protect Customer's Non-Public Data and Personal Data from unauthorized dissemination and use with the same degree of care that each such party uses to protect

its own confidential information and, in any event, will use no less than a reasonable degree of care in protecting such confidential information.

22.3 The execution, delivery and performance of the Contract and any ancillary documents and the consummation of the transactions contemplated by the Contract or any ancillary documents by Supplier will not violate, conflict with, or result in a breach of any provision of, or constitute a default (or an event which, with notice or lapse of time or both, would constitute a default) under, or result in the termination of, any written contract or other instrument between Supplier and any third parties retained or utilized by Supplier to provide goods or services for the benefit of the Customer.

22.4 Supplier shall not knowingly upload, store, post, e-mail or otherwise transmit, distribute, publish or disseminate to or through the Hosting environment any material that contains software viruses, malware or other surreptitious code designed to interrupt, destroy or limit the functionality of any computer software or hardware or telecommunications equipment or circumvent any “copy-protected” devices, or any other harmful or disruptive program.

23 INDEMNITY

Supplier agrees to defend, indemnify and hold the State, its officers, directors, employees, and agents harmless from all liabilities, claims, damages, losses, costs, expenses, demands, suits and actions (including without limitation reasonable attorneys’ fees and costs required to establish the right to indemnification), excluding damages that are the sole fault of Customer, arising from or in connection with Supplier’s breach of its express representations and warranties in these Information Technology Terms and the Contract. If a third party claims that any portion of the products or services provided by Supplier under the terms of another Contract Document or these Information Technology Terms infringes that party’s patent or copyright, Supplier shall defend, indemnify and hold harmless the State and Customer against the claim at Supplier’s expense and pay all related costs, damages, and attorney’s fees incurred by or assessed to, the State and/or Customer. The State and/or Customer shall promptly notify Supplier of any third-party claims and to the extent authorized by the Attorney General of the State, allow Supplier to control the defense and any related settlement negotiations. If the Attorney General of the State does not authorize sole control of the defense and settlement negotiations to Supplier, Supplier shall be granted authorization to equally participate in any proceeding related to this section, but Supplier shall remain responsible to indemnify Customer and the State for all associated costs, damages and fees incurred by or assessed to the State and/or Customer. Should the software become, or in Supplier’s opinion, be likely to become the subject of a claim or an injunction preventing its use as contemplated in connection with Hosting services, Supplier may, at its option (i) procure for the State the right to continue using the software or (ii) replace or modify the software with a like or similar product so that it becomes non-infringing.

24 TERMINATION, EXPIRATION AND SUSPENSION OF SERVICE

24.1 During any period of service suspension, Supplier shall not take any action to intentionally disclose, alter or erase any Customer Data.

24.2 In the event of a termination or expiration of the Contract, the parties further agree:

Supplier shall implement an orderly return of Customer Data in a format specified by the Customer and, as determined by the Customer:

- a. return the Customer Data to Customer at no additional cost, at a time agreed to by the parties and the subsequent secure disposal of State Data;
- b. transitioned to a different Supplier at a mutually agreed cost and in accordance with a mutually agreed data transition plan and the subsequent secure disposal of State Data or
- c. a combination of the two immediately preceding options.

24.3 Supplier shall not take any action to intentionally erase any Customer Data for a period of:

- a. 10 days after the effective date of termination, if the termination is in accordance with the contract period;
- b. 30 days after the effective date of termination, if the termination is for convenience; or
- c. 60 days after the effective date of termination if the termination is for cause.

After such period, Supplier shall, unless legally prohibited or otherwise stipulated, delete all Customer Data in its systems or otherwise in its possession or under its control.

24.4 The State shall be entitled to any post termination or expiration assistance generally made available with respect to the services.

24.5 Disposal by Supplier of Customer Data in all of its forms, such as disk, CD/DVD, backup tape and paper, when requested by the Customer, shall be performed in a secure manner. Data shall be permanently deleted and shall not be recoverable, according to National Institute of Standards and Technology (NIST)-approved methods. Certificates of destruction shall be provided to Customer within thirty (30) calendar day of its request for disposal of data.

25 GENERAL INFORMATION SECURITY REQUIREMENTS

25.1 No employee of Contractor or its subcontractors will be granted access to State of Oklahoma agency information systems without the prior completion and approval of applicable logon authorization and acceptable use requests.

25.2 Contractor or its subcontractors will notify applicable State of Oklahoma agencies when employees who have access to agency information systems are terminated.

25.3 Contractor or its subcontractors will disclose to Client any suspected breach of the security of the information system or the data contained therein in the most expedient time possible and without unreasonable delay and will cooperate with Client during the investigation of any such incident.

- 25.4 Contractor or its subcontractors agree to adhere to the State of Oklahoma “Information Security Policy, Procedures, and Guidelines” available at: <https://oklahoma.gov/content/dam/ok/en/omes/documents/InfoSecPPG.pdf>

26 HIPAA REQUIREMENTS

26.1 Contractor shall agree to use and disclose Protected Health Information in its possession or control in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 C.F.R. Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The definitions set forth in the Privacy Rule are incorporated by reference into this Contract (45 C.F.R. §§ 160.103 and 164.501).

26.2 If applicable, Contractor will sign and adhere to a Business Associate Agreement (BAA). The Business Associate Agreement provides for satisfactory assurances that Contractor will use the information only for the purposes for which it was engaged. Contractor agrees it will safeguard the information from misuse and will comply with HIPAA as it pertains to the duties stated within the contract. Failure to comply with the requirements of this standard may result in funding being withheld from Contractor, and/or full audit and inspection of Contractor’s security compliance as it pertains to this contract.

26.3 Business Associate Terms Definitions:

- a. Unless otherwise defined in this BAA, all capitalized terms used in this BAA have the meanings ascribed in the HIPAA Regulations, provided; however, that “PHI” and “ePHI” shall mean Protected Health Information and Electronic Protected Health Information, respectively, as defined in 45 C.F.R. § 160.103, limited to the information Business Associate received from or created or received on behalf of the applicable State of Oklahoma agency as a Business Associate. “Administrative Safeguards” shall have the same meaning as the term “administrative safeguards in 45 C.F.R. § 164.304, with the exception that it shall apply to the management of the conduct of Business Associate’s workforce, not the State of Oklahoma agency workforce, in relation to the protection of that information.
- b. Business Associate. “Business Associate” shall generally have the same meaning as the term “Business Associate” at 45 C.F.R. 160.103, and in reference to the party to this agreement, shall mean the entity whose name appears below.
- c. Covered Entity. “Covered Entity” shall generally have the same meaning as the term “Covered Entity” at 45 C.F.R. 160.103.
- d. HIPAA Rules. “HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Part 160 and Part 164, all as may be amended.
- e. 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, Sub-Contractor, Unsecured PHI, and Use.

26.4 Obligations of Business Associate: Business Associate may use Electronic PHI and PHI (collectively, “PHI”) solely to perform its duties and responsibilities under this Agreement and only as provided in this Agreement. Business Associate acknowledges and agrees that PHI is confidential and shall not be used or disclosed, in whole or in part, except as provided in this Agreement or as required by law. Specifically, Business Associate agrees it will, as applicable:

- a. use or further disclose PHI only as permitted in this Agreement or as Required by Law, including, but not limited to the Privacy and Security Rule;
- b. use appropriate safeguards, and comply with Subpart C of 45 C.F.R. Part 164 with respect to Electronic PHI, to prevent use or disclosure of PHI other than as provided for by this Agreement;
- c. implement and document appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of PHI that it creates, receives, maintains, or transmits for or on behalf of Covered Entity in accordance with 45 C.F.R. 164;
- d. implement and document administrative safeguards to prevent, detect, contain, and correct security violations in accordance with 45 C.F.R. 164;
- e. make its applicable policies and procedures required by the Security Rule available to Covered Entity solely for purposes of verifying BA’s compliance and the Secretary of the Department of Health and Human Services (HHS);
- f. not receive remuneration from a third party in exchange for disclosing PHI received from or on behalf of Covered Entity;
- g. in accordance with 45 C.F.R. 164.502(e)(1) and 164.308(b), if applicable, require that any Sub-Contractors that create, receive, maintain or transmit PHI 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; this shall be in the form of a written HIPAA Business Associate Contract and a fully executed copy will be provided to the Contract Monitor;
- h. report to Covered Entity in writing any use or disclosure of PHI that is not permitted under this Agreement as soon as reasonably practicable but in no event later than five calendar days from becoming aware of it and mitigate, to the extent practicable and in cooperation with Covered Entity, any harmful effects known to it of a use or disclosure made in violation of this Agreement;
- i. promptly report to Covered Entity in writing and without unreasonable delay and in no case later than five calendar days any successful Security Incident, as defined in the Security Rule, with respect to Electronic PHI;
- j. with the exception of law enforcement delays that satisfy the requirements of 45 C.F.R. 164.412, notify Covered Entity promptly, in writing and without

unreasonable delay and in no case later than five calendar days, upon the discovery of a breach of Unsecured PHI. Such notice shall include, to the extent possible, the name of each individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such Breach. Business Associate shall also, to the extent possible, furnish Covered Entity with any other available information that Covered Entity is required to include in its notification to Individuals under 45 C.F.R. § 164.404(c) at the time of Business Associate's notification to Covered Entity or promptly thereafter as such information becomes available. As used in this Section, "breach" shall have the meaning given such term at 45 C.F.R. 164.402;

- k. to the extent allowed by law, indemnify and hold Covered Entity harmless from all claims, liabilities costs, and damages arising out of or in any manner related to the unauthorized disclosure by Business Associate of any PHI resulting from the negligent acts or omissions of Business Associate or to the breach by Business Associate of any applicable obligation related to PHI;
- l. provide access to PHI it maintains in a Designated Record Set to Covered Entity, or if directed by Covered Entity to an Individual in order to meet the requirements of 45 C.F.R. 164.524. In the event that any Individual requests access to PHI directly from Business Associate, Business Associate shall forward such request to Covered Entity within five working days of receiving a request. This shall be in the form of a written HIPAA Business Associate Contract and a fully executed copy will be provided to the Contract Monitor. Any denials of access to the PHI requested shall be the responsibility of Covered Entity;
- m. make PHI it maintains in a Designated Record Set available to Covered Entity for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. 164.526;
- n. document disclosure of PHI it maintains in a Designated Record Set and information related to such disclosure as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI, in accordance with 45 C.F.R. 164.528, and within five working days of receiving a request from Covered Entity, make such disclosure documentation and information available to Covered Entity. In the event the request for an accounting is delivered directly to Business Associate, Business Associate shall forward within five working days of receiving a request such request to Covered Entity;
- o. make its internal practices, books, and records related to the use and disclosure of PHI received from or created or received by Business Associate on behalf of Covered Entity available to the Secretary of the Department of HHS, authorized governmental officials, and Covered entity for the purpose of determining Business Associate's compliance with the Privacy Rule. Business Associate shall give Covered Entity advance written notice of requests from HHS or government officials and provide Covered Entity with a copy of all documents made available; and

- p. require that all of its Sub-Contractors, vendors, and agents to whom it provides PHI or who create, receive, use, disclose, maintain, or have access to Covered Entity's PHI shall agree in writing to requirements, restrictions, and conditions at least as stringent as those that apply to Business Associate under this Agreement, including but not limited to implementing reasonable and appropriate safeguards to protect PHI, and shall require that its Sub-Contractors, vendors, and agents agree to indemnify and hold harmless Covered Entity for their failure to comply with each of the provisions of this Agreement.

26.5 Permitted Uses and Disclosures of PHI by Business Associate: Except as otherwise provided in this Agreement, Business Associate may use or disclose PHI on behalf of or to provide services to Covered Entity for the purposes specified in this Agreement, if such use or disclosure of PHI would not violate the Privacy Rule if done by Covered Entity. Unless otherwise limited herein, Business Associate may:

- a. use PHI for its proper management and administration or to fulfill any present or future legal responsibilities of Business Associate;
- b. disclose PHI for its proper management and administration or to fulfill any present or future legal responsibilities of Business Associate, provided that; (i) the disclosures required by law; or (ii) Business Associate obtains reasonable assurances from any person to whom the PHI is disclosed that such PHI will be kept confidential and will be used or further disclosed only as Required by Law or for the purpose(s) for which it was disclosed to the person, and the person commits to notifying Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached;
- c. disclose PHI to report violations of law to appropriate federal and state authorities; or
- d. aggregate the PHI with other data in its possession for purposes of Covered Entity's Health Care Operations;
- e. make uses and disclosures and requests for protected health information consistent with Covered Entity's minimum necessary policies and procedures;
- f. de-identify any and all PHI obtained by Business Associate under this BAA, and use such de-identified data, all in accordance with the de-identification requirements of the Privacy Rule [45 C.F.R. § 164.502(d)].

26.6 Obligations of Covered Entity

- a. 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 PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
- b. Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to or is required to abide by under 45 C.F.R. 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of protected health information.

- c. Covered Entity shall not request Business Associate use or disclose PHI in any manner that would violate the Privacy Rule if done by Covered Entity.
- d. Covered Entity agrees to timely notify Business Associate, in writing, of any arrangements between Covered Entity and the Individual that is the subject of PHI that may impact in any manner the use and/or disclosure of the PHI by Business Associate under this BAA.
- e. Covered Entity shall provide the minimum necessary PHI to Business Associate.

26.7 Term and Termination:

- a. **Obligations of Business Associate upon Termination.** Upon termination of this Agreement for any reason, Business Associate, with respect to PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, shall as applicable:
 - i. retain only that PHI that is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
 - ii. return to Covered Entity (or, if agreed to by Covered Entity, destroy) the remaining PHI that the Business Associate still maintains in any form;
 - iii. continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;
 - iv. not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at above under “Permitted Uses and Disclosures By Business Associate” that applied prior to termination; and
 - v. return to Covered Entity (or, if agreed to by Covered Entity, destroy) the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.
- b. All other applicable obligations of Business Associate under this Agreement shall survive termination.
- c. Should the applicable State of Oklahoma agency become aware of a pattern of activity or practice that constitutes a material breach of a material term of this BAA by Business Associate, the agency shall provide Business Associate with written notice of such a breach in sufficient detail to enable Contractor to understand the specific nature of the breach. The Client shall be entitled to terminate the Underlying Contract associated with such breach if, after the applicable State of Oklahoma agency provides the notice to Business Associate, Business Associate fails to cure the breach within a reasonable time period not less than thirty (30) days specified in such notice; provided, however, that such

time period specified shall be based on the nature of the breach involved per 45 C.F.R. §§ 164.504(e)(1)(ii)-(iii) & 164.314 (a)(2)(i)(C).

26.8 Miscellaneous Provisions:

- a. No Third-Party Beneficiaries: Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.
- b. Business Associate recognizes that any material breach of this Business Associate Terms section or breach of confidentiality or misuse of PHI may result in the termination of this Agreement and/or legal action. Said termination may be immediate and need not comply with any termination provision in the parties' underlying agreement, if any.
- c. The parties agree to amend this Agreement from time to time as is necessary for Covered Entity or Business Associate to comply with the requirements of the Privacy Rule and related laws and regulations.
- d. The applicable State of Oklahoma agency shall make available its Notice of Privacy Practices.
- e. Any ambiguity in this Agreement shall be resolved in a manner that causes this Agreement to comply with HIPAA.
- f. If Business Associate maintains a designated record set in an electronic format on behalf of Covered Entity, then Business Associate agrees that within 30 calendar days of expiration or termination of the parties' agreement, Business Associate shall provide to Covered Entity a complete report of all disclosures of and access to the designated record set covering the three years immediately preceding the termination or expiration. The report shall include patient name, date and time of disclosures/access, description of what was disclosed/accessed, purpose of disclosure/access, name of individual who received or accessed the information, and, if available, what action was taken within the designated record set.
- g. Amendment: To the extent that any relevant provision of the HIPAA Regulations is materially amended in a manner that changes the obligations of Business Associates or Covered Entities, the Parties agree to negotiate in good faith appropriate amendment(s) to this Agreement to give effect to these revised obligations. The parties agree to amend this Agreement from time to time as is necessary for Covered Entity or to comply with the requirements of the Privacy Rule and related laws and regulations.

27 **42 C.F.R. PART 2 RELATED PROVISIONS**

- 27.1** Confidentiality of Information. Contractor's employees and agents shall have access to private data to the extent necessary to carry out the responsibilities, limited by the terms of this Agreement. Contractor accepts the responsibilities for providing adequate administrative supervision and training to their employees and agents to ensure

compliance with relevant confidentiality, privacy laws, regulations and contractual provisions. No private or confidential data collected, maintained, or used shall be disseminated except as authorized by statute and by terms of this Agreement, whether during the period of the Agreement or thereafter. Furthermore, Contractor:

- 27.2** Acknowledges that in receiving, transmitting, transporting, storing, processing, or otherwise dealing with any information received pursuant to this agreement that identifies or otherwise relates to the individuals under the care of or in the custody of a State of Oklahoma agency, it is fully bound by the provisions of the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the HIPAA, 45 C.F.R. 45 Parts 142, 160, and 164, Title 43 A § 1-109 of Oklahoma Statutes, and may not use or disclose the information except as permitted or required by this Agreement or by law;
- 27.3** Acknowledges that pursuant to 43A O.S. §1-109, all mental health and drug or alcohol treatment information and all communications between physician or psychotherapist and patient are both privileged and confidential and that such information is available only to persons actively engaged in treatment of the client or consumer or in related administrative work. Contractor agrees that such protected information shall not be available or accessible to staff in general and shall not be used for punishment or prosecution of any kind;
- 27.4** Agrees to resist any efforts in judicial proceedings to obtain access to the protected information except as expressly provided for in the regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
- 27.5** Agrees to, when applicable and to the extent within Contractor's control, use appropriate administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the State of Oklahoma agency and to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected health information, and agrees that protected information will not be placed in the Child Protective Services (CPS) record of any individual involved with the Oklahoma Department of Human Services (DHS).
- 27.6** Agrees to report to the State of Oklahoma agency any use or disclosure or any security incident involving protected information not provided for by this Agreement. Such a report shall be made immediately when an employee becomes aware of such a disclosure, use, or security incident.
- 27.7** Agrees to provide access to the protected information at the request of the State of Oklahoma agency or to an authorized individual as directed by the State of Oklahoma agency, in order to meet the requirement of 45 C.F.R. §164.524 which provides clients with the right to access and copy their own protected information;
- 27.8** Agrees to make any amendments to the protected information as directed or agreed to by the State of Oklahoma agency, pursuant to 45 C.F.R. §164.526;
- 27.9** Agrees to make available its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of protected information received from the

State of Oklahoma agency or created or received by the Contractor on behalf of the State of Oklahoma agency, to the State of Oklahoma agency and to the Secretary of the Department of Health and Human Services for purpose of the Secretary determining the giving party's compliance with HIPAA;

- 27.10** Agrees to provide the State of Oklahoma agency, or an authorized individual, information to permit the State of Oklahoma agency to respond to a request by an individual for an accounting of disclosures in accordance with 45 C.F.R. §164.528.

28 DATA SECURITY

The Contractor agrees to, when applicable and to the extent within Contractor's control, maintain the data in a secure manner compatible with the content and use. The Contractor will, when applicable to the extent within Contractor's control, control access to the data in Contractor's possession or control compliance with the terms of this Agreement. Only the Contractor's personnel whose duties require the use of such information, will have regular access to the data. The Contractor's employees will be allowed access to the data only for the purpose set forth in this Agreement.

- 28.1** Data Destruction. Contractor agrees to, when applicable and to the extent within Contractor's control, follow State of Oklahoma agency policies regarding secure data destruction.

- 28.2** Use of Information. Contractor agrees that the information received or accessed through this Agreement shall not be used to the detriment of any individual nor for any purpose other than those stated in this Agreement.

- 28.3** Redisclosure of Data. The Contractor agrees not to redisclose any information to a third party not covered by the Agreement unless written permission by the State of Oklahoma agency is received and redisclosure is permitted under applicable law.

29 FEDERAL TAX INFORMATION REQUIREMENTS IRS PUBLICATION 1075

- 29.1** PERFORMANCE: If Contractor takes possession or control of Federal Tax Information in performance of this contract, the Contractor agrees to, when applicable and to the extent within Contractor's control, comply with and assume responsibility for compliance by officers or employees with the following requirements:

- 29.2** All work will be performed under the supervision of the State of Oklahoma.

- 29.3** The contractor and contractor's officers or employees to be authorized access to FTI must meet background check requirements defined in IRS Publication 1075. The contractor will maintain a list of officers or employees authorized access to FTI. Such list will be provided to the agency and, upon request, to the IRS.

- 29.4** FTI in hardcopy or electronic format shall be used only for the purpose of carrying out the provisions of this contract. FTI in any format shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this contract. Inspection or disclosure of FTI to anyone other than the contractor or the contractor's officers or employees authorized is prohibited.

- 29.5** FTI will be accounted for upon receipt and properly stored before, during, and after processing. In addition, any related output and products require the same level of protection as required for the source material.
- 29.6** The contractor will certify that FTI processed during the performance of this contract will be completely purged from all physical and electronic data storage with no output to be retained by the contractor at the time the work is completed. If immediate purging of physical and electronic data storage is not possible, the contractor will certify that any FTI in physical or electronic storage will remain safeguarded to prevent unauthorized disclosures.
- 29.7** Any spoilage or any intermediate hard copy printout that may result during the processing of FTI will be given to the agency. When this is not possible, the contractor will be responsible for the destruction of the spoilage or any intermediate hard copy printouts and will provide the agency with a statement containing the date of destruction, description of material destroyed, and the destruction method.
- 29.8** All Contractor computer systems receiving, processing, storing, or transmitting FTI must meet the requirements in IRS Publication 1075. To meet functional and assurance requirements, the security features of the environment must provide for the managerial, operational, and technical controls. All security features must be available and activated to protect against unauthorized use of and access to FTI.
- 29.9** No work involving FTI furnished under this contract will be subcontracted without the prior written approval of the IRS.
- 29.10** Contractor will ensure that the terms of FTI safeguards described herein are included, without modification, in any approved subcontract for work involving FTI.
- 29.11** To the extent the terms, provisions, duties, requirements, and obligations of this contract apply to performing services with FTI, the contractor shall assume toward the subcontractor all obligations, duties and responsibilities that the agency under this contract assumes toward the contractor, and the subcontractor shall assume toward the contractor all the same obligations, duties and responsibilities which the contractor assumes toward the agency under this contract.
- 29.12** In addition to the subcontractor's obligations and duties under an approved subcontract, the terms and conditions of this contract apply to the subcontractor, and the subcontractor is bound and obligated to the contractor hereunder by the same terms and conditions by which the contractor is bound and obligated to the agency under this contract.
- 29.13** For purposes of this contract, the term "contractor" includes any officer or employee of the contractor with access to or who uses FTI, and the term "subcontractor" includes any officer or employee of the subcontractor with access to or who uses FTI.
- 29.14** The agency will have the right to void the contract if the contractor fails to meet the terms of FTI safeguards described herein.

30 CRIMINAL/CIVIL SANCTIONS

- 30.1** Each officer or employee of a contractor to whom FTI is or may be disclosed shall be notified in writing that FTI disclosed to such officer or employee can be used only for a purpose and to the extent authorized herein, and that further disclosure of any FTI for a purpose not authorized herein constitutes a felony punishable upon conviction by a fine of as much as \$5,000 or imprisonment for as long as 5 years, or both, together with the costs of prosecution.
- 30.2** Each officer or employee of a contractor to whom FTI is or may be accessible shall be notified in writing that FTI accessible to such officer or employee may be accessed only for a purpose and to the extent authorized herein, and that access/inspection of FTI without an official need-to-know for a purpose not authorized herein constitutes a criminal misdemeanor punishable upon conviction by a fine of as much as \$1,000 or imprisonment for as long as 1 year, or both, together with the costs of prosecution.
- 30.3** Each officer or employee of a contractor to whom FTI is or may be disclosed shall be notified in writing that any such unauthorized access, inspection or disclosure of FTI may also result in an award of civil damages against the officer or employee in an amount equal to the sum of the greater of \$1,000 for each unauthorized access, inspection, or disclosure, or the sum of actual damages sustained as a result of such unauthorized access, inspection, or disclosure, plus in the case of a willful unauthorized access, inspection, or disclosure or an unauthorized access/inspection or disclosure which is the result of gross negligence, punitive damages, plus the cost of the action. These penalties are prescribed by IRC sections 7213, 7213A and 7431 and set forth at 26 CFR 301.6103(n)-1.
- 30.4** Additionally, it is incumbent upon the contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a(i)(1), which is made applicable to contractors by 5 U.S.C. 552a(m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than \$5,000.
- 30.5** Granting a contractor access to FTI must be preceded by certifying that each officer or employee understands the agency's security policy and procedures for safeguarding FTI. A contractor and each officer or employee must maintain their authorization to access FTI through annual recertification of their understanding of the agency's security policy and procedures for safeguarding FTI. The initial certification and recertifications must be documented and placed in the agency's files for review. As part of the certification and at least annually afterwards, a contractor and each officer or employee must be advised of the provisions of IRC sections 7213, 7213A, and 7431 (see IRS Publication 1075, Exhibit 4, Sanctions for Unauthorized Disclosure, and IRS Publication 1075, Exhibit 5, Civil Damages for Unauthorized Disclosure). The training on the agency's security policy and procedures provided before the initial certification and annually thereafter must also cover the incident response policy and procedure for reporting unauthorized disclosures and data breaches. For the initial certification and the annual recertifications, the contractor and each officer or employee must sign, either with ink or

electronic signature, a confidentiality statement certifying their understanding of the security requirements.

31 INSPECTION

The IRS and the Agency, with 24-hour notice, shall have the right to send its inspectors into the offices and plants of the contractor to inspect facilities and operations performing any work with FTI under this contract for compliance with requirements defined in IRS Publication 1075. The IRS' right of inspection shall include the use of manual and/or automated scanning tools to perform compliance and vulnerability assessments of information technology (IT) assets that access, store, process or transmit FTI. Based on the inspection, corrective actions may be required in cases where the contractor is found to be noncompliant with FTI safeguard requirements.

32 SSA REQUIREMENTS

- 32.1** PERFORMANCE: If Contractor takes possession or control of in SSA provided information in the performance of this contract, the contractor agrees to, where applicable and to the extent within Contractor's control comply with and assume responsibility for compliance by his or her employees with the following requirements:
- 32.2** All work will be done under the supervision of the State of Oklahoma.
- 32.3** Any SSA provided information made available shall be used only for carrying out the provisions of this Agreement. Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this contract. Inspection by or disclosure to anyone other than an officer or employee of the Contractor is prohibited.
- 32.4** All SSA provided information shall be accounted for upon receipt and properly stored before, during, and after processing. In addition, all related output and products will be given the same level of protection as required for the source material.
- 32.5** No work involving SSA provided information furnished under this contract shall be subcontracted without prior written approval by the applicable State of Oklahoma agency and the SSA.
- 32.6** The Contractor shall maintain a list of employees authorized access. Such list shall be provided upon request to the applicable State of Oklahoma agency or the SSA.
- 32.7** Contractor or agents may not legally process, transmit, or store SSA-provided information in a cloud environment without explicit permission from SSA's Chief Information Officer. Proof of this authorization shall be provided to the Contractor by the applicable State of Oklahoma agency prior to accessing SSA provided information.
- 32.8** Contractor shall provide security awareness training to all employees, contractors, and agents who access SSA-provided information. The training should be annual, mandatory, and certified by the personnel who receive the training. Contractor is also required to certify that each employee, contractor, and agent who views SSA-provided information certify that they understand the potential criminal, civil, and administrative sanctions or penalties for unlawful assess and/or disclosure.

- 32.9** Contractor shall require employees, contractors, and agents to sign a non-disclosure agreement, attest to their receipt of Security Awareness Training, and acknowledge the rules of behavior concerning proper use and security in systems that process SSA-provided information. Contractor shall retain non-disclosure attestations for at least five (5) to seven (7) years for each employee who processes, views, or encounters SSA-provided information as part of their duties.
- 32.10** The applicable State of Oklahoma agency shall provide the Contractor a copy of the SSA exchange agreement and all related attachments before initial disclosure of SSA data. Contractor is required to follow the terms of the applicable State of Oklahoma agency's data exchange agreement with the SSA. Prior to signing this Agreement, and thereafter at SSA's request, the applicable State of Oklahoma agency shall obtain from the Contractor a current list of the employees of such Contractor with access to SSA data and provide such list to the SSA.
- 32.11** Where the Contractor processes, handles, or transmits information provided to the applicable State of Oklahoma agency by SSA or has authority to perform on the agency's behalf, the applicable State of Oklahoma agency shall clearly state the specific roles and functions of the Contractor within the Agreement.
- 32.12** SSA requires all parties subject to this Agreement to exercise due diligence to avoid hindering legal actions, warrants, subpoenas, court actions, court judgments, state or Federal investigations, and SSA special inquiries for matters pertaining to SSA-provided information.
- 32.13** SSA requires all parties subject to this Agreement to agree that any Client-owned or subcontracted facility involved in the receipt, processing, storage, or disposal of SSA-provided information operate as a "de facto" extension of the Client and is subject to onsite inspection and review by the Client or SSA with prior notice.
- 32.14** If the Contractor must send a Contractor computer, hard drive, or other computing or storage device offsite for repair, the Contractor must have a non-disclosure clause in their contract with the vendor. If the Contractor used the item in a business process that involved SSA-provided information and the vendor will retrieve or may view SSA-provided information during servicing, SSA reserves the right to inspect the Contractor's vendor contract. The Contractor must remove SSA-provided information from electronic devices before sending it to an external vendor for service. SSA expects the Contractor to render SSA-provided information unrecoverable or destroy the electronic device if they do not need to recover the information. The same applies to excessed, donated, or sold equipment placed into the custody of another organization.
- 32.15** In the event of a suspected or verified data breach involving SSA provided information, the Contractor shall notify the Client immediately.
- 32.16** The Client shall have the right to void the contract if the contractor fails to provide the safeguards described above.

33 CRIMINAL/CIVIL SANCTIONS

The Act specifically provides civil remedies, 5 U.S.C. Sec. 552a(g), including damages, and criminal penalties, 5 U.S.C. Sec. 552a(i), for violations of the Act. The civil action provisions are premised violations of the Act committed by parties subject to this Agreement or regulations promulgated thereunder. An individual claiming such a violation by parties subject to this Agreement may bring civil action in a federal district court. If the individual substantially prevails, the court may assess reasonable attorney fees and other litigation costs. In addition, the court may direct the parties subject to this Agreement to grant the plaintiff access to his/her records, and when appropriate direct an amendment or correction of records subject to the Act. Actual damages may be awarded to the plaintiff for intentional or willful refusal by parties subject to this Agreement to comply with the Act.

33.1 Civil Remedies

- a. In any suit brought under the provisions of 5 U.S.C. § 552a(g)(1)(C) or (D) in which the court determines that the parties subject to this Agreement acted in a manner which was intentional or willful, shall be liable in an amount equal to the sum of
- b. actual damages sustained by the individual because of the refusal or failure, but in no case, shall a person entitled to recovery receive less than the sum of \$1,000; and
- c. the costs of the action together with reasonable attorney fees as determined by the court.
- d. An action to enforce any liability created under 5 U.S.C. § 552a may be brought in the district court of the United States in the district in which the complainant resides, or has his principal place of business, or in which the records are situated, or in the District of Columbia, without regard to the amount in controversy, within two years from the date on which the cause of action arises, except that where parties subject to this Agreement have materially and willfully misrepresented any information required under this section to be disclosed to an individual and the information so misrepresented is material to establishment of the liability of the agency to the individual under 5 U.S.C. § 552a, the action may be brought at any time within two years after discovery by the individual of the misrepresentation. Nothing in this section shall be construed to authorize any civil action because of any injury sustained as the result of a disclosure of a record prior to September 27, 1975.

33.2 Criminal Penalties

- a. Any officer or employee of an agency, who by virtue of his employment or official position, has possession of, or access to, agency records which contain individually identifiable information the disclosure of which is prohibited by this section or by rules or regulations established thereunder, and who knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than \$5,000. See 5 U.S.C. § 552a(i)(1).

- b. Any officer or employee of any agency who willfully maintains a system of records without meeting the notice requirements of subsection (e)(4) of this section shall be guilty of a misdemeanor and fined not more than \$5,000. See 5 U.S.C. § 552a(i)(2).
- c. Any person who knowingly and willfully requests or obtains any record concerning an individual from an agency under false pretenses shall be guilty of a misdemeanor and fined not more than \$5,000. See 5 U.S.C. § 552a(i)(3).

34 CHILD SUPPORT FPLS REQUIREMENTS

- 34.1** Contractor, when applicable and to the extent within Contractor's control, and the applicable State of Oklahoma agency must comply with the security requirements established by the Social Security Act, the Privacy Act of 1974, the Federal Information Security Management Act of 2002 (FISMA), 42 United States Code (USC) 654(26), 42 UCS 654a(d)(1)-(5), the U.S. Department of Health and Human Services (HHS), the U.S. Department of Health and Human Services Administration of Children and Families Office of Child Support Enforcement Security Agreement and the Automated Systems for Child Support Enforcement: A Guide for States Section H Security and Privacy. Contractor and applicable State of Oklahoma agency also agree to use Federal Parent Locator Service (FPLS) information and Child Support (CS) program information solely for the authorized purposes in accordance with the terms in this agreement. The information exchanged between state Child Support agencies and all other state program information must be used for authorized purposes and protected against unauthorized access to reduce fraudulent activities and protect the privacy rights of individuals against unauthorized disclosure of confidential information.
- 34.2** This is applicable to the personnel, facilities, documentation, data, electronic and physical records and other machine-readable information systems of the applicable State of Oklahoma agency and Contractor, including, but not limited to, state employees and contractors working with FPLS information and CS program information and state CS agency data centers, statewide centralized data centers, contractor data centers, state Health and Human Services' data centers, comprehensive tribal agencies, data centers serving comprehensive tribes, and any other individual or entity collecting, storing, transmitting or processing FPLS information and CS program information. This is applicable to all FPLS information, which consists of the National Directory of New Hires (NDNH), Debtor File, and the Federal Case Registry (FCR). The NDNH, Debtor File and FCR are components of an automated national information system.
- 34.3** This is also applicable to all CS program information, which includes the state CS program information, other state and tribal program information, and confidential information. Confidential information means any information relating to a specified individual or an individual who can be identified by reference to one or more factors specific to him or her, including but not limited to the individual's Social Security number, residential and mailing addresses, employment information, and financial information. Ref. 45 Code of Federal Regulations (CFR) 303.21(a).

35 FERPA REQUIREMENTS

- 35.1** If Contractor takes possession or control of Information covered by FERPA in performance of this Agreement, Contractor agrees to, when applicable and to the extent within Contractor's control comply with and assume responsibility for compliance by its employees with the Family Educational Rights and Privacy Act; (20 U.S.C. § 1232g; 34 CFR Part 99) ("FERPA") and the Oklahoma Student Data Accessibility, Transparency, and Accountability Act of 2013; (70 O.S. § 3-168), where personally identifiable student education data is exchanged.

36 CJIS REQUIREMENTS

- 36.1** INTRODUCTION - This section shall be applicable to the extent that Contractor takes possession or control of CJIS data. The use and maintenance of all items of software or equipment offered for purchase herein must be in compliance with the most current version of the U.S. Department of Justice, Federal Bureau of Investigation ("FBI"), Criminal Justice Information Services (CJIS) Division's CJIS Security Policy ("CJIS Security Policy" or "Security Policy" herein).
- 36.2** The Entity or Affiliate acquiring the data or system is hereby ultimately responsible for compliance with the CJIS Security Policy and will be subject to an audit by the State of Oklahoma CJIS Systems Officer ("CSO") and the FBI CJIS Division's Audit Staff.
- 36.3** CJIS SECURITY POLICY REQUIREMENTS GENERALLY - The CJIS Security Policy outlines a number of administrative, procedural, and technical controls agencies must have in place to protect Criminal Justice Information ("CJI"). Our experience is that agencies will generally have many of the administrative and procedural controls in place but will need to implement additional technical safeguards in order to be in complete compliance with the mandate. A Criminal Justice Agency ("CJA") and certain other governmental agencies procuring technology equipment and services that could be used in hosting or connecting or transmitting or receiving CJI data may need to use the check list herein to make sure that the software, equipment, location, security, and persons having the ability to access CJI will meet the CJIS requirements per the then current CJIS Security Policy. A completed Appendix H to said Security Policy will need to be signed by Vendor or a 3rd party if it has access to CJI, such as incident to the maintenance or support of the purchased hardware or software within which resides CJI. Per Appendix "A" to said Security Policy, "access to CJI is the physical or logical (electronic) ability, right or privilege to view, modify or make use of CJI."
- 36.4** DIRECTIVE CONCERNING ACCESS TO CRIMINAL JUSTICE INFORMATION AND TO HARDWARE OR SOFTWARE WHICH INTERACTS WITH CJI AND CERTIFICATION- The FBI CJIS Division provides state-of-the-art identification and information services to the local, state, tribal, federal, and international criminal justice communities for criminal justice purposes, as well as the noncriminal justice communities for noncriminal justice purposes.
- 36.5** This Directive primarily concerns access to CJI and access to hardware and software in the use, retention, transmission, reception, and hosting of CJI for criminal justice purposes and not for noncriminal justice purposes. In that regard, this Directive is not only applicable to such data, but also to the hardware and software interacting with such data, their location(s), and persons having the ability to access such data. The CJIS data applicable to the Security Policy is the data described as such in said Policy plus all data

transmitted over the Oklahoma Law Enforcement Telecommunications System (“OLETS”) which is operated by DPS.

36.6 In order to have access to CJIS or to the aforesaid hardware or software, the vendor must be familiar with the FBI CJIS Security Policy, including but not limited to the following portions of said Security Policy:

- a. the Definitions and Acronyms in §3 & Appendices “A” & “B”;
- b. the general policies in §4;
- c. the Policies in §5;
- d. the appropriate forms in Appendices “D”, “E”, “F” & “H”; and
- e. the Supplemental Guidance in Appendices “J”.

36.7 This FBI Security Policy is located and may be downloaded at:

- a. https://le.fbi.gov/file-repository/cjis_security_policy_v5-9-2_20221207-5.pdf
- b. By executing the Contract to which this Directive is attached, the vendor hereby CERTIFIES that the foregoing directive has and will be followed, including but not limited to full compliance with the FBI CJIS Security Policy, as amended and as applicable.

37 NOTICES

37.1 In addition to notice requirements under the terms of the Contract otherwise, the following individuals shall also be provided the request, approval or notice, as applicable:

Chief Information Officer
3115 N. Lincoln Blvd
Oklahoma City, OK 73105

With a copy, which shall not constitute notice, to:

OMES Deputy General Counsel
3115 North Lincoln Blvd
Oklahoma City, Oklahoma 73105



Attachment E, EV00000681

Bidder Responses

Plan Year 2026 Health

Bidder must respond to each of the below items. If Bidder is also providing an exhibit, it should be referenced within this Attachment E.

A. ALL BIDS

A.1. Identify which one of the below bid combinations Bidder is offering:

- A.1.1. HMO and Medicare Supplement
- A.1.2. HMO and MAPD
- A.1.3. HMO and Medicare Supplement and MAPD
- A.1.4. Standalone national MAPD

Humana is proposing a standalone, national MAPD Passive PPO plan.

A.2. Financial Standing

- A.2.1. Does the Bidder 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?

Confirmed. Humana Insurance company is in good financial standing, not in any form of bankruptcy or zone of insolvency and is current in the payment of all taxes and fees.

A.3. Fraud and Abuse Investigations.

Describe how the Bidder will accomplish monitoring for fraud and abuse and provide EGID with a quarterly report of fraud and fraud-prevention activities and discoveries relating to the OEIBA Program, as well as when any fraudulent or suspicious activity relating to the OEIBA Program is detected or brought to the Bidder's attention by EGID or others.

Humana's fraud research, analytics and concepts team (FRAC) conducts a variety of initiatives to proactively detect insurance fraud, waste and abuse (FWA). This includes review of information provided through a variety of sources, including communications from government agencies, industry associations, and other private payers. These initiatives also include risk assessment and data analysis to determine which potential fraudulent activities require further investigation.

Data mining is performed based on identified risk. The process includes the accumulation and analysis of large amounts of data. The analysis of the data includes comparing claims information against other data, such as provider information, diagnoses, drugs purchased, member information, etc., which could assist in identifying potential instances of FWA by providers, prescribers, pharmacies, agents, and members.

State of the art software applications are utilized to construct analytical, statistical, and predictive models that identify and detect FWA. Models can be focused on specialty or type of services. Data is selected based upon detailed investigation and research into potential fraud schemes impacting



potential models. Data mining analysis attempts to identify data markers that potentially indicate FWA, including:

- Outlier analysis
- Trend analysis
- Anomaly detection
- Statistical analysis
- Rules based anomaly detection

Humana's FRAC team utilizes Power BI for data mining to aid in the detection and prevention of healthcare claims fraud and assist in the investigation process. SIU and FRAC utilize this tool to build dynamic models that can accept data from many different sources. It can take large amounts of data and, using a variety of visualizations, can dynamically identify interesting and suspicious billing patterns.

A FRAC analyst reviews the output of a data mining model for accuracy and applicability. Suspected cases of FWA are referred through the case tracking system for triage review. Feedback is applied to the enhancement of the data mining model.

Claim Code Edits

Humana develops claim code editing logic internally and partners with several outside organizations to obtain recommendations for claim code editing logic. In all cases, the claim code editing rules are reviewed and approved by a multidisciplinary group that includes medical directors, nurses, certified coders and policy/compliance consultants. The rules are based on correct coding, industry and specialty society billing guidelines, AMA directives, CMS coding and billing guidelines, state and federal guidelines, and standards of medical practice. examples include bundling/NCCI, DX to PX, Maximum Units, Modifier Validity, Age and Place of Service.

Prepayment Review of Claims

The SIU may utilize a pre-pay review process to identify and prevent payment on fraudulent or inappropriate claims submitted by providers SIU is investigating. During the course of an investigation, the investigator may determine that pre-pay review of a provider's claims is warranted to identify and stop payment on potentially fraudulent or inappropriate claims or codes.

A.4. Eligibility Transmission

What is the Bidder's policy regarding retroactive changes/terminations/adds?

Retroactivity rules follow the enrollment and disenrollment guidelines established by CMS. Retroactive changes are not permitted per CMS' regulations. Cases can be filed to allow such changes; however, EGID must submit documentation stating that the enrollment holdup was due to the group and not the member. Enrollment must be received by EGID prior to the requested effective date and terminations must be received prior to the requested end date. Cancellations must be received prior to the member's effective date. Cases filed with CMS may take up to 90 days, and there is no guarantee that the case will be approved.

**A.5. Network Changes**

Describe how Bidder will provide notification to members as required.

Humana does everything in our power to provide our members with a consistent member experience allowing members to see any provider in or out of Humana's network as long as the provider is willing to bill Humana. Periodically there can be a provider termination that results in a provider ceasing to bill Humana for non-emergency services.

Outbound calls will be made to members when a provider terminates from the Medicare network. These calls will be automated through Virgin Pulse and the member will be given an option to transfer to an advocate if further assistance is needed.

Typically the first point of escalation for a provider issue is EGID's dedicated account concierge specialist, Meridith Warner, who will use her resources to resolve the issue. Should the provider issue require further escalation, your senior account executive, Julie Bodenski, will work to address the provider issue with provider engagement and network leadership as appropriate, providing status reports to EGID as needed.

For a major medical provider term or a term that impacts over 50 members, Julie will notify EGID in a timely manner.

A.6. Internal Grievance Procedures

A.6.1. Provide the third-party company information (i.e., name, location, contact information) that members appeal to for grievances, if applicable.

Not applicable; grievances are handled internally in accordance with CMS guidelines.

A.6.2. How many grievances has Bidder had regarding the network in the prior calendar year per 1,000 members?

Typically, a grievance is in regards to quality of care, not regarding the network.

A.7. Reporting

A.7.1 Indicate (by report number in Exhibit 27) which of the reports the Bidder already makes public in some form.

Humana does not make any of the reports listed in Exhibit 27 public.

A.8. Acquisitions and Mergers

A.8.1 Are there any known or planned name change for the Bidder's company over the next twelve (12) to twenty-four (24) months?

At this time there are no known or planned name changes for Humana for the next 12 to 24 months.



A.8.2 Summarize any mergers with or acquisitions of other organizations completed in the past twenty-four (24) months and summarize how these actions directly impact this solicitation.

In August 2024, CenterWell Home Health (a wholly owned subsidiary of Humana Inc.), completed the acquisition of select home health assets of Intrepid USA, a full-service provider of home health, hospice and personal care services headquartered in Dallas, Texas. This acquisition supports the expansion strategy for Humana's Home Solutions business and allows CenterWell Home Health to further scale its home health offerings across the country, putting the combined organization in a stronger position to improve health outcomes and deliver holistic, value-based care (VBC) in a variety of settings. Furthermore, it adds talented associates to Humana's growing clinical workforce to advance our integrated senior care strategy.

A.8.3 Describe, to the best of Bidder's knowledge, any acquisitions or mergers which Bidder is expected to be involved within the next twelve (12) months.

Humana has a long-standing policy of not commenting on future merger or acquisition activities. We cannot comment on rumor, speculation, or news reports about our merger or acquisition activities. Please refer to our most recent quarterly (10-Q) and annual (10-K) financial and business reports filed with the Securities and Exchange Commission (SEC) for any pending or recently completed, publicly announced transactions. These documents can be found online at [Humana.com](https://www.humana.com) under Investor Relations – SEC Filings.

A.9. Implementation

A.9.1. New Supplier Transition Process. Provide the following information:

As the incumbent, the New Supplier Transition Process is not applicable.

A.9.1.1 Provide the Transition Manager name and contact information.

Damont Neeley has been with Humana for nearly 19 years and has been in his current role for nearly seven years. He has served EGID since their implementation with Humana in 2020.

Following is his contact information:
 Email address: dneeley@humana.com
 Phone: 502-580-7027

A.9.1.2 How many other implementation projects will the Transition Manager work on in addition to this contract?

Damont currently oversees 30 groups, including EGID. Our installation administration professionals standardly have no more than three new implementations at one time. Installation administration professionals also manage renewing clients.



A.9.1.3 Provide a copy of a typical implementation project plan.

As the incumbent, an implementation project plan is not necessary to outline the process of transitioning since EGID's plan is already in place with Humana.

A.10. Premium Calculation

A.10.1 Describe the methodology used for developing the rates being proposed.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] for risk score, sequestration, and any CMS reimbursement methodology changes.



[REDACTED]

[REDACTED]

[REDACTED]

A.11. License

A.11.1 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 Bidder must provide a copy of its license issued by the Insurance Commissioner for the State of Oklahoma. Refer to Exhibit 18.

The Oklahoma Secretary of State does not register insurance companies pursuant to OK State § 18-1132(A)(5). As such, Humana Insurance Company maintains our authority to transact business in Oklahoma through the OK Insurance Department.

Humana has included our Certificate of Authority as Exhibit 18.

A.12. Actuary Certification

A.12.1 Bidders are required to submit a statement from a qualified actuary certifying that the Bidder's information submitted in response to Exhibits 6-9 and Exhibits 15 and 16 are true, complete, and accurately reflects the experience of this account. The qualified actuary certification shall be submitted as part of the Bidder's response to this RFP (Exhibit 19). A "qualified 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 signed actuary certification for each proposed plan will not be accepted and the Bidder shall be ineligible for award of contract.

Please refer to Exhibit 19 for Humana's actuarial certification.

A.13. Lawsuits and Litigation

A.13.1. 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 Bidder 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 preceding the Plan Year or affirm there are none.

Humana is party to a variety of legal actions in the ordinary course of business. Humana does not expect that any of the recent or pending litigation against Humana Insurance Company could reasonably be expected to impair our performance under this contract.

Please refer to our most recent quarterly (10-Q) and annual (10-K) financial and business reports filed with the Securities and Exchange Commission (SEC) for recent and pending litigation that Humana deems material for disclosure purposes.

- A.13.2. 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 Solicitation Specifications in this RFP that was initiated by persons or entities against the Bidder that resulted in a settlement with or judgment against the Bidder 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.**

Humana affirms there are none.

Humana is party to a variety of legal actions in the ordinary course of business. Humana does not expect that any of the recent or pending litigation against Humana Insurance Company could reasonably be expected to impair our performance under this contract.

Please refer to our most recent quarterly (10-Q) and annual (10-K) financial and business reports filed with the Securities and Exchange Commission (SEC) for recent and pending litigation that Humana deems material for disclosure purposes.

- A.13.3. Disclose any data security breaches and specifically HIPAA security breaches that required notification to affected persons or a regulatory authority.**

Humana takes the privacy of our members' information seriously and as such addresses and reports any inappropriate use or disclosure of information promptly and effectively in accordance with applicable laws, contractual obligations, and industry best practices.

Notwithstanding its industry-leading compliance program, like all major healthcare companies, Humana and its subsidiaries may have data breaches. Humana reports breaches involving 500 or more individuals as required by law. Details of those events can be found on the Office for Civil Rights website at: ocrportal.hhs.gov/ocr/breach/breach_report.jsf.

- A.13.4. List and describe any current malpractice suits filed against the Bidder or a provider in the network.**

Humana is party to a variety of legal actions in the ordinary course of business. Humana does not expect that any of the recent or pending litigation against Humana Insurance Company could reasonably be expected to impair our performance under this contract.



Please refer to our most recent quarterly (10-Q) and annual (10-K) financial and business reports filed with the Securities and Exchange Commission (SEC) for recent and pending litigation that Humana deems material for disclosure purposes.

A.14. P-Cards

A.14.1. The State of Oklahoma has issued payment cards to most State agencies. The current P-Card contract holder utilizes VISA. If awarded a contract, will your company accept the State of Oklahoma approved purchase card? Indicate whether "Yes" or "No."

No.

EGID's current method of payment is wire transfer. Groups cannot pay premiums via Debit/Credit card so the P-Card would unfortunately not be an option.

A.15. Electronic Funds Transfer (EFT)

A.15.1. The State of Oklahoma passed legislation in 2012 requiring funds disbursed from the State Treasury be sent electronically. If awarded a contract will your company accept payment for invoices from the State by EFT? Indicate whether "Yes" or "No."

Yes.

EGID currently pays via wire transfer and can continue using this payment method.

D. MAPD PROPOSAL

D.1. The Bidder shall complete Exhibit 9 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.

Confirmed.

Please refer to Humana's completed Exhibit 9, MAPD Benefits Summary.

D.2. Bidder Identification. Provide a response to each item listed below.

D.2.1. Bidder's legal name.

Humana's national standalone Passive MAPD PPO plan is offered by Humana Insurance Company.

CareNetwork, Inc., a Wisconsin-based, general business corporation, owns 100% of the issued and outstanding stock of Humana Insurance Company. CareNetwork, Inc. is a wholly owned subsidiary of Humana Inc., the ultimate parent in the holding company system.



D.2.2. Address (including city, state, and zip code).

Humana's headquarters are located at 500 West Main Street, Louisville, Kentucky 40202.

D.2.3. Office location responsible for this account, if different than above. If this office will be located outside of Oklahoma, explain the Bidder's plans to interact closely with EGID.

Our Group Medicare Customer Care and Claims Processing teams are located in Louisville, Kentucky.

Julie Bodenski will continue to serve as the designated senior account executive for EGID. Julie is located in Luther, Oklahoma. She will be the main point of contact for EGID and is able to make in-person visits with EGID and attend required member-facing meetings.

D.2.4. Trade name that the Bidder intends to use for marketing purposes.

The trade name for marketing purposes is Humana.

D.2.5. Provide contact information (name and phone number) of a customer service supervisor for MAPD plan.

Justin Hill, Consumer Service Operations Lead
502-476-5298

D.2.6. Provide an electronic copy of the Bidder's brand logo that the Bidder intends to use for marketing purposes. This should be in the form of a vector graphic or a high-resolution JPG/PNG of at least 300 dpi (Exhibit 21).

Please refer to Exhibit 21 for the Humana logo.

NOTE: Following Humana Brand standards, if EGID wishes to use our logo, EGID would need to visit the Humana Brand site and follow the steps regarding Humana logo usage. The request for usage will be reviewed and can be denied.

Your communications consultant, Nathalie Farris, will assist EGID to facilitate any co-branding opportunities upon request.

D.2.7. Name and contact information (e.g., title, phone number(s), and email address) for Account Manager that will be assigned to the OEIBA Program.

Julie Bodenski, Senior Account Executive
Phone: 720-252-7728
Email: jbodenski@humana.com



D.2.8. Include years of experience, the number of other clients, and the size and industry of clients.

Humana offered our first private Medicare coordinated plans in 1985 and our first Medicare secondary plans for employers in 1990. Since then, we have continuously provided the stability, depth of expertise, infrastructure, and sophistication to meet all our Medicare members' needs.

In 2003, with the passage of the Medicare Modernization Act in 2003, which introduced Part D coverage and renamed the plans to "Medicare Advantage," we developed and executed an aggressive plan to grow both our Medicare product lines and service areas. In 2007, we implemented Group Medicare Prescription Drug Plans (PDP) and Medicare Advantage private fee-for-service (PFFS) plans throughout the United States and Puerto Rico.

Today, Humana is licensed to offer employee-sponsored, network-based MA solutions in all 50 states plus the District of Columbia and Puerto Rico. Humana is also licensed to cover retirees residing in the US Virgin Islands, Guam, Marianas Islands and American Samoa. Medicare is a significant part of Humana's business, with over 8.25 million members we are one of the largest Medicare Advantage carriers nationwide.

We serve over 600 Group Medicare accounts with over 600,000 members. Our customers come from many different business segments including federal, state and local entities, higher education, Taft-Hartley and other union-based organizations, as well as private industry. Our member counts for our customers range from under 50 employees to over 50,000 employees.

To serve the large size and geographic scope of Humana's Medicare Advantage program, we have built a large infrastructure to support our Medicare and other senior products. As of today, our Senior Products Division has nearly 14,000 associates engaged in supporting every aspect of Medicare plan operations: product development, sales, compliance, enrollment, claims processing, and member services.

For over 60 years, Humana has been the nation's premier health benefits innovator. We leverage new products, technology, and partnerships to deliver solutions that evolve with the healthcare landscape and ensure our members have access to convenient, affordable care. Our goal is to continuously evolve the solutions we offer to best fit your needs, while maintaining focus on member engagement, quality products, service excellence, and whole-person health.

D.2.9. Name and contact information (e.g., title, phone number(s), and email address) for highest ranking official with direct involvement with the OEIBA Program's account.

Stephanie Heller, Director, Group Medicare Account Management
Phone: 502-476-4534
Email: sheller2@humana.com



D.2.10. The name and contact information (e.g., title, phone number(s), and email address) for the Bidder's designated personnel authorized to enter into BAFO competitive negotiations. In the event the Bidder's designated personnel changes, the Bidder's shall notify OMES/CP immediately in writing.

Scott Richardson, Associate Vice President, Group Medicare
 Phone: 502-580-2227
 Email: srichardson3@humana.com

D.2.11. Outline the account management team that will be assigned to EGID upon contract.

The following Account Management team currently supports and will continue to support EGID:

- Senior Account Executive – Julie Bodenski
- Installation Administration Professional – Damont Neeley
- Communications Consultant – Nathalie Farris
- Consumer Engagement Professional – Jay Vance
- Enrollment Analyst – Marissa Stevens
- Account Concierge Specialist – Meridith Warner
- Electronic Data Interchange Consultant – Anita Link
- Amanda Brown – Billing Representative

Please refer to Exhibit 21 for Human's Account Team Organizational Chart.

D.2.12. Are any services outsourced? If so, provide name, location and function of the company.

Humana performs all core services included in this proposal. We utilize external vendors to perform specific program and administrative services related to our Medicare Advantage and prescription drug plans. All of Humana's approved vendors undergo a rigorous due diligence process prior to doing business with us and are some of the best vendors used by other major insurance companies in the United States.

All access to information within our systems is restricted, monitored, and carefully protected and is never stored or maintained outside of Humana's secure firewalls. Vendors are subject to all of the same HIPAA privacy restrictions and IT security agreements as Humana and are regularly audited. We agree to assume all financial and operational responsibility for services performed on behalf of all insured groups, regardless of whether those services are performed internally by Humana or through an approved vendor. In addition, Humana complies with all CMS regulations applicable to the use and oversight of contracted vendors performing services for Medicare Advantage and prescription drug plans.

Below is a list of known vendors who provide services to Group Medicare clients and may have contact with EGID's members:



[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]



[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

D.3. Web Capabilities.

D.3.1. What is Bidder’s web address?

Our website is Humana.com

D.3.2. How often is the Bidder’s website updated?

Humana.com is updated on an as-needed basis with little to no impact to our members.

Our online provider search tool is refreshed nightly. Anyone can access the online provider search tool, Find a Doctor, at Humana.com/finder/medical. We provide robust web support and will ensure your members understand the website and how to use the tools available. Humana’s employer portal is typically available at all times. We do not anticipate any downtime for scheduled maintenance.

D.3.3. How often does scheduled downtime occur?

There is no regularly scheduled downtime.

D.3.4. Complete the attached chart regarding capabilities for participants on the Bidder’s website:

Service	Y/N	Comments
Provider Locator	Y	Our online provider search tool is refreshed nightly. Anyone can access the online provider search tool, Find a Doctor, at Humana.com/finder/medical .



Service	Y/N	Comments
Plan Benefit Information	Y	Members can view coverage, benefits and plan details, including coverage and out-of-pocket responsibility.
Out-of-Network Claim Form	Y	
Print ID Cards Online	Y	
Request additional replacement ID cards to be mailed	Y	
Online Explanation of Benefits (EOBs)	Y	
Claims History and Claims Status	Y	
How long is claim history accessible online for a termed member, if applicable?	Y	Claim history is typically accessible online for Humana members for a period of up to 18 months through the Humana member portal at Humana.com .
Educational Information about MAPD	Y	
Cost estimation/budgeting tools	Y	
Member Grievance Resolution	Y	A Humana member can track a grievance through Humana's member portal at Humana.com . Members typically need to log in to their account to access their grievance status and any updates related to their concerns.
Pharmacy Information	Y	<p>Robust pharmacy information and tools help members understand what's covered, the estimated cost of a drug at retail pharmacies and mail-order, prior authorization (PA) status, drug alternatives, and drug library and drug interaction tools.</p> <p>The medication list on the MyMeds page lets members store and keep track of their medicines and allergies all in one place. Members can populate their medication list using their previous claims and have the opportunity to edit their list, add OTC medications, and print the list to share with their doctor.</p> <p>Humana will also inform members of savings opportunities.</p>
Members can download and print forms	Y	
Wellness program activities	Y	Humana's Go365 fitness plan utilizes its own website. Members will be able to access this site from Humana.com .
Is a mobile app available?	Y	Our MyHumana mobile app allows members to manage healthcare needs virtually anywhere, anytime. Accessible on any smartphone device, members can download



Service	Y/N	Comments
		the MyHumana app. Through our mobile app, Medicare members can: <ul style="list-style-type: none"> • Access medical, pharmacy and dental ID cards • Send their ID card to their provider through fax or save the image to their photo gallery • Find a doctor, pharmacy, dentist, hospital, urgent care center or retail clinic. Members can use their current location to find the closest in-network provider – no matter where they are. Providers can be filtered with a set of different criteria. • Search prescription and over-the-counter drugs and price them (must be ordered on the CenterWell Pharmacy app) • Manage list of prescription and over-the-counter drugs that user is currently taking using the MyMeds flow. • View medical, dental, and pharmacy claims • View plans and coverage details, including deductibles • Pay bill balances • Find a telehealth provider
Other (Describe)	Y	<ul style="list-style-type: none"> • Get reminders to complete screenings or other preventive health care that can help the member achieve their best health • Find out how to use telehealth (also called virtual visits) for getting care • Download Blue Button health data – a record of a member’s protected health information (PHI) – including information on current conditions, prescription history, or lab history

D.4. Bidder Eligibility.

D.4.1. Bidder 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 Bidder’s relevant licensure for the programs it intends to bid (Exhibit 18).



The Oklahoma Secretary of State does not register insurance companies pursuant to OK State § 18-1132(A)(5). As such, Humana Insurance Company maintains our authority to transact business in Oklahoma through the OK Insurance Department.

Humana has included our Certificate of Authority as Exhibit 18.

D.5. Bidder Operating Staff. Refer to Attachment A Section D.18.

D.5.1. Attach a complete organizational chart for the Bidder, including all departments/functions listed above, as well as lines of authority, and relationships among the Bidder’s Board of Directors, administration, medical services, and other functions (Exhibit 21). If expansions or changes are anticipated, show as much detail as possible reflecting the changes.

Please refer to Exhibit 21 for Human’s Account Team Organizational Chart.

No major expansions or changes are anticipated at this time.

D.6. MAPD Networks.

D.6.1. Identify any use of subcontracted or “leased” network(s).

Humana does not utilize a leased network. We contract directly with all of our own providers in our proprietary network.

D.6.2. Does the MAPD require members to have a PCP? If so, complete Exhibit 3.

Under a Passive PPO plan, members are not required to have a primary care physician (PCP).

D.6.3. 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?

Humana tracks only Voluntary vs. Involuntary terminations for our national PPO network. Involuntary terminations are typically associated with a license restriction or a regulatory action by CMS.

Involuntary Terminations (PPO Network)	Provider Type	Count	2022	2023	2024
Oklahoma	Hospitals	Number	0	2	1
		Percent	0%	1.69%	0.77%
	PCP	Number	39	84	49
		Percent	3.31%	6.85%	3.74%
	Specialist	Number	62	128	68
		Percent	1.88%	3.76%	1.93%



D.6.4. List the MAPD’s current ratio of PCPs to members:

D.6.4.1. Tulsa

- D.6.4.1.1. Number of PCPs: 719
- D.6.4.1.2. Number of Members: 1,700
- D.6.4.1.3. Ratio: 0.4

D.6.4.2. Oklahoma City

- D.6.4.2.1. Number of PCPs: 1,139
- D.6.4.2.2. Number of Members: 4,423
- D.6.4.2.3. Ratio: 0.3

D.6.4.3. All Other/Rural

- D.6.4.3.1. Number of PCPs: 3,923
- D.6.4.3.2. Number of Members: 23,299
- D.6.4.3.3. Ratio: 0.2

D.6.5. Provide the percentage of MAPD’s PCPs based on length of contract.

- D.6.5.1. Over 5 Years (%)
- D.6.5.2. 3 to 5 Years (%)
- D.6.5.3. 2 to 3 Years (%)
- D.6.5.4. Less than 2 Years (%)

The majority of Humana’s provider contracts are considered evergreen, with provisions for automatic renewals as long as conditions and terms are met. Other contracts may have periodic negotiations. The average length of a provider contract with Humana can vary based on the specific agreements and services involved. Typically, provider contracts may range from one to three years, but some contracts can be longer, especially for established relationships or for specific programs.

D.6.6. How many PCPs and Specialists have terminated contracts with the MAPD in the last two (2) years (at the physician’s request)?

Humana tracks only Voluntary vs. Involuntary terminations for our national PPO network. Voluntary terminations are typically associated with changes in business focus, dissatisfaction with contract terms, or other personal or professional considerations.

Voluntary Terminations (PPO Network)	Provider Type	Count	2023	2024
Oklahoma	PCP	Number	6	13
		Percent	0.49%	0.99%
	Specialist	Number	17	16
		Percent	0.50%	0.45%



D.6.7. 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 percentage of total PCPs.

Humana's turnover rate of PCPs in our Group Medicare MAPD network during the last two years was 14.26%:

- Voluntary turnover: 5.02%
- Involuntary turnover: 9.24%

D.6.8. 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.

Our network physician agreements indicate physicians must provide a 120-day notice prior to contract termination. In most instances, provisions for termination both "for cause" and "without cause" are reciprocal; however, specific listed instances may escalate one party's right to terminate a physician agreement. Ancillary providers must submit notice to terminate the contract 120 days after the initial term of the contract (usually one year). Hospitals must submit notice to terminate the contract 90 days after the initial term (usually three years).

In the event of a breach of Agreement by either party, the non-breaching party may terminate this Agreement upon at least sixty (60) days prior written notice to the breaching party.

Please refer to Attachment D.6.8, Humana Sample Provider Contract.

D.6.9. 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. Risk adjustments will not apply to Medicare Advantage.

Value-based reimbursement is the foundation on which Humana developed our accountable care continuum where physicians are paid based on patient health outcomes and experiences instead of receiving fee-for-service reimbursement. VBC has offered the business context for payers and healthcare providers to align incentives and to consistently focus on what is most important for patients. The continuum recognizes practice complexity by offering several levels of participation in Humana's Provider Quality Rewards Program, including Star Rewards, Model Practice, and Medical Home.

Through critical investments in programs, services and technologies, we have created a successful Medicare strategy to reduce costs and improve quality and outcomes that will make your MAPD plan successful and provide a sustainable, long-term value proposition. This is best illustrated through the results of our value-based provider relationships.



Humana's state of the art interoperability and connectivity solutions allows us to meet providers where they are on the value-based path-to-risk continuum.

Please refer to Attachment D.6.9 for Humana's 2024 Value-Based Care Report for more details. The **Humana Value-Based Care Report** highlights the benefits of value-based payment models for Medicare Advantage beneficiaries. Key findings include:

- 68% of Humana individual Medicare Advantage beneficiaries in value-based payment models experienced better health outcomes, lower costs, and more preventive care
- 30.1% fewer inpatient admissions and 12.7% fewer emergency room (ER) visits for the VBC population compared to traditional Medicare
- Despite pandemic-related delays, value-based care physicians outperformed non-value-based models in terms of quality across all care categories

D.6.10. 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. Actuarial equivalence is defined as (Total Pharmacy Allowed – Member Pharmacy Cost Sharing)/Total Pharmacy Allowed. Federal reinsurance, Low Income Cost Sharing, Coverage Gap Discount, and Rebates should not be reflected in the actuarial equivalence calculation. As a point of comparison, the actuarial value of the Medicare High Option plan for 2026 is approximately 90%.

Humana's robust pharmacy network currently has over 61,000 retail pharmacies in all 50 states, Puerto Rico, Guam, and the United States Virgin Islands, including every major national and regional chain as well as over 22,000 popular independent local pharmacies, giving most members convenient or reasonable access to multiple pharmacy locations. There are no major chain pharmacies excluded from our retail network.

Humana offers a single, robust national network for our Group Medicare members. More than 99% of these pharmacies dispense 90-day prescriptions, and all pharmacies within our retail network are contracted to dispense specialty prescriptions. We also provide members solutions for extended day supply medications, long-term care pharmacy services, home infusion pharmacy services, compounding pharmacy services, and mail-order pharmacy.

Some of Humana's point-of-sale capabilities include:

- The Concurrent Drug Utilization Review (DUR) edits that Humana applies during the processing of prescription drug claims, in conjunction with other benefit edits, are used to meet the following goals:
 - Provide guidance to reduce cost
 - Prevent over and under utilization
 - Provide concurrent DUR
 - Apply internal medication error identification and reduction systems
 - Provider education of appropriate medication use



Examples of DUR edits include:

- Drug/drug interaction
- Drug/Age or Drug gender-related contraindications
- Drug/disease contraindications
- Preferred product
- Duplicate therapy monitoring
- Minimum/Maximum dosage ranges
- Step-Therapy
- Opioid Overutilization

Humana's DUR program is structured as a series of separate program edits. They can be used individually or in combination to form the optimum screening environment. Our DUR program helps pharmacists screen the medications prescribed for a member. Through the required protocols and therapy screenings, our adjudication system provides pharmacists with real-time information via a telecommunications network by monitoring all submitted claims. When processing, each claim submitted is compared with other active prescriptions for each member and pertinent messages are provided to pharmacists alerting them of potentially harmful situations.

IntelligentRx is an exciting software platform integrated with Humana's claim adjudication process that provides automated real-time pharmacy and medical MAPD claim analysis. This innovative program to manage utilization and maximize quality of care provides our clients enhanced cost controls, patient safety, and medical outcomes.

Through this platform, Humana was first in the industry to deploy an automated capability called Fast Pass that determines if Utilization Management (UM) criteria have been met. If a claim denies at point-of-sale, IntelligentRx searches the member's drug and medical claim history for the required diagnosis or alternative drugs. If the Fast Pass criteria is met, an authorization is instantly sent to the point-of-sale, preventing the member from having to seek further approval. If criteria are not detected electronically, POS messaging lists alternatives for the prescriber or alerts the pharmacist that entering a diagnosis code could allow the claim to pay without member disruption.

Humana provides mail order and specialty pharmacy services through our wholly owned pharmacies, CenterWell Pharmacy and CenterWell Specialty Pharmacy.

CenterWell Pharmacy prescriptions are typically shipped via United States Postal Service. Cold-packed, controlled substances, and specialty prescriptions are shipped via UPS or FedEx for tracking purposes.

CenterWell Specialty Pharmacy typically ships medications via UPS to the location of the member's choosing.

Actuarial Equivalence of Humana's Part D Plan = 94.59%.



D.6.11. Provide the name, address and contact name for the Pharmacy Benefit Manager (PBM) who handles the MAPD's pharmacy plan of benefits.

Our PBM is Humana Pharmacy Solutions, which is a complete business unit within the Humana Inc. diversified family of health and well-being solutions. Humana Pharmacy Solutions is located at 500 West Main Street, Louisville, Kentucky.

D.6.12. 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.

Under a Passive PPO plan, members are not required to have a PCP.

D.6.13. Briefly describe all service areas covered by the Bidder'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. Bidders may also elect to include separately any areas being considered for future expansion.

Humana offers EGID an industry-leading Medicare PPO network footprint with over 1 million providers across all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands and Guam. These plan designs allow us to take advantage of our Medicare Stars rating to provide competitive rates for retirees, which enhances member activation and engagement in wellness and chronic condition management programs, care management compliance and cost effectiveness, and our ability to more effectively manage medical cost trends.

We also cover individuals living outside our Medicare Advantage PPO service areas under our Medicare Advantage PPO Expansion Waiver with CMS. This waiver permits us to provide traditional or passive Medicare Advantage PPO benefits to these members and results in 100% of all members being provided a single, uniform, national plan of benefits. Members who reside outside the Humana service area have the same benefits and access to care as members who reside within the Humana service area.

Please refer to Attachment D.6.13 for Humana's National Service Area Map.

D.6.13.1. Provide an Excel list of every zip code that is part of Bidder's service area (Exhibit 1).

Humana has completed Exhibit 1 and included in our response submission.

D.6.14. What changes have been made in the Bidder's service area in the past year? Include a map showing the changes.

There were no changes to Humana's service area in the past year.

D.6.15. What are the MAPD Bidder's procedures for after-hours care and emergencies in the service area and outside the service area?



Under the passive PPO plan approach, members have the same benefit level for any provider (participating or nonparticipating) that accepts Medicare and the Medicare Advantage plan's payment terms.

We cover emergency medical care whenever needed, from any provider or facility. Our plan covers ambulance services in situations where getting to the ER by any other means could endanger the member's health. Out-of-network facilities are paid as in-network when emergency care is received.

When receiving emergency services outside of the United States, plan members must pay for services out of pocket and submit claims to Humana for reimbursement. Foreign providers include all physical locations outside the United States (all 50 states) or outside Puerto Rico and while on cruise ships. Reimbursement requests should include the following information:

- Member identification number
- Member group number
- Patient date of birth
- Statement/receipt of services rendered
- Charge amount from the provider
- Type of currency
- Provider name and address

Descriptions of the rendered services are necessary, as the diagnosis and procedure codes used within the United States are not internationally recognized. Foreign claims use descriptive medical terminology that we must translate into the appropriate coding for accurate claim processing.

D.6.16. Based upon the OK Medicare retiree census data (Exhibit 24), identify any counties of the state in which the Bidder is filed to operate where its provider network may not have adequate capacity to meet the potential Oklahoma demand.

There are no counties in Oklahoma where Humana is filed to operate that our provider network will not have adequate capacity to meet potential Oklahoma demand.

Humana ensures adequate provider access, including access to specialists for the Medicare-enrolled population, by following CMS standards for coverage to their members. CMS requires a specific percentage (varies by county classification) of Medicare eligibles have access to all available provider types within the time and distance standards set for each county. CMS acknowledges certain contracting limitations and offers credits to offset the standard, like a certificate of need and telehealth credits.

CMS also identifies county designations (large metro, metro, micro, rural, and CEAC), which outlines the population requirements and the corresponding adequacy requirements. Key providers include acute care hospitals and other medical facilities (such as ambulatory surgery centers and skilled nursing and rehabilitation facilities), PCP, high



volume specialists (such as cardiologists, ophthalmologists, and orthopedic surgeons), and ancillary care providers (such as diagnostic laboratories, imaging centers, and home health providers).

D.6.17. Does the Bidder foresee any significant provider contracts coming up for negotiation in the next three (3) years based on the Oklahoma Retirees locations?

The only significant provider contract due for negotiation is Integris Health. Contract negotiations will take place for a January 1, 2027 renewal.

D.6.18. Provide a listing of all acute care Oklahoma hospitals that are considered out-of-network hospitals in the Bidder's Medicare Advantage plans.

The following acute care Oklahoma hospitals are currently out-of-network with Humana. Our passive PPO plan design allows members to visit any doctor without penalty, and maintain a high level of trust and care with their physicians, even when visiting providers outside of the network.

- Clinton Regional Hospital
- Duncan Regional Hospital
- Exceptional Community Hospital, Ardmore
- Great Plains Regional Medical Center
- Heart Hospital at Saint Francis
- Jackson County Memorial Hospital
- Oklahoma State University Medical Center
- Saint Francis Hospital (Muskogee, Muskogee East, South, Vinita)
- Stillwater Medical Center

D.6.19. Describe the Bidder's MA network growth and development plans.

Humana is committed to offering competitive, appealing and valuable solutions to our Medicare members throughout the nation. We continually evaluate our Medicare Advantage networks to keep up with the ever-changing Medicare and healthcare environment.

The key components of our long-term network growth strategy focus on geographic expansion where needed and moving our relationships with PCPs along the value-based reimbursement spectrum which includes the goal of driving quality of care to 5-Star quality status in all our provider networks.

Our industry-leading Medicare Advantage PPO network includes over 1 million providers in all 50 states, plus the District of Columbia and Puerto Rico. Humana is also licensed to cover retirees residing in USVI, Guam, Marianas Islands and American Samoa. In addition to pursuing network growth, we simultaneously measure the quality, cost, and efficiency of our existing network. As a result, we are constantly building better performing networks, by analyzing provider performance using an episode-of-care methodology that



analyzes inpatient, outpatient, ambulatory and pharmacy claims data, adjusting it for differences in patient severity and geographic variation.

Using this and other techniques, Humana is improving network performance in a number of ways, including:

- Engaging providers that are performing less favorable than their peers to improve their performance against key measures.
- Challenging average performing providers with opportunities to improve based on best practices demonstrated by highest performing peers.
- Providing high performers with additional opportunities and incentives to excel.

Our strategy also includes a goal of moving a higher percentage of our existing and new Medicare PPO and HMO provider contracts further across the value-based reimbursement spectrum. Today we have 70% of our MA members affiliated with PCPs in value-based arrangements. This strategy targets independent providers and healthcare systems that will partner with Humana to develop value-based care programs such as accountable care relationships that offer incentives when providers perform to established industry quality metrics.

Humana considers several factors in managing networks, including accessibility requirements, access to geographic patterns of care, physician efficiency patterns using industry-standard episode-of-care methodology-based metrics. To that end, Humana periodically adjusts our Medicare Advantage networks as part of this strategy. We continually work to manage the performance of our provider networks to remain competitive and to meet the needs of our stakeholders, including plan sponsors, members, CMS Network access and adequacy standards and patterns of care.

Our industry intelligence suggests that our large, early commitment to Medicare Advantage PPO in many critical markets has enabled us to gain a competitive advantage in provider contracting over late or slower PPO plan entrants. Many providers are reluctant or are refusing to contract on the same terms for many other carriers. Various carriers are now paying providers more than Medicare rates.

While we manage our Medicare Advantage networks to meet and/or exceed service access and adequacy standards. As your Medicare Advantage partner, we will collaborate with you to identify highly utilized providers and develop a mutually acceptable educational outreach plan. We have extensive experience and significant success in satisfactorily addressing any network issues with numerous state health plans and retirement systems.

Geographic Expansion

Through geographic expansion and increasing membership, Humana's network efforts are aimed at maintaining or improving provider access both in new and existing service areas, as well as focusing on the cost and quality of these relationships.



Expanding networks nationally is a year-round activity for our Provider Contracting, Provider Relations, and Education teams. These teams continually respond both to Humana's service area and product expansion plans and to the needs and requests of our members and plan sponsors, like, to add physicians, hospitals, and other providers they wish or need to use in their communities. This expansion has been significant both in terms of absolute numbers of provider under contract and the number of Humana's CMS-approved PPO service areas. Humana's national MA PPO network has expanded from 625,000 providers in 2016 to over 1 million providers today.

Pharmacy

Our broad national network has nearly every available pharmacy in the country. We maintain a robust network with audit oversight to ensure that participants meet our contract requirements.

We also periodically review the list of independent and chain pharmacies retirees are currently utilizing and expand our network as appropriate with pharmacies that meet our requirements and quality criteria. This strategy has helped us minimize member disruption and maintain our robust pharmacy network appropriately to meet customer and member needs.

D.6.20. Describe the Bidder's approach for selecting and recruiting providers to participate in its MA networks.

Humana's approach to recruiting and credentialing providers and pharmacies includes imperatives to control costs while improving outcomes. This approach drives our strategy to work and contract with providers to develop more efficient and cost-effective networks for both our HMO and PPO products.

Humana also accepts broker and member requests for providers to be added to our network.

Our process began several years ago when we started implementing a disciplined high performance network development strategy. This resulted in improved contracts with numerous hospital and physician providers and contracted rates for many ancillary services that are as much as 40% below traditional Medicare Fee for Service rates. We are confident our contracting strategy leads to an overall savings of seven to 10% in claims costs.

Our industry intelligence also suggests that our large, early commitment to Medicare Advantage HMO and PPO solutions in many critical markets has enabled us to gain a competitive advantage in provider contracting over late or slower HMO and PPO plan entrants. Many providers are reluctant or are refusing to contract on the same terms for many other carriers as they are with Humana, and now various carriers are paying providers more than Medicare rates.



We ensure adequate provider access by contracting with a minimum of 65% of available providers required by CMS (across key specialty categories) in all network service area counties. Key providers include hospitals and other medical facilities (such as ambulatory surgery centers and skilled nursing and rehabilitation facilities), PCPs, high-volume specialists (i.e., cardiologists, ophthalmologists, and orthopedic surgeons), and ancillary care providers (i.e., diagnostic laboratories, imaging centers, and home health providers). We assess and monitor network adequacy, scope and performance, CAHPS scores, and member complaints using a variety of industry-accepted tools, such as Quest Analytics, as well as our own proprietary programs.

Provider Contracting and Credentialing

Providers applying for participation with Humana must submit a credentialing application and meet credentialing criteria prior to approval. Once initially credentialed, providers are recredentialed every three years.

Each Humana region manages its own contracting process and activity, to ensure responsiveness to the competitive, economic, political, and other circumstances unique to each market. The following outlines the general steps used by Humana's provider contracting staff, although the order and nature of each activity can vary:

- Providers are identified through member/group nominations, provider requests to join, hospital rosters, and community searches.
- For hospitals, physician practices, solo practices, and other facility providers, a provider contractor contacts each provider and discusses the Medicare and commercial product line opportunities for participating with Humana.
- Solo and small physician practices have the ability to request participation through an online tool via Humana's website. The request is then submitted to the market office to follow up directly with physician practice.
- Humana and provider representatives may or may not reach mutually-agreeable contract terms for participation in one or more of Humana's provider networks.
- Upon reaching agreement, each provider must successfully complete Humana's credentialing process. This process may take 45 to 90 days due to the time involved in verifying provider license, certification, malpractice, liability insurance and other information.
- Once credentialing is approved, the provider contractor submits the signed agreement and other necessary information to load the provider into Humana's provider directory, claims payment, and other systems.
- The next step is for the provider contractor or a provider relations representative to begin the process of educating the provider and its staff regarding Humana's policies and procedures, claims submission process, benefit plans, and so forth. Each provider receives a welcome letter with the effective date with Humana, a copy of their signed agreement, and educational materials.
- When providers render services to a patient, they submit a claim to Humana (increasingly electronically but occasionally on paper), and Humana processes the claim.
- If the providers have any questions, they contact Humana through a secure provider portal at Humana.com or by phone at 1-800-4-HUMANA.



- When a provider changes contact information (phone number, address, etc.), they submit the changes to Humana in writing via letter or email, and Humana then makes the changes to our systems.
- A provider wishing to terminate its contract must first submit a termination letter to Humana that includes the reason for and date of termination.

Credentialing Criteria

The decision to credential or recredential providers is based on the following criteria:

- Holds a current valid state professional license
- Holds a current federal Drug Enforcement Agency (DEA) certificate and/or a CDS certificate, if applicable to profession
- Holds current PLI
- Has completed appropriate education and training for applied specialty
- Demonstrates appropriate history of employment and clinical practice
- Holds current clinical privileges in good standing at a participating facility, if applicable to profession
- Has acceptable liability claims history
- Represents sanction-free status by federal, state, and local authorities
- Demonstrates lack of physical or mental impairment, including impairments due to chemical dependency that may impair the practitioner's ability to practice or may pose a risk of harm to patients
- Demonstrates acceptable office survey results, if applicable

Hospitals

Humana generally enters into full service, direct contracts with network hospitals in order to facilitate member convenience and access. In addition, we utilize specific service agreements with hospitals for organ transplant coverage and to provide coverage at a hospital in an area where our primary network facility does not offer a certain medical specialty service.

Behavioral Providers

We are continuously expanding our extensive behavioral health network through various development initiatives, including provider recruitment via member referral and direct outreach by our provider contracting team. Following recruitment, practitioners and facilities must complete our credentialing and contracting processes. If a member is in immediate need of care, we will initiate a single case agreement with a qualified local provider and authorize services until the full contracting process can be completed.

Pharmacy Credentialing

At point of contracting, all pharmacies are required to provide the following for credentialing purposes:

- Copy of active facility state license
- Copy of active DEA registration or state-controlled substance certificate (as applicable)
- Proof of professional liability insurance coverage that meets the minimum requirement of \$1,000,000 per claim and aggregate



- Pharmacist in charge must complete a credentialing form and provide a copy of their current state pharmacist license

Once contracted, all pharmacies are required to comply with our recredentialing process which includes providing current copies of the items above.

Humana also has a long-standing history with regard to working with independent pharmacies and currently has greater than 90% of available independent pharmacies participating in our networks. Humana strives to offer cost parity for our members when they select a network pharmacy between chains and independents, but there may be situations where an independent pharmacy may be more costly than a chain pharmacy, especially in a more rural area where chain pharmacies are less available. Certain chain pharmacies also may be expected to offer a low-cost generic drug program that may not be available through an independent pharmacy.

D.6.21. Describe the Bidder's process for collaborating with employers and key providers to address provider acceptance issues that may surface over time.

Humana does everything in our power to provide our members with a consistent member experience allowing members to see any provider in or out of Humana's network as long as the provider is willing to bill Humana.

Periodically there can a provider termination that results in a provider ceasing to bill Humana for non-emergency services.

Humana will make outbound calls to members when a provider terminates from the Medicare network. These calls will be automated through Virgin Pulse and the member will be given an option to transfer to an advocate if further assistance is needed.

Typically the first point of escalation for a provider issue is EGID's dedicated account concierge specialist who will use their resources to resolve the issue. Should the provider issue require further escalation, your senior account executive, Julie Bodenski, will work to address the provider issue with provider engagement and network leadership as appropriate, providing status reports to EGID as needed.

For a major medical provider term or a term that impacts over 50 members, Julie will notify EGID in a timely manner.

D.6.22. Complete pharmacy disruption of the top utilized Oklahoma pharmacies. List the pharmacies utilized for the OEIBA Program during 2024 and provide the number of utilizers, the number of prescriptions, and the plan paid dollar amounts. If the Bidder was not a participant in 2024, then the report should be for its book of business specific to Oklahoma.

Humana has completed a pharmacy disruption of the top utilized Oklahoma pharmacies.



Please refer to Attachment D.6.22 for Humana’s Pharmacy Disruption.

D.7. Medicare Experience.

D.7.1. Provide Bidder’s total Medicare enrollment for 2023 and 2024.

A table with 8 columns and 4 rows. The cells are mostly blacked out, indicating redacted information. There are some green rectangular highlights in the top and bottom rows of the table.

D.7.2. Describe the Bidder’s experience participating in Medicare as a private plan option. Include the number of years that Bidder has participated in Medicare and a brief history of key developments over this time, such as when Bidder’s first group Medicare plan was offered.

Humana offered our first private Medicare coordinated plans in 1985 and our first Medicare secondary plans for employers in 1990. Since then, we have continuously provided the stability, depth of expertise, infrastructure, and sophistication to meet all our Medicare members’ needs.

In 2003, with the passage of the Medicare Modernization Act in 2003, which introduced Part D coverage and renamed the plans to “Medicare Advantage,” we developed and executed an aggressive plan to grow both our Medicare product lines and service areas. In 2007, we implemented Group Medicare Prescription Drug Plans (PDP) and Medicare Advantage private fee-for-service (PFFS) plans throughout the United States and Puerto Rico.

Today, Humana is licensed to offer employee-sponsored, network-based MA solutions in all 50 states plus the District of Columbia and Puerto Rico. Humana is also licensed to cover retirees residing in the US Virgin Islands, Guam, Marianas Islands and American Samoa. Medicare is a significant part of Humana’s business, with over 8.25 million members we are one of the largest Medicare Advantage carriers nationwide.

D.7.3. Has Bidder been sanctioned by CMS in the past five (5) years? If so, describe further.

Humana received notice that it would receive a civil monetary penalty in January 2023 related to a CMS financial audit of information from calendar year 2019. The civil monetary penalty was issued in the amount of \$131,660. Humana remediated the issues identified in the audit. There is no outstanding balance on the monetary penalties.

A more timely, and, thus, accurate, assessment of Humana’s compliance is reflected in the results of its 2022 CMS Program Audit. While opportunities for improvement were identified, CMS did not issue civil monetary penalties related to this audit.



D.7.4. Describe the Bidder's strategy and key initiatives to assure that Medicare Advantage will offer the Plan a sustainable value proposition.

Our short-term strategic priorities to improve the value proposition of our group PPO plans include partnering with providers on VBC, investing in integrated patient-centered care, and focusing on member interaction satisfaction. Details on our efforts in each of these areas follow:

Partnering with Providers on Value-Based Care

VBC is a contracting model that reimburses and rewards healthcare providers for improved patient care and health outcomes rather than paying them solely for the quantity of services they provide, in contrast to a fee-for-service system. Humana has made a strategic commitment and investment in moving providers from a fee-for-service model to a pay-for-value model.

Investing in Integrated Patient-Centered Care

In conjunction with a Health First approach for our members, Humana's clinical infrastructure uses the most sophisticated technology to give an in-depth picture of each member's health and enhance the overall effectiveness of our clinical programs. All our clinical associates use one comprehensive system, enhancing clinical continuity and coordination. Among other things, our platform can assist with pre-certifications and authorizations, chronic or acute nursing programs, and behavioral health services.

Focusing on Member Interaction Satisfaction

The Humana Group Medicare Custom Connect philosophy changes a standard call center atmosphere into an environment filled with personalized advocacy representatives. We take a whole-person approach to supporting our members through every aspect of their health journey. Through this advocacy model, each associate is empowered to deliver a compassionate, informed and proactive experience for members. Our Group Medicare associates are encouraged to take responsibility for owning the end-to-end member transactional experience, including making outbound calls when necessary or scheduling a time to follow up with members when needed.

Our long-term strategic priorities are closely tied to our short-term strategic priorities. We will continue to focus on ways to improve the health and well-being of the members we serve.

At the core of our strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Core elements of the model are to improve the consumer experience by simplifying the interaction with us, engaging members in clinical programs, and offering assistance to providers in transitioning from a fee-for-service, or FFS, to a value-based arrangement. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience.



We have conviction the strong core fundamentals and growth outlook for both MA and VBC remain intact. By taking a whole-person comprehensive approach to addressing seniors' healthcare needs, including focusing intently on preventing chronic diseases from progressing, ensuring the right care in the right setting, and closing gaps to care, such as isolation, MA shows the path forward to strengthen individual health outcomes, while directly tackling root drivers of high cost, inefficient healthcare system spending. Humana's platform, a unique focus on MA, will allow us to compete effectively, drive better outcomes for our members and patients, and deliver compelling, sustainable value over the long term.

D.8. Member Services Telephone Assistance.

D.8.1. Provide the hours that customer service representatives regarding plan benefits and network service problem resolution will be available for telephone assistance.

Customer Care is available from 8 a.m. to 9 p.m. Eastern time, Monday through Friday. While Customer Care is largely based out of Louisville, Kentucky, our Customer Care advocates are empowered to work in a virtual environment from Humana-approved locations across the United States.

D.8.2. How are after-hours phone calls handled?

Humana provides a 24-hour interactive voice response (IVR) system that can assist members with commonly asked questions and requests. Members can verify benefits and eligibility, check a claim status, request ID cards, proof of coverage provider directory and plan benefit documents, initiate or check state on pre-certification, and inquire on billing. Extensive self-service functions are also available on our website, Humana.com.

For emergency situations, Humana's Clinical Intake Global Authorization team handles after-hour calls. This team is staffed round-the-clock with approximately three to four associates available at all times. In an emergency situation, the facility/provider may call in at any time to have an authorization approved.

D.8.3. How does the Bidder's Member Services (call center) accommodate non-English speaking and hearing-impaired callers?

For our members with disabilities or limited English proficiency, we provide the following communication services at no cost when interacting with Humana:

- Over-the-phone interpretation available in 150 languages
- Humana Customer Care Spanish, Chinese/Mandarin, and Korean line interpreters
- American Sign Language interpreters (in-person or video)
- Linguistically trained interpreters for visually impaired customers
- Video interpretation from a smartphone or computer
- Teletype (TTY) services



[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]



[Redacted text block]

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[Redacted text block]

D.10.2. What measures are taken for poor or unacceptable performance?

[Redacted text block]

[Redacted text block]

D.10.3. What is the ratio of full-time customer service representatives to covered members?

[Redacted text block]



D.10.4. What number of customer service representatives has the Bidder dedicated to this contract?

[Redacted]

D.11. Member Materials.

D.11.1. Does Bidder provide membership I.D. cards? If so, furnish a copy of the membership I.D. Card (Exhibit 20).

Yes, Humana provides membership ID cards. Please refer to Exhibit 20 for a sample ID card.

D.11.2. Describe the process that providers and the MAPD call center staff utilize to determine member eligibility when a member calls for information or to make an appointment.

[Redacted]

[Redacted]

[Redacted]

D.12. Medical Management/Staff.

D.12.1. Does the Medicare Advantage include a 24-hour Nurse Line that would be available to members under this contract?

Due to advancements in technology that allow us to better support our members, Humana no longer offers a 24-hour nurse line. For immediate medical concerns, Humana's Group Medicare Advantage plan includes 24/7 virtual access to a medical provider via phone or video through our vendor partners or any in-network provider that offers virtual visits.

Humana also expanded this offering beyond the acute non-emergent to offer mental and behavioral health virtual visits. Members have access to board-certified providers for



internal medicine, family practice, emergency medicine, and dermatology as well as licensed psychiatrists and mental health professionals.

Alternatively, our internal nurse advice line is available Monday through Friday, 8:30 a.m. to 6:30 p.m. ET. We are not marketed or branded and here to assist our non-care managed members.

Members already enrolled in a Humana care management program will be directed to their care management program manager for questions and/or assistance to maintain consistency for the member. Case management and chronic care programs are available to eligible members as part of their benefit plan and at no additional cost. Eligible members with a can get a personal care manager to help better manage their health. A member's nurse care manager is available by telephone for many services, and the member can call them with any questions. Calls can be scheduled for medical reviews, PCP outreach, and to connect with community resources.

D.12.2. Provide details on which medical management programs in place now (either retiree or eligible current employee population) that would be most effective for a retiree-only population.

Our suite of health management programs addresses the entire spectrum of health needs for our MA population in a holistic and coordinated manner. Some key, included clinical and wellness programs include:

- Go365 by Humana with Health Coaching
- SilverSneakers®
- Humana Health Alerts
- In-home Health and Well-being Assessments
- Virtual Visits and Tele-health
- Humana Care Management (telephonic care with integrated Behavioral Health and care management)
- UM
- Post-Discharge Nutritional Support (Humana Well Dine® Food Program)
- Transplant Management
- Late-Stage Chronic Kidney Disease (CKD) and End-Stage Kidney Disease (ESKD) Support
- Humana Health Alerts

Please refer to Attachment D.12.2, Humana Clinical Touchpoints, for details on clinical programs that control costs.

D.12.3. Describe the Bidder's medical management experience with groups that have significant retiree population.

Humana has more than three decades of experience delivering services to the Medicare population, and we use industry leading clinical infrastructure to proactively identify individuals for care management services. Our experience includes over 600 MA and



MAPD groups encompassing union, corporate, and state Medicare Advantage plans with significant member populations.

We have demonstrated success with large MA member populations through our comprehensive clinical care model, developed specifically to address the needs of this population. Our model centers on:

- **Predictive modeling and early identification:** Focusing outreach on the members who most need our clinicians' support
- **Quick outreach:** Engagement by case managers, behavioral health clinicians, and Humana telephonic care manager clinicians for longer-term support; and
- **Effective Programs** that support the care plan of the members' primary care providers and are structured to address all aspects of the member's well-being, rather than focusing exclusively on one specific chronic condition, including social determinants of health (SDOH).

We will continue to complement our partnership with EGID through dedicated resources on the ground in Oklahoma— account management, clinical, network and service— identifying and delivering on targeted strategies to drive membership engagement while optimizing the execution of our mutual strategies. Your current Account Management team will remain intact, which enables us to continue our deep sense of responsibility to EGID and our shared goals to help your members and the community.

Through our experience in serving MAPD groups, including large state retirement plans like EGID, we understand the complex needs of both administration and membership. We demonstrate this understanding through delivery of customized reporting on clinical and utilization trends, as well as personalized responses to inquiries about clinical program outreach and UM decisions. Humana's strength in clinical capabilities drives real results by improving member health.

Humana has proven we are adept at working with retirement systems like EGID so the members are engaged, clinical data is used appropriately, and outreach is impactful for the members.

D.12.4. Describe how the Bidder's medical management program design enhances quality of care, including improvements in health status and clinical outcomes.

Within our programs we regularly monitor overall member and associate satisfaction, staffing models, quality scores, system availability, response times for transactions and availability of analytics and data.

Some models, discussed in more detail below, have showed strong early results, including experience (e.g., 80+ NPS (Net Promoter Score) across most offerings/markets), cost (e.g., cost of DispatchHealth ER at Home visit is 80% less than in a facility), and outcomes (e.g., members receiving home health from CenterWell Home Health demonstrate 13.4% lower 30-day readmission rates). Delivering care in the home can enable better patient experiences, extended provider influence, greater affordability, and improved outcomes.



Humana has built a continuum of home-centric care capabilities, ranging from preventative, to acute, to advanced illness care.

Humana's Key capabilities include:

- Home-centric Primary Care: value-based care via house calls by MD/NP, virtual visits, and in-home labs/diagnostics
- ER at Home: on-demand treatment for moderate acuity, emergent needs
- Home health: post-acute recovery and additional home support
- In-home assessments: evaluation by MD/NP to understand health needs
- Virtual care: primary and specialist care delivered via telemedicine
- Humana Telephonic Care Management Model
Humana telephonic care management targets those members on whom we can make real impact, based on analytics and claims. Our care management services reduce ER visits, hospitalization, and readmission rates - three key drivers of high medical costs for this age group.

In tandem with VBC, our Humana Telephonic Care Management care delivery and coordination and has demonstrated the following successes:

- 32% fewer inpatient admissions for VBC compared with Original Medicare (also known as traditional Medicare) in 2023, saving 278,000 admissions
- 7% fewer admissions than non-VBC MA, saving 63,000 admissions or 422,000 inpatient days
- 11% fewer ER visits than non-VBC MA, saving 159,000 visits

Engaging Targeted Individuals into Care Management

For members identified for outreach through one of our tools, the program calls the member to extend an invitation to participate. Chronic condition management programs are opt-in, and participants must consent to be counted as participants. Specialists are trained in how to explain the benefits of the programs to identified members, how to overcome objections, and how to apply behavior change methodologies.

Care managers are trained in how to handle different learning and personality styles, as well as establish ongoing rapport with individuals and reinforce knowledge about their conditions and goals. Which results in very few members declining services.

Identified members receive a telephone call when a member becomes eligible for the Humana Care Management program. Call timeline is:

- Six call attempts within 24 days to all phone numbers on file
- One letter to complex care members only at 14 days
- Unsuccessful attempts to reach the member result in a “well managed” status
- Process will repeat upon a trigger event or market/provider request



Value-based Care Model

Our yearly report allows us to review how well we are performing; our areas of growth and sustainability; our provider relationships; and our member satisfaction, and respond to it.

Humana's eleventh annual report's data shows that MA patients receiving care under value-based arrangements saw fewer emergency department visits, fewer inpatient hospitalizations, and received more preventive care screenings. Key findings from the report include:

- Regular primary care appointments mean better prevention and healthcare maintenance. In 2023, VBC members saw their primary care clinicians 10% more than non-value-based care patients.
- VBC Medicare Advantage patients report 90 out of 100 satisfaction with their healthcare provider, per Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data.
- Less time spent in the hospital. VBC Medicare Advantage patients saw 32.1% fewer inpatient admissions in 2023 versus those enrolled in Original Medicare.
- Humana Medicare Advantage members treated by value-based clinicians experienced 11.6% fewer ER visits and 7.2% fewer admissions than those not in a value-based arrangement.
- Humana Medicare Advantage members receive more preventive screenings than those under non-value-based practices across these measures: annual wellness exam, colorectal screening, diabetes eye exam, and mammogram.
- Value-based care allows for better chronic disease management. Humana Medicare Advantage members were more likely to receive diabetes care eye exam screenings and to meet blood sugar control measures versus members not in a value-based care arrangement.
- Senior-focused primary care organizations (PCOs) combine a VBC model with a care delivery approach tailored for seniors. Black patients visited their senior-focused primary care clinician 39% more and low-income beneficiaries had 21% more visits versus Original Medicare.
- Senior-focused primary care patients had 17% more primary care visits, 6% fewer hospitalizations and 11% fewer ER visits.
- Value-based arrangements allow for investments in benefits members value most at an affordable price. In 2023, Humana Medicare Advantage value-based arrangements saved 25.8%, in medical costs compared to Original Medicare. Humana invests these savings directly into more member benefits, such as lower premiums, home care, prescription delivery and healthy food cards.

VBC enables providers to deliver higher-quality, more comprehensive, and coordinated care that leads to better outcomes for our members. We have found that providers in VBC arrangements have improved utilization among their members and have demonstrated better utilization and quality than their counterparts not in VBC arrangements.



D.12.5. How does the Bidder's approach differ in its MA products vs. its commercial plans?

Humana understands that members in our MA plans have needs separate from the commercial population, so we developed Care Management that focuses specifically on addressing the unique needs of our MA members.

Humana delivers a suite of clinical programs to improve quality of care and control costs for our members and plan sponsors like EGID. Humana understands the Medicare population, and by embracing the ever-changing landscape of technology and healthcare we have responded to their unique needs through our investments in enhancing members' access to care through the expansion of telehealth, in-home care services and technological advances that coordinate member health data. This offers accessible, flexible, and holistic care options for Medicare Advantage members— where they need it, when they need it.

Humana's Telephonic Care Management

Humana's Medicare Telephonic Care Management model offers an approach that considers health issues and functionality, while allowing us to offer what is needed for the member's overall well-being.

This model of care aligns with our commitment to lifelong well-being, where we have made a substantial investment in supporting people with multiple, complex chronic conditions and functional limitations through an expansion of our care management offerings. The evidence-based approach substantially improves the health outcomes of members who need the most support and helps them manage their health in their own homes, where they want to be, rather than in hospitals and skilled nursing facilities. This significantly improves member satisfaction, while also reducing the total cost of care.

Our Humana Telephonic Care Management care delivery and coordination and has demonstrated the following successes:

- 32% fewer inpatient admissions for VBC compared with Original Medicare (also known as traditional Medicare) in 2023, saving 278,000 admissions
- 7% fewer admissions than non-VBC MA, saving 63,000 admissions or 422,000 inpatient days
- 11% fewer ER visits than non-VBC MA, saving 159,000 visits

Support includes:

- Evidence-based assessments, interventions, and care planning in accordance with National Committee on Quality Assurance (NCQA) guidelines
- Rich data and analytics to help identify needs
- Pharmacist-assisted medication reconciliation, when appropriate
- Proprietary community resource database
- Fully prepared meals post discharge

Components of Humana's Care Management program include:

- Discharge Planning



- Post-Discharge Care Coordination
- Complex Case Management

Interventions may include the following:

- Telephone outreach
- Personalized health education, guidance, and chronic condition management
- Printed and electronic educational materials
- Social services support by a social worker via telephone
- Referral to community resources
- Physician review and consultation by the Humana medical officer and/or Humana clinical pharmacist
- Nutrition guidance
- Self-care management coaching and coping skills
- Reinforcement of the treating physician's plan of care
- Medication adherence monitoring and awareness of customer's pharmacy benefit design
- Referral to benefits and resources as needed by each member

D.13. MAPD CAHPS Survey Results. Provide annual CAHPS results for 2024 (Exhibit 23). If Bidder is unable to provide CAHPS, annual submission of HEDIS results may be used in place of this requirement.

Please refer to Exhibit 23, Humana CAHPS Survey and HEDIS Report.

Humana has provided measure-level performance which includes HEDIS and CAHPS, as well as other measure categories.

D.14. CMS Stars Quality.

D.14.1. Describe the Bidder's commitment to the Stars quality rating program.

Humana remains committed to providing a cohesive and holistic experience to our members to improve health outcomes and easily access quality care. Humana is further enhancing our operational discipline and is actively identifying opportunities across the enterprise to consistently deliver greater improvement in Star measure results. Examples include enhanced member and provider engagement strategies, customer service improvements and strengthening technology integrations to support operational excellence.

D.14.2. Briefly describe the Bidder's CMS Stars quality rating, enhancement strategy and timeline. Describe the continuous quality improvement initiatives in this strategy.

Humana's commitment to the stars quality is best demonstrated by removing barriers for members and focusing on our members' experience with their plans and the health system overall. To achieve this, we continuously identify opportunities to improve through continuing provider education, aiding in relevant specialist connections, encouraging specific doctor-patient conversations, and by enhancing the ease of interacting with the



plan itself. We also deploy multi-channel marketing campaigns to encourage members to complete screenings and offer scheduling assistance and/or an in-home test kit (if applicable). Additionally, to encourage our members to take medications as prescribed, we leverage both internal and external partners to ensure we are supporting Humana members who are at risk for non-adherence.

Humana's unwavering commitment to the Stars quality program is best exemplified through targeted initiatives designed to remove barriers for members, making it easier to access care. Some examples include:

1. **Member Experience and Provider Collaboration:** Humana's strong provider relationships allow for a more holistic and proactive approach to care for our members. Humana is also hyper-focused on our members' experience with their plan and health system overall. We identify opportunities to improve these measures through continuing provider education, aiding in relevant specialist connections, encouraging specific doctor-patient conversations, and simplifying the ease of interacting with the plan itself.
2. **Preventive screening strategy:** Outreach to members through multi-channel strategy. During those encounters members are reminded of the importance of, and encouraged to, complete screenings and may be offered scheduling assistance and/or an in-home test kit (if applicable).
3. **Patient safety focusing on medication adherence:** To encourage our members to take medications as prescribed by their physician, or post discharge, we leverage internal Humana associates and collaborate with external strategic partners to ensure we are helping Humana members who are at risk for non-adherence.

D.14.3. Describe how the Bidder's Stars enhancement strategy fits with its overall Medicare Advantage strategy.

Humana continues to place significant focus and investments on the quality of care and the experiences our members receive to align with our overall Medicare Advantage strategy. By optimizing our enterprise capabilities and partnerships, we are working diligently every day to assure the long-term success of our Quality and Stars program. We will do so by focusing on several complementary capabilities:

- Advanced Analytics
- Clinical Integration and Guidance
- Provider Partnerships
- Member Experience

The steps and procedures we have and continue to execute to enable our Stars improvement strategy include:

- Sustaining our Stars operating model, which consists of a right-sized organizational structure, an enterprise-focused governance model along with a culture and processes that support enhanced execution of key priorities.
- Building out our cross-functional, multi-disciplined team across the enterprise accountable for developing the strategy and tactics that will drive improved industry leading Stars results with additional key partners



- Advancing predictive analytics capabilities to identify and execute on Stars improvement opportunities
- Enhancing provider partnerships to improve education and focus on patient experience data
- Evolving our member experience through proactive, targeted, and personalized approaches
- Continuing investment in our integrated care delivery model and Stars operational processes and procedures

Continued improvement requires us to:

- Know our members – their needs, their behaviors, their circumstances
- Strengthen partnerships with Providers to simplify member care management
- Create progressive interventions helping our member and provider communities maximize health opportunities
- Execute flawlessly on operations management to fully create and deliver value to our community

D.14.4. Provide the Bidder’s previous three (3) years CMS Stars quality ratings.

	2023	2024	2025
H5216	4.5	4.5	3.5

D.15. Customer Service Experience.

D.15.1. What methods/service support does the Bidder have in place to ensure consistency of experience for retirees?

Humana uses tailored communication strategies to reach retirees, ensuring that information about benefits, services, and health resources is relevant and accessible. Humana provides dedicated customer service teams to assist retirees with their specific needs. These teams are trained to handle inquiries related to Medicare and other retirement-related services.

Through our customer service model, Humana Group Medicare Custom Connect®, our advocates undergo extensive call monitoring and ongoing training and support. The focus is to ensure associates are adhering to the call flow created with advocacy and resolution in mind. Additionally, Humana actively solicits feedback from retirees through surveys and focus groups, which helps the organization understand their needs and preferences. This feedback is used to refine services and improve overall satisfaction. These methods collectively contribute to a consistent and positive experience for retirees, addressing their unique healthcare needs and preferences.

D.15.2. Describe required CSR training, with emphasis on any retiree-sensitivity training.

At Humana, we strive to provide exceptional service to our Medicare members. All new Customer Care advocates participate in an intensive 33-day learning experience using a Learn/Do/Review approach. Through this method, training is streamlined to include three



return to learn training days and nine live call days. Advocates get hands-on practice along with new technology to simulate systems and processes, and scenario –based exercises to improve readiness.

The program introduces the learners to Humana’s integrated care delivery model focused on consumer centric experiences. The modules are interwoven for maximum impact and presented in a blended learning format. The training modules include:

- Humana: our vision, purpose, brand positioning, and strategic intents
- The health benefits field
- Medical terminology
- Mentor online reference tool
- Medicare 101 — the basics
- Humana Medicare products and plans
- HIPAA privacy and other legislation
- The customer care systems
- Provider networks
- Eligibility and the enrollment process
- Premium and billing
- Customer service skills
- Pharmacy benefits and terminology
- Focus on guidance
- Quality customer experience orientation
- Senior sensitivity

Humana’s redesigned training helps to progressively build skills, apply and reinforce learning and enhance retention. In turn, this optimizes our “Learn Anywhere” approach, whether it’s in-person or virtual. Altogether, training will include the three waves of hands-on-practice and complete interactive slides, 50 process simulation e-modules, 28 call listening exercises, 16 role play scenarios, and six assessments all to maintain engagement and verify competency.

To ensure senior members are treated with the utmost respect, our Customer Care advocates in the Medicare dedicated unit are required to attend internally developed senior sensitivity training classes. The main objective of this training is to heighten our associates’ awareness of the senior population, to dispel negative or stereotyped images, and to provide the facts and skills to handle many types of interests and personalities, and sometimes hearing or other disabilities that can make conversation challenging. The training is structured to enable associates to provide appropriate, enhanced service to our senior members.

Following the initial training, advocates enter a second six weeks of training. This training includes the following modules and is necessary prior to a Customer Car advocate becoming a Humana Medicare Customer Care advocate:

- Claims and benefits
- Medical provider calls
- Medicare specifics



- Access to care

Our Group Medicare Customer Care staff are typically selected from our large individual Medicare Advantage service team. They are chosen based on tenure, skill, attendance history, experience with Medicare, and individual performance, which includes measurements of call quality, Voice of the Customer scores, and standard call management metrics. Selected individuals then undergo Group Medicare specific training with focused learning around client plan specifics and unique call handling processes.

In addition to corporate-wide privacy and ethics training, Humana's Customer Care unit undergo approximately 12 to 20 hours of reinforcement or refresher training each year. Internal systems enable us to distribute real-time alerts and daily updates to customer advocates on any new policies or changes to existing policies, and we develop ongoing training based on issues such as the results of audits, new regulations, and implementation of new policies or procedures as needed. Customer Care advocates are allotted up to 30 to 40% of non-production time during their workday, as service levels allow, to familiarize themselves with ongoing client activities and alerts, attend huddles and training sessions, and make return phone calls to members.

Customer Care advocates also complete "Contact Center Readiness" training to ensure associates are fully prepared for open enrollment during the month of October. All of our Medicare Customer Care advocates attend regular training sessions related to Medicare plans. To confirm retention of information, associates attend regularly scheduled meetings with supervisors and leaders, followed by assessment activities.

D.15.3. Provide any additional customer service differentiators for the Bidder's proposed MA plans.

Our dedicated Group Medicare Customer Care unit is completely focused on Medicare Advantage plans and serving retirees and their families. These associates are selected from the vast staff of our individual Medicare Advantage and PDP teams, which provide a superb training ground for our Group Medicare associates. This unit grows as our Group Medicare business continues to grow and is comprised of the top operations associates in our Medicare business.

All associates in this unit undergo intense training to become knowledgeable in the benefits and dynamics specific to EGID prior to joining this team. Furthermore, these associates have access to the most up-to-date customer information. In addition, Humana has the ability to create system alerts to make Customer Care specialists aware of any special circumstances or messaging specific to that group or member.

Our dedicated Group Medicare Customer Care unit uses Genesys Quality Assurance, an AI driven tool that provides the ability to administrate quality through policies as well as provide a single pane for reviewing recordings, interaction details, and forms for easy evaluation of agents. Unlike other quality systems, our quality solution enables end-to-end quality assurance activities take place in a single platform, evaluations are



automatically assigned, forms are partially filled in by AI using Speech Analytics, and coaching sessions can be scheduled with associates. Genesys delivers data driven insights giving leaders access to perform targeted analysis and coaching, focusing on agent courtesy, agent knowledge, and issue resolution.

D.15.4. Describe how the Bidder differentiates its service from its competitors.

Humana is the only national carrier to focus primarily on the senior market. With decades of Medicare experience and a deep working relationship with CMS, we are considered pioneers in the industry. Our Group Medicare organization believes a strong team is composed of both account management and operational professionals who work together to fulfill the contract terms. As such, our team includes an associate vice president of Account Management, director of Account Management, account executive, and client engagement professional(s) who report up to the senior vice president for Group Medicare who also serves as the executive sponsor. Supporting operations, a Group Medicare installation administration professional, communications consultant, and account concierge specialist(s) are assigned for the life of the contract. These roles are under the leadership of the director of Operations.

These combined resources make up our “Core Account” team, which meets on a regular basis to ensure contract terms are followed, deliverables are being met, and risks are identified and mitigated to ensure client and member satisfaction. The executive sponsor and other leadership participating on the Core Account team ensures that team members have a platform to elevate concerns and can act swiftly to respond to and resolve issues without delays or lengthy approval processes.

Providing Medicare Advantage services is our core business—simply put—it is what we do best. This is an important feature that distinguishes Humana from our competitors. Our strategy for managing senior healthcare is to serve members in a holistic and coordinated manner. Nearly 14,000 Humana associates are dedicated to our Medicare Advantage business, and our Customer Care teams are trained to communicate with and understand the needs of Medicare beneficiaries.

Humana’s Medical Management Differentiators in the Member Sphere

Humana is committed to helping Medicare Advantage groups and members achieve their financial and health goals. Our successful history in care delivery and health plan administration is helping us create a new type of integrated care with the power to improve health and well-being and lower costs for both plan sponsors like EGID and your members. Our efforts are leading to a more efficient healthcare plan, better quality of life for people with Medicare.

To accomplish that, we support physicians and other healthcare professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources, and tools – such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions – combine to produce a simplified experience that makes health care easier to navigate and more effective.



Two of Humana's Key differentiators that work together to support our objectives are **VBC** and our **Home Solutions Capabilities**. Members receiving care from PCPs in value-based payment models experienced, on average, better health outcomes, lower costs, and more preventive care compared to non-value-based models for reimbursement that reward quality, and effectiveness of care, rather than quantity of care.

We've built industry-leading value-based care capabilities, a core structural component of MA plans. Our approach to addressing customers' holistic needs (clinical, social, etc.) proactively has proven to improve health outcomes and lower the cost of care, benefiting everyone involved. Clinicians get to do the kind of work they went to medical school for, which increases their job satisfaction. Patients get concentrated time with a clinician deeply vested in their health and who understands their broader context; and Humana can put the cost savings to work by reinvesting in our products to improve benefits and make them more affordable for customers.

Humana combines these VBC partnerships with our expanded technological capabilities to include primary and preventative care in the home; urgent and complex care at home; home health and personal home care; and palliative and hospice care at home. By aligning these incentives with home health programs and providers and, most importantly, with members, we foster deeper collaboration, more proactive and preventive care, and a profound commitment to the experiences and outcomes of our members. This means savings and efficiency for EGID and enhanced quality care for your members.

Humana is the only national carrier to focus primarily on the senior market. With over 30 years of Medicare experience and a deep working relationship with CMS, we are considered pioneers in the industry.

Humana's differentiating core competencies include the uniqueness of our business model: a consumer health-focused, integrated care model, oriented toward seniors.

At the core of accomplishing our mission, we deliver a three-step, holistic and personalized care model, putting your members at the center of everything we do.

- **Understand Your Members:** Blending data analytics, predictive modeling, member assessments, and behavioral and social determinants to fully understand your members
- **Support Holistic Health and Wellness:** Supporting members with the right programs to effectively drive medication adherence, close care gaps, and prevent the advancement of disease
- **Personalize Senior Care Delivery:** Tailoring a care team and programs to individual members, wherever they are on the health and wellness spectrum

D.15.5. On an ongoing basis, what are the Bidder's standards in assuring transition of care for new members to the Bidder's Medicare Advantage PPO/HMO?

Humana is not the only insurance option available to the retirees. The plan sponsor will require employees working past age 65 to remain on the active employee plan. Employees



working past age 65 will be given the opportunity to elect any Medicare plan available to them within 30 days of termination of active employment and movement to a former employee account.

As a whole, EGID's retirees can enroll any time throughout the year, but at an individual level EGID will monitor to ensure the retirees are within an enrollment period based on when they aged into Medicare.

CMS requires that members receive certain plan information prior to the effective date of their plan. Humana would need to receive a mail file of age-in retirees at least 45 days prior to their age-in effective date. Because EGID uses an EDI file as an enrollment method, the new members should be placed on the file prior to their effective date and will be enrolled in the plan and sent to CMS for acceptance as part of the ongoing EDI process.

Transition of Care

When a new member has an active treatment plan for specific situations, medical conditions, or medical equipment, Transition of Care (TOC) is utilized to ensure that healthcare is not disrupted during the member's move to the new plan, including allowing the active treatment plan with an out-of-network provider to be maintained at the in-network level of coverage for a specified period. When TOC is approved, it is for the approved provider/physician/facility and specific medical condition only.

Process to initiate TOC Process

1. To begin the TOC process, members complete a TOC form and either fax or mail the request to Humana. With this option, contacting the prior carrier is unnecessary. This form is part of the member's enrollment package. Once this form is received at the local office, one of our clinicians reviews it and communicates with the member and their provider to ensure there is no delay in care during the transition to our plan. This process can and does often occur early in the enrollment process so that there is adequate lead time to ease any transitional concerns the member may have. The care management team's review includes an assessment of the current condition and course of treatment related to the medical needs of members.
2. For members who are in an inpatient setting or have ongoing critical needs, we will develop a formal TOC plan. Our UM team contact acute and post-acute facilities to learn about the members current plan of care and discharge plan to ensure the member has everything they need when they leave the facility.
3. The movement between levels of care involves the senior case managers in our local offices and regional medical directors. All care received in skilled nursing facilities, long-term care housing, or rehabilitation facilities is reviewed by a medical director. If needed, the medical director facilitates a peer-to-peer discussion with the provider to expedite the member receiving care in the most appropriate location. This facilitates the member's desire to age in place and be in his or her home if possible.
4. The clinical team evaluates each admission, once notified, to assess the level of care needed. They work with the member, provider, and care team to ensure the member



receives care at the appropriate level. If the member is discharged to home, the discharge team follows up to address any gaps in care and prevent a readmission.

D.16 Pharmacy.

D.16.1 Does the Bidder's Medicare Advantage PPO plan utilize a drug formulary beyond the drugs covered and reimbursed under traditional Medicare?

Our current Group Plus formulary offered in this proposal is an open four-tier Medicare formulary. The majority of medications allowed by CMS are covered either under Parts D or B based upon CMS guidelines in the Medicare Prescription Drug Benefit Manual.

Group Plus Formulary Four Tier

- Tier 1 Generics
- Tier 2 Preferred Brand Name
- Tier 3 Non-preferred Brand Name
- Tier 4 Specialty

Additionally, some categories excluded by CMS are available as enhancements for EGWP groups for an additional cost, including: cosmetics, cough/cold, dental, erectile dysfunction, enhanced erectile dysfunction, fertility, senior care, vitamin/mineral, and weight loss medications.

D.16.2 Describe under what circumstances prior authorization of a drug is required.

[Redacted text block]

[Redacted text block]

[Redacted text block]



D.16.3 For MAPD plan, will the Bidder issue a combined ID card for medical care and PBM services?

Yes, Humana issues a combined ID card for medical care and PBM services.

D.17 Organizational Infrastructure. Describe the organizational infrastructure responsible for administering a Group Medicare Advantage program.

Humana's operating strategy is focused on engaging our members as their health and well-being partner and bringing simplicity and connectivity to the healthcare experience. Humana knows that sustainability is derived from our members' satisfaction, and we are committed to offering more programs and benefits to address our members' needs and help them achieve their best health. We have built a large infrastructure to support the large size and geographic scope of our MA program and other senior products.

Our Senior Products Division staffs nearly 14,000 associates engaged in supporting every aspect of Medicare plan operations. We have hundreds of associates dedicated just to Humana's Group Medicare business. The combined size of our individual and employer Medicare business gives us key advantages in meeting EGID's needs, including, but not limited to:

- **Experienced Account Management:** We have a large national Group Medicare Account Management team that specializes in assisting and serving the Group Medicare population that consists of a designated senior account executive, Julie Bodenski, with multiple years' experience in managing Group Medicare plans, as well as a designated Humana installation manager, who serves as a single point of contact for the group both during and after renewal.
- **Knowledgeable Customer Service:** Our Group Medicare Operations unit, created over 10 years ago, was the industry's first customer service team and call center dedicated completely to serving Group MA customers. Humana has undergone a fundamental transformation in how we view customer service, which ultimately changes a standard call center atmosphere to personalized advocacy representatives. Our Group Medicare service model, **Humana Group Medicare Custom Connect**, is focused on empowering associates to encapsulate our values-driven approach to serving retirees like family.
- **Superior Implementation Assistance:** Service to EGID will be organized around teams, each led by the assigned installation administration professional, Damont Neeley, who works extremely close with EGID and your Humana senior account executive, Julie Bodenski, to coordinate plan renewals. Damont then continues after renewal as your daily inside connection to our Group Medicare Operations and Customer Care.
- **Designated Communications Consultant:** Your communications consultant, Nathalie Farris, will work closely with Damont and Julie to serve as a liaison between EGID and numerous Humana resources, including the areas that prepare and ensure regulatory compliance of written retiree communications and presentations, education, and messaging for our pre-enrollment call center, post-enrollment Customer Service team, and the Group Medicare field enrollment team.
- **Expert Compliance and Product Design:** Our Group Medicare product, marketing, and enrollment compliance teams track federal and state laws and regulations with the assistance of Humana's Law department and corporate Medicare Compliance team. They also oversee the design of the benefits in our plans and provide advice and guidance regarding CMS rules



and regulations. EGID will have access to these associates through Julie, Damont, and Nathalie.

- **Skillful Actuarial and Underwriting:** We also have a team of actuaries and underwriters dedicated to setting rates for Humana's Group Medicare Advantage and Part D business. This team compiles and analyzes claims and revenue data, determining trends and overseeing the management of Humana's proprietary pricing models. Heading the team are an underwriting director and actuarial director who report to Humana's Chief Medicare Actuary. They also work closely with Humana's Medicare risk score team and individual Medicare Advantage and Part D product actuarial teams.
- **Exceptional Clinical and Care Management Services:** Our Integrated Care Delivery model marries Humana's unique Humana Care Support data management technology for collecting, analyzing, and sharing member claims and health information with extensive corporate and field clinical and care management staff resources that are all aimed at helping members achieve their best health, regardless of their circumstances. It is population health in action. Our services help members whether they are in the hospital, doctor's office, or at home. For example, we make extensive use of health analytics to identify and address gaps in care and use predictive modeling to engage members whose chronic conditions are likely to become worse without specific interventions.
- **Member-Focused Enrollment:** The communications consultant orchestrates the enrollment process. With the help of Humana's team of over 1,500 experienced, licensed and certified Medicare field sales staff, our account management teams across the country conduct enrollment meetings and seminars. We also provide enrollment call centers with specially trained teams to take and follow-up on calls from prospect Group Medicare members. On an ongoing basis, our Group Medicare Customer Care advocates are available to help age-in members and other new members.
- **Proficient Medicare Risk Adjustment:** Our corporate and field-based Medicare risk adjustment team of statisticians, analysts, and coders, along with our actuarial, compliance, and clinical professionals, develop, maintain and administer innovative and comprehensive proprietary processes and mechanisms. This helps to provide CMS with the constant flow of complete and accurate diagnostic, encounter, and other data it needs to set accurate risk scores that then help to determine correct amounts of CMS reimbursements.
- **Incomparable Network Development and Management:** We have an industry-leading Provider Network Development and Management team that can collaborate with our customers and address provider acceptance and other issues as they surface.

Exhibit 9
MAPD Benefits Summary (BAFO)
Humana
Plan Year 2026

What type of MAPD plan is Bidder offering for this bid?

- MAPD in combination with a non-Medicare HMO
- MAPD in combination with an MSP and a non-Medicare HMO
- Standalone national MAPD

Instructions:

1. All plan design options must correspond to Exhibit 10 MAPD Premium Rate and LIS Quote.
2. All Part D pharmacy coverage descriptions and benefits listed must reflect compliance with CMS benefit guidance for MAPD plans and meet the Creditable Coverage definition.
3. List complete benefits when submitting “PY2026 No Plan Changes” and the “PY2026 With Proposed Plan Changes.”
4. Column “PY2026 No Plan Changes” is required for all Bidders and should list complete plan benefits unless the Supplier’s current MAPD plan is not an option for this solicitation.
 - a. For Bidders with current contracts with the OEIBA Program, this column should list the Supplier’s current plan benefits with no changes.
5. Only Bidders with current contracts have the option to also complete column “PY2026 with Proposed Plan Changes.”
 - a. This column should include all PY2025 plan benefits along with proposed plan changes for PY2026.
Proposed plan changes must be in bold.
6. Benefit Summary must be from the member’s perspective.
7. No more than one (1) MAPD plan proposed by the Supplier will be accepted for PY2026.
8. MAPD Benefit Summary must be signed by the Bidder’s President, Chief Executive Officer or authorized representative.

Example

Services	PY2026 No Plan Changes (Required for all Bidders)	PY2026 With Proposed Plan Changes (Optional only for current Suppliers)
In-Area Urgent Care Services	\$10 copay for each visit	\$15 copay for each visit

All Benefits Based on Medicare-covered Services

SERVICES	PY2026 No Plan Changes (Required for all Bidders)	PY2026 With Proposed Plan Changes (Optional only for current Suppliers)
HOSPITALIZATION Semi-private room (private if medically necessary) Nursing Services and medications All meals, including special diets Laboratory tests X-rays and other radiology services Inpatient physician and surgical services, including anesthesia Necessary medical supplies and appliances Blood and its administration Operating room, Special care units and rehabilitation services	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible and \$250 copay per admission
ORGAN TRANSPLANTS AT A MEDICARE-APPROVED TRANSPLANT FACILITY	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
OUTPATIENT HOSPITAL SERVICES Including outpatient surgical services in an ambulatory surgical center or outpatient hospital facility	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
RADIATION THERAPY	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
BLOOD	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
IN-AREA URGENT CARE SERVICES	Member pays \$0	Member pays \$0
OUT-OF-AREA URGENT CARE SERVICES Urgently needed services worldwide (during a temporary absence from the service area)	Member pays \$0	Member pays \$0
EMERGENCY SERVICES Emergency services needed worldwide	Member pays \$0	Member pays \$50 copay
AMBULANCE SERVICES Medically necessary	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
SKILLED NURSING FACILITY CARE (Inpatient Services) 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	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
PROFESSIONAL SERVICES Office Visits Consultation, diagnosis, and treatment by specialist Medical and surgical care Allergy tests and treatment (serum) Diagnostic tests and treatments	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible

Medical supplies including casts, dressings and splints		
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY SERVICES	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
X-RAY/DIAGNOSTIC RADIOLOGY SERVICES Including annual mammography screening, if medically indicated.	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
LABORATORY SERVICES	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPY	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
HEARING EXAMINATIONS	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
CHIROPRACTIC Limited to manual manipulation of the spine	Member pays \$0 for Medicare covered services after \$250 deductible	Member pays \$0 for Medicare covered services after \$250 deductible
PART-TIME OR INTERMITTENT SKILLED NURSING CARE Home health aide in conjunction with skilled care Medical social services under direction of a physician Medical supplies (other than drugs) and equipment provided by the agency	Member pays \$0 for Medicare covered services after \$250 deductible	Member pays \$0 for Medicare covered services after \$250 deductible
DURABLE MEDICAL EQUIPMENT DME and supplies, prosthetic devices, therapeutic shoes/inserts for severe diabetes	Member pays \$0 for Medicare covered services after \$250 deductible	Member pays \$0 for Medicare covered services after \$250 deductible
BARIATRIC SURGERY	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
CDC-RECOGNIZED DIABETES PREVENTION PROGRAM	Member pays \$0	Member pays \$0
TELEHEALTH/TELEMEDICINE/VIRTUAL VISITS	In Network: Member pays \$0 Out-of-Network: N/A	In Network: Member pays \$0 Out-of-Network: N/A
IMMUNIZATIONS Includes flu injections and all Medicare-approved immunizations	Member pays \$0	Member pays \$0
PHYSICAL EXAM Examination	Member pays \$0	Member pays \$0
WELL FEMALE EXAM Examination Pap Smear	Member pays \$0	Member pays \$0
INPATIENT MENTAL HEALTH CARE Inpatient services and supplies in a Medicare-approved psychiatric hospital.	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible and \$250 copay per admission
OUTPATIENT MENTAL HEALTH CARE Outpatient services of psychiatrist, psychologists and other mental health and substance abuse providers	Member pays \$0 for Medicare covered services after \$250 deductible	Member pays \$0 for Medicare covered services after \$250 deductible
ALCOHOL/DRUG TREATMENT Inpatient Outpatient	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible
PODIATRY CARE Treatment of disease or injuries of the foot.	Member pays \$0 for Medicare covered services after \$250 deductible	Member pays \$0 for Medicare covered services after \$250 deductible
SELF-ADMINISTERED ORAL ANTI-CANCER DRUGS	Member pays \$0 after \$250 deductible	Member pays \$0 after \$250 deductible

Includes drugs as approved by Medicare or its generic equivalent SELF-ADMINSTERED ERYTHROPOIETIN Drug for dialysis patients	Part D covered services cost-share will be in the applicable tier of the specific prescription drug	Part D covered services cost-share will be in the applicable tier of the specific prescription drug
INJECTABLE DRUGS FOR OSTEOPOROSIS Post-menopausal homebound women under physician's supervision.		
IMMUNOSUPPRESSIVE DRUGS Includes Imuran, Sandimmune & any other FDA-approved outpatient immunosuppressive agent		
OPTIONAL BENEFITS Dental Health education Vision care Other (Please explain)		

Pharmacy Copay Structure for Network Benefits

General Information	PY2026 No Plan Changes (Required)	Specify if there is a difference between retail and mail order, preferred retail or standard	PY2026 No Plan Changes (Optional)
<p>Mandatory generic and formulary medications you get at a Network Pharmacy</p> <p>Some drugs require prior authorization</p> <p>Quantity limits apply to certain drugs</p> <p>Only copays for covered drugs purchased at Network Pharmacies count toward out-of-pocket maximums</p> <p>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003</p> <p>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003</p> <p>You will be notified before</p>	30- Day Supply (Fill in type of drug for each tier. Example: generic drugs)		
	Generic or Preferred Generic Generic or brand drugs that are available at the lowest cost-share for this plan = \$5	(Tier 1) Generic or Preferred Generic Drugs	
	Preferred Brand Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug = \$45	(Tier 2) Preferred Brand Drugs	
	Non-Preferred Drug Generic or brand drugs that Humana offers at a higher cost than Tier 2 Preferred Brand drugs = \$75	(Tier 3) Non-Preferred Brand Drugs	
	Specialty Tier Some injectables and other higher-cost drugs offers = \$100	(Tier 4) Specialty Drugs	
	Buproban, Chantix, Generic Statins and Nicotrol = \$0	(Tier 5) N/A Drugs	
	31- to 90-Day Supply (Fill in type of drug for each tier)		
	Generic or Preferred Generic Generic or brand drugs that are available at the lowest cost-share for this plan = \$10	(Tier 1) Generic or Preferred Generic Drugs	
	Preferred Brand Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug = \$90	(Tier 2) Preferred Brand Drugs	

any changes are made to your plan's formulary.

CMS regulated changes to Part D coverage must be included **in bold** regardless of if Supplier is proposing plan changes.

Non-Preferred Drug Generic or brand drugs that Humana offers at a higher cost than Tier 2 Preferred Brand drugs = \$150	(Tier 3) Non-Preferred Brand Drugs	
Specialty Tier = N/A Specialty Drugs are not available for 90-day supply	(Tier 4) Specialty Drugs	
Buproban, Chantix, Generic Statins and Nicotrol = \$0	(Tier 5) N/A Drugs	
Member pays \$0 in the Catastrophic Phase Maximum Out-Of-Pocket \$2,100	Catastrophic Coverage/Out-of-Pocket Maximum/Gap Coverage	
The \$0 member cost-share in the Catastrophic Coverage Phase is mandated by the Inflation Reduction Act.	Additional Notes	



Signature

G. Alan Stewart

Printed Name

July 21, 2025

Date

Senior Vice President, Division Leader/Senior Products

Title

(To be signed by the Supplier's President, Chief Executive Officer or authorized representative.)

Humana

Supplier Name

Exhibit 10
MAPD Premium Rate and LIS Quote
Best and Final Offer (BAFO)
Humana
Plan Year 2026

What type of MAPD plan is Bidder offering for this bid?

- MAPD in combination with a non-Medicare HMO
- MAPD in combination with an MSP and a non-Medicare HMO
- Standalone national MAPD

Instructions:

1. Estimated premium quote(s) for an MAPD plan will be due with the bid submission.
2. The due date for the final MAPD rate(s) of Plan Year 2026 will be the later of:
 - a. August 1, 2025; or
 - b. Two business days following CMS deadlines for rebate allocation calculations based upon the release of the CMS national average monthly bid amounts.
3. The rate sheet shall include the plan name.
4. Administrative cost rate (\$4.477 PMPM) for PY2026 should be included in the premium quote. This fee is determined annually by EGID and is subject to change either up or down in pricing. Refer to OEIBB Commercial Carrier Policy.
 - a. In the event of renewals, any change in the administrative assessment will be communicated to the Supplier no later than May 1st of the year preceding the following Plan Year.
5. Anything other than a fixed dollar amount will not be accepted and may cause the Bidder's bid to be rejected. Any cents quoted in the Bidder's rates shall be an even number and shall be **divisible by two**.
6. The MAPD benefits shall be those specified in Exhibit 9 for reference.
7. "PY2026 Quote with No Plan Changes" for MAPD is required for all Bidders to complete. (Table 1)
 - a. "PY2026 Quote with Proposed Plan Changes" for MAPD is optional and only for Bidders with current health contracts with the OEIBA Program. (Table 2)
8. **Low Income Subsidy Table 3 is due with the final MAPD rates in August.**

Supplier agrees to provide annual renewal rates for each contracted option no later than the first business day in May preceding the Plan Year for which the rates apply:

1. May 1, 2026, for Plan Year 2027 (January 1, 2027, through December 31, 2027)
2. May 3, 2027, for Plan Year 2028 (January 1, 2028, through December 31, 2028)

TABLE 1 – MAPD Monthly Premium Quote **with No Plan Changes
 PY2026 Quote (January 1, 2026, through December 31, 2026)**

	Plan Name	Per Member Monthly Rate
PY2026 Quote with No Plan Changes (Required)	No plan name changes for PY2026 renewal.	\$277.74

TABLE 2 – MAPD Monthly Premium Quote **with Plan Changes
 PY2026 Quote (January 1, 2026, through December 31, 2026)**

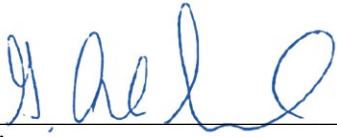
	Plan Name	Per Member Monthly Rate
PY2026 Quote with Plan Changes (Optional)	No plan name changes for PY2025 renewal.	\$273.42

TABLE 3 – MAPD Plan Low Income Subsidy (LIS) **with No Plan Changes
 (January 1, 2026, through December 31, 2026)**

LIS %	Rate for Medicare-eligible members after LIS is applied
100%	\$247.04 (LIS \$30.70)
75%	Not applicable
50%	Not applicable
25%	Not applicable

TABLE 34– MAPD Plan Low Income Subsidy (LIS) **with Plan Changes
 (January 1, 2026, through December 31, 2026)**

LIS %	Rate for Medicare-eligible members after LIS is applied
100%	\$242.72 (LIS \$30.70)
75%	Not applicable
50%	Not applicable
25%	Not applicable



Signature

G. Alan Stewart
Printed Name

August 13, 2025
Date

Senior Vice President, Division Leader/Senior Products

Title

(To be signed by the Supplier's President, Chief Executive Officer or authorized representative.)

Humana

Supplier Name



Humana Medicare Group Plan – Premium Information

STATE OF OKLAHOMA - PPO - Proposed Alternate Plan

PROPOSED ALTERNATE PLAN

Date: 5/5/2025
 Humana Medicare Group Plan
 Plan Names: Passive PPO Custom Medical with Custom Rx
 Passive Waiver Custom Medical with Custom Rx
 Rx Formulary: Group Plus Formulary - 26800
 Additional Buy-ups: Smoking Cessation, Generic Statins

Plan Year	Final Billed Premium (Per Member Per Month)
1/1/2026 - 12/31/2026	\$273.42

Passive PPO Custom Medical and Rx Benefit Custom Overview

	(In-Network Benefits match Out-of-Network Benefits)
Deductible	\$250 Part A & B Combined
Inpatient Acute Hospital	\$250 Copayment per Admission
Skilled Nursing Facility	\$0 Copayment (days 1-100)
Physician Office Visits	\$0 Copayment
Specialist Office Visits	\$0 Copayment
Outpatient Surgical	\$0 Copayment
Ambulance	\$0 Copayment
Emergency Room	\$50 Copayment
Medical Maximum Out of Pocket	\$500 Combined Medical Only (Medicare Covered Services)
Prescription Drugs (Retail 30 day supply)	Custom Rx \$250 Deductible; \$5/\$45/\$75/\$100 from \$250 to Catastrophic

See attached sheet for rating assumptions and stipulations. The benefits presented above are a high-level summary. Please consult the Plan Design Exhibit for a more detailed list of covered services, member cost shares, services subject to deductibles and any plan limitations.



Humana Medicare Group Plan – Rating Assumptions and Stipulations

STATE OF OKLAHOMA - PPO - Proposed Alternate Plan

Proposal Terms

The benefits presented on the previous page are a high-level summary. Please consult the Plan Design Exhibit for a more detailed outline of the benefits proposed. Final benefits may differ due to annual changes in CMS benefit requirements.

For members with End Stage Renal Disease (ESRD), the Humana Group Medicare Advantage Plan is only offered to eligible members who are diagnosed and enrolled in a manner that is consistent with applicable Medicare secondary laws, and the rules and regulations set forth by CMS.

The rates provided do not reflect any potential premium adjustments provided by Center for Medicare and Medicaid Services (CMS) or federal regulations based on a Medicare beneficiary's income.

Humana shall have the right to unilaterally adjust the proposed premium rates set forth in this rate sheet if:

- i. a change in or clarification to Law affects Medicare Part C or D program costs or revenue;
- ii. a natural disaster, pandemic, act of God or other cause beyond the reasonable control of Humana affects Medicare Part C or D programs costs or revenue;
- iii. highly utilized specialty or high-cost drugs are introduced, or additional indications are added to such a drug resulting in an increase in the pharmacy allowed per member per month; or
- iv. Humana determines that data provided and relied upon by Humana in development of the premium rates was inaccurate, incomplete, biased, misleading, or otherwise contributed to Humana underestimating actual plan expenses or revenue incurred by Group.

For purposes of this proposal, "Law" shall mean, "any federal, state, or local law, statute, regulation, ordinance, code, rule, order, or other similar requirement enacted, adopted, or enforced by a government authority, including, without limitation, Medicare laws and CMS regulations and requirements, including CMS manuals, CMS payment methodology, and other directives.

Humana will hold the proposed rates, assuming all of the information provided is accurate, and could be subject to change should any of the following differ:

All members are retired and enrolled in Medicare Part A and Part B.

A minimum average employer contribution level of \$105 Per Retiree Per Month of the proposed premium for the plan.

A majority of members' (51% or more) primary residence is in an adequate Humana Medicare Advantage network service area. Humana will monitor network adequacy throughout the year to confirm standards are met.

Part D, administered by Humana Pharmacy Solutions, will utilize Humana's Group Plus formulary and include utilization management programs such as: quantity limits, prior authorization, and step therapy. Humana continually updates its drug list and quantity limits, and ensures these updates are in accordance with CMS regulations.

Benefits, deductibles, maximum out of pocket accumulators, and any applicable pharmacy accumulators will be reset on January 1 each year.

Humana's Medicare Advantage plan can be offered alongside another carrier(s) plan. However, there should be no additional secondary plan wrapping around, coordinating with, or offered in conjunction with this plan for all current and future Medicare eligible retirees. Humana will hold the proposed rates assuming there are no material changes in the final plan selection, employer contribution or number of competing plans offered to the group.

We are pleased to present this Humana Group Medicare Advantage proposal to you and assume all information provided is accurate with the understanding if there is a material change from the provided information, including the offering environment, Humana has a right to revise or rescind the quote.

HUMANA MEDICARE EMPLOYER LPPO PLAN

2026 LPPO for State of Oklahoma Plan 079 Option TBD1 - Passive
Effective Date: 01/01/2026 - 12/31/2026

Annual Maximum Out-of-Pocket	<ul style="list-style-type: none"> • In-Network: \$500 per individual per plan year (excludes Part D Pharmacy, Extra Services and the Plan Premium). • Combined In and Out-of-Network: \$500 per individual per plan year (excludes Part D Pharmacy, Worldwide Coverage and the Plan Premium). 		
Annual Deductible	<ul style="list-style-type: none"> • Combined In and Out-of-Network: \$250 per individual per plan year • Combined In-Network Exclusions: Part D Pharmacy, Diabetic Monitoring Supplies received at a Pharmacy, Preferred Diabetic Supplier, All Preventive Services, All Emergency Services, Urgently Needed Care, Diabetic Eye Exam, All Medicare Part B Insulin Drugs, Additional Telehealth Services, Extra Services and the Plan Premium • Combined Out-of-Network Exclusions: Part D Pharmacy, Diabetic Monitoring Supplies received at a Pharmacy, All Preventive Services, All Emergency Services, Urgently Needed Care, Diabetic Eye Exam, All Medicare Part B Insulin Drugs, Worldwide Coverage and the Plan Premium 		
Place of Treatment	Benefit	Network Coverage Plan Pays (1):	Non-Network Coverage Plan Pays (1):
Primary Care Physician	• Office Visit	100% after combined annual deductible	100% after combined annual deductible
	• Diagnostic Procedures and Tests	100% after combined annual deductible	100% after combined annual deductible
	• Lab Services	100% after combined annual deductible	100% after combined annual deductible
	• Surgical Procedures	100% after combined annual deductible	100% after combined annual deductible
	• Allergy Shots and Injections	100% after combined annual deductible	100% after combined annual deductible
	• Mental Health/Substance Abuse Services	100% after combined annual deductible	100% after combined annual deductible
	• Administration of Drugs in a Physician's Office	100% after combined annual deductible	100% after combined annual deductible
	• Medicare Part B Insulin Drugs	100%	100%
Specialist	• Office Visit	100% after combined annual deductible	100% after combined annual deductible
	• Advanced Imaging Services	100% after combined annual deductible	100% after combined annual deductible
	• Diagnostic Procedures and Tests	100% after combined annual deductible	100% after combined annual deductible
	• Lab Services	100% after combined annual deductible	100% after combined annual deductible
	• Surgical Procedures	100% after combined annual deductible	100% after combined annual deductible
	• Diagnostic Colonoscopy	100% after combined annual deductible	100% after combined annual deductible
	• Podiatry Services (Medicare-covered)	100% after combined annual deductible	100% after combined annual deductible
	• Chiropractic Services (Medicare-covered)	100% after combined annual deductible	100% after combined annual deductible
	• Cardiac Therapy	100% after combined annual deductible	100% after combined annual deductible
	• Supervised Exercise Therapy (SET) Symptomatic Peripheral Artery Disease (PAD) Services	100% after combined annual deductible	100% after combined annual deductible
	• Pulmonary Therapy	100% after combined annual deductible	100% after combined annual deductible
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after combined annual deductible	100% after combined annual deductible
	• Radiation Therapy	100% after combined annual deductible	100% after combined annual deductible
	• Allergy Shots and Injections	100% after combined annual deductible	100% after combined annual deductible
	• Mental Health/Substance Abuse Services	100% after combined annual deductible	100% after combined annual deductible
	• Opioid Treatment Services	100% after combined annual deductible	100% after combined annual deductible
	• Administration of Drugs in a Physician's Office	100% after combined annual deductible	100% after combined annual deductible
	• Medicare Part B Insulin Drugs	100%	100%
	• Chemotherapy Drugs	100% after combined annual deductible	100% after combined annual deductible
	• Dental Services (Medicare-covered)	100% after combined annual deductible	100% after combined annual deductible
	• Hearing Services (Medicare-covered)	100% after combined annual deductible	100% after combined annual deductible
	• Vision Services (Medicare-covered)	100% after combined annual deductible	100% after combined annual deductible
	• Eyewear for Post-Cataract Surgery	100% after combined annual deductible	100% after combined annual deductible
• Diabetic Eye Exam	100%	100%	
• Acupuncture Services (Medicare-Covered) for Chronic Lower Back Pain - CLB309 - Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting Original Medicare provider requirements.	•100% for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	•100% for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. •Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	
Preventive Services	<ul style="list-style-type: none"> • Abdominal Aortic Aneurysm Screening • Alcohol Misuse Screening and Counseling • Annual Wellness Visit • Bone Mass Measurement • Breast Cancer Screening • Cardiovascular Disease Behavioral Therapy • Cardiovascular Disease Screening • Cervical and Vaginal Cancer Screening • Colorectal Cancer Screening • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Glaucoma Screening • Hepatitis C Screening • HIV Screening • Kidney Disease Education Services • Immunizations • Lung Cancer Screening • Medicare Diabetes Prevention Program (MDPP) • Medical Nutrition Therapy • Obesity Screening and Therapy • Physical Exams (Routine) • Prostate Cancer Screening Exam • Smoking and Tobacco Use Cessation • STI Screening and Counseling • "Welcome to Medicare" Preventive Visit 	100%	100%

Inpatient Hospital Services	• Inpatient Care (All Authorized Admissions)	100% after combined annual deductible and \$250 copayment per admission	100% after combined annual deductible and \$250 copayment per admission
	• Inpatient Physician Services	100% after combined annual deductible	100% after combined annual deductible
Inpatient Psychiatric Facility	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% after combined annual deductible and \$250 copayment per admission •190 day lifetime limit in a psychiatric facility.	100% after combined annual deductible and \$250 copayment per admission •190 day lifetime limit in a psychiatric facility.
	• Inpatient Mental Health/Substance Abuse Physician Services	100% after combined annual deductible	100% after combined annual deductible
Outpatient Hospital	• Surgical Services	100% after combined annual deductible	100% after combined annual deductible
	• Diagnostic Colonoscopy	100% after combined annual deductible	100% after combined annual deductible
	• Advanced Imaging Services	100% after combined annual deductible	100% after combined annual deductible
	• Nuclear Medicine Services	100% after combined annual deductible	100% after combined annual deductible
	• Diagnostic Procedures and Tests	100% after combined annual deductible	100% after combined annual deductible
	• Lab Services	100% after combined annual deductible	100% after combined annual deductible
	• Radiation Therapy	100% after combined annual deductible	100% after combined annual deductible
	• Cardiac Therapy	100% after combined annual deductible	100% after combined annual deductible
	• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	100% after combined annual deductible	100% after combined annual deductible
	• Pulmonary Therapy	100% after combined annual deductible	100% after combined annual deductible
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after combined annual deductible	100% after combined annual deductible
	• Chemotherapy Drugs	100% after combined annual deductible	100% after combined annual deductible
	• Renal Dialysis Services	100% after combined annual deductible	100% after combined annual deductible
	• Mental Health/Substance Abuse Services	100% after combined annual deductible	100% after combined annual deductible
	• Partial Hospitalization	100% after combined annual deductible	100% after combined annual deductible
	• Intensive Outpatient Services	100% after combined annual deductible	100% after combined annual deductible
	• Opioid Treatment Services	100% after combined annual deductible	100% after combined annual deductible
	• Other Medicare Part B Drugs	100% after combined annual deductible	100% after combined annual deductible
	• Medicare Part B Insulin Drugs	100%	100%
	Skilled Nursing Facility (SNF)	• SNF Care (no 3 day hospital stay is required)	100% after combined annual deductible per day (days 1-100) •Plan pays \$0 after 100 days.
• SNF Physician Services		100% after combined annual deductible	100% after combined annual deductible
Urgent Care Center	• Urgently Needed Care	100%	100%
	• Lab Services	100% after combined annual deductible	100% after combined annual deductible
Emergency Room	• Emergency Services (2)	100% after \$50 copayment • Waived if admitted within 24 hours	100% after \$50 copayment • Waived if admitted within 24 hours
	• Emergency Room Physician Services	100%	100%
Ambulance	• Ambulance Services	100% after combined annual deductible per date of service •Limited to Medicare-covered transportation.	100% after combined annual deductible per date of service •Limited to Medicare-covered transportation.
Travel Benefit	• US Travel Benefit	Member receives in-network benefit when services are received from a participating PPO provider in another Humana PPO service area.	N/A
Worldwide Coverage	• Emergency Services and Urgently Needed Care Only	N/A	100% •Limited to emergency Medicare-covered services.
Comprehensive Outpatient Rehabilitation Facility	• Pulmonary Therapy	100% after combined annual deductible	100% after combined annual deductible
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after combined annual deductible	100% after combined annual deductible
Freestanding Radiological Facility	• Advanced Imaging Services	100% after combined annual deductible	100% after combined annual deductible
	• Nuclear Medicine Services	100% after combined annual deductible	100% after combined annual deductible
	• Diagnostic Procedures and Tests	100% after combined annual deductible	100% after combined annual deductible
	• Radiation Therapy	100% after combined annual deductible	100% after combined annual deductible
Ambulatory Surgical Center	• Surgical Procedures	100% after combined annual deductible	100% after combined annual deductible
	• Diagnostic Colonoscopy	100% after combined annual deductible	100% after combined annual deductible
Freestanding Laboratory	• Lab Services	100% after combined annual deductible	100% after combined annual deductible
Dialysis Center	• Renal Dialysis Services	100% after combined annual deductible	100% after combined annual deductible
Home Health	• Home Health Care	100% after combined annual deductible •Excludes Personal Home Care.	100% after combined annual deductible •Excludes Personal Home Care.
DME Provider	• Durable Medical Equipment	100% after combined annual deductible	100% after combined annual deductible
	• Diabetic Monitoring Supplies	100% after combined annual deductible	100% after combined annual deductible
	• Continuous Glucose Monitor	100% after combined annual deductible	100% after combined annual deductible
Medical Supply Provider	• Medical Supplies	100% after combined annual deductible	100% after combined annual deductible
Preferred Diabetic Supplier	• Diabetic Monitoring Supplies	100%	N/A
Prosthetics Provider	• Prosthetics	100% after combined annual deductible	100% after combined annual deductible
Pharmacy (Part B Only)	• Durable Medical Equipment	100% after combined annual deductible	100% after combined annual deductible
	• Medical Supplies	100% after combined annual deductible	100% after combined annual deductible
	• Diabetic Monitoring Supplies	100%	100%
	• Continuous Glucose Monitor	100% after combined annual deductible	100% after combined annual deductible
	• Other Medicare Part B Drugs	100% after combined annual deductible	100% after combined annual deductible
	• Medicare Part B Insulin Drugs	100%	100%

Additional Telehealth Services	• Primary Care Physician - Virtual Visit	100%	N/A
	• Specialist - Virtual Visit	100%	N/A
	• Behavioral Health and Substance Abuse - Virtual Visit	100%	N/A
	• Urgently Needed Care - Virtual Visit	100%	N/A

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor.

Extra Benefits (MSB)	• SilverSneakers®	Access to fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations.
	• Personal Health Coaching	Personal Health Coaching for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.
	• Smoking Cessation (Additional)	A comprehensive smoking cessation program available online, email and phone to aid in the effort to quit smoking.
	• Meal Program	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are eligible for nutritious meals delivered to their door at no cost.
	• Post-Discharge Transportation Services	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are provided transportation to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle at no cost.
	• Post-Discharge Personal Home Care	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members may receive assistance performing activities of daily living (ADLs) within the home and Instrumental Activities of Daily living related to personal care. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.
Care Management	<ul style="list-style-type: none"> • Clinical Programs/Disease Management (3) <ul style="list-style-type: none"> - Case Management - Humana at Home® - Chronic Condition Management - Transplant Management - Behavioral Health Care Coordination 	Health education and clinical programs that provide support to members and caregivers to optimize health outcomes.

(1) All coinsurance percentages are based on the Medicare fee schedule and not billed charges. All copayments are on a 'per visit' basis, unless otherwise noted.

(2) Emergency room copayment waived if admitted or if hospital is outside the U.S.

(3) We have provided examples of various Health Education and clinical programs. Actual programs may vary by market.

Go365® by Humana is included in this plan

A wellness program that rewards Medicare beneficiaries for completing eligible healthy activities that help your members establish and maintain a healthy lifestyle. As your members achieve manageable health goals, Go365 keeps them engaged and motivated by acknowledging their efforts. By completing healthy activities like walking, getting an Annual Wellness Exam, or volunteering, your members earn rewards they can redeem for gift cards in the Go365 Mall.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. Certain services under the plan require authorization by network providers. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.