This OMES EGID Specific Terms is a Contract Document in connection with a Contract awarded by OMES on behalf of EGID.

All Exhibits referenced in this Contract Document are incorporated herein.

In addition to other terms contained in an applicable Contract Document, the parties agree to the following:

# GENERAL TERMS

## Supplier shall be responsible for processing eligible Health, Dental, and Life claims incurred prior to the contract effective date (“Run-In Claims”). Including claims that are open (unprocessed) from the incumbent Supplier and/or eligible for appeal, audit, adjustment, or reconsideration/resubmission under EGID policies and provisions.

## Supplier and EGID shall work collaboratively through strategic planning efforts to provide, with the highest degree of efficiency, a wide range of quality insurance benefits that are competitively priced and uniquely designed to meet the needs of a defined population.

## Supplier shall comply with all applicable EGID policies and procedures which may be updated from time to time. The requirements outlined herein may be changed or amended only by written agreement signed by both Supplier and EGID.

## Supplier shall provide quality operational and administrative services on behalf of the HealthChoice health, dental and life plans, the Department of Corrections inmate health plan, and the Department of Rehabilitation Services health plan. Services for each plan shall include customer services, benefits management, claims processing, utilization management and other functions as outlined herein.

## Supplier shall be compliant with State and federal regulations, including the Health Insurance Portability Accountability Act (HIPAA), as well as Agency defined policies and rules.

# IDENTIFICATION

## Employees Group Insurance Division (EGID)

### EGID is a division of the Office of Management and Enterprise Services (OMES). EGID was established by, and operates pursuant to, the Oklahoma Employees Insurance and Benefits Act, 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 makes decisions on all policy matters affecting the group insurance plans, including member benefits, premium rates and the investment of premiums. EGID also maintains its own network of providers for the HealthChoice plans, DOC, and DRS. EGID serves over 900 employer groups with multiple retirement systems. See www.ok.gov/sib/ for more information about EGID and plans offered.

### Pursuant to legislative authority, EGID Administrative Rules set forth the eligibility, type of participation and benefits guidelines for all participating employers. A copy of the official Administrative Rules is on file with the Office of the Secretary of State beginning at Oklahoma Administrative Code Title 260:45, or the Rules may be found at <https://oklahoma.gov/omes/services/employees-group-insurance-division.html> (“About EGID”).

## HealthChoice

### The state of Oklahoma’s self-funded health, dental and life insurance plans administered by EGID are known as the HealthChoice plans.

### HealthChoice members are all persons covered by one or more of the HealthChoice insurance plans offered by EGID including eligible current and qualified former employees of participating entities and their eligible covered dependents.

### HealthChoice “Network Provider” means a practitioner who or facility that is duly licensed under the laws of the state in which the provider operates, satisfies additional credentialing criteria as established by EGID, and has entered into a contract with EGID to accept scheduled reimbursement for covered medical or dental services and supplies provided to HealthChoice members. EGID maintains a separate network of providers for HealthChoice and shall transmit exports of Network providers to the Supplier.

### Non-Network providers must meet the same definition as above but have not entered into a contract with EGID for purposes of scheduled reimbursement. It shall be the responsibility of the Supplier to identify and maintain non-Network HealthChoice provider records.

## Oklahoma Department of Corrections (DOC)

### Pursuant to an interagency agreement with the Oklahoma DOC, EGID provides DOC with operational and administrative services pursuant to this contract, including claims administration, customer service, network management quality assurance, and reporting.

## Oklahoma Department of Rehabilitation Services (DRS)

### Pursuant to an interagency agreement with the Oklahoma DRS, EGID provides DRS with operational and administrative services pursuant to this contract, including claims administration, customer service, network management quality assurance, and reporting.

# HEALTHCHOICE

## Member Eligibility

### EGID administers member eligibility in a multi-employer environment. Eligibility and Enrollment rules are outlined in the EGID Administrative Rules and HealthChoice member handbook(s).

### Member demographic and enrollment information is maintained by the EGID Member Accounts units within the EGID Eligibility and Premium Accounting system. EGID assigns a unique identification (ID) number for HealthChoice members that consists of eight system generated digits plus a two-digit person ID. EGID also assigns a unique ID number for employer groups. Throughout each plan year, EGID enrolls and disenrolls employer groups and members. Member eligibility changes are processed daily and may include, but are not limited to new enrollments, transfers, terminations, corrections, changes to member demographic information and other changes. Retro-activity is common in all of these types of changes. A member may transfer from one EGID employer group to another EGID employer group, from one HealthChoice plan to another HealthChoice plan, from a member status to dependent status, and vice versa. EGID may change an existing unique member ID number that is assigned to a member or dependent to a different unique system generated member ID number for the member or dependent. Split coverage, double coverage on life insurance, and dependent coverage under multiple members are all allowed.

#### Supplier shall be responsible for loading and utilizing the EGID assigned HealthChoice ID number in all forms of communication to members, providers and EGID, including reporting and data file feeds.

#### Supplier shall be responsible for loading and maintaining the EGID unique employer ID number, including both the group and division code(s) assigned, so that it can be utilized in reporting and data file feeds.

#### Supplier shall be responsible for maintaining HealthChoice member demographic and enrollment information, as provided by EGID, to ensure proper claim adjudication, benefit administration and reporting.

##### Supplier shall assist EGID with ensuring a member’s Medicare Beneficiary Identifier (MBI) number is provided and accurate in both the eligibility and claims payment system(s).

#### Supplier shall not change or modify any member information provided by EGID to the Supplier without the specific written consent of EGID. Supplier shall notify EGID of all changes of addresses, names, and dates of births indicated on forms and/or correspondence from plan members, as well as any reported deaths and early Medicare eligibility for a member, on a daily basis.

#### Supplier shall accept and process eligibility and enrollment data daily in accordance with the EGID member eligibility incremental change file layout and processing guidelines provided in Exhibit 1. EGID and the Supplier will work collaboratively to identify and document needed modifications.

##### Supplier shall load daily incremental change files the day of receipt, except during scheduled down time pre-approved by EGID.

##### Supplier shall generate and provide to EGID a daily electronic report of records that failed to load, were partially loaded or loaded with errors, and indicate the reason for the errored data record.

#### EGID shall provide the Supplier a full member eligibility file monthly, or upon request, to reconcile eligibility data.

##### Supplier shall conduct a full reconciliation audit within 14 calendar days of receipt of the monthly full file to identify and correct any discrepancies in the member data loaded in the Supplier’s system versus EGID’s system.

##### Supplier shall generate and provide to EGID an electronic reconciliation report of all discrepancies found. The report shall indicate the date of the load error, description of the discrepancy, and the date the error was corrected.

## Provider Eligibility

### Network provider demographic and enrollment is maintained by the EGID Network Management unit within the EGID provider database management system for both the HealthChoice plan(s) and the HealthChoice Select program (two separately maintained networks). EGID contracts with eligible providers at the tax identification number (TIN) and national provider identification number (NPI) level. For practitioners, EGID utilizes the Type 1 NPI. For Independent Health Organizations and Facilities, EGID utilizes the Type 2 NPI. Provider eligibility and enrollment changes are processed daily and may include, but are not limited to new contract enrollment, terminations, corrections, changes to provider demographic information and other changes. Retro-activity is common in all of these types of changes. Effective dates begin at 12:01 AM CT while termination dates end at 11:59 PM CT of the date indicated on the provider export. Specialty order on the provider export shall determine the specialty’s rank for reimbursement purposes.

#### The supplier shall use, at a minimum, the TIN and national NPI number to identify Network providers from the data supplied by EGID for claims adjudication and customer service. Any additional data elements used to identify Network providers other than provider’s TIN and NPI number shall require EGID approval. EGID shall supply all Network Provider demographics data needed by the Supplier’s software and shall be the sole source of that information unless agreed upon by EGID.

#### Under no circumstances shall the Supplier create, modify or delete any Network provider records without direction and/or approval from EGID.

#### Supplier shall maintain EGID Network provider data separate and distinct from any other of the Supplier’s lines of business.

#### Supplier shall accept and process provider network eligibility and enrollment data daily in accordance with the EGID provider eligibility incremental change file layout and processing guidelines provided in Exhibit 2. Supplier shall replace any existing data with new data contained on the provider exports unless instructed otherwise by EGID or otherwise specified in the layout or processing guidelines. EGID and the Supplier will work collaboratively to identify and document needed modifications.

##### Supplier shall load daily incremental change files the day of receipt, except during scheduled down time pre-approved by EGID.

##### Supplier shall generate and provide to EGID a daily detailed electronic report of records that failed to load, were partially loaded or loaded with errors, and indicate the specific data that failed to load and the reason for the incomplete, partially loaded, or errored data record.

#### EGID shall provide the Supplier a full provider eligibility file quarterly, or upon request, to reconcile provider network eligibility data.

##### Supplier shall conduct a full reconciliation audit within 14 calendar days of receipt of the quarterly full file to identify and correct any discrepancies in the provider data loaded in the Supplier’s system versus EGID’s system.

##### Supplier shall generate and provide to EGID an electronic reconciliation report of all discrepancies found. The report shall clearly indicate, at a minimum, what the different data elements are, what the error is, the date the error was identified, how the error was fixed, and any additional items that may be identified by the Supplier or EGID as necessary to evaluate the quarterly reconciliations.

#### Non-Network provider eligibility is determined by the criteria outlined in section I (2) of the HealthChoice network contract(s). Providers who are ineligible to contract with HealthChoice, or who do not meet otherwise approved criteria set by EGID, are ineligible for reimbursement.

##### Supplier shall collect and maintain demographic information and determine eligibility for non-Network providers.

##### Supplier shall maintain all non-Network HealthChoice provider eligibility records separate and distinct from any other of the Supplier’s lines of business.

##### Supplier shall administer benefits and claim adjudication functions as outlined herein and in accordance with EGID policies and rules for non-Network provider services, just as they are applied network provider services.

###### 74 O.S. §§1304.1.M.19 and 1307.3 requires out-of-state providers receive payment at the same level as in-state providers unless an Administrative Exception has been approved by EGID or the claim meets defined criteria, as documented and mutually agreed upon by Supplier and EGID, for negotiation.

## Customer Service

### Call Center:

#### HealthChoice offers members and providers customer service via a dedicated call center to verify benefits, discuss claim status or reimbursement, find a provider, learn more about HealthChoice programs and initiatives and more.

##### Supplier shall provide a toll-free customer service phone line dedicated to HealthChoice, and/or any entities approved by EGID for use through interagency agreements.

##### Supplier shall support and maintain Interactive Voice Response (IVR) technology but provide easy access to a live person at any time upon request. Providers and Members shall be provided separate dedicated paths within the phone tree. The telephone system shall be equipped with the functionality to interface with all associated HealthChoice programs and vendors for easy automatic transfers.

##### Supplier shall provide callers with the option to complete a survey at the conclusion of each call regarding the quality of service provided after each call.

###### Survey results and feedback shall be shared with EGID quarterly.

##### Supplier shall provide Teletype (TTY) or Telecommunication Device for the Deaf (TDD) technology and/or translation services to non-English speaking, hearing impaired and visually impaired members in accordance with the Affordable Care Act (ACA).

##### Supplier shall maintain a dedicated call center for HealthChoice with adequate call center staff to support both outbound and inbound customer service support to HealthChoice members and providers Monday through Friday, except for State of Oklahoma observed holidays, from 7:30 a.m. to 6:00 p.m. Central Standard Time. State observed holidays are posted to the Oklahoma Secretary of State’s website annually at: https://www.sos.ok.gov/home/holidays.aspx.

###### Supplier shall notify EGID of all scheduled closures for approved holidays at least 21 business days in advance. When the call center is closed for authorized State holidays, the Supplier shall include a message, approved by EGID, indicating the holiday being observed for closure and when it will reopen.

##### Supplier shall develop and maintain scripts and call guides specific to the HealthChoice book of business; scripts and call guide material shall be edited in accordance with plan changes and new initiatives within 1 business day of such changes and shall be made accessible to EGID.

##### Supplier shall support and promote HealthChoice programs and initiatives while striving to steer members to the most cost-efficient providers and facilities for covered services.

##### Supplier shall maintain an open call tracking system, with the ability for auditing and oversight, for call inquiries that cannot be resolved initially and require follow-up to the caller, and shall ensure timely status updates are provided to the requestor until the inquiry is resolved.

##### Supplier shall provide staff interface and support to internal EGID departments and HealthChoice vendors and programs, as needed, to promote health initiatives, provide support and identify cost savings for the HealthChoice member and provider populations.

### Material and Marketing

#### EGID supports marketing avenues such as email, mobile application push-messaging, websites and more. EGID requires review and approval of all material sent to or posted for plan members and providers, regardless of the format.

##### Supplier shall be responsible for drafting material and information, at the request of EGID and in coordination with EGID or other vendors, in support of ongoing program initiatives.

##### Supplier shall assist EGID and/or other partnering vendors in developing criteria, reporting and material for targeted populations and Plan initiatives.

##### Supplier shall be responsible for reviewing draft material developed by EGID and/or partnering vendors to provide feedback and edits.

### HealthChoice Website

#### EGID requires the Supplier to maintain and manage a secure mobile responsive website for HealthChoice participants and providers to access eligibility information, plan benefit information, accumulator totals and more.

##### Supplier’s managed website shall provide a landing page for both members and providers to easily access plan information/resources and/or interface with the State’s website and other HealthChoice vendors/programs, and provide the ability for secure login to access eligibility and claim status, benefit accumulations, printable ID card, explanation of benefits (EOB), remittance advice (RA), update or provide verification of other insurance and more.

##### Supplier shall develop and maintain the ability for members and providers to submit Plan forms and inquiries, such as but not limited to appeal requests, ID card requests, and coordination of benefit changes electronically from the Supplier’s website.

##### Supplier shall provide the ability to house Plan documents and communications that go out to members online for a specified amount of time. Documents such as EOBs, appeal determination(s), overpayment notice and other outgoing communications sent by the Supplier to a member and/or provider should be accessible through the member’s online account.

##### Supplier shall offer and maintain the ability to utilize a Security Assertion Markup Language (SAML) provider for credentialing passthrough with other EGID and/or vendor systems.

### HealthChoice Mobile Application

#### EGID currently provides a mobile application through an external vendor for the benefit of HealthChoice participants. At EGID’s request, Supplier shall provide a secure mobile application for participants to access all plan information including but not limited to eligibility and enrollment information, search for a network provider and/or Select procedure, access claim and EOB information, view accumulator totals, view plan benefit information and provide electronic delivery of plan changes/updates, promotions, newsletters to participants and provide chat functionality for live assistance.

#### EGID currently contracts with an external vendor to offer mobile app technology and services, including the ability for members to “chat with a Care Guide” through in-app text functionality.

##### Supplier shall provide support and promotion of the EGID mobile application and/any programs initiatives through the mobile application vendor or services.

##### Supplier acknowledges that it has the capabilities to integrate its existing mobile app technology with the secure mobile application that EGID utilizes.  Supplier shall cooperate with EGID’s mobile app vendor to facilitate this successful integration.

## Programs and Initiatives

### Supplier shall at no additional cost cooperate and integrate, in good faith, with all existing and future vendors contracted to provide products or services for the HealthChoice member and/or provider population, including, but not limited to, wellness program initiatives, drug benefit management, disease management, site of care alignment, new system/technology services, etc.

### Section 125

#### Internal Revenue Code, Section 125 Cafeteria plan with a Flexible Spending Account (FSA) for medical reimbursement is offered to State of Oklahoma State active employees. Within the FSA, a debit card program allows a participating member to use a pre-loaded debit card that works like any other debit MasterCard or debit Visa Card, except that it is charged only against the cardholder’s personal FSA balance, not against a general bank balance.

##### Supplier shall interface with the debit card company and provide paid claims utilization on a weekly basis. The attached Exhibit 3 is the file format required by the current debit card company.

### Select Program

#### The HealthChoice Select program is designed to reduce the costs of certain services for the HealthChoice plans by contracting with certain medical facilities to provide these services and bill HealthChoice a single bundled amount for all related costs; the bundled amount covers the cost from the facility and all other providers for the procedure and related services rendered on that day. The program is available to any enrolled person in any non-Medicare Supplement plan when HealthChoice is the individual’s primary insurer. For specified services, an incentive payment is issued to members when utilizing a Select network provider. There is no need for the participant to opt-in or sign-up to qualify for coverage under the program. The Select network provider demographic and enrollment information is maintained by the EGID Network Management unit. EGID maintains the services covered under Select, which are reimbursed at 100% of the bundled allowable fee with no out-of-pocket costs to members when received from facilities participating in Select, except when bound by federal or state regulation(s), such as the requirement for any High Deductible Plan, or other relevant plan(s), for members to meet their deductible before the Plan can waive costs. Qualifying service bundles are reviewed quarterly and maintained by the HealthChoice Select fee.

##### Supplier shall be responsible for proper adjudication of all Select network claims in accordance with EGID policy and rules, to include bundled reimbursement to the facility, denial of charges from affiliated providers for related services, and member incentive payment processing for qualifying service(s).

##### Supplier shall interface and work collaboratively with other HealthChoice vendors and programs to offer member support and education, navigation services, issue resolution and provider education/assistance relative to the Select program.

##### Supplier shall promote services and participating facilities while providing education and assistance to members regarding the Select program and network.

##### Supplier shall accept and process provider Select network eligibility and enrollment data daily in accordance with the EGID Select provider eligibility incremental change file layout and processing guidelines provided in Exhibit 4. Supplier shall replace any existing data with new data contained on the Select provider export unless instructed otherwise by EGID or otherwise specified in the layout or processing guidelines. EGID and the Supplier will work collaboratively to identify and document needed modifications.

###### Supplier shall load daily Select incremental change file the day of receipt, except during scheduled down time pre-approved by EGID.

###### Supplier shall generate and provide to EGID a daily detailed electronic report of records that failed to load, were partially loaded or loaded with errors, and indicate the specific data that failed to load and the reason for the incomplete, partially loaded, or errored data record.

##### EGID shall provide the Supplier a full Select provider eligibility file quarterly, or upon request, to reconcile Select provider network eligibility data.

###### Supplier shall conduct a full reconciliation audit within 14 calendar days of receipt of the Select quarterly full file to identify and correct any discrepancies in the provider data loaded in the Supplier’s system versus EGID’s system.

###### Supplier shall generate and provide to EGID an electronic Select reconciliation report of all discrepancies found. The report shall clearly indicate, at a minimum, what the different data elements are, what the error is, the date the error was identified, how the error was fixed, and any additional items that may be identified by the Supplier or EGID as necessary to evaluate the Select quarterly reconciliations.

### Care Management Program

#### HealthChoice requires Supplier to provide care management and navigation services designed to assist patients and their support systems in managing medical conditions and health care needs more effectively in an effort to improve overall patient health. Program services shall be available to all HealthChoice health plan members, excluding Medicare, and shall specifically target members with multiple chronic or complex conditions to ensure they obtain access to needed care and services, as well as coordination of care to meet health goals and improve outcomes.

##### Supplier shall provide a comprehensive program model aimed to reduce avoidable admissions for acute care, reduce re-admissions, reduce emergency room visits, reduce care gaps, and improve clinical outcomes and overall quality of life.

##### Supplier shall use evidence-based clinical guidelines recognized and approved by the Care Coordination Institute (CCI), Quality of Care Model Committee and/or best practices by the Case Management Society of America.

##### Supplier shall utilize and provide a comprehensive data analytics solution based on HEDIS evidence/based guidelines and best practices; supplier shall provide adequate reporting and data to EGID as needed.

##### Supplier shall coordinate and integrate with EGID and its programs, providers and vendors to administer the program; all services shall be administered in accordance with EGID plan policies and provisions.

##### Supplier shall provide, at a minimum, the below services within the program:

###### Care Coordination;

###### Stakeholder Engagement;

###### Transitional Care Management;

###### Disease Management;

###### Medication Support;

###### Emergency Room Management;

###### Urgent Care Education.

### Telemedicine

#### HealthChoice offers telemedicine services through a contracted vendor for diagnosis and/or treatment of many common, minor medical issues via phone or videoconference Telemedicine coverage is available through the contracted vendor to any enrolled person on the HealthChoice High, High-Alternative, Basic, Basic-Alternative or High Deductible Health Plan (HDHP) with no member out-of-pocket costs, except when bound by federal requirements under the High Deductible Plan for members to meet their deductible before the Plan can waive costs.

#### EGID provides member eligibility directly to the designated telemedicine vendor. Supplier shall interface and coordinate with EGID and the vendor to resolve reported eligibility issues.

#### Member transactions with the telemedicine vendor will be provided to Supplier in a mutually agreed upon layout; claim details will not be provided. The file will include all visit transactions, including “no charge” visits. Supplier shall load each transaction file into the claims system daily, Monday through Sunday, and reflect the visit in the members online account, and apply any amounts charged to a member to the member deductible and out-of-pocket accumulation totals.

#### Supplier shall provide the telemedicine vendor with a daily accumulator file that reflects each individual participant deductible and maximum out-of-pocket status using a mutually agreed upon layout. The file shall be provided to the vendor daily, Monday through Friday.

### Diabetes Prevention Program

#### The national DPP is recognized by the CDC as a lifestyle change program that offers evidence-based, cost effective interventions to help prevent type 2 diabetes. HealthChoice maintains its own DPP network and fee schedule of covered services and reimbursement. Coverage is allowed for DPP network services in accordance with HealthChoice preventive service benefits with no out-of-pocket costs to members. There is no non-Network DPP coverage.

##### Supplier shall process claims in accordance with EGID policy and benefit reimbursement guidelines.

##### Supplier shall interface and work collaboratively with other HealthChoice vendors and programs to offer member support and education, navigation services, issue resolution and provider education/assistance relative to the DPP.

### Bariatric Program

#### HealthChoice maintains its own Bariatric network and fee schedule of covered services that covers specific bariatric surgical procedures subject to certification and clinical criteria and guidelines set forth by the Certification Administrator, currently utilizing Milliman Care Guidelines for Bariatric Surgery. These procedures must be obtained from a Metabolic Bariatric Surgery Accreditation and Quality Improvement Program (MBSA-QIP) Comprehensive Center of Excellence contracted with HealthChoice as a network bariatric facility provider.

##### Supplier shall process bariatric claims per plan policy and design utilizing the Bariatric fee schedule that provides for a bundled payment to the Network facility that includes the facility, surgeon, assistant surgeon, anesthesiology, laboratory, pathology, radiology and other related services when those services are rendered on the same date or during the hospital confinement. The bundled payment as well as all related pre-operative and workup services are subject to all plan provisions including member liability for copay, coinsurance and deductible amounts.

##### Supplier shall interface and work collaboratively with other HealthChoice vendors and programs to offer member support and education, navigation services, issue resolution and provider education/assistance relative to the Bariatric program.

## Benefit and Claims Administration

### ID Card

#### HealthChoice ID card administration is required for all HealthChoice medical plans, including Medicare, and the HealthChoice Dental plan. HealthChoice utilizes one ID card for participants enrolled in both a Medical and Dental HealthChoice plan. Pharmacy ID cards are generated and administered separately by the HealthChoice Pharmacy Benefits Manager (PBM).

##### Supplier shall be responsible for maintaining all data element requirements defined by the ACA. Supplier shall not charge EGID for redesign costs necessitated by any Federal mandates.

##### Supplier shall include, at a minimum, EGID’s system generated and assigned HealthChoice member ID, the member’s name, all covered dependent(s) name, claims submission information and customer service contact information for phone and website. ID cards shall be branded HealthChoice in accordance with OMES branding guidelines and requirements.

#### ID cards shall be generated based on designated eligibility updates and plan changes, and/or upon request from a member. Supplier shall maintain the ability to identify and issue ID cards based on changes submitted from the EGID Member Eligibility export, including:

##### New enrollments – including first time HealthChoice enrollee or re-instatement of coverage after a lapse of greater than 30 days

##### Dependent changes: adds or terminations

##### HealthChoice Member ID change

##### First or Last name change of the member or dependent(s)

#### Supplier shall maintain the ability for members to request a new ID card via the HealthChoice website, the customer service IVR and/or verbally by contacting the Supplier’s HealthChoice call center.

#### Supplier shall generate and issue one ID card for member only coverage and two (2) ID cards for member plus dependent coverage; unless additional cards are requested by the member

#### Supplier shall mail ID cards to the member’s address on file, as provided within the V3 Eligibility Export

#### Supplier shall be responsible for all aspects of producing and mailing, via first class mail, an accurate ID card to the member’s address provided by EGID. ID cards shall be generated nightly, five (5) days a week (Sunday through Thursday), for all requests or updates loaded that day and cards shall be mailed the next business day

### Mail Service

#### HealthChoice requires both incoming and outgoing mail service. Mail and correspondences processed by Supplier may often contain sensitive information such as Personal Health Information (PHI) or Personally Identifiable Information (PII) and shall be safeguarded in accordance with federal and/or State requirements. Outgoing mail services include paper and/or electronic correspondence. Returned member and network provider mail shall be managed by EGID. Supplier shall manage and handle all returned mail for non-Network providers.

###### Supplier shall establish an internal mail service that supports the service needs and size of the HealthChoice book of business.

###### Supplier shall maintain metrics and statistics for received mail, including the total mail received and processed each day.

##### Managing Incoming Mail

###### Supplier shall be responsible for establishing appropriate mail management protocols to ensure information and mail is shared appropriately, stored securely and, when applicable, disposed of properly.

###### Supplier shall prepare written instruction and guidelines for processing incoming mail for the HealthChoice account and should, at a minimum address:

How to collect and process/distribute mail.

How to handle incorrectly delivered and returned mail.

How to process electronically-transmitted messages such as facsimile and telegram transmissions.

###### Supplier shall establish and maintain a separate dedicated Post Office box for incoming HealthChoice mail. Supplier may, as needed and with EGID approval, establish multiple dedicated PO boxes to support various service area needs.

###### Supplier shall establish, in coordination with EGID, internal processes to route mail, when applicable, to EGID timely.

###### Supplier shall track and maintain the ability to provide reporting on monthly volumes specific to HealthChoice.

##### Managing Outgoing Mail

###### Supplier shall establish, in coordination with EGID, guidelines for outgoing mail to adhere to the requirements specific to the information or process.

###### Supplier shall work with EGID to establish guidelines and service level agreement (SLA) for outgoing mail generation and distribution. Some processes shall require daily generation and distribution while others may only require a weekly distribution process; and some processes may require only electronic distribution versus a paper letter.

###### Supplier shall ensure all mail, both electronic and paper, is branded as HealthChoice in accordance with most current OMES branding guidelines.

All outgoing correspondence shall be sent on an EGID approved letterhead.

Templates shall be established and approved by EGID for recurring correspondence processes such as, but not limited to, explanation of benefits (EOB), appeal determination notices, life claim correspondence, etc.

###### Supplier shall track and maintain the ability to provide reporting on monthly volumes specific to HealthChoice.

### Coordination of Benefits

#### HealthChoice requires the Coordination of Benefits (COB) to establish the order in which each insurance plan pays claims when an individual has coverage under more than one plan. Plan participants are required to provide verification of other insurance coverage (VOIC) annually on a rolling 12-month basis. Claims for a participant who has not provided VOIC within the last 12 months are denied once accumulated billed charges exceed $1,000.

##### Supplier shall administer COB for health and dental claims in accordance with EGID rules and policy.

##### Supplier shall generate and provide to EGID a weekly electronic file of member COB status and details using the layout provided in Exhibit 5.

##### Supplier shall provide members the ability to provide verification of other insurance and relevant plan information electronically via the Supplier maintained HealthChoice website, by mail or by phone through the HealthChoice customer service call center.

##### Supplier shall support the ability to import VOIC updates from EGID during each open enrollment period via the incremental member eligibility file.

### Subrogation

#### EGID reserves the right to recover funds from members, dependents, tortfeasors, liability policies, underinsured/uninsured motorist policies, medical payment policies and/or other identifiable sources of funds, in amounts equal to any and all claim payments made on behalf of a member or dependent for injury caused by a third party’s wrongful act or negligence as outlined in the EGID Administrative Rules (Part 15). Subrogation applies to all HealthChoice plans, including the HealthChoice Dental plan, excluding the Medicare Supplement plan. EGID partners with an external subrogation administrator for Subrogation services. The Subrogation vendor identifies qualifications for claims for subrogation and coordinates with the members, attorneys or other entities throughout the process and until settlement is achieved. The Subrogation administrator shall coordinate with the Supplier on status and findings to allow proper adjudication of claims.

##### Supplier shall coordinate with the contracted EGID Subrogation vendor in accordance with EGID rules, policies and procedures.

###### Supplier shall suspend qualifying claims for review by the EGID Subrogation Administrator based on pre-established criteria; claims meeting Subrogation criteria shall not be eligible for reimbursement without release by the Subrogation administrator.

###### Supplier shall provide a file of suspended claims to the Subrogation administrator a minimum of 3 times per week using the layout provided in Exhibit 6.

Supplier shall ensure claims suspended for Subrogation review are distinctly identifiable within the claims system; including the date the claim was received/suspended and provided for Subrogation review.

###### Supplier shall, in coordination with and at the direction of the Subrogation administrator, pay or deny claims in accordance with the Subrogation review outcome.

Supplier shall receive and process, at a minimum, a weekly file indicating the outcome of a Subrogation claim(s) review using the file layout provided in Exhibit 7.

Supplier shall process Subrogation claims in accordance with pre-approved claim remark and reason codes for each applicable scenario or outcome.

Once final determination is provided to the Supplier by the Subrogation administrator, claims shall be processed accordingly within 5 business days of receipt.

###### In addition to the pre-payment review process, the Subrogation administrator reviews Health plan claims data retrospectively to identify additional claims for research or review.

Supplier shall provide medical paid claims data to the Subrogation administrator monthly using the file layout provided in Exhibit 6.

### Pharmacy

#### Supplier shall transmit to EGID’s Pharmacy Benefits Manager (PBM) in real time, health deductible and out-of-pocket maximum information on each HealthChoice HDHP participant.

#### Supplier shall accept from the PBM in real-time, pharmacy accumulation information for integration of health and pharmacy deductible, copayment and out-of-pocket information.

#### Supplier shall reconcile with EGID’s PBM all HDHP member deductibles, copayment, and out-of-pocket information on a monthly basis.

#### Supplier shall accept HealthChoice pharmacy claims data provided monthly by the PBM. EGID, the PBM and Supplier will work collaboratively to identify and document needed modifications.

##### Supplier shall load the Pharmacy claims data files the day of receipt, except during scheduled down time pre-approved by EGID, to the Supplier’s data warehouse.

##### Supplier shall establish a process with the PBM to verify and reconcile an accurate and complete data load using control totals for number of records or financials, attribution to correct member records, and/or other measures.

### Claim Submission

#### HealthChoice requires Supplier to offer and accept claim submissions in various formats and means from both members and providers. Members and/or providers shall have the ability to submit a claim online, by mail or via common HIPAA-compliant EDI transactions. Claims data shall be accurately and timely populated into the into the claims processing system.

##### Network and non-Network Providers

###### Supplier shall provide a user-friendly, industry standard, HIPAA-compliant online claim submission portal to both health and dental providers at no cost to the provider.

Supplier shall provide a user-guide and training material for assistance with online claim submissions.

###### Supplier shall accept industry recognized UB and HCFA claim forms (currently UB-04 and HCFA-1500), and/or the electronic equivalent from eligible providers, including facilities and ambulatory surgery centers.

###### Supplier shall accept industry recognized ADA and HCFA claim forms (currently ADA-2012 and HCFA-1500), and/or the electronic equivalent from eligible providers, including dental providers.

###### Supplier shall accept roster bills for specific services and/or from specific providers or specialties at EGID’s discretion.

##### Members/Beneficiaries

###### Supplier shall develop and provide a downloadable member claims submission form that can either be completed on the computer and printed out, or printed blank and then completed by hand for members to complete and mail to the Supplier for handling of Health, Dental and Life claims.

Supplier shall provide instructions and guidance for completing the form accurately and submitting the form and other required information to HealthChoice.

###### Supplier shall provide a user-friendly, online self-service claim submission option for members.

Supplier shall provide a user-guide and training material for assistance with online claim submissions.

### Imaging

#### HealthChoice requires that all incoming and outgoing documentation and correspondence, including but not limited to claims, checks, EOBs, RAs, medical records, appeals, and other correspondence or supporting documentation, be properly imaged and accessible within the TPA’s claims system environment whether transmitted via mail, facsimile or electronically. Supplier shall maintain an integrated imaging platform that retains all imaged files in an easily accessible manner with the ability to query within the claims system.

##### Supplier shall be responsible for ensuring all received and/or produced files or documents are indexed and accessible within 48 hours of being generated (for outgoing) or receipt (for incoming).

##### Supplier shall ensure all files are adequately indexed and associated with the appropriate member, claim and/or provider.

##### Supplier shall ensure electronically submitted files or documents are imaged and properly indexed in a human-readable format; such as but not limited to, the HIPAA 837 transaction (electronic claim) detail.

##### Supplier shall provide EGID staff with access to all imaged files and documents from within the claim system.

##### Supplier shall, at the request of EGID, provide all indexed files to EGID in a mutually agreed upon format.

### Claims Processing/Adjustments

#### Supplier shall process all claims in accordance with Oklahoma Statutes as applicable, including, but not limited to 74 O.S. § 1328 and 36 § 1219.

##### Supplier shall be responsible for settlement of incurred interest.

##### Supplier shall track and report interest payments by provider and at a claim level to EGID monthly and shall report all applicable interest as a separate line item on the monthly TPA invoice as a reduction to the administration fee(s).

##### Supplier shall provide medical and dental pre-determination services.

#### Adjustments are defined as any correction or change to a previously processed claim. Adjustments can occur at line, claim, member or provider level. Adjustments may be processed at the request of a provider due to a corrected or voided claim submission, due to a claim or benefit processing error, due to a retroactive change in enrollment, benefit, policy or statute, or due to an EGID administrative exception.

##### Supplier shall process adjustments submitted by a provider via a corrected or voided claim in accordance with applicable statute(s) and EGID policy.

##### Supplier shall process adjustments identified from a processing error(s) or retroactive change in enrollment, benefit, policy or statute within 45 days of the date the error was identified, unless otherwise instructed or approved by EGID.

###### In instances where system programming modifications and testing is required to adjust a claim(s), Supplier shall track and manage the ticket in accordance with EGID Change Management rules and policies.

##### Supplier shall process adjustments identified from an EGID approved exception or Administrative Approval within 10 business days, unless otherwise instructed or approved by EGID.

### Life Claims

#### The HealthChoice Life Insurance Plan is a group term life insurance plan which pays benefits upon the death of the insured, but has no cash surrender value. Coverage includes Basic Life benefits, Supplemental Life benefits, Accidental Death and Dismemberment (AD&D) benefits and Dependent Life coverage.

##### Supplier shall process claims in accordance with Federal and State laws and requirements, as well as EGID rules and policies.

### Editing, Bundling, and Grouping

#### HealthChoice relies on industry-recognized edits sourced from guidelines issued by CMS, the AMA and other national standards organizations. Claims editing rules are distinct and specific as to facility claims and professional claims. Sourced edits should be kept up to date and explained at the level of code-to-code relationships. HealthChoice may also utilize custom claim edits. HealthChoice relies on a grouper program/software to assign MS-DRG classification for acute care inpatient claim reimbursement, and MS-LTC DRG for long term acute care facility reimbursement. EGID also utilizes a modified CMS APC grouper payment methodology for outpatient urban facility claims that contain a HCPCS code assigned a Status Indicator of J1 on the CMS Outpatient Payment Perspective System (OPPS) Addendum B. EGID reserves the rights to change, add, or remove payment methodologies, editing, grouping, and bundling requirements at any time during the term of the contract.

##### For both medical and dental claims, Supplier shall utilize a comprehensive claim editing system to assist in determining which charges for covered services to allow for payment and to assist in determining inappropriate billing and coding.

##### Supplier’s system shall rely on CMS, industry standards, and EGID policy and benefits in the development of its mutually exclusive, incidental, re-bundling, age conflict, gender conflict, frequency, cosmetic, experimental, procedural editing and any other edits as defined by EGID.

##### Supplier shall utilize and maintain a sufficient editing solution to detect coding errors related to modifier and place of service appropriateness, mutually exclusive and incidental procedures, duplicate claims, revenue code and Healthcare Common Procedure Coding System (HCPCS) relationships, and more, in accordance with EGID policies and rules.

##### Supplier shall utilize and maintain an editing solution to enable Supplier to align standard rule sets with the HealthChoice Plan(s) through customization of editing logic to support user-defined rules and reimbursement policies, the ability to create or modify rule logic and add new edits, and the ability turn-on or turn-off specific rules as applicable to EGID benefit policies, rules and reimbursement methodologies.

##### Supplier agrees to process specified claims utilizing EGID bundled payment methodologies which includes all related services from related facilities and practitioners on the date(s) service.

##### Supplier shall determine the appropriateness of billed implants/implantable devices and billed charges, in accordance with industry standards and EGID policy or rules.

##### Supplier shall maintain an editing solution specific to rules and reimbursement policies for HealthChoice facility claims processing utilizing industry standards and as defined by EGID.

###### Supplier shall utilize an industry standard comprehensive facility-specific claims editing solution for facility claims to streamline the claims processing workflow; catch errors, omissions, and questionable coding relationships; and improve payment integrity to maximize potential savings.

##### Supplier shall utilize industry standard MS-DRG and MS-LTC DRG grouping software to group inpatient claims and assign classification, except in the case of inpatient mental health and substance abuse, in which case, Supplier shall utilize the revenue codes as indicated in EGID policy. Supplier shall utilize industry standard APC grouping software in accordance with EGID payment methodology.

###### Supplier shall thoroughly test all claims editing software and APC, MS-DRG, and MS-LTC DRG grouping software updates prior to moving into production. In accordance with established Change Management processes, Supplier shall notify EGID of any software updates timely.

### Explanation of Benefits (EOB)

#### After HealthChoice processes a claim an explanation of benefits (EOB) is sent with the final claim adjudication and payment information. A standard human-readable “paper” EOB is generated in an Adobe Acrobat accessible format and posted to the Supplier-maintained HealthChoice web portal for all plan members. For Medicare plan members, a printed copy of the EOB shall be mailed. Upon request, non-Medicare plan members may request to have a copy of EOBs printed and mailed.

##### Supplier shall develop the EOB template in accordance with EGID and shall not change the template without pre-approval by EGID.

##### Supplier shall generate and distribute the EOB in accordance with EGID plan rules and policies that accurately reflects and details HealthChoice payment and benefit information.

##### For Medicare members, and non-Medicare members who opt-in to receive a printed copy, the Supplier shall print and mail the EOB within 1 business day of final adjudication.

##### Supplier shall utilize clear and concise explanation/remark codes that allow members to understand benefits and which provide sufficient information to appeal claim reductions and denials.

##### Supplier shall manage and track all EOB remark codes and information relative to the HealthChoice account; changes to language or rules shall be communicated to EGID in advance of any changes being presented for the consumer.

### Remittance Advice

#### After HealthChoice processes a claim a remittance advice is prepared with the final claim adjudication and payment information. A standard human-readable “paper” remittance advice (RA) is generated in an Adobe Acrobat accessible format and posted to the Supplier-maintained HealthChoice web portal and, when applicable, an electronic remittance advice (ERA) is generated and transmitted to the provider. The standard RA is a hard copy version of an ERA. For each claim or line item payment, and/or adjustment, there is an associated remittance advice item detailing the information used to determine payment, including the billing code that was used to adjudicate the claim and all relative remark codes. One RA/ERA may include adjudication decisions about multiple claims with itemized information provided within the RA or ERA for each claim and/or line to enable the provider to associate the adjudication decisions and outcomes with those claims/lines as submitted by the provider to HealthChoice. The RA/ERA shall report the reason for any adjustment, and the value of each adjustment. In the instance of an ERA the adjustment reasons are reported through standard codes and for any line or claim level adjustment, three sets of codes are required: Claim Adjustment Group Code, Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC). Provider Level Balance (PLB) reason codes are also used to explain the reason for the adjustment when, at the provider level, the adjustment isn’t related to any specific claim in the RA or ERA. The corresponding RA should also provide these standard codes, and include code text as well.

##### Supplier shall generate and distribute an RA/ERA in accordance with EGID plan rules and policies that accurately reflects and details HealthChoice payment and benefit information.

##### Supplier shall produce ERA transactions in the most current HIPAA compliant ASC X12 835 version issued by CMS.

##### Supplier shall include on both the RA and ERA the patient name, original date of service, and provider’s patient account number from the original claim when there is a recovery taken from that payment to satisfy outstanding receivables.

##### Supplier shall maintain and use the most current valid CARC, RARC, and PLB codes in ERA and RA transactions.

##### Supplier shall ensure proper remittance balancing for both paper and electronic remittance formats. Balancing requires that the total paid amount is equal to the total submitted charges plus or minus payment adjustments for a single remittance. A remittance must balance at the service, claim and provider levels.

##### Supplier shall maintain a crosswalk between CARC and RARC codes to internal system codes to ensure codes can be easily and appropriately be updated when impacted by a CARC/RARC code change.

###### Supplier shall notify EGID and assist in development of a provider bulletin or education materials to notify providers of the new and/or modified codes that impact the HealthChoice account, and their meanings, prior to issuance of RA/ERA transactions.

### Claims Pricing and Payment

#### EGID creates and maintains fee schedules with allowable fees for eligible services rendered by an eligible provider to HealthChoice health and dental plan participants. Codes and allowable fees are reviewed and updated by EGID on a quarterly basis and provided to the Supplier; however, EGID does reserve the right to add or delete codes and update specific allowable fees at any time. While not common, some benefits, fees and codes are retroactively added or updated.

##### Supplier shall test, audit and load fee schedules into the claim payment system within 10 business days of receipt; and shall hold applicable claims, if needed, until fee schedule updates have been applied and audited for release into the claims system production environment.

##### Supplier shall test and audit fee schedule loads prior to release into production and claim adjudication.

##### Supplier shall utilize established fee schedules for pricing both network and non-Network claims.

##### Supplier shall identify and adjust claims in the event EGID adds or updates benefit coverage, codes or fees retroactively.

#### Fee Negotiation Services

##### Supplier shall provide fee negotiation services for non-Network incurred claims outside the State of Oklahoma, which meet the qualifications and criteria set by EGID or when requested and approved by EGID.

#### EGID shall be responsible for funding all HealthChoice claims but will not establish bank account(s) outside of the Oklahoma State Treasury; and therefore, will not establish a bank account with the Supplier or its banking institution. EGID supports the ability for a Supplier to issue payments against EGID’s bank account with the State Treasury, or through the Supplier’s bank account. EGID will fund the State Treasury account or wire funds to the Supplier accordingly (some processes and requirements vary depending on the elected funding process).

##### Supplier shall consolidate multiple claim payments into one check or EFT for each payee for each cycle.

###### Check numbers/payment IDs shall be unique to each payment and shall not be reused for reissued or subsequent payments.

##### Supplier shall cancel/void unclaimed payments after 90 days (referred to as ‘stale dated’) in accordance with Oklahoma Statutes as applicable, including 62 O.S. § 62-263).

###### Supplier shall coordinate with EGID to support and facilitate applicable escheatment requirements outlined in the Oklahoma Administrative Code, Title 735 Chapter 80.

##### Supplier shall be responsible for collecting and maintaining banking information to facilitate payments.

##### Supplier shall issue all payments to members and providers on behalf of the plan using an integrated payment platform for all accounts payable activities. In addition to support for requirements outlined herein, Supplier’s payment platform shall:

###### Provide end-to-end transaction workflow tracking and reconciliation;

###### Provide EGID the ability to access and view transaction workflows and reporting within the platform or system;

###### Provide automated and accurate reporting in accordance with EGID report matrix (see section 3.9 Reporting);

###### Provide EGID the ability to run adhoc reporting;

###### Provide easy enrollment solutions, and customer service assistance to both network and non-Network providers and members;

###### Securely maintain accurate updated information and payment preferences;

###### Offer both network and non-Network providers and members the option for Electronic Fund Transfer (EFT) in lieu of paper checks;

###### Provide balanced, detailed and HIPAA compliant 835 transactions;

###### Provide online portal access to network and non-Network providers and members to update payment information and preference.

##### Supplier shall produce and mail, within thirty (30) calendar days following the end of the calendar year, the Federal Tax 1099s to all network and non-Network providers. If the Supplier’s TIN is used, 1099’s may be combined into one 1099 for the same provider for services to EGID, DRS and DOC if applicable or preferred by Supplier.

###### Supplier shall provide the electronic 1099 tax files to the IRS and the Supplier shall be responsible to reconcile all 1099 errors that are provided to the Supplier by the IRS.

###### Supplier shall handle all IRS “B” notices and resolve in accordance with the IRS requirements and Supplier shall notify EGID of any network provider changes.

##### Specifications for Payment Process through State Treasury Account:

###### Supplier shall comply with State 62 O.S. § 34.64 .

Exceptions to print paper checks can be requested for low volume or one-time payments from the State Treasury account.

###### Supplier shall provide accurate, adequate daily issue files to facilitate a positive payment and EFT process through EGID with State Treasury.

###### Supplier shall coordinate with EGID for handling and processing of voids, stop payments, stale date reissues, returned EFTs, check copy requests and EFT trace IDs in accordance with EGID rules and procedures. EGID must authorize stop-payments, voids and cancelations prior to reissue or adjustment.

##### Specifications for Payment Process from Supplier Account:

###### Supplier shall provide a cleared transaction report (see section 3.9 Reporting) to serve as an invoice/funding request.

###### EGID shall fund claims by same day, or next day, wire transfer dependent on the timely delivery of invoice and supporting details and reconciliation outcome; reconciliation of payment activity and supporting details is required in advance of wire funding to Supplier.

###### Funding may be delayed due to State holidays and inclement weather or other unexpected office closures.

###### Supplier shall give credit for voided and/or stale dated payments, as they occur, in the reconciliation of daily claim payments and associated funding requests.

###### In instances where a provider or member does not designate a payment preference, Supplier shall default to and issue a paper check.

Other options, such as virtual payment solutions may be offered but not issued without the provider or member’s explicit consent

###### Supplier shall perform a monthly reconciliation of bank account transactions and provide all supporting payment level detail for each line item of the reconciliation within 10 business days of each month’s end.

Supplier shall generate and provide to EGID an electronic report of all discrepancies, reasons for discrepancies, corrective actions taken and timeline for such actions.

### Overpayment and Recovery

#### An overpayment is defined as a payment to a member or provider that exceeds properly payable amounts in accordance with Plan policies, fee schedules, directives and/or guidelines. The overpaid amount becomes a debt owed to the Plan by the payment recipient. The recovery of identified overpayments shall be handled in accordance with federal and State law, as well as plan policies and guidelines, that outline the criteria of settlement for liable parties and the Plan.

##### Supplier shall accurately and specifically identify and report, in detail, the reason of all identified claim overpayments.

##### Supplier shall provide means in which to proactively review and identify claims that were processed and result in an overpayment. The supplier shall adjust the claim, determine/calculate the amount(s) owed by the member(s) and/or provider(s), send a demand notice that provides for payment options, and pursue the collection of the overpayment(s) in accordance with the EGID Overpayment Debt Collection Activities schedule.

###### Overpayments that are due to the Supplier’s error are the responsibility of the Supplier. If the overpayment is not recovered within 180 days of the date it is identified, a penalty in the amount of a 1% of the total of such overpayments will be applied as a reduction from the Supplier’s administrative fees each month until the debt is resolved.

##### Supplier shall maintain an accounts receivable system that accurately tracks debt(s) assigned to individuals, groups, facilities or any party and records any changes in settlement activity and status. Said system shall support queries and reports such that the status of a debt can be determined at any point in time and considering all activity posted against the debt.

##### Supplier shall provide liable parties with options and instructions for repayment of the identified debt in accordance with the Overpayment Debt Collection Activities schedule). Options shall include:

###### Immediate Payment via Check

###### Immediate Recoupment – provider requests/approves that HealthChoice can immediately begin to recover the overpayment by offsetting the payment of future claims.

###### Standard Recoupment – HealthChoice will automatically begin to recover an overpayment by offsetting the payment of any future claims in accordance with the standard Overpayment Debt Collection Activities schedule.

##### Supplier shall generate overpayment demand notices using EGID approved templates and timelines. A notice shall explain:

###### Overpayment reason(s)

###### Repayment/Recoupment Options

###### Repayment/Recoupment Instructions

###### Repayment/Recoupment Timeline

###### Appeal Rights

### Aged-Claim and Adjustment Inventory

#### Supplier shall be responsible for accurate inventory management and reporting for any claim identified as not fully or accurately settled.

##### Supplier shall maintain a comprehensive aged-claim and adjustment inventory that details the full backlog of all Health, Dental and Life claims that have been received by the Supplier but not fully or accurately settled. Aged claims and adjustments shall have an assigned adjudication category or status, which shall be queriable and reportable.

### Disputed Claim Appeals

#### EGID allows members and Network providers the right to two levels of internal appeal review when a claim is denied in whole or in part for any reason. Non-Network providers only have the right to one level of appeal. Members may request a third level independent, external review by either an independent review organization (IRO) or a grievance panel. An appeal is defined as a dispute or disagreement regarding an adverse determination made by the plan, with written request by the appellant to change the claim adjudication outcome.

##### Supplier shall be responsible for maintaining criteria, processes and procedures in compliance with EGID policy and rules, and the Affordable Care Act (ACA).

##### Supplier shall act as the primary contact for disputed claim appeal submissions and properly notify the provider and/or member that the Supplier is in receipt of an appeal request in accordance with EGID established policy and procedure guidelines.

##### Supplier shall maintain a dedicated Appeals unit for HealthChoice with adequate staff to support both inbound and outbound functions of the appeals process for HealthChoice members and providers.

##### Supplier shall maintain a comprehensive appeals inventory that details the full backlog of all Health, Dental and Life claim appeals, for both members and providers, which have been received by the Supplier but not yet resolved through a communicated response to the appellant.

##### Supplier shall provide members and providers the ability to submit disputed claim appeal requests electronically, or by mail to a dedicate P.O. Box for timely processing.

##### Supplier shall be responsible for conducting the first level internal review of disputed claim appeals and notifying the member or provider of the outcome in accordance with the EGID established policy and procedure guidelines.

##### Supplier shall be responsible for routing second level internal disputed claim appeals to EGID for review and handling; upon request, the Supplier shall provide EGID with any needed information relevant to the claim or adjudication outcome to properly assess and decision the appeal.

###### Supplier shall be responsible for loading the EGID decision and relative documents into the claims system and/or other applicable systems for proper tracking, claim adjudication and customer service inquiries.

##### Supplier shall be responsible for routing third level independent, external review appeals to EGID for review and handling. EGID shall determine the appropriate external review entity submit the appeal for review.

###### Supplier’s IRO processes and procedures must comply with all applicable state and federal law.

###### Supplier shall be reimbursed for any approved IRO review submission at a rate agreed up by EGID and Supplier in advance.

###### Supplier shall be responsible for providing research, documentation and witnesses requested by EGID for grievance hearings and litigation arising from health, dental, and life claim disputes.

## Utilization Management and Certification

### Utilization Management (UM) is defined as the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the HealthChoice benefit plans in an effort to manage costs, improve patient care and increase the overall health of the population. HealthChoice requires UM services for prospective, concurrent or retrospective reviews for specified services that require certification approval for coverage.

#### Supplier shall provide UM reviews that facilitate quality, cost-effective and medically appropriate services and are supported by objective, evidence-based, nationally recognized medical policies, clinical guidelines and criteria.

#### Supplier shall provide EGID with reporting and metrics for all Utilization Management activity; reports shall include total certifications reviewed, decision metrics, appeals and other statistical impacts, comparisons with benchmarks and savings.

##### Supplier shall present findings and recommendations to EGID each quarter.

#### Supplier shall be accredited by the Utilization Review Accreditation Commission (URAC) and proof of accreditation renewal throughout the life of this contract.

#### Supplier shall provide utilization review services in accordance with all provisions of the Hospital and Medical Services Utilization Review Act (OHMSURA).

#### Supplier shall provide an integrated medical management system or software tool that supports referral management and requirements outlined herein.

##### Supplier’s solution shall include, at a minimum, the ability to maintain member and provider eligibility (including the ability to indicate a member’s Medicare primary status), flag cases for penalties and document interactions with members and providers.

### Certification is defined as a process that includes verification of eligibility and enrollment, verification that the requested service is a covered benefit, and determination of medical necessity, appropriateness, and efficiency of the use of health care services, equipment, procedures, and facilities. All HealthChoice plans require certification for coverage of specified services.

#### EGID has an internal Health Care Management Unit (HCMU) that administers certification review for specified health care services. Supplier shall administer certification review for other designated health care services.

#### Supplier shall administer prospective, concurrent and retrospective certification review services, as defined herein, based upon URAC standards, the OHMSURA and in accordance with EGID policies and rules.

#### For services that require certification, where certification approval is not obtained and/or if the certification review results in an adverse determination/denial, the Supplier shall deny claim submissions for those services.

#### EGID requires that network utilization is encouraged and managed. Supplier shall identify service requests from non-network facilities and/or providers and shall coordinate with the EGID HCMU for referral to case management in accordance with plan guidelines and rules.

#### Services that require certification are reviewed and updated quarterly. Supplier shall accommodate changes to certification requirements in accordance with EGID policies and rules.

#### Supplier shall provide notification, in accordance with URAC timelines and standards, to providers and members of the certification review determination explaining the results of any review, including the entities appeal rights.

#### Supplier shall offer, upon request and in accordance with established criteria, peer-to-peer reviews that align with URAC, OHMSURA and EGID standards and policies.

### HealthChoice plans allow providers and members the right to file a formal written appeal to an adverse certification determination. Both providers and member are allowed two levels of internal appeal reviews. Members may request a third level independent, external review by either an independent review organization (IRO) or a grievance panel. The entity that performs the external review depends on the nature of the appeal. An appeal is defined as a dispute or disagreement regarding an adverse determination made by the plan, with written request by the appellant to change the certification decision.

#### For services where the Supplier performs certification review, Supplier shall provide two internal levels of appeal review that comply with URAC, OHMSURA and EGID policy and rules at no additional cost to the member, provider or plan.

##### Supplier shall be responsible for maintaining process and procedure documentation specific to the Suppliers certification appeals process for the HealthChoice plan(s), and must be approved by EGID.

#### For services where the EGID HCMU performs certification review, Supplier shall act as the primary contact for certification appeal submissions and properly notify the provider and/or member that the Supplier is in receipt of an appeal request in accordance with EGID established policy and procedure guidelines.

##### Supplier shall be responsible for routing first and second level internal disputed claim appeals to EGID for review and handling; upon request, the Supplier shall provide EGID with any needed information relevant to the claim or adjudication outcome to properly assess and decision the appeal.

##### Supplier shall be responsible for loading the EGID decision and relative documents into the claims system and/or other applicable systems for proper tracking, claim adjudication and customer service inquiries.

#### Supplier shall be responsible for routing member third level independent, external review appeals to EGID for review and handling in accordance with EGID policy and procedure guidelines. EGID shall determine the appropriate external review entity submit the appeal for review.

##### Supplier shall provide EGID with access to its IRO networks, if available, and submit the IRO review packet for review on EGID’s behalf.

##### Supplier’s IRO processes and procedures must comply with all applicable state and federal law.

##### Supplier shall be reimbursed for any approved IRO review submission at a rate agreed up by EGID and Supplier in advance.

##### Supplier shall be responsible for providing research, documentation and witnesses requested by EGID for grievance hearings and litigation arising from health, dental, and life claim disputes.

### Case Management

#### Case management is defined as the planning, managing and monitoring of healthcare services given to a patient by a coordinated group of healthcare providers. It’s designed to provide for a patient’s needs while monitoring costs. Case management navigates complex care needs, which may involve different services being offered at different times by different healthcare providers. A case manager evaluates what services are available and considered medically necessary when a new case is started and works with different service providers to ensure that the required services are being given in the appropriate setting(s).

##### The EGID HCMU provides case management services for HealthChoice members.

##### Supplier shall provide case management services in collaboration with the HCMU for transplant patients.

##### Supplier shall process claims in accordance with approval administrative exceptions to plan policies and pricing, as outlined and provided to the Supplier in writing

## Systems and Data

### Encryption

#### EGID policy dictates that all files at rest must be encrypted. Supplier shall use Pretty Good Privacy (PGP) as its standard encryption application and encrypted files shall be sent over secure File Transfer Protocol (sFTP).

### Electronic Data Interchange (EDI)

#### Supplier shall accept EDI submissions of health and dental claims from Clearinghouses, other vendors and Medicare Part A and Part B.

### HIPPA Transactions

#### Supplier shall accept the HIPAA Transaction Standards for conducting business with and on behalf of EGID, DRS, DOC and all Business Associates.

### Environments

#### Supplier shall utilize a system or compilation of systems that interface to meet the needs and requirements outlined within this contract.

##### Notwithstanding anything to the contrary in another Contract Document, Supplier shall inform EGID immediately via email upon notification of down time for any systems that are utilized by Supplier, EGID or other vendors and impact EGID business.

##### Supplier shall inform EGID a minimum of two (2) weeks prior to scheduled system downtime by the Supplier for maintenance of any system, or component of a system that is utilized by and/or impacts EGID business.

##### Supplier shall not undertake a major system or software conversion for, or related to, a system used to deliver services to EGID, member(s) or provider(s) without specific written notice to and approval from EGID. Notice of intent for a major conversion must be provided no less than twelve (12) months prior to anticipated release to production.

###### Supplier shall be responsible for developing a project plan for review and consent by EGID before conversion can be approved.

##### Supplier shall not undertake any minor system or software conversion for, or related to, a system used to deliver services to EGID, member(s) or provider(s) without specific written notice to and approval from EGID. Notice of minor conversions, to include changes, fixes, modifications and enhancements that may impact EGID, member(s) or provider(s) must be provided to EGID no less than thirty (30) days prior to anticipated release to production.

###### Supplier shall be responsible for developing a project plan for review and consent by EGID before conversion can be approved.

#### Supplier shall maintain an adequate system environment to accurately manage the HealthChoice account and ensure proper change control and testing prior to any system update or configuration.

##### Supplier shall maintain, at a minimum, the following types of environment

###### Development environment – where configuration, coding, programing and source control is developed before promoting it to another environment (an upgrade procedure is also developed that will follow in each target environment).

###### Test environment – where testing of the upgrade procedure against controlled data is performed along with controlled testing of the System updates.

###### QA environment – where testing of the upgrade procedure against data, hardware, and software that closely simulate the Production environment is performed; and where end users perform testing.

###### Production environment – where the final version is available for business use.

### Access to Supplier’s Network and Systems

#### Supplier shall allow EGID staff read-only concurrent remote access to any system(s) that are utilized for their account.

#### Supplier shall provide EGID staff read and write access to its medical management (certification) system

#### Supplier shall allow EGID concurrent remote access to its certification system for update access.

### Access for Supplier to EGID’s Network and Systems

#### Supplier shall be required to access and utilize internal EGID networks or systems, if needed, as determined by EGID.

##### As a condition of gaining remote access to any internal EGID network or system, the Supplier shall comply with EGID policies and procedures. EGID remote access request procedures shall require the Supplier to submit a Remote Access Request form for EGID’s review and approval

#### EGID Eligibility System and Workflow Application

##### Supplier will utilize EGID’s read-only Eligibility system interface to reconcile eligibility issues when needed.

##### EGID’s Workflow application is a component of the Eligibility system and allows EGID and the Supplier to initiate and track member specific matters such as call inquiries, documentation and other items. The application is accessible remotely using a Microsoft Internet Explorer compatible browser and a connection to the Internet.

###### Supplier shall utilize the workflow application in accordance with EGID policies and procedures which will include initiation and response of workflows for matters such as eligibility verification or issue resolution, life claim beneficiary confirmation, appeal reviews, and more.

###### Supplier shall have designated staff assigned to manage workflows within timeframes outlined in established service level agreements.

### Data Warehouse

#### Supplier shall house medical paid claims, and pharmacy paid claims data received from EGID’s PBM, in a data warehouse. The data warehouse shall be compatible with modern platform providers and have data analytics capabilities, including dashboard and custom reporting as well as normative and benchmarking data. EGID shall have access to all functions and features of the data warehouse.

## Fraud, Waste and Abuse

### Supplier shall provide pre- and post- payment solutions, support and assistance to EGID’s internal Compliance unit in their efforts to combat fraud, waste and abuse (FWA).

### Supplier shall provide a dedicated liaison responsible for responding to inquiries and requests submitted by EGID’s Compliance Unit.

## Reporting

### EGID requires ongoing data reporting needs on a daily, weekly, monthly and annual basis. Reporting criteria and scheduled delivery shall be documented and tracked within the EGID “TPA Report Matrix”. Reports shall be delivered in accordance with EGID’s established Data and Encryption policies. In addition to scheduled reporting requirements, EGID may request ad hoc reporting from time to time and determine if the reporting is needed on a scheduled basis going forward. In instances where an ad hoc report or data is needed consistently, EGID and Supplier shall amend the EGID TPA Report Matrix to implement the ongoing delivery of the report.

#### Supplier shall provide accurate, detailed data feeds and reporting in accordance with the requirements outlined in the TPA Report Matrix, Exhibit 8.

#### Supplier shall develop ad hoc reports in accordance with established processes and criteria as needed by EGID. Once an ad hoc report is developed and implemented, it may be adopted as a standard scheduled report and performance standards shall apply.

##### Supplier shall maintain an ad hoc reporting request process, including a standard ad hoc report request form to ensure adequate understanding and delivery of requested data or metrics.

## Quality Assurance

### Supplier shall govern its internal controls, systems and adjudication processes to ensure services, processes and systems are sufficient enough to achieve quality, accurate results.

### Supplier shall have and maintain an internal quality assurance unit or program with adequate staffing levels to support claims and benefit auditing of all HealthChoice plans. The internal quality assurance program shall be independent of operations and staffed by individuals that possess significant experience and expertise in claims auditing and systemic adjudication functions.

### Supplier’s internal audit department shall perform at a minimum of monthly, independent claim adjudication audits which include financially stratified samples and targeted (benefit type, service type, specific adjuster or auto-adjudicated) audits, and provide payment incidence and financial accuracy results, a copy of which shall be provided to EGID. Audit findings shall be reviewed for potential individual or global training opportunities and/or systematic programming or processing impacts and the results of each review shall be provided to EGID.

#### EGID, or its designated representative, reserves the right to periodically conduct audits to verify that performance standards and contractual obligations are being met. The findings of the audits performed by EGID, or its designated representative, shall be conclusive.

### Supplier shall maintain proper Change Management processes and protocols to facilitate appropriate and complete tracking, testing and implementation of needed system, software, policy, benefit and other systemic or functional changes (including bug and error fixes) for the Plans.

#### Supplier shall report all identified global issues/bugs with information regarding areas of impact to the Plan to EGID within 1 business day of discovery.

#### Supplier shall properly manage changes to and implementation of Plan policy and benefit updates initiated by EGID and report areas of impact to the Plan to EGID.

#### Supplier shall utilize the EGID Global Ticket Tracking log and/or provide system or software to support the functions and criteria of that process, as approved by EGID.

##### Supplier shall maintain the ability to provide real-time updates and metrics within each ticket, as well as accurate reporting, root cause analysis and vetted testing for application of changes to production. Once completed, all tickets (including all data fields and information within the ticket) shall remain accessible and searchable for historic reference, with the ability (if maintained within the Supplier’s system) to be extracted and provided to EGID upon request.

## External Audits

### EGID reserves the right to hire or utilize external auditors at its discretion. For all external auditors Supplier shall:

#### Coordinate and cooperate with EGID’s external auditors including granting access to systems, records, files, and personnel with reasonable notice and conditions.

#### Promptly provide any requested supporting documentation including detail or summary claims data.

#### Respond in writing to each audit finding within fifteen (15) calendar days of receipt of the audit; response shall include timelines and action plans for resolution.

#### Review all audit findings for potential individual or global personnel training opportunities and/or systematic programming or processing impacts and the results of each review shall be provided to EGID.

#### Follow established Change Management protocols in coordination with EGID to identify and adjust claims when necessary and process the recovery of resulting overpayment(s).

### EGID may contract with an independent audit firm that performs onsite audits at the provider of service, primarily for overpayment identification and resolution. The audit firm will provide the Supplier with the necessary information required to adjust claims as a result of the audit.

### EGID contracts with an independent audit firm to conduct an annual audit of the financial statements of EGID.

### EGID contracts with an independent audit firm responsible for providing inpatient Medicare Severity Diagnosis Related Group (MS-DRG) validation services for HealthChoice plans. The audit includes review of inpatient facility claims for appropriate coding, billing and processing. The firm works independently with providers through established internal processes, approved by EGID. The audit firm will provide the Supplier with the necessary information required to adjust claims as a result of the audit.

### EGID contracts with an independent claims audit firm to conduct post payment review of claims adjudication.

### EGID may contract with an independent audit firm that performs operational audits of the Supplier to include a review of Supplier’s organizational structure, workflow processes, and technology. The scope of such audit shall include, but may not be limited to, provider and member data load and maintenance, claims operational policies and functions, and customer service.

## Disaster Recovery

### Supplier shall have a disaster recovery plan; including policies and procedures in place to control, limit or prevent the transportation and storage of client data on laptop computers, compact disks, flash memory devices or any other portable member device.

## Account Management

### Supplier shall provide representation at periodic meetings or functions as requested by EGID which include, but are not limited to, quarterly Board meetings at EGID. Supplier must be available upon advance request to attend or present at monthly Committee meetings or any other special meetings.

### The supplier shall notify EGID immediately upon knowledge of any significant event. As used in this provision, a “significant event” is any occurrence or anticipated occurrence which might reasonably be expected to have a material effect upon the Supplier’s ability to meet its obligations including, but not limited to, any of the following:

#### Disposal of major assets

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

#### Termination or modification of any contract or subcontract, if such termination or modification may have a material effect on the Supplier’s obligations under this contract

#### 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

#### The withdrawal of, or notice of the intent to withdraw, any license required under state or federal law

#### Default on a loan or other financial obligations

#### 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

#### Changes in background information about the Supplier or its subcontractor(s)

#### Reduction or changes in key personnel and any fluctuation of claims examiners, customer service representatives or claims adjusters

#### Known or anticipated merger or acquisition

#### Known, planned or anticipated stock sales

#### Any reorganization

#### Any litigation filed by a member against the Supplier

#### Any sale or corporate merger

#### Any name changes

## Compensation

### In accordance with Oklahoma State Statutes, EGID shall compensate Supplier on a monthly basis for services that have been performed for the preceding month, pursuant to the terms of this contract. The Administrative Fee shall be the sole compensation for all duties required by the Contract. Any additional services that the State directs Supplier to perform shall be separately invoiced and paid. The Administrative Fee and any additional services offered by Supplier must be priced on Exhibit 9. All invoices and payments of invoices are subject to subsequent adjustments based upon proper documentation. EGID shall pay uncontested invoices in full within forty-five (45) calendar days of the invoice date. Invoices shall not be dated earlier than the 1st day of the month subsequent to the month of service.

## Performance

### The execution, delivery and performance of this Contract is binding and is enforceable in accordance with its terms. EGID shall incur no damages for the Supplier’s failure to meet the terms and obligations outlined within this Contract, including but not limited to interest payments to member and/or providers.

#### Supplier shall adhere to the terms and conditions included within this Contract. Failure to meet the obligations outlined herein shall constitute a breach of Contract and may result in termination, liquidated or actual damages, penalty and/or suspension by the State of Oklahoma’s Purchasing Director.

#### Supplier agrees that failure to meet the terms and conditions outlined herein shall result in an assessment of actual damages, provided actual damages can be calculated; otherwise, liquidated damages shall be assessed in accordance with this agreement and for the sole purpose of compensating EGID an amount of money sustained by the Supplier’s breach of contract. In instances where there are no direct damages, but Supplier has failed to strictly perform requirements as stated within the Contract, EGID retains the right to reduce the administrative fee up to 10% for the month in which the failure occurs and every month thereafter until the issue is resolved.

##### In the case that EGID intends to invoke this right, EGID will notify Supplier of the deficiency and allow at least 10 business days for Supplier to cure such deficiency. If the deficiency is not sufficiently cured, EGID may elect to reduce the administrative fee up to 10% for that month and any subsequent month in which the deficiency remains uncured.

### EGID requires a quarterly performance assessment of key service level agreements (SLAs), defined as Performance Guarantees in Exhibit 10. Failure to meet the established SLAs shall constitute a breach of the duties of the Supplier pursuant to this Contract. In the event of a breach of any provision outlined within Exhibit 10, the Supplier shall be liable to EGID for an immediately due and payable penalty. The penalty for a breach of a Performance Guarantee shall be assessed at a percent (%) of the total value of this Contract, and shall apply as indicated in the Performance Guarantee Conditions. All Performance Guarantees are based and assessed on a quarterly basis using the accumulative quarterly data.

#### Supplier shall agree to the Performance Guarantees in Exhibit 10 and provide the proposed penalty Supplier is willing to put at risk. Penalty will be applied as a percent reduction to the overall administrative fee.

#### Supplier shall be responsible for reporting Performance Guarantee statistics and findings to EGID monthly, and provide accumulative reporting each quarter.

#### Supplier shall report any Performance Guarantee penalty as a separate line item reduction to Administrative costs on the monthly invoice following the finalized quarterly assessment that resulted in a penalty. Any penalty amount owed by the Supplier under the Performance Guarantee clause and conditions shall be automatically increased by 10% if EGID has not been compensated within 45 days following an assessed penalty.

#### Supplier shall immediately provide, upon request by EGID, needed documentation or data to support Supplier’s findings or calculations of each quarterly assessment.

## Implementation

### EGID requires that Supplier provide adequate project management for the implementation of the services and terms outlined within this contract. No invoice(s) will be paid prior to EGID authorizing Supplier to begin processing claims.

#### Supplier shall assign a project manager responsible for developing and maintaining an implementation plan that defines scope and deliverables, details project timelines, identifies milestones, assigns clear roles and responsibilities for all individuals involved in the project implementation, develops a risk mitigation plan and administers a progress-monitoring scorecard to the EGID leadership oversight committee.

##### Supplier shall obtain EGID liaison approval on project material, timelines and scope.

##### Supplier’s project manager shall work collaboratively with the internal EGID assigned project manager and business liaison throughout the life of the project.

#### Supplier shall be responsible for processing eligible Health, Dental, and Life claims incurred prior to the contract effective date (“Run-In Claims”).

##### Supplier shall load and test historical files and information needed to allow accurate adjudication and handling of run-in claims, including claims that are open (unprocessed) from the incumbent Supplier and/or eligible for appeal, audit, adjustment, or reconsideration/resubmission under EGID policies and provisions; including but not limited to:

###### Member eligibility;

###### Provider eligibility;

###### Fee schedules;

###### Certification determinations;

###### Plan benefits and provisions;

###### Member cost share accumulators;

###### Pharmacy accumulators; and

###### Historical paid claim files.

##### Supplier shall be responsible for supporting all aspects of customer service, for both members and providers, for Health, Dental, and Life claims incurred prior to the contract effective date.

#### The authority for Supplier to begin claims processing is determined at EGID’s sole discretion. EGID reserves the right to conduct pre- and post- implementation audits to validate that claims adjudication is in accordance with EGID’s benefit and plan designs and to review the production of EOBs and RAs and corresponding required financial reports and files. Any independent external auditor(s) shall be approved by EGID prior to performance.

##### Supplier shall pass a pre-implementation audit, conducted by EGID or it’s delegate, to be completed by August 31, 2022. The scope of the audit shall include verification of member and provider eligibility, determination of accurate processing of claims in accordance with plan design and benefits and provider reimbursement policies and contracts, accurate EOB/RA generation, and claim payment settlement provisions.

##### Supplier shall pass a post-implementation contract compliance audit, conducted by an external independent audit firm appointed or approved by EGID, to be completed by April 30, 2023. The scope of the audit shall include processed claims incurred from January 1, 2023 through March 31, 2023 (audit period) and the following:

###### Medical and Dental benefit-specific audit(s) of claims processed by Supplier to assure correct application of deductibles, copayments, coinsurance, out-of-pocket maximums, fee schedules, benefit maximums and coverage.

###### Audit for application of proper Select program benefits, ensuring appropriate and timely payment of Select facility claims, and appropriate and timely denial of related, affiliated professional claims.

###### Audit for accuracy of generated Explanation of Benefits (EOB) and Remittance Advice (RA); including electronic RAs (ERAs) and correct distribution (electronic, mail, portal).

###### Audit for appropriate claim payment (settlement).

###### Audit of Supplier’s customer service staff to assure that members and providers are receiving accurate information and confirm Supplier is meeting contracted service level agreements.

###### Audit to confirm that Supplier is providing accurate reports.

###### Audit to assure correct process is followed for determining network discounts and allowances for out of network providers.

###### Audit to determine the correct network is utilized for providers.

###### Audit to determine timeliness of claims payment and other provider satisfaction issues.

###### Audit to assure that Supplier has correctly interpreted EGID’s eligibility records and loaded them into the claim processing system accordingly, i.e. confirm eligibility.

###### Audit to assure that Supplier has correctly interpreted EGID’s Network provider records and loaded into the claims processing system accordingly, i.e. confirm network status.

###### Audit to assure proper controls and coordination of benefits, i.e. primary vs. secondary coverage, etc.

###### Review of records, policies and procedures, staffing as compared to industry best practices and /or benchmarks.

###### Determination of whether controls and procedures are adequate.

###### Determine opportunities to automate procedures.

###### Provide suggestions on how to enhance productivity or recommended changes to improve operations and administration to achieve savings and improve efficiency and effectiveness.

###### Determine redundant, inefficient, or burdensome activities.

#### Supplier shall produce and distribute an initial new ID card to HealthChoice members for receipt prior to January 1, 2023, as identified, needed or confirmed by EGID.

#### Supplier shall begin providing call center services to both members and providers no later than December 01, 2022.

#### Supplier shall begin collecting and maintaining banking information for settlement services no later than December 01, 2022.

## Termination

### Supplier shall provide at least three hundred sixty-five (365) days written notice of non-renewal.

### Termination of this Contract by either party shall not be construed as fully discharging Supplier of all obligations. Supplier shall cooperate with EGID and its business partners in good faith to ensure accurate, timely and complete transfer of all data and information to ensure continuity of services for EGID and its business partners. Upon termination, Supplier shall continue to provide needed services outlined in this Contract for a period of up to twelve (12) months (“Run-Out Period”), as determined by EGID. All services and terms outlined in this Contract shall remain available until the expiration of this run-out period or approved by EGID for earlier resolution. Services during the run-out period shall be provided for all claims incurred during the term of this Contract. Performance Guarantees will apply to services during the run-out period.

#### Upon notice of termination and as part of the transition to a new Supplier or as part of terms for the run-out period, Supplier shall, at no cost to EGID, coordinate with EGID or its business partners to:

##### Copy and deliver to EGID all files and databases in an agreed upon electronic format, together with necessary and appropriate documentation (including record layouts and data dictionaries of the databases and systems) used in the administration of the program. If return of all information in files and databases is not feasible, the Supplier shall continue to extend the protections described in the Contract to such information, and limit further use of Private Health Information (PHI) to those purposes that make the return or destruction of such PHI infeasible. Supplier shall destroy the PHI, upon written approval from EGID. If the Supplier elects to destroy the PHI, the Supplier shall certify in writing to EGID that such PHI has been destroyed.

##### Provide to EGID or its designee all relevant processing and procedure guidelines or documentation utilized for EGID, DRS and DOC in a manner that is mutually agreed upon.

##### Provide needed historical and unprocessed transactions in a mutually agreed upon format, or in the format required by EGID to ensure continuity of EGID business services. This shall include, but not be limited to, historical claims data files, historical certification data files and documents, open claims and certification data files, open accounts receivable records and associated information; and accumulator data files.

##### Transfer to EGID or its designee all toll-free phone numbers, local phone numbers, local fax numbers, TDD phone numbers and PO boxes for EGID, DRS and DOC.

#### Following the completion of the run-out period, this contract shall be of no further force and effect, except that each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to the effective date of termination of this contract or any surviving obligations of this contract.

# DEPARTMENT OF CORRECTIONS

## DOC is funded by legislative appropriations and is a payor of last resort. Supplier shall be responsible for providing the services noted below under the same terms and conditions applicable for the HealthChoice account, unless otherwise noted or approved by DOC. Supplier shall maintain and report DOC plan activity separately. DOC shall provide inmate eligibility information to the Supplier. EGID maintains a separate network of providers for DOC and shall transmit an export of Network providers to Supplier; however, Supplier shall identify and maintain all non-Network DOC provider records. EGID shall provide provider eligibility requirements to the Supplier.

### Eligibility

#### Member (inmate)

#### Provider

### Customer Service

#### Call Center

##### Supplier shall maintain a separate phone tree option for DOC providers.

#### Website

##### Supplier shall provide services for Provider to securely access benefit and claims information, including RA/ERA information.

### Programs

#### Select

### Benefit and Claims Administration

#### Mail Service

##### Supplier shall maintain a separate PO Box for DOC business.

#### Coordination of Benefits

##### DOC is a payer of last resorts.

#### Pharmacy

#### Claim Submission

##### DOC shall utilize a separate EDI.

#### Imaging

#### Claims Processing / Adjustments

#### Editing / Bundling / Grouping

#### Remittance Advice

#### Claims Pricing and Payment

##### DOC maintains its own Network Fee Schedules.

##### DOC utilizes Oklahoma Medicaid Fee Schedule for non-Network services.

#### Overpayment and Recovery

#### Aged-Claim and Adjustments

#### Disputed Claim Appeals

##### DOC maintains its own Appeals requirements and procedures.

### Systems and Data

### Reporting

#### Supplier shall coordinate with DOC to determine finalize reporting schedule for reports outlined in Exhibit 8 (DOC Reports).

### Quality Assurances

### Disaster Recovery

### Account Management

### Performance Standards

### Implementation

### Termination

# DEPARTMENT OF REHABILITATION SERVICES

## DRS is federally funded. Supplier shall be responsible for providing the services noted below under the same terms and conditions applicable for the HealthChoice account, unless otherwise noted or approved by DRS. Supplier shall maintain and report DRS plan activity separately. DRS shall provide all client eligibility information to the Supplier. EGID maintains a separate network of providers for DRS and shall transmit an export of Network providers to Supplier. EGID shall provide provider eligibility requirements to the Supplier. Non-Network providers are not eligible for reimbursement under DRS. All services require pre-certification (through DRS) for coverage.

### Eligibility

#### Member (Client)

#### Provider

### Customer Service

#### Call Center

##### Supplier shall maintain a separate phone tree option for DRS providers.

#### Website

##### Supplier shall provide services for providers to securely access benefit and claims information, including RA/ERA information.

### Programs

#### Select

### Benefit and Claims Administration

#### Mail Service

##### Supplier shall maintain a separate PO Box for DRS business.

#### Coordination of Benefits

##### DRS maintains separate COB policy in coordination with internal pre-certification services.

#### Pharmacy

#### Claim Submission

##### DRS shall utilize a separate EDI.

#### Imaging

#### Claims Processing / Adjustments

#### Editing / Bundling / Grouping

#### Remittance Advice

#### Claims Pricing and Payment

##### DRS require pre-certification for services (through DRS) and determines allowable fee for each service case approved.

#### Overpayment and Recovery

#### Aged-Claim and Adjustments

#### Disputed Claim Appeals

##### DRS maintains its own Appeals requirements and procedures.

### Systems and Data

### Reporting

#### Supplier shall coordinate with DRS to determine finalize reporting schedule for reports outlined in Exhibit 8 (DRS Reports).

### Quality Assurances

### Disaster Recovery

### Account Management

### Performance Standards

### Implementation

### Termination