



## INVITATION FOR SEALED BID

**RFP 02-721**

**Description: Managed Health Care**

**Department: Human Resources**

**NIGP Commodity Code(s): 958-61-00-000-0**

**Total pages including this page is 42**

**Note: Faxing of Bid Not Accepted**

**Important Instruction – Read Carefully:**

**If you have obtained these bid specifications from either of:**

**City of Tulsa's Fax-on-Demand (918-596-1171) or**

**City of Tulsa's Website : <http://www.cityoftulsapurchasing.org/>**

**you must notify the buyer Patricia Cummings of your intent to bid by e-mail at [pcummings@ci.tulsa.ok.us](mailto:pcummings@ci.tulsa.ok.us) in order to receive addenda. The buyer will always acknowledge your e-mail for your records. All addenda will be posted on fax-on-demand and the website.**

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**Pay special attention to those pages with a reference to the following notes:**

**Note #1: Signature of authorized agent required**

**Note #2: Signature of an authorized agent and notarized required**

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**Your bid response should follow the same format listed above plus any additional format requested in the body of the bid invitation.**

**INVITATION FOR SEALED BIDS  
TO  
City of Tulsa**

200 CIVIC CENTER, ROOM 109, TULSA, OKLAHOMA 74103

Bid number and date of bid opening must appear on the lower  
left outside corner of bid envelopes and all related containers.

**DATE OF OPENING:**      December 12, 2002

**BID NUMBER:** RFP 02-721

**BID MUST BE IN THE CITY CLERK'S OFFICE AT THE ABOVE ADDRESS BY 5:00 P.M. THE DAY PRECEDING THE "DATE OF OPENING" SHOWN ABOVE.**

**BIDS WILL BE OPENED AT 8:30 A.M. IN THE CITY COUNCIL ROOM ON THE DAY SPECIFIED UNDER "DATE OF OPENING."**

PUBLISHED IN THE TULSA DAILY COMMERCE AND LEGAL NEWS: November 7, 2002

Bid must be accompanied by bidder's bond, cashier's check or certified check in the amount of: NONE

PLEASE READ TERMS AND CONDITIONS ON THE NEXT PAGE BEFORE COMPLETING BID DOCUMENTS

\*\*\*\*\* **THE FOLLOWING SECTION MUST BE COMPLETED BY BIDDER** \*\*\*\*\*

Delivery will be made in not more than \_\_\_\_\_ days after receipt of order.

Payment terms \_\_\_\_\_ % \_\_\_\_\_ days.

City of Tulsa may increase quantity of order at the unit price bid for \_\_\_\_\_ days. (Bidder to Specify Days) I have examined the terms and specifications and the instructions to bidders herein and agree, provided I am awarded a contract, to provide the above described items for the sum shown in accordance with the terms and specifications stated herein. All deviations are in writing and attached hereto.

Enclosed is a  BID BOND ;  CASHIER'S CHECK;  Certified Check in the amount of \$ \_\_\_\_\_, which I agree the City of Tulsa may retain as liquidated damages in the event of my failure to comply with the terms of this bid.

**MUST BE SIGNED BY AUTHORIZED AGENT TO BE VALID**

FIRM NAME \_\_\_\_\_ by \_\_\_\_\_  
SIGNATURE OF AUTHORIZED AGENT

STREET \_\_\_\_\_ TITLE \_\_\_\_\_

CITY STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_ DATE \_\_\_\_\_

## GENERAL TERMS AND CONDITIONS OF SEALED BIDS

THESE ITEMS APPLY TO AND BECOME A PART OF THE BID.

**NO EXCEPTIONS TO THESE TERMS & CONDITIONS WILL BE CONSIDERED.**

1. **BIDS MUST BE SUBMITTED ON THIS FORM ONLY INCLUDING A SIGNATURE OF AN AUTHORIZED AGENT.** Each bid shall be placed in a separate envelope. Be sure envelope is completely and properly identified and sealed, showing the bid number and date in the lower left hand corner. Bids must be time stamped in the office of the City Clerk by 5:00 P.M. on the day before date of opening.
2. No bidder may withdraw his proposal for a period of thirty (30) days after the date and hour set for the opening of bids.
3. All prices shall be quoted F.O.B. Tulsa, Oklahoma, and delivery to City of Tulsa location shall be without additional charge.
4. The bidder shall attach the manufacturer's name of the equipment or material to be furnished, type, model numbers, manufacturer's descriptive bulletins and specifications. All guarantees and warranties should be clearly stated. This data shall be in sufficient detail to describe accurately the equipment or material to be furnished. Manufacturer's specifications, in respect to the successful bidder, shall be considered as part of his contract with the City of Tulsa.
5. The bidder shall show in the proposal both the unit prices and total amount, where required, of each item listed. In the event of error or discrepancy in the mathematics, the unit prices shall prevail.
6. Any exceptions or deviations from written specifications shall be shown in writing and attached to the bid form.
7. Each bidder agrees to comply with the terms of Title 5, Chapter 1, of Tulsa, Oklahoma Charter and revised ordinances relating to equal employment opportunity.
8. **THE ENCLOSED FORMS REGARDING NON-COLLUSION AND FINANCIAL INTEREST MUST BE SIGNED, NOTARIZED, AND RETURNED WITH THE BID.**
9. The City of Tulsa reserves the right to reject any and all bids, to waive any technicalities in the bidding, and to award each item to different bidders or all items to a single bidder.
10. All bids must be accompanied by bidders bond, cash, certified or cashier's check in the amount shown on the face of the bid form. This amount shall be retained by the City of Tulsa as liquidated damages in the event the successful bidder (or bidders) fails to execute a contract, if required. The bidder agrees that said amount is presumed to be the damages sustained by the City due to the impracticability and extreme difficulty in fixing the actual damages. The office of the City Clerk will return the bid deposits to the unsuccessful bidders, after a contract has been awarded or all bids have been rejected.
11. In the event cash discounts are offered by the bidder, the discount date shall begin with the date of invoice, the date of receipt of all material covered by the purchase order, or the date of receipt by the City of Tulsa of the original copy of the purchase order with properly executed Affidavit of Claimant, whichever is the later date.
12. Direct purchase of certain items of equipment or material by the City of Tulsa are exempt from Federal Excise Tax and Oklahoma Sales Tax. In such cases the bidder shall quote prices which do not include Federal Excise Tax and Oklahoma Sales Tax. The City of Tulsa will furnish executed exemption certificates upon presentation by the bidder at the time of purchase.
13. Bid must show number of days required for delivery under normal conditions. Failure to state delivery time obligates bidder to complete delivery in fourteen (14) calendar days. Unrealistically short or long delivery promises may cause bid to be disregarded. Contractor must keep Purchasing Department advised at all times of status of order. Default in promised delivery or failure to meet specifications authorizes the Purchasing Agent to purchase supplies elsewhere and charge full increase of cost and handling to defaulting contractor. Consistent failure to meet delivery promises without valid reason may cause removal from bid list.
14. Bidder agrees to defend and save City of Tulsa from and against all demands, claims, suits, costs, expenses, damages and judgments based upon infringement of any patent relating to goods specified in this order or the ordinary use or operation of such goods by City or use or operation of such goods in accordance with bidders direction.
15. If the bid requires a written contract, the successful bidder shall execute a written contract with the City of Tulsa and return the required bonds and insurance certificates within ten (10) days after submission of contracts to said bidder by the City.

# INTEREST AFFIDAVIT

STATE OF \_\_\_\_\_ }  
  } ss  
COUNTY OF \_\_\_\_\_ }

\_\_\_\_\_, of lawful age, being first duly sworn, states that s(he) is the agent authorized by the bidder to submit the attached bid. Affiant further states that no officer or employee of the City of Tulsa either directly or indirectly, owns a twenty-five percent (25%) interest in the bidder's business or such a percentage which constitutes a controlling interest. Affiant further states that the following officers and/or employees of the City of Tulsa have some direct or indirect interest in the bidder's business:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Title)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC SIGNATURE

My Commission Expires:

\_\_\_\_\_

**The Interest Affidavit must be completed, signed by an authorized agent, and notarized.**

# BIDDER AFFIDAVIT - TITLE 74 O.S. (1974 SUPP.) 85.22-85.25

STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_

\_\_\_\_\_, of lawful age, being first duly sworn on oath says  
**Authorized Agent**

1. (s)he is the duly authorized agent of \_\_\_\_\_, the bidder submitting the competitive bid which is attached to this statement, for the purpose of certifying the facts pertaining to the existence of collusion among bidders and between bidders and municipal officials or employees, as well as facts pertaining to the giving or offering of things of value to government personnel in return for special consideration in the letting of any contract pursuant to the bid to which this statement is attached.
2. (s)he is fully aware of the facts and circumstances surrounding the making of the bid to which this statement is attached and has been personally and directly involved in the proceedings leading to the submission of such bid; and
3. neither the bidder nor anyone subject to the bidder's direction or control has been a party;
  - a. to any collusion among bidders in restraint of freedom of competition by agreement to bid at a fixed price or to refrain from bidding,
  - b. to any collusion with any municipal official or employee as to quantity, quality or price in the prospective contract, or as to any other terms of such prospective contract, nor
  - c. in any discussions between bidders and any municipal official concerning exchange of money or other thing of value for special consideration in the letting of a contract.

\_\_\_\_\_  
SIGNATURE OF AUTHORIZED AGENT

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
MY COMMISSION EXPIRES

**The Bidder Affidavit must be completed, signed by an authorized agent, and notarized.**

# CONTRACTOR/BIDDER INFORMATION SHEET

To be completed by all Bidders  
For Contracts with the City of Tulsa  
(Please print or type)

Project No. or Description \_\_\_\_\_

\_\_\_\_\_

Full Name of Bidder \_\_\_\_\_

Legal Identity  
(Corporation, Partnership,  
Individual, etc.) \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Telephone No. \_\_\_\_\_

FAX No. \_\_\_\_\_

Taxpayer Identification Number \_\_\_\_\_

Contact Person \_\_\_\_\_

Phone No. \_\_\_\_\_

Fax No. \_\_\_\_\_

E-mail address \_\_\_\_\_

Webpage Address \_\_\_\_\_

**REQUEST FOR PROPOSAL  
THE CITY OF TULSA  
MANAGED CARE OBJECTIVES AND STRATEGY**

The cost of the City of Tulsa's health plan has been consistent over the past three years. The premium has increased over the last 3 years by approximately 10% per year. The contract with Community Care expires June 30, 2003. The Community Care Plan includes an HMO, Point-of-Service, and two indemnity Plans. The current statistics show that of all claims paid, 88% of these claims were paid for In-Network services. The City is interested specifically in a five-year arrangement. You are invited to submit your proposal for this coverage. The City would prefer a minimum commitment of three years with rate quotations for those initial three years. One medical provider with the triple option feature or multiple vendors with HMO's and a POS or PPO will be awarded the contract. The City objectives are as follows:

- Ensure employee access to quality care and providers.
- Maintain a strategy which will effectively reduce the rate at which health benefits costs increase in the future for all employees and not just those who elect an HMO or HMO look alike option.
- Maintain maximum benefit flexibility while controlling cost objectives.

City employees and retirees fall into the following categories:

- Non-union employees (active, agencies, under age 65 retirees, and COBRA participants) - 2,282 employees
- Union employees represented by:
  - American Federation of Municipal, State and County Employees (AFSCME) - 1,026 employees
  - Fraternal Order of Police (FOP) - 821 employees

Approximately 84% of all retirees and active employees are enrolled in the Community Care HMO plan.

The City does not include those employees that are covered by the International Association of

Firefighters Local No. 176 within our medical plan. Approximately 90% of all Firefighter retirees and active employees are enrolled in the Aetna U.S. Healthcare Inc. HMO plan currently offered by a Firefighter Trust, outside of City insurance programs. Although the City of Tulsa does not currently cover active firefighters and any firefighters who retired after 1994, we would request that a three year quotation be provided within your response that will include coverage for the firefighter group and another three year quotation be given excluding the firefighter group coverage. Information relevant to the Firefighter inclusive response is as follows:

International Association of Firefighters Local No. 176:

- IAFF active employees 700 employees
- Retired Firefighters 213 retirees

In 1994, the I.A.F.F. Local 176 entered into a Trust Agreement with the City of Tulsa to manage and administer a separate Tulsa Firefighter Health and Welfare Trust. Information which should be considered when including a quotation for this group is the use of an agent with standard commissions (paid by the Trust) and separate billing requirements to, Dee Sink, North American Group, 6846 South Canton, Suite 250, Tulsa, Oklahoma, 74136-3400. Additionally, while the City pre-pays premiums for covered employees, the Firefighter Trust provides payment on a forty-five (45) day delayed basis and after review of billings by the agent, which should be taken into account.

Retirees under age 65 participate in the same plan options available to active employees. For retirees that retired prior to July 1, 1998, the city contributes 15% toward the premium cost for retiree plan coverage. For retirees that retired on or after July 1, 1998, the city contributes 25% for single coverage and 15% for family coverage. The Plan design for retirees is the same as employees.

The managed care program will be a point of service (POS) or a PPO product along with an HMO or HMO look alike (lock-in) coverage, and the low option and out of area indemnity plan(s). All employees will participate in these plans unless they waive coverage due to alternative insurance sources. The number of HMO options available will be limited to just those HMO's with proven ability to control costs. The medical plan must include primary care physician or an explanation of how control will be handled.

We would request that information be provided as to the infertility benefits that you would recommend

based on normal book of business practices, and the related cost impact should that feature be added to the City's plan.

The current medical contract is fully insured. The current Community Care contract expires June 30, 2003. The City would prefer a minimum commitment of three years with rate quotations for those initial three years. Rate quotations may prefer to either a fixed increase amount for years two and three, or may be set forth in a manner that simply provides a maximum cap on increases for the second and third years. We would also request that renewal-over provisions be included within the contract for an additional two (2) years, (total of five years), subject to rate negotiation agreement being reached between the parties for the final two years. Due to State Law requirements, the new contract would be renewable annually on consent of both parties involved, or to cancel the contract with a sixty (60) day written notice.

We hope this background information is helpful. It cannot be stressed too often that the City is very concerned about quality and continuity of care. The perception of City employees will make or break any managed care initiative, and the successful bidder will be the one able to demonstrate and communicate quality care.

Your response must include:

- a copy of your standard contract;
- a list of exclusions;
- the completed Interest Affidavit;
- the completed Bidder Affidavit;
- completion of Questionnaire A;
- pricing page Attachment A;
- summary plan description Attachment C.

All questions should be submitted to:

**Patricia Cummings, City of Tulsa**  
**200 Civic Center, Room 802F**  
**Tulsa, OK 74103**  
**918/596-7561**  
**Fax 918/699-3021**

All responses to questions will be in writing to all potential bidders. Questions received later than five days prior to proposal submission date may not be answered.

Included in the specifications you will find a Summary of Benefits and the census for the City of Tulsa employees.

#### **ESTIMATED TIMETABLE FOR PROPOSALS**

<b><u>ACTIVITY</u></b>	<b><u>COMPLETION DATE</u></b>
Release of specifications	October 24, 2002
Submission of proposals	December 11, 2002, by 5 p.m. CST
Opening of Proposals	December 12, 2002, at 8:30 am
Selection of Finalists	January 21, 2003
Finalists presentations	February 4, 2003
Enrollment elections completed	May 23, 2003

#### **SUBMISSION OF PROPOSALS**

Each proposal package must be sealed and include twenty (20) copies of the completed proposal. The original bid must be clearly identified as "original." All proposals must be received by 5 p.m. CST on December 11, 2002, and be addressed to:

**Deputy City Clerk**  
**Attention: Dana Towers**  
**City Hall, Room 109**  
**200 Civic Center Plaza**  
**Tulsa, OK 74103**

**Proposals received after this time and date will not be accepted.**

## **EFFECTIVE PERIOD OF PROPOSALS**

All terms and conditions within the proposal must remain in effect until at least August 1, 2003, to allow sufficient review, negotiation and approval time by the City of Tulsa.

## **EVALUATION OF PROPOSALS**

Each finalist will be evaluated by the City of Tulsa based on factors including the capabilities described in the written proposal, the oral presentation, on-site network visits and reference information that may be gathered through contacts with other major, local or other firms and organizations currently utilizing the vendors services..

Each proposal will be evaluated according to a number of criteria that will be grouped into seven (7) major categories:

1. General organization and experience of the administrator.
2. Financial arrangement, including guaranteed cost contract and performance guarantees.
3. Scope, responsiveness, and quality of administrative services, including data processing and management information reporting capabilities.
4. Claims processing organization and procedure.
5. Utilization management and quality assurance programs and services.
6. Customer service including reference gained information and/or previous contact with the provider.
7. Provider network(s) offered within the bid, including factors such as number of primary care providers, number of specialists offered, hospital choices and geographic locations of providers.

## **IMPORTANT**

Selection shall be based on the determination of the most attractive offer as evaluated by the City of Tulsa. Each finalist will be notified in writing of the City's final decision. The final approval of the selected administrator will be subject to the final determination of the City and will be contingent on the successful completion of a contract between the City and the successful bidder.

## **ORAL PRESENTATION**

Each finalist, not to exceed four (4) and as determined by the Benefits Committee of the City of Tulsa, will be required to conduct oral presentations at the City's headquarters at a time selected by the City and agreeable to the administrator. Such presentations are tentatively scheduled for February 4, 2003.

The purpose of this presentation will be to:

- Substantiate proposal representations made by the finalists.
- Supplement information obtained through the proposal questionnaire.
- Provide a better understanding of the services and operations of the administrator.
- Meet the individuals who will have a significant role in providing services to the City.
- Gain information about any part of the bid offering that is not sufficiently clear in the determination of the Board members, as well as any clarification of the impact of those offerings if different from the understanding used for the original bid.

## **Award of contract**

1. Authority of the Mayor. The Mayor shall have the authority to award contracts within the purview of this charter.
2. Lowest Secure Bidder. Contracts shall be awarded to the lowest secure bidder meeting specifications and providing the best overall offering based on all factors and as determined by the City of Tulsa. In determining "lowest secure bidder," in addition to price, the following factors shall be considered:
  - a. the ability, capacity and skill of the bidder to perform the contract or provide the

- service required;
  - b. whether the bidder can perform the contract or provide the service promptly or within the time specified, without delay or interference;
  - c. the character, integrity, reputation, judgment, experience and efficiency of the bidder;
  - d. the quality of performance of previous contracts or services;
  - e. the previous and existing compliance by the bidder with laws and ordinances relating to the contract or service;
  - f. the sufficiency or the financial resources and ability of the bidder to perform the contract or provide the service;
  - g. the quality, availability and adaptability of the supplies or contractual services to the particular use required;
  - h. the ability of the bidder to provide future maintenance and service for the use of the subject of the contract, and;
  - i. the number and scope of conditions attached to the proposal.
  - j. the provider network(s) offered within the bid, including the number of primary care providers, number of specialists offered, hospital choices and geographic locations of providers.
  - k. customer service factors including reference gained information and/or previous contact with the provider.
3. The City of Tulsa reserves the right to refuse any and all proposals.

Additionally, the City shall evaluate proposals based on those criteria identified in the Mayor's Executive Order No. 90-08 as factors to be considered in the review of proposals including:

1. Professional qualifications, specialized, experienced and technical competence of the firm with respect to the types of service required;
2. Capacity and capability of the firm with respect to such factors as cost control, quality of work and ability to meet schedules;
3. Record of past performance with the City and other jurisdiction(s) or companies;
4. Proximity to and familiarity with the area of service;

5. Qualifications and experience of the principals of the firm, managing professional and key staff professionals selected for the project;
6. Size and experience of the professional and technical staff with respect to the magnitude of the assignment;
7. Financial standing;
8. Estimated schedule for completion of the project.

Your proposal responses should be based on the following assumptions:

### **EFFECTIVE DATE**

July 1, 2003

July 1, 2004 (if quoting, first renewal, with quoted rate)

July 1, 2005 (if quoting, second renewal, with quoted rate)

July 1, 2006 (if quoting, third renewal, rate negotiable)

July 1, 2007 (if quoting, fourth renewal, rate negotiable)

### **TWO REQUESTED GROUPINGS ARE TO BE QUOTED**

1. All active employees, retirees under age 65 and COBRA participants, excluding firefighters.
2. All active employees and retirees under age 65 and COBRA participants, including firefighters and firefighter retirees currently under the IAFF plan.

### **CONTRACT**

The City reserves the right to renew the contract for four (4) additional one-year periods, renewable annually on consent of both parties involved, or to cancel the contract with a sixty (60) day written notice. The parties understand that rate guarantees for the initial three years shall be based on the vendors response to this request for proposal. The additional two option years shall be based on mutual agreement of the parties at the appropriate time and subject to negotiations and/or contract cancellation.

### **RENEWAL CONTRACT RATES**

Price adjustment of any renewal contracts shall be approved prior to each renewal period. Any escalation or de-escalation of prices shall be based on the verifiable data approved by and agreed upon

by the City of Tulsa.

In the event a price adjustment is requested, the contract holder shall notify the City (in writing) by March 1 prior to the expiration of each contract period of such price adjustments. Such notice shall be delivered to Tina Fazendine, Insurance & Retirement Services Manager, City of Tulsa.

## **AUDITED FINANCIAL STATEMENT**

Each bidder must include in his response to this request for proposal an audited financial statement covering the bidders most recent fiscal year of operation and any other financial data which will serve to support the financial strength of the company.

## **NEGOTIATION**

The City of Tulsa reserves the right to negotiate any portion of the contract in order to clarify any areas of concern and to reach agreement on other factors.

## **Section II**

### **PLAN OF BENEFITS TO BE QUOTED**

Carriers should bid on the medical expense plan, including Mental Health and Substance Abuse (MH/SA) benefits. If a PPO is offered in place of the current POS, the loss of the gatekeeper concept must be replaced by an alternate cost control methodology explained in the vendor's bid. Currently, coverage for dependent daughter maternity care expenses is covered under all plans and we want that benefit to remain in place in the new contract. Additionally, we would like a quotation that would allow us the option to continue the current Voluntary Wellness Program as outlined in *Attachment D - Health Promotion Program*. This program includes a cross section of the employee population.

*Questionnaire A* must accompany your proposal.

## **FUNDING**

All proposals should assume liability for claims **incurred on and after the effective date** (July 1, 2003).

The current carrier will be responsible for administration of run out claims incurred through June 30, 2002.

## **ACCOUNT STRUCTURE**

See *Attachment A*

## **COB**

Regular Coordination of Benefits

## **ACCOUNT SERVICE**

**The vendor shall be responsible to provide medical plan program provisions which shall include the following services:**

- Routine account administration and service to be provided to include the review of late entrant and/or incapacitated application for approval or denial.
- Participation in employee enrollment meetings.
- Ability for employees to receive (by phone or printed list) credential information on network providers.
- The City desires the ability to provide a monthly eligibility tape to the administrator.
- Overall account responsibility is to be handled by one primary contact that is located in Tulsa.
- The City desires the ability for employees to have a 24-hour hotline by which employees traveling out-of-area can call for direction to network providers in other locations.

## **ACTIVELY-AT-WORK REQUIREMENT**

- All participants currently enrolled in the City's Medical Expense Plan and HMO option must continue to receive coverage; the quotes should reflect the cost of these participants.
- No disabled individuals or their dependents, retirees or their dependents, or COBRA participants or any of their dependents shall lose coverage as a result of a change in carrier.

## **PREMIUM AND BILLING RATES**

- Currently, the City has a two tier rate structure (single, family) for medical premiums. We are interested in receiving quotes structured as follows:

### **Two tier structure:**

- 1-Employee Only
- 2-Employee and family
- Direct claim submission; the administrator will certify eligibility and is totally responsible for its errors.
- No commissions will be paid.
- The first plan year is to be from July 1, 2003, through June 30, 2004.

Subsequently, changes in rates and fees must be provided to Tina Fazendine, Insurance & Retirement Services Manager, City of Tulsa, by March 1, for rates to be effective on the subsequent July 1 and based on the original bid amounts and/or maximum increases set forth in the original bid.

## **ADMINISTRATION MATERIALS**

Customized ID cards, claim forms, etc., to be prepared by the carrier, but billed separately for printing costs. The Administrator will be required to use enrollment/change forms customized by the employer.

## **UTILIZATION REVIEW (UR) SERVICES**

The UR services to be quoted should include the following:

- Hospital pre-admission review.
- Concurrent stay review.
- Discharge planning.
- Ambulatory pre-certification and management.
- Large case management.
- Referral for voluntary second surgical opinion.
- Management of all MH/SA services by a specialized team of utilization management staff.
- Hospital Audit program for out-of-network admissions that generate charges in excess of an amount agreed upon in conjunction with the City and the selected carrier.

## **RISK SHARING**

It is vitally important that the City be able to accurately budget the future costs of its medical benefits plan and minimize the volatility of such costs over an extended time period. Therefore, the City prefers and is looking for an aggressive risk sharing arrangement that would include a 3-year rate guarantee for Administrative Service Fees and claims. Although the current benefit structure and level of benefits should be included in the quotation the City encourages bidders to submit alternative benefit structures and designs that help to control cost and risk factors and are appropriately within line with marketplace trends. The City has not identified a single "preferred" methodology, and each bidder is encouraged to submit the risk sharing formula it feels can most effectively attain the cost controls sought by the City of Tulsa.

## **PERFORMANCE GUARANTEES**

Performance guarantees related to claim payment, service, member satisfaction, etc., will be negotiated prior to the nomination of an administrator. Proposals should include any performance guarantees and standards that the bidder wishes to propose.

## **CONTRACT GUARANTEE**

All contracts must be guaranteed for the rate guarantee periods and cannot be canceled by the administrator except for the City's non-payment of rates or fees.

## **COBRA ADMINISTRATION**

The City handles COBRA administration.

## **CONVERSIONS**

Available coverage through provider.

## **ELIGIBILITY**

The City will establish and be responsible for plan eligibility (for current rules see *Attachment B*) for all participants except for the possible inclusion of Firefighters and Fire retirees. The Tulsa Firefighters Health and Welfare Trust along with its agent will be responsible for firefighter participants plan eligibility. However the eligibility rules shall basically be the same for both plans.

## **MANAGEMENT REPORTS**

Management reports will be required quarterly, showing utilization patterns and trends. The reports must provide sufficient detail that the City can use to more clearly understand differences by employee group, provider, inpatient vs. outpatient services and MH/SA care. Results compared to budget and risk sharing projections will also be needed. The following is a listing of specific information and employee group breakouts that should be reflected in the reports:

- Report groupings: by account structure as outlined.
- Information:

- GHAA report formats for days, length of stay, and charges per admission
- MDC 19 and 20 experience separately detailed
- In-Network vs. Out-of-Network/non-network provider use, by type of provider (hospital, PCP, specialist, lab/x-ray, pharmacy, MH provider, SA provider, HHC, SNF, etc.)
- Utilization and cost experience by in-patient, out-patient and type of provider
- Ability to produce utilization experience by specific diagnosis.

## **AUDITS**

With reasonable prior notice, the selected carrier must agree to allow City auditors to conduct an audit of all claims and billing systems and records related to the City account at no additional cost to the City.

## **EMPLOYEE DEMOGRAPHICS**

(See attached demographic and plan participation detail.)

## **CURRENT PLAN DESIGNS**

*See Attachment C.*

## **PROPOSED PLAN DESIGNS**

The network providers are those hospitals, physicians and other medical providers who have negotiated agreements with the carrier. Please submit a list of all providers and exclusions for all proposed Medical Plans.

### **A. HMO NETWORK PLAN**

To receive HMO network benefits, plan participants **must** access network providers through their network primary care physician, who functions as the primary care case manager in the management of the participants' overall health care. The structure should provide for network providers' referring participants to other network providers when a

primary care physician medically indicates such referral. However, plan participants will be entitled to network benefit levels if they are mistakenly referred to a non-network provider by the primary care physician, the employee would not be liable for any other financial responsibilities. Claim form submission by participants will be eliminated where network providers are utilized.

**Out-of-Network**

All covered services or treatments not accessed through the network primary care provider will not be a covered expense

**B. PREFERRED PROVIDER ORGANIZATION OR POINT OF SERVICE NETWORK PLAN**

**In-Network**

To receive network benefits, plan participants **must** access network providers through their network primary care physician, who functions as the primary care case manager in the management of the participants' overall health care. The structure should provide for network providers' referring participants to other network providers when a primary care physician medically indicates such referral. However, plan participants will be entitled to network benefit levels if they are mistakenly referred to a non-network provider by the primary care physician, the employee would not be liable for any other financial responsibilities. Claim form submission by participants will be eliminated where network providers are utilized.

**Out-of-Network**

All covered services or treatments not accessed through the network primary care provider will be covered as a non-network expense.

**C. NON-NETWORK PLAN (INDEMNITY)**

The City is required to provide an alternative low option medical plan that includes both employee and dependent coverage. Contribution for this plan option is minimal to the employee. In the past, enrollment in this plan has averaged 10 employees. The last year, we have had one participant enrolled in the low option plan.

The City is required to provide an alternative low option medical plan that includes both employee and dependent coverage. If your HMO/PPO/POS network covers, or can be expanded to include the employee's who live in the Lake Eucha or Lake Spavinaw areas, then those employees will be eligible for the HMO/PPO/POS plan as outlined in this proposal. If the HMO/PPO/POS network does not include the employees that live at Lake Eucha or Lake Spavinaw, then under the proposed benefits plan, all claims related to care received through health care providers practicing within 75 miles of Lake Eucha or Lake Spavinaw will be reimbursed at the In-Network benefit level.

In addition, the City provides an alternative medical plan that includes retiree, cobra and dependent coverage to those members who no longer live within the in network service area. Participation in the plan is limited.

## QUESTIONNAIRE A

***The information contained in this section of the proposal is important and will be used in evaluating your proposal. Please be certain to answer all questions completely and accurately. If you are selected to administer the City's employee benefit plans, your responses to the questionnaire will be considered part of your contractual responsibilities. You are also requested to return the indicated exhibits as part of your proposal.***

This section provides the format for the administrator's proposal. Your response to the questions in this section must be based on your current proven capabilities. You should describe your future capabilities only as a supplement to your "current capabilities" response. All responses should be as complete and succinct as possible.

### A. **GENERAL INFORMATION AND ADMINISTRATIVE SERVICES**

1. Has your network been reviewed and accredited by any external agency in industry organization (NCQA, AAPPO, JCAHO, etc.)?
2. What is the minimum amount of time you believe is necessary to convert the City's plans in an effective manner?
3. What specific activities would the City be responsible for with respect to the conversion process? How much time (full-time equivalent hours) do you estimate that each of the City's tasks would take to complete?
4. What specific claim records and other information not included in this RFP would you need from incumbent administrators in order to effect conversion?
5. To concisely verify your ability to meet the requirements outlined in Section II, please complete the following statements (If your requires any additional clarification regarding the stated requirements, please provide such clarification at the end of this section).
  - a. We have the ability to handle claims administration on a \_\_\_\_\_ local, \_\_\_\_\_ regional, \_\_\_\_\_ national level and recommend \_\_\_\_\_ as the preferred approach.

- b. We will be able to accept a monthly eligibility tape from the City. \_\_\_\_\_ Y  
\_\_\_\_\_ N.

The format in which we would need to have the tape provided is:

\_\_\_\_\_

6. In the past providers have contributed to the cost involved with our annual HealthFair (last year's approximate expenses were \$10,000.)

Are you willing to commit to that dollar figure if you are awarded the contract?

Y \_\_\_\_\_ N

### **PROVIDER NETWORKS AND QUALITY ASSURANCE**

1. Please describe the organizational structure of your national and regional managed care program. Provide an organizational chart along with the names, specific responsibilities, telephone numbers and resumes for any key corporate or regional managed care staff who are instrumental in the effective operations of the Tulsa network. Please note that these individuals may be contacted at some time during the proposal evaluation process.
2. Please provide:
  - sample hospital and physician agreements,
  - a current pcp network directory (identify pcp open and closed to new patients)
  - a current network directory of specialists
  - current prescription drug formulary
  - listing of any services not available within the Tulsa network
  - listing of all plan exclusions
3. Under what circumstances would you be willing to expand or reduce the network (service area and additional hospitals and/or physicians)? What criteria do you generally use to indicate the need to expand or reduce the network?
4. Does the network provide patients with after hour care and urgent care services? If yes, please explain in detail.

5. What time frame are you willing to commit to for expanding the current network to include providers in Lake Eucha and Lake Spavinaw?
6. What criterion automatically disqualifies a provider from participation?
7. What re-credentialing process and criteria are used and how often are providers re-credentialed?
8. Are participants required to select a primary care physician? What medical specialties are included as PCPs?
9. Do members actually need to have an office visit with their PCP before a referral to a specialist can be made or can a phone call to the PCP be sufficient to initiate a referral?
10. So that the City can determine whether there is sufficient distribution of physicians between the network hospitals and that the network provides a sufficient representation of physicians practicing within the community, please complete the following statements:
  - At least \_\_\_\_\_% of the primary care physicians on staff at **each** network hospital are participating in our network.
  - The Tulsa network includes # \_\_\_\_\_ primary care physicians, # \_\_\_\_\_ specialists and # \_\_\_\_\_ acute care hospitals.
  - The Tulsa network includes # \_\_\_\_\_ primary care physicians who are accepting new patients.
  - The Tulsa network has # \_\_\_\_\_ PCPs per 1,000 eligible and # \_\_\_\_\_ specialists per 1,000 eligible.
11. What has your physician turnover been for the last three years in the Tulsa network?
12. How (and how often) do you determine reasonable and customary (R&C) expense allowances? What percentile do you use to establish R&C expense allowances? Can this vary by case/client without charge?

### **QUALITY OF CARE/CUSTOMER SERVICE**

13. Can representatives of the City of Tulsa participate in Quality Assurance committee or

subcommittee meetings?

14. How are individual providers monitored? Include sample reports that are provided to network providers on their performance. Detail the physicians profiling processes and provide average (aggregate) statistics for the network as well as sample profile report formats.
15. Describe the specific grievance system that is in place or would be implemented to hear and resolve plan participant's problems regarding the network and its operation. How are provider-related grievances reflected in the provider's file and in the system?
16. What type of information on quality assurance and focused studies would you make available to the City on a periodic basis? The City's Employee Benefits Committee is very interested in a partnership with the network administrator whereby both groups work together toward the goal of continuous quality improvement. Would you allow the City's Employee Benefits Committee to designate a representative to participate in quality assurance meetings and/or other types of quality assurance programs?
17. Describe how the network organizes and performs the member services function.
  - a. How is your member services function organized?
  - b. Who is accountable for member services?
  - c. What is the staffing ratio per 1,000 members?

## **PROCEDURES**

18. Pre-Certification/Concurrent Review  
What guidelines do you use for determining necessity for pre-operative days and appropriate?
19. Do you have psychiatric/psychological/mental health providers in your network? How are those providers selected, monitored and reimbursed?
  - a. Please provide a mental health/substance abuse provider and facility listing.
  - b. Would you be willing to expand your network to include currently utilized mental health/substance abuse providers as identified by the City?
20. Are there any methodologies utilized within your provider network by design that are monitored and that are aimed at pro-active, preventative medical practices to reduce major illnesses and to ensure early detection of problems? Examples may be notification

programs to participants in certain established categories related to appropriate and periodic physical examinations, etc. Please explain.

21. Are the contractual and financial arrangements different for mental health providers and facilities than medical/surgical providers? If yes, please explain.
22. Will you hold the City harmless with regard to any actions taken by the network?
23. Please provide sample provider agreements and a sample employer contract for a POS plan.

C. **REFERENCES**

1. Please provide the name, address, telephone number and contact name for each of your three largest Tulsa clients for whom your have administered managed care programs.
2. Please provide the name, address, telephone number and contact name for each of your three largest Tulsa clients for whom you have administered utilization review services.

**ACCOUNT STRUCTURE**  
**SINGLE PROVIDER**

**Attachment A**

**Proposed Rate Sheet**

	<b>Year One</b>	<b>Year Two</b>	<b>Year Three</b>
	<b>2003/04)</b>	<b>(2004/05)</b>	<b>(2005/06)</b>
• Two tier structure:			
• 1-Employee Only	_____	_____	_____
• 2-Employee and family	_____	_____	_____
 Health Promotion Program:	_____	_____	_____

**ELIGIBILITY**

**EMPLOYEE:**

You are eligible for coverage described in this booklet if you are in an Eligible Class. You are in an Eligible Class, if you were hired as a permanent, full-time employee, an elected official of the City of Tulsa, or a permanent full-time employee of an approved agency.

You become eligible on your Eligibility Date, which is the first of the month following the date you complete one month (30 days) of continuous service for your employer.

Your coverage becomes effective on your Eligibility Date. If, on this date, you happen to be both disabled and away from work, your coverage will not go into effect until you return to full time work for one full day.

**EMPLOYEE AND DEPENDENTS:**

Your spouse and unmarried children under the age of 19 may be covered as dependents under this plan. Your unmarried child(ren) under age 26 may also be covered if he/she attends school full-time and depends on you for financial support. When a dependent child(ren) is no longer a full-time student and is between the age of 19 and 26 they are entitled to COBRA. If the dependent(s) become a full time student, and is less than 26 years of age, he/she can be immediately enrolled in the plan as a qualified dependent of the employee. The Employer must be notified within 30 days of the requalification or evidence will be required.

Your child(ren) include your own, and other child(ren) who depend on you for financial support and maintenance. Other child(ren) includes, but is not limited to: Foster child(ren), adopted child(ren), step child(ren), and grand child(ren).

A dependent also includes a fully handicapped child beyond age 19 under certain circumstances. In order to continue coverage for your handicapped child, the handicap must exist at the time your child reaches age 19, or 26 if a full-time student. For purposes of this plan provision, a fully handicapped child is unable to earn his/her own living because he/she is mentally and physically handicapped and depends on your for financial support.

For a death of an employee covered by one of our health plans, the covered dependent(s) will be allowed to retain their coverage until age 65 or any other terminating event.<sup>1</sup> The dependent(s) who retain the coverage will be subject to the same rules, rates, and administrative procedures as those participants covered by COBRA, except for the COBRA insurance retention time limit.

## **RETIREE:**

Individuals who retire from the City of Tulsa are eligible for insurance coverage under this plan. A retiree is eligible to continue the medical plan insurance coverage to age 65, except when Medicare (Medicare Part A or Part B) benefits are not available. Retiree includes individuals receiving a retirement benefit, and those individuals who defer retirement, including disabilities, after five years of vesting service.

## **RETIREE AND DEPENDENTS:**

Your spouse and unmarried children under the age of 19 may be covered under this plan. Your unmarried child(ren) under age 26 may also be covered if he/she attends school full-time and depends on you for financial support. When a dependent child(ren) is no longer a full-time student and is between the age of 19 and 26 they are entitled to COBRA. If the dependent(s) becomes a full time student, and less than 26 years of age, he/she can be immediately enrolled in the plan as a qualified dependent of the employee. The Employer must be notified within 30 days of the requalification or evidence will be required.

Your child(ren) include your own, and other child(ren) who depend on you for financial support and maintenance. Other child(ren) includes, but is not limited to: Foster child(ren), adopted child(ren), step child(ren) and grand child(ren).

A dependent also includes a fully handicapped child beyond age 19 under certain circumstances. In order to continue coverage for your handicapped child, the handicap must exist at the time your child reaches age 19, or 26 if a full-time student. For purposes of this plan provision, a fully handicapped child is unable to earn his/her own living because he/she is mentally and physically handicapped and depends on you for financial support.

For a death of a retiree covered by one of our health plans, the covered dependent(s) will be allowed to retain their coverage until age 65 or any other terminating event.<sup>2</sup> When a retiree attains age 65 and converts to Medicare, the covered dependents will be eligible to continue their coverage until age 65 or any other terminating event.<sup>2</sup>

The dependent(s) who retains the coverage will be subject to the same rules, rates, and administrative procedures as those participants covered by COBRA, except for COBRA insurance retention time limit.

## **GENERAL COBRA INFORMATION:**

For a death of an employee or retiree covered by one of the health plans, the covered dependent(s) will be allowed to retain their coverage until age 65 or any other terminating event. When a retiree attains age 65 and converts to Medicare, the covered dependents will be eligible to continue their coverage until age 65 or any other terminating event.

The dependents that retain the coverage will be subject to the same rules rates and administrative procedures as those covered by COBRA except for the COBRA insurance retention time limit. For additional information on COBRA see the “When Your Insurance Ends” Section of this booklet.

## **LOSS OF COVERAGE INFORMATION:**

Your dependent(s) may be added to your coverage through LOSS OF COVERAGE, if the dependents of an employee are in the eligible class of a dependent. Loss of coverage occurs when insurance coverage ends due to loss of employment (voluntary or involuntary). The dependent(s) must be added within 30 days of the loss of coverage and the employer must be able to verify the loss.

<sup>2</sup>Examples of some events are: surviving spouse turns age 65, dependent child(ren) turns age 19 and doesn't continue school, dependent child(ren) turns age 26, individual receives other coverage or doesn't pay the monthly premium.

## **HB926/325:**

Purpose: Compliance with State House Bill 926/325.

### **Eligibility:**

A survivor of a retiree, employee or elected official is eligible for the medical and dental plans. Survivor shall mean the surviving spouse or the surviving minor child or children of a person who was an employee, retiree or elected official on or after July 1, 1992 (minor child is defined as an unmarried child(ren) under age 26, if he/she attends school full-time). When a minor child(ren) is no longer a full-time student and is between the age of 19 and 26, they are entitled to COBRA. If the minor child becomes a full-time student and is less than 26 years of age, he/she can be immediately enrolled in the plan as a covered survivor. The employer must be notified within 30 days of the re-qualification or evidence of insurability will be required.

**Enrollment:**

A defined survivor has 30 days from the date of death to enroll regardless of whether the survivor had been enrolled as a dependent when the employee/retiree was alive. The same time frame as COBRA participants receive.

**Premium:**

Premium for medical and dental plan benefits is the same as what is charged retirees. Whenever possible, the premiums will be deducted from the survivor's retirement check.

**Enrollment after Election Period:**

Survivors will be classified as retirees. Therefore, they will be able to enter the plans after the 30 day election period through evidence of insurability.

**Termination of Coverage:**

Non-payment of premium will cause coverage to be terminated. Survivors will be given same payment grace period as retirees. The grace period is 30 days after the premium is due. Dental plan coverage will cease after 36 months (same as current beneficiaries receive).

**Past claim information is available upon request to buyer at 918-596-7561.**

## **HEALTH PROMOTION PROGRAM**

### **Introduction**

This request for proposal has been developed to ensure the City of Tulsa's Health Promotion services are fulfilled in the most effective and efficient manner possible. These requirements represent the City's goals in reaching a contractual arrangement with a provider insurance company for resources to fund the health promotion program for City employees and the City's annual Health and Safety Expo. Current enrollment of participants is 1680; however, it is the City's intent to continue to increase this number. Program planning should include the potential for an increase in this number. It is the City's intention to offer all City employees the opportunity to participate in a wellness program.

### **Background**

In 1995, the City of Tulsa initiated a pilot health promotion program that was funded by the insurance carrier for 300 active volunteer employees. The program included a baseline collection of morale absentee data, employee health risk questionnaire, mini screen (cholesterol, blood pressure and weight), stages of change questionnaire, behavior modification programs, specific education packets on a quarterly basis, health newsletter sent to employees' homes six times a year and management aggregate reports. Coordination of certain aspects of the program was difficult because out-of-state management of the program created concern for the development of future programming.

In 1997, CommunityCare contracted with Nutex Corporation, a healthcare cost management company, at the City's request, to initiate a second attempt at implementing a City health promotion program. A modifiable claims analysis along with a demographic audit provided the basis for identifying modifiable lifestyle behaviors and "readiness for change" staging. Management questionnaires provided valuable information about management's attitude toward the program, while an employee questionnaire identified "best approach" strategies. Both an internal management team and a health promotion committee were organized. These two teams serve to assist in the design, budget approval and implementation of the program.

Our current health promotion activities include:

- Classes provided by local hospitals
- 24-hour teletriage services
- Monthly City of Tulsa newsletter along with a professional health newsletter
- An on-going incentive program for participants of various activities
- Nutrition/exercise programs delivered on-site, aimed at reducing sedentary lifestyles and improving dietary habits
- A focused intervention project that provides a personal health consultant with a minimum of quarterly contact with "at-risk" individuals (participants have been defined

as a result of health risk assessment). Individuals have access to this consultant Monday through Friday. This project is designed to reduce health risks.

- Screens that include blood pressure, body composition, breast cancer risk assessment, variable heart rate testing, health risk assessments, weight and height
- Continuation of maternity productivity project that includes distribution of *Baby-Go-To-Sleep* tapes to new mothers
- Ongoing interactive communication to employees with online capabilities.
- Maintenance of intranet Web site to provide online users with health information
- One-on-one personalized nutritional counseling services
- Personalized stress facilitation and monitoring of outcomes through claims
- Integrating health promotion classes with the City's Career Growth and Development Training program
- Regular exercise classes offered on-site, i.e. yoga
- *Weight Watchers At Work* program offered on-site
- Coordination with insurer's disease state management program
- Diabetic support group
- Self-care initiative which includes alternative medicine

The benchmark modifiable claims analysis identified the following areas as having the greatest modifiable cost potential: sedentary lifestyle, accidents and obesity.

### **Health Promotion Objectives**

Maintain a core management team

- City's liaison with contracted agency
- Maintain a decision-making oversight body
- Composed of departmental coordinators and divisional team leaders

Health Promotion Planning

- Identification and ongoing review of program objectives based on justification
- Identification and ongoing review of existing health insurance claims to identify five to seven of the highest modifiable risk factors
- Individual health risk assessments at periodic intervals, not to exceed one per year

Development of the health promotion program

- Promotion of the program to City employees
- Identify and plan health seminars and programs
- Define space availability for assessments and seminars

Conduct the health promotion program

- Track participant achievement and incentive awards
- Conduct seminars and programs at least monthly
- Meet with the health promotion committee bi-monthly
- Meet with the management team bi-monthly
- Prepare and distribute monthly health promotion newsletter including calendar of events

- Follow-up with focused intervention contacts

#### Management reporting

- Monitor participation and employee satisfaction
- Track employee absenteeism based on health promotion participants vs. non-participants
- Track modifiable claims
- Track worker's compensation as related to health risks, i.e. allergies/asthma
- Track "readiness for change" model for both "high-risk" and "low-risk" individuals
- Track self-care emergency room claims
- Monitor and report overall results of the health promotion program

#### Other activities

- Plan and implement publicity campaigns
- Make presentations regarding health promotion programs to employee groups
- Implement an effective health promotion program, as required.

#### Organize employee health and safety fair

- Identify and provide the annual City Health and Safety Expo based on the needs and interests of the participants
- Provide an interactive health and safety fair that will include a minimum of the following screens and educational opportunities:
  - Cholesterol screening, including on-site results and detailed counseling from a pharmacist regarding results
  - Stress assessment
  - Skin cancer education
  - Allergy education
  - On-site pharmacist to answer questions
  - H. pylori screening
  - Health risk assessment
  - Body composition
  - Blood pressure
  - Breast cancer risk assessment
  - Bone density screening
  - Pulmonary screening
  - Provide summary reporting of "at-risk" percentages of health fair screens to be used to assist in the development of health promotion program design.

#### Overall goals

- To create an environment to assist employees who want to develop a personalized plan for behavior change and health improvement
- To continue to implement the health promotion program in such a manner as to integrate it into the City of Tulsa's culture
- To provide a health promotion program that meets City employee satisfaction

- To track, identify and report health “risks” and “costs” impact of the health promotion program.

**Funding**

Accounting of funds collected for the health promotion program is subject to discussion. The current annual program budget is \$100,000.00. This reflects program cost and consultant management cost.

**CITY OF TULSA  
PARTICIPATION DEMOGRAPHICS**

<b>HMO DIVISION</b>	<b>SINGLE</b>	<b>FAMILY</b>
Active Police	211	506
Active City of Tulsa	845	1,225
Active MTTA	91	105
Police Retirees	57	71
Fire Retirees	20	21
Municipal Retirees	109	69
EMSA/OKC	3	13
COBRA	95	12
Port of Catoosa	3	5
<b>POS DIVISION</b>	<b>SINGLE</b>	<b>FAMILY</b>
Active Police	34	70
Active City of Tulsa	137	251
Active MTTA	5	12
Police Retirees	10	19
Fire Retirees	13	11
Municipal Retirees	31	14
EMSA/OKC	3	2
COBRA	24	3
Port of Catoosa	0	1
<b>INDEMNITY/LOW OPTION</b>	<b>SINGLE</b>	<b>FAMILY</b>
Active Police	0	0
Active City of Tulsa	1	0
<b>OUT OF AREA DIVISION</b>	<b>SINGLE</b>	<b>FAMILY</b>
Police Retirees	5	3
Fire Retirees	5	3
Municipal Retirees	4	3
COBRA	4	0
<b>TOTAL</b>	<b>1,710</b>	<b>2,419</b>

CITY OF TULSA 2003 SUMMARY OF BENEFIT PLANS					
	HIMO Plan	IN NETWORK	POS Plan OUT-OF-NETWORK	Low Option Indemnity Plan	Out of Area Plan
<b>Concept</b>	All care managed through pre-selected Primary Care Physician. Available to all in area employees & participants who live or work within the designated zip code service area.	All care managed through pre-selected Primary Care Physician. Available to all in area employees & participants who live or work within the designated zip code service area.	No limitation of providers. Available to employees who actively work for the City of Tulsa and associated agencies.	Traditional insurance. No limitation of providers. Coverage available to all employees and associated agencies.	Traditional insurance. No limitation of providers. Coverage available to all employees and associated agencies.
<b>Annual deductible per calendar year</b>	None	None	\$500 per person \$1250 per family	\$500 per person \$1000 per family	\$250 per person \$750 per family
<b>Deductible per hospital confinement</b>	None	None	\$200 limited to one per individual per calendar year.	\$500 per day	None
<b>Precertification</b>	Obtained through Primary Care Physician.	Obtained through Primary Care Physician.	Required. Without it, 20% reduction of payable benefits.	Required. Without it, 20% reduction of payable benefits.	Required. Without it, 20% reduction of payable benefits.
<b>Second Surgical Opinion</b>	Obtained through Primary Care Physician.	Obtained through Primary Care Physician.	Required. Without it, 50% reduction of payable benefits.	Required. Without it, 50% reduction of payable benefits.	Required. Without it, 50% reduction of payable benefits.
<b>Out of pocket maximum per calendar year</b>	\$750 per individual \$1,500 per family (Some copays do not apply)	\$1,500 per individual \$1,500 per family (Some copays do not apply)	\$1000 per individual \$3000 per family (plus the amount of your deductible. Some copays do not apply.)	\$5,000 per individual \$10,000 per family (plus the amount of your deductible. Some copays do not apply)	\$2,500 per individual \$5,000 per family (plus the amount of your deductible. Some copays do not apply)
<b>Individual Lifetime Maximum Benefit</b>	Unlimited	Unlimited	\$1,000,000	\$1,000,000	\$1,000,000
<b>Coinsurance</b>	Coinsurance amounts apply to the Reasonable & Customary charges (Amounts in excess will not be considered eligible covered expenses) until the out-of-pocket limit is reached, then plan pays 100% of eligible expenses for the calendar year. Substance abuse, DME, prescription drugs, prosthetic and fertility evaluation benefits do not apply to the out of pocket maximum.	Coinsurance amounts apply to the Reasonable & Customary charges (Amounts in excess will not be considered eligible covered expenses) until the out-of-pocket limit is reached, then plan pays 100% of eligible expenses for the calendar year. Substance abuse, DME, prescription drugs, prosthetic and fertility evaluation benefits do not apply to the out of pocket maximum.	After deductible, 70% of reasonable & customary expenses until out-of-pocket limit is reached, then the plan pays 100% of the reasonable & customary expenses for the balance of the calendar year. Substance Abuse benefits are never paid at 100%.	After deductible, 70% of reasonable & customary expenses until out-of-pocket limit is reached, then the plan pays 100% of the reasonable & customary expenses for the balance of the calendar year. Substance Abuse benefits are never paid at 100%.	After deductible, 80% of reasonable & customary expenses until out-of-pocket limit is reached, then the plan pays 100% of the reasonable & customary expenses for the balance of the calendar year. Substance Abuse benefits are never paid at 100%.
<b>Physicians Office Visits/Preventive Care</b>	100% after \$10 copay per visit	100% after \$15 copay per visit	70% of reasonable & customary charges - subject to deductible. (does not include preventive care such as routine physicals, pap smears, and immunizations. Well baby care covered for 1st seven days in hospital only)	70% of eligible expenses - subject to deductible. Well baby care (under age 2, immunizations (childhood - birth to age 18, routine health assessments (age 2 and up; limited to one per calendar year)	80% of eligible expenses - subject to deductible. Well baby care (under age 2, immunizations (childhood - birth to age 18, routine health assessments (age 2 and up; limited to one per calendar year)
<b>Radiology &amp; Pathology</b>	No additional copay when referred by PCP.	No additional copay when referred by PCP.	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	80% of reasonable & customary charges - subject to deductible and out-of-pocket limit.

CITY OF TULSA 2003 SUMMARY OF BENEFIT PLANS					
	HMO Plan	IN NETWORK	OUT-OF-NETWORK	Low Option Indemnity Plan	Out of Area Plan
	100% after \$10 copay (initial visit only)	\$15 copay (initial visit only)	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	70% of eligible expenses - subject to deductible and out-of-pocket limit. Pre-admission certification is required within 30 days prior to expected date of delivery.	80% of eligible expenses - subject to deductible and out-of-pocket limit. Pre-admission certification is required within 30 days prior to expected date of delivery.
<i>Maternity Care (includes dependent children)</i>	Testing - \$10 copay Serum- 20% coinsurance	Testing - \$15 copay Serum - 20% coinsurance	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	70% of eligible expenses - subject to deductible and out-of-pocket limit.	80% of eligible expenses - subject to deductible and out-of-pocket limit.
<i>Allergy Treatment and Testing</i>	Testing - \$10 copay Serum- 20% coinsurance	Testing - \$15 copay Serum - 20% coinsurance	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	70% of eligible expenses - subject to deductible and out-of-pocket limit.	80% of eligible expenses - subject to deductible and out-of-pocket limit.
<i>Hospital Services (including room &amp; board, inpatient medical detoxification, anesthesia, nursing, physician visits, services &amp; supplies, lab tests/diagnostic testing, and all other medically necessary</i>	No copay	100% after \$100 copay per day up to out of pocket maximum.	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	70% after \$500 per day up to out of pocket maximum. Pre-admission certification is required prior to inpatient hospitalization. If treatment is not certified, coverage reduces by 20%.	80% of reasonable and customary charges. Pre-admission certification is required prior to inpatient hospitalization. If treatment is not certified, coverage reduces by 20%.
<i>Outpatient Surgery</i>	No copay	\$100 copay per visit.	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	70% of eligible expenses - subject to deductible and out-of-pocket limit.	80% of eligible expenses - subject to deductible and out-of-pocket limit.

CITY OF TULSA 2003 SUMMARY OF BENEFIT PLANS					
	HMO Plan		POS Plan		Out of Area Plan
	IN NETWORK	OUT-OF-NETWORK	Low Option Indemnity Plan	Out of Area Plan	
<i>Inpatient Mental Health</i>	No copay	100% after \$100 copay per day up to out of pocket maximum.	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	70% of eligible expenses, subject to applicable deductible and out of pocket maximum.	80% of reasonable & customary charges, subject to applicable deductible and out of pocket maximum.
<i>Outpatient Mental Health</i>	\$10 copay per visit	\$15 copay per visit. Must be authorized by Behavioral Health Case Manager.	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit. Must be authorized by Behavioral Health Case Manager.	70% of reasonable & customary charges - subject to deductible and out of pocket maximum.	80% of reasonable & customary charges, subject to applicable deductible and out of pocket maximum.
<i>Hospital Emergency Room</i>	\$50 copay per visit (waived if admitted)	\$50 copay per visit (waived if admitted)	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	80% of reasonable & customary charges - subject to deductible and out of pocket limit.
<i>Minor Emergency Room</i>	\$20 copay per visit	\$25 copay per visit	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	80% of reasonable & customary charges - subject to deductible and out-of-pocket limit.
<i>Ambulance Services</i>	No copay (must be pre-authorized except for emergencies)	\$50 copay per use (must be pre-authorized except for emergencies)	\$50 copay per use (must be pre-authorized except for emergencies)	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit.	80% of reasonable & customary charges - subject to deductible and out-of-pocket limit.
<i>Durable Medical Equipment</i>	20% coinsurance (or total cost) with authorization (\$3,000 annual maximum).	20% coinsurance (or total cost) with authorization (\$3,000 annual maximum).	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit. Must be preauthorized.	70% of reasonable & customary charges - subject to deductible, \$1,000 annual maximum, some exclusions apply.	80% of reasonable & customary charges - subject to deductible, \$1,000 annual maximum, some exclusions apply.
<i>Convalescent Nursing Home Care (Skilled Nursing Care)</i>	No copay - up to 60 treatment days per disability.	100% after \$25 copay per visit - up to 60 treatment days per disability.	70% of reasonable & customary charges - subject to deductible, (\$10,000 reasonable & customary charge limit per calendar year).	70% of reasonable & customary charges - subject to deductible. One third average semi-private room charge of the last hospital room charge of the last hospital in which the covered person was confined prior to confinement in the skilled nursing facility. Maximum benefit - 60 consecutive days per disability.	80% of reasonable & customary charges - subject to deductible. On third average semi-private room charge of the last hospital in which the covered person was confined prior to confinement in the skilled nursing facility. Maximum benefit - 60 consecutive days per disability.
<i>Home Health Care</i>	No copay.	No copay.	70% of reasonable & customary charges - subject to deductible, up to 60 visits per calendar year (\$35 maximum plan benefit per visit)	70% of reasonable & customary charges - subject to deductible, up to 60 visits per calendar year (\$35 maximum plan benefit per visit)	80% of reasonable & customary charges - subject to deductible, up to 60 visits per calendar year (\$35 maximum plan benefit per visit)
<i>Hospice Care</i>	No copay.	No copay.	70% of reasonable & customary charges - subject to deductible (\$7,400 maximum plan benefit per visit)	70% of reasonable & customary charges - subject to deductible and out-of-pocket limit. Limited to \$35 per day and 60 visits per calendar year.	80% of reasonable & customary charges - subject to deductible and out-of-pocket limit. Limited to \$35 per day and 60 visits per calendar year.

CITY OF TULSA 2003 SUMMARY OF BENEFIT PLANS				
	HMO Plan	POS Plan		Out of Area Plan
		IN NETWORK	OUT-OF-NETWORK	Low Option Indemnity Plan
<b>Prescription Drug Benefit</b>	<p>\$10 copay, generic formulary, \$20 copay, brand formulary, \$35 generic formulary brand, when generic is available and all Non-formulary. If the price of the drug is less than the stated copay you will only be charged the lesser amount. If your physician prescribes or you choose a brand name drug when the generic is available, then the cost will be the brand copayment in addition to the cost difference between the brand and generic, up to a maximum of \$35.</p>	<p>\$10 copay, generic formulary, \$20 copay, brand formulary, \$35 generic formulary brand, when generic is available and all Non-formulary. If the price of the drug is less than the stated copay you will only be charged the lesser amount. If your physician prescribes or you choose a brand name drug when the generic is available, then the cost will be the brand copayment in addition to the cost difference between the brand and generic, up to a maximum of \$35.</p>	<p>70% of reasonable &amp; customary charges - subject to a separate \$50 deductible per person.</p>	<p>80% of eligible expenses - subject to a separate \$200 deductible per person.</p>