**PART III – APPLICATION**

**COMMONWEALTH CONTRACT REQUIREMENTS**

**FOR**

**GROUP MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS  
AND  
PRE-65 MANAGED CARE PLANS**

**ISSUING OFFICE: COMMONWEALTH OF PENNSYLVANIA,**

**PUBLIC SCHOOL EMPLOYEES’ RETIREMENT SYSTEM**

**INVITATION FOR APPLICATION NUMBER: PSERS IFA 2024-01**

**DATE OF ISSUANCE: April 1, 2024**

**COMMONWEALTH CONTRACT REQUIREMENTS**

**FOR**

**GROUP MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS**

**AND COMPANION**

**PRE-65 MANAGED CARE PLANS**

**INVITATION FOR APPLICATION NUMBER: PSERS IFA 2024-01**

**TABLE OF CONTENTS**

**Part I—GENERAL INFORMATION**

**Appendix A – PSERS Health Options Program Regions**

**Appendix B – Census Information**

**Appendix C – Enrollment by State**

**Appendix D – New Eligible Retirees Turning Age 65**

**Appendix E – Benefit Plan Information**

**Part II—CONTRACT REQUIREMENTS AND VENDOR QUALIFICATION**

**Part III—APPLICATION**

**Part IV—CONTRACT DOCUMENT**

**Part V—COMMONWEALTH STANDARD CONTRACT TERMS**

**Form A – TRADE SECRET CONFIDENTIAL PROPRIETARY INFORMATION NOTICE FORM**

**PART III**

**APPLICATION**

In accordance with the requirements of this IFA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“ADMINISTRATOR”) hereby applies to offer a group Medicare Advantage plan with Prescription Drug benefits (MAPD) and a companion Pre-65 managed care plan to eligible retirees of the Public School Employees’ Retirement System of Pennsylvania (PSERS) as part of the Health Options Program (HOP).

By signing this Application, ADMINISTRATOR warrants that it has read and understands the scope of services required under this IFA, and that all responses contained in this Application are true and correct to the best of its knowledge and belief.

This Application incorporates the following documents by reference:

Part I – General Information

Part II – Contract Requirements and Vendor Qualification

Part IV – Contract Document

Part V – Commonwealth Standard Contract Terms

**III-1. General Representations.**

ADMINISTRATOR represents the following regarding this Application:

1. Calendar year for which application is made;
2. Legal name of applicant firm;
3. Home office address, telephone and fax numbers;
4. Location and address of primary office that will service PSERS;
5. Official contact person for applicant’s contract, including name, title, full address, email address and telephone and fax numbers;
6. Primary day-to-day contact who will work with PSERS, including name, title, full address, email address and telephone and fax numbers;
7. Secondary day-to-day contact who will work with PSERS (must be different contact than in Part III-1.6), including name, title, full address, email address and telephone and fax numbers;
8. Contact responsible for communication and coordination with PSERS’ third party administrator regarding operational issues, enrollments, customer service and premium payment;
9. Federal Tax Identification Number for applicant firm;
10. Pennsylvania Tax Identification Number or business license number for applicant firm;
11. Address for ADMINISTRATOR notice, as follows:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

in accordance with Contract Document section 13.14; and

1. That its proposal made through this application will remain valid for 180 days from the due date for applications, or to the date a contract is fully executed, if longer.
2. Please include a **Cover Letter** with your submission. The Cover Letter should summarize the changes you are proposing for 2025. To facilitate the review process, please be sure to acknowledge any changes to the documents that occurred after the final contract documents to ensure you are submitting the most updated documents for review.

**III-2. Organization Information and Financial Capability.**

1. Provide the following information with respect to your organization:
   1. In what state and under what formal name is your organization incorporated?
   2. Is your company independently owned or affiliated either as a subsidiary or division of another organization? Identify all ownership entities.
   3. Has your organization acquired, been acquired by, or merged with another organization in the past 24 months? If yes, please explain.
2. Indicate in the following table your most current ratings:

| **Independent Rating Agency** | **Rating** | **Date** |
| --- | --- | --- |
| AM Best |  |  |
| Standard & Poor |  |  |
| Moody’s |  |  |
| Other |  |  |

1. Have there been any downgrades in your ratings in the past two years? If so, please disclose and explain.
2. Describe the type and amount of fidelity and surety insurance and bond coverage you carry to protect this plan in the event of loss.
3. Provide a certificate proving existence of your current errors and omissions or fiduciary responsibility insurance policy in force that would apply to this agreement. The policy certificate should be labeled as **Attachment 1**.
4. List and describe any investigations by governmental entities into your Medicare or other programs, including those by State Attorneys General or the federal government or agencies thereof, which are currently ongoing or have been completed within the last year, and state the investigating entity, contact person, and nature of investigation.
5. Disclose any sanctions or other limitations imposed on your Medicare or other programs by the Centers for Medicare and Medicaid Services (CMS). Provide the effective date of the sanction and a summary of the current status, along with an expected date the sanction will expire or be lifted, if such date is known.
6. Describe whether any benefit category (medical, prescription drug, dental, vision, fitness, etc.) or functions are outsourced or subcontracted. If so, describe what functions, to whom, and where the referenced entities are located.
7. Provide your most recent audited financial statement as **Attachment 2**. Please make sure the attachment is unlocked.

**III-3. Application by Region.**

ADMINISTRATOR applies to provide coverage in the following PSERS regions:

1. ADMINISTRATOR applies to provide a group MAPD Plan and Pre-65 Managed Care Plan with prescription drug benefits for the following PSERS regions. **For the Pennsylvania (PA) regions, if coverage will not be available for the entire region, please list the counties where coverage will be provided. Out-of-State coverage areas will be indicated in question three.** (See Appendix A of Part I – General Information for description of counties or states covered within each PSERS region.):

\_\_ Southeastern PA Region

\_\_ Northern and Central PA Region

\_\_\_ Southwest PA Region

\_\_ Out-of-State Region

**If you are applying to add a New Active Benefit Plan, both the MAPD and pre-65 plans must have identical coverage areas as your other offerings.**

1. Confirm that your firm is licensed and approved by CMS and the Commonwealth insurance regulatory authorities to offer and provide the MAPD products you are proposing for each county in each PA region for which you are applying and that your firm is licensed and approved by the Commonwealth insurance regulatory authorities to offer and provide the proposed companion Pre-65 Managed Care Plan coverage for each of those same counties. List and describe any exceptions, including a specific listing of counties in which you are not approved in each region for which you are applying.
2. If you are applying to provide coverage for out-of-state HOP participants, indicate the states for which you are making application:

\_\_ Delaware

\_\_ Florida

\_\_ Maryland

\_\_ New Jersey

\_\_ New York

\_\_ All other states

**If you are applying to add a New Active Benefit Plan, both the MAPD and pre-65 plans must have identical coverage areas as your other offerings.**

1. Confirm that your firm is licensed and approved by CMS and the appropriate state insurance regulatory authorities to offer and provide the proposed MAPD products you are proposing for each state for which you are applying and that your firm is licensed and approved by the appropriate state insurance regulatory authorities to offer and provide the companion pre-65 managed care coverage in each state for which you are applying. List and describe any exceptions.

**III-4. Experience**

1. Provide the following information about your firm’s current overall book of business for Medicare Advantage plans and Medicare supplement group plans and individual policies.

| **Type of Medicare Plan** | **# of Group Plans** | **# of Covered Group Lives** | **# of Covered Individual Plan Lives** |
| --- | --- | --- | --- |
| MA-PPO Plans |  |  |  |
| MA POS Plans |  |  |  |
| MA HMO Plans |  |  |  |
| **Total All MA Plans** |  |  |  |
| Medicare Supplement Plans |  |  |  |
| **Total All Medicare Plans** |  |  |  |

1. Complete the same table as above, but showing plans and policies that include both Medicare Advantage and Medicare prescription drug coverage (MAPD).

| **Type of Medicare Plan** | **# of Group Plans** | **# of Covered Group Lives** | **# of Covered Individual Plan Lives** |
| --- | --- | --- | --- |
| MAPD PPO Plans |  |  |  |
| MAPD POS Plans |  |  |  |
| MAPD HMO Plans |  |  |  |
| **Total All MAPD Plans** |  |  |  |
| Medicare Supplement Plans + Rx |  |  |  |
| **Total All Medicare Plans** |  |  |  |

1. Provide information about your firm’s book of business for Medicare group benefit plans and individual insurance products for each PSERS region for which application is being made. The number of plans and individuals covered must represent only those actually covered in the respective region, without overlap to other PSERS regions and without reference to the firm’s overall book of business. Complete and label the following table separately for each region for which your firm is applying. Include multiple copies of the table as needed to match regions for which you are applying. If you are applying to provide coverage for the out-of-state region, please complete a separate copy of the table for each of the following states: Delaware, Florida, Maryland, New Jersey and New York.

**PSERS Region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| **Type of Medicare Plan** | **# of Group Plans** | **# of Covered Group Lives** | **# of Covered Individual Plan Lives** |
| --- | --- | --- | --- |
| 1. MAPD-PPO Plans |  |  |  |
| 2. MAPD-POS Plans |  |  |  |
| 3. MAPD-HMO Plans |  |  |  |
| 4. MAPD-PFFS Plans |  |  |  |
| **5. Total All MAPD Plans** (total lines 1 through 4) |  |  |  |
| 6. Medicare Supplement Plans |  |  |  |
| **7. Total All Medicare Plans** (line 5 plus line 6) |  |  |  |

1. If you are applying to provide out-of-state region MAPD Plan coverage, complete the following table showing your group and individual MAPD Plan coverage by state or territory.

| **State/Territory** | **# of Group MAPD Plans** | **# of Covered Group MAPD Lives** | **# of Covered Individual MAPD Plan Lives** |
| --- | --- | --- | --- |
| Alabama |  |  |  |
| Alaska |  |  |  |
| Arizona |  |  |  |
| Arkansas |  |  |  |
| California |  |  |  |
| Colorado |  |  |  |
| Connecticut |  |  |  |
| Delaware |  |  |  |
| District of Columbia |  |  |  |
| Florida |  |  |  |
| Georgia |  |  |  |
| Hawaii |  |  |  |
| Idaho |  |  |  |
| Illinois |  |  |  |
| Indiana |  |  |  |
| Iowa |  |  |  |
| Kansas |  |  |  |
| Kentucky |  |  |  |
| Louisiana |  |  |  |
| Maine |  |  |  |
| Maryland |  |  |  |
| Massachusetts |  |  |  |
| Michigan |  |  |  |
| Minnesota |  |  |  |
| Mississippi |  |  |  |
| Missouri |  |  |  |
| Montana |  |  |  |
| Nebraska |  |  |  |
| Nevada |  |  |  |
| New Hampshire |  |  |  |
| New Jersey |  |  |  |
| New Mexico |  |  |  |
| New York |  |  |  |
| North Carolina |  |  |  |
| North Dakota |  |  |  |
| Ohio |  |  |  |
| Oklahoma |  |  |  |
| Oregon |  |  |  |
| Pennsylvania |  |  |  |
| Rhode Island |  |  |  |
| South Carolina |  |  |  |
| South Dakota |  |  |  |
| Tennessee |  |  |  |
| Texas |  |  |  |
| Utah |  |  |  |
| Vermont |  |  |  |
| Virginia |  |  |  |
| Washington |  |  |  |
| West Virginia |  |  |  |
| Wisconsin |  |  |  |
| Wyoming |  |  |  |
| Guam |  |  |  |
| Puerto Rico |  |  |  |
| U.S. Virgin Islands |  |  |  |
| **TOTAL ALL STATES / TERRITORIES** |  |  |  |

1. Complete the table below for your organization’s current book-of-business for group and individual Pre-65 Managed Care Plans for early retirees. Lives covered under Individual Plans should include State Exchange plans.

| **Type of Pre-65 Retiree Plan** | **# of Group Plans** | **# of Covered Group Lives** | **# of Covered Individual Plan Lives** |
| --- | --- | --- | --- |
| PPO Plans |  |  |  |
| POS Plans |  |  |  |
| HMO Plans |  |  |  |
| Indemnity plans |  |  |  |
| Other (specify) |  |  |  |
| **Total All Pre-65 Retiree Coverage** |  |  |  |

**III-5. Benefit Plans**

1. For the group MAPD plan that will be available for selection by eligible HOP participants in the region(s) for which you are making application, provide the following attachments to this Application:
   1. **Attachment 3** – Active Plan design summary using the format provided.
   2. **Attachment 4** – Active Benefit summary of the plan design using your own format. Confirm that this benefit summary is fully consistent with Attachment 3.
   3. **Attachment 5** – Provide a hyperlink to the Evidence of Coverage (“EOC”) for the calendar year for which application is made. For the initial submission of this Application, provide a hyperlink of the current EOC for this plan. If the proposed plan is new to PSERS, provide either a hyperlink of the current year EOC for the plan offering or a hyperlink of the draft EOC for the contract year. ADMINISTRATOR shall submit the final EOC document (not a hyperlink) as a replacement for this attachment within 10 days of publication, but not later than December 31, 2024.

Note: Attachments 3-5 are for the *active* plan each Administrator is offering. If a new active plan is introduced, the previously active plan will become a legacy plan. You may only offer one active plan.

1. For any group MAPD Plan currently maintained as a Legacy Benefit Plan (Original Legacy Plan) that will continue to be maintained as a frozen plan for existing participants, provide the following attachments to this Application. Clearly mark each attachment to reflect the exact name of the plan to which it applies (e.g., “Attachment 6 for XYZ Senior HMO – Benefit Design Summary”):
   1. **Attachment 6** – Original Legacy Plan design summary using the format provided.
   2. **Attachment 7** – Original Legacy Benefit summary of the plan design using your own standard format. Confirm that this benefit summary is fully consistent with Attachment 6.
   3. **Attachment 8** –Provide a hyperlink to the EOC for the calendar year for which application is made. For the initial submission of this Application, provide a hyperlink of the current EOC for this plan. ADMINISTRATOR shall submit the final EOC document (not a hyperlink) as a replacement for this attachment within 10 days publication, but not later than December 31, 2024.
2. If applicable, for any additional legacy group MAPD Plan (if a new active plan has been introduced), provide the following attachments to this Application. Clearly mark each attachment to reflect the exact name of the plan to which it applies (e.g., “Attachment 18 for XYZ Senior HMO – Benefit Design Summary”):
   1. **Attachment 18** – Additional Legacy Plan design summary using the format provided.
   2. **Attachment 19** – Additional Legacy Benefit summary of the plan design using your own standard format. Confirm that this benefit summary is fully consistent with Attachment 18.
   3. **Attachment 20** –Provide a hyperlink to the EOC for the calendar year for which application is made. For the initial submission of this Application, provide a hyperlink of the current EOC for this plan. ADMINISTRATOR shall submit the final EOC document (not a hyperlink) as a replacement for this attachment within 10 days publication, but not later than December 31, 2024.

Note: Attachment 18-20 are for the Additional Legacy Plans in the event that the Managed Care Organization is currently maintaining two Legacy Plans, due to the addition of a new active plan. You may maintain no more than two Legacy Plans.

For the group Pre-65 Managed Care Plan with prescription drug benefits that will be available for selection by HOP participants not eligible for Medicare in the region(s) for which you are making application, provide the following attachments to this Application:

* 1. **Attachment 9** – Active Plan design summary using the format provided.
  2. **Attachment 10** – Active Benefit summary of the plan design using your own standard format. Confirm that this benefit summary is fully consistent with Attachment 9.

Note: Attachments 9 and 10 *active* plan each Administrator is offering. If a new active plan is introduced, the previously active plan will become a legacy plan. You may only offer one active plan.

1. For any group Pre-65 Managed Care Plan with prescription drug benefits currently maintained as a Legacy Benefit Plan (Original Legacy Plan) that will continue to be maintained as a frozen plan for existing participants, provide the following attachments to this Application. Clearly mark each attachment to reflect the exact name of the plan to which it applies (e.g., “Attachment 11 for XYZ HMO – Plan Design Summary”):
   1. **Attachment 11** – Original Legacy Plan design summary using the format provided.
   2. **Attachment 12** – Original Legacy Benefit summary of the plan design using your own format. Confirm that this benefit summary is fully consistent with Attachment 11.
2. If applicable, for any additional legacy group Pre-65 Managed Care Plan with prescription drug benefits plan (if a new active plan has been introduced), provide the following attachments to this Application. Clearly mark each attachment to reflect the exact name of the plan to which it applies (e.g., “Attachment 21 for XYZ HMO – Plan Design Summary”):
   1. **Attachment 21** – Additional Legacy Plan design summary using the format provided.
   2. **Attachment 22** – Additional Legacy Benefit summary of the plan design using your own format. Confirm that this benefit summary is fully consistent with Attachment 21.

Note: Attachment 21-22 are for the Additional Legacy Plans in the event that the Managed Care Organization is currently maintaining two Legacy Plans, due to the addition of a new active plan. You may maintain no more than two Legacy Plans

1. Confirm that, upon request by PSERS while you participate in this contract, your organization will make available the same seniors’ fitness program you provide for members of your MAPD and pre-65 managed care plans on a pass-through cost basis for use by participants in the PSERS HOP Medicare Plan and HOP Pre-65 Medical Plan, with pricing and specific program design to be proposed and agreed upon separately when such request is made by PSERS.
2. Confirm that your proposed plan designs take into consideration that many PSERS retirees are eligible for a service based premium assistance pension benefit credit of up to $100 per month for premium costs on an approved medical benefit plan.
3. Provide as **Attachment 13** the following provider and hospital network information:
   1. A list of website links to your current online provider directory for each MAPD Plan, Pre-65 Managed Care Plan, Legacy, and New Active Benefit Plan for which you are making application. Do not include printed copies of these provider directories.
   2. A list of hospitals covered in each PSERS region for each MAPD Plan, Pre-65 Managed Care Plan, Legacy, and New Active Benefit Plan for which you are making application.

**III-6. Service and Administration**

1. Confirm that you will provide a toll-free number to PSERS and HOP participants in your plan to request information and to handle claims or other service issues.
2. Confirm that the toll-free number will be staffed at least during the hours required in Part II, section II-8.1. a.
3. Confirm your commitment to implement this program for the calendar year in accordance with the stated implementation requirements in Part II, section II-9.1.
4. Provide below the most up-to-date PSERS HOP specific website link as well as the most up-to-date PSERS HOP specific toll-free phone numbers for Medicare members and Pre-65 members to call as noted in Part II-8.3 and Part IV-9. These links and phone numbers are used in member communications and posted on the HOPbenefits.com website.
5. Are you able to support adding the HOP logo onto ID cards? Please indicate where the HOP logo could be placed on your ID card and submit as **Attachment 23**.

**III-7. Management Information**

1. Confirm that you will provide a premium/eligibility reconciliation report to PSERS (or its designated third-party administrator) on a monthly basis, covering enrollments and terminations reconciled with premium payments, and due within 15 days following the end of each calendar month.
2. Confirm that you will provide a Call Volume Report to PSERS on a monthly basis, identifying monthly and year-to-date calls offered, calls handled, abandonment rate, average speed of answer and average call time. Report must be submitted in a format acceptable to PSERS. For an ADMINISTRATOR with total PSERS HOP participation (MAPD and Pre-65) of 5,000 or more participants, the Call Volume Report must be specific to the PSERS HOP group account and is due within 15 days after the end of the calendar month. For an ADMINISTRATOR with less than 5,000 PSERS HOP participants, the Call Volume Report may provide book of MAPD business results, but must also identify the total number of calls reported for PSERS plans on a monthly, quarterly and year-to-date basis, and is due within 45 days after the end of each calendar quarter.
3. Confirm that you will provide a report to PSERS on a quarterly basis including at least the medical loss ratio for each MAPD Plan and each Legacy MAPD Plan. This report will be due no later than 45 days following the end of each calendar quarter.
4. Confirm that for any calendar quarter during which ADMINISTRATOR’s total PSERS HOP enrollment for all MAPD plans reaches 1,000 or more and for the remainder of that year, ADMINISTRATOR will provide to PSERS a Claims and Experience Report, including quarterly summary of current and prior year-to-date information, including at least:
   1. Enrollment information;
   2. Payments by claims type;
   3. Utilization breakdown (e.g., inpatient, outpatient, professional and prescription drug);
   4. Top inpatient and outpatient facilities;
   5. High-cost claims summary by dollar levels (e.g., $10,000-$19,999; $20,000-$29,999, etc.);
   6. Average number and cost of prescriptions per member;
   7. Brand vs. generic analysis as percentage of prescriptions and as percentage of cost;
   8. Top five prescription drugs by dollar;
   9. Top therapeutic classes of drugs; and
   10. Other supporting information as discussed and agreed.

The format of such quarterly report may be proposed by ADMINISTRATOR at the time this section takes effect; however, the report must include the information requested.

1. Confirm that you will provide to PSERS a Final Annual Report, to include a summary of the year’s activities and experience. This requirement may be met by submitting the final monthly or quarterly reports required above, provided such reports show the year-to-date activity for the entire calendar year. The Final Annual Report is due within 45 days following the end of the calendar year.
2. Confirm that you will provide to PSERS an Appeals and Grievance Report, including a listing of appeals and grievances for the month, sent by secure email message and due no later than 25 days following end of each month.

**III-8. Performance Measures and Guarantees**

1. Confirm that you will meet the performance measures and guarantees reflected in Part II, section II-5, including quarterly reporting of results and annual settlement of penalties incurred.
2. Provide your proposed guarantees for each performance measurement factor as **Attachment 14**, using the format provided for that attachment.

**III-9. Cost Submittal.** Provide your proposed rates for the MAPD plan and for the companion Pre-65 Managed Care Plan proposed for the next calendar year using the tables contained in the **excel document Attachment 15** & **Attachment 16** and clearly mark each set of rates to reflect the appropriate plan name. If you are applying to continue offering a Legacy Benefit Plan, provide your proposed rates for the Legacy Benefit Plan in the clearly labeled tables. . **Please note that Attachments 15 and 16 have a different submission date than the initial application (see Part I – section I-31). You may propose preliminary rates at the initial application date. If you elect to propose preliminary rates at that time, please include Attachments 15 and 16. If not, to preserve appropriate page numbering in the submitted application, please submit Attachments 15 and 16 in blank with the initial application and mark each as “*To be submitted June 6, 2024*”. When the completed rate Attachments are submitted, they will be substituted into the final Application documents.**

1. Instructions on Providing Proposed Rates.
   1. MAPD Plan. For the MAPD Plan, provide a single per person rate that will apply throughout all counties in each PSERS HOP region in PA for which application is being made. The rate must apply to all counties in the region. No separate rates by county will be considered or approved.

If you are applying to provide out-of-state MAPD coverage, you may propose a maximum of two per-person premium rates. Only one per person rate will apply to all counties in a state, except for the indicated states where only one per person rate will apply to each county in the state.

* 1. Pre-65 Managed Care Plan. You must propose a single per person rate for the proposed Pre-65 Managed Care Plan that will apply in every location. The two-person and three person rates must be straight multiples of the single per person rate.

1. Submit proposed rates with the Application. Final rates may be requested and must be submitted on new Attachments 15 and 16 to replace the original submission.

**III-10. Implementation Plan.** Provide your proposed implementation plan for 2025 as **Attachment 17**. The plan should include all work elements involved to set up the proposed MAPD and Pre-65 Plans for PSERS to become effective January 1, 2025. For an ADMINISTRATOR approved and contracted for the 2024 calendar year, the 2025 implementation plan must be provided, but may be abbreviated and need only reflect changes to current administration to prepare for the new plan year.

**III-11. List of Attachments**

The following Attachments are made part of this Application:

Cover Letter – Letter summarizing the application.

Attachment 1 – Insurance certificate(s) for errors and omissions or fiduciary responsibility insurance.

Attachment 2 – Unlocked Audited financial statement

Attachment 3 – Active MAPD Plan Design Summary

Attachment 4 – Active MAPD Plan Benefit Summary

Attachment 5 – Active MAPD Plan EOC

Attachment 6 – Original Legacy MAPD Plan Design Summary

Attachment 7 – Original Legacy MAPD Plan Benefit Summary

Attachment 8 – Original Legacy MAPD Plan EOC

Attachment 9 – Active Pre-65 Managed Care Plan Design Summary

Attachment 10 – Active Pre-65 Managed Care Plan Benefit Summary

Attachment 11 – Original Legacy Pre-65 Managed Care Plan Design Summary

Attachment 12 – Original Legacy Pre-65 Managed Care Plan Benefit Summary

Attachment 13 – List of Website Links to Provider Directories for Each Plan Proposed

Attachment 14 – Performance Guarantees

Attachment 15 – Premium Rate Proposal

Attachment 16 – Out-of-State Region Rate Tier Assignments

Attachment 17 – Implementation Plan

Attachment 18 *(Optional)* – Additional Legacy MAPD Plan Design Summary

Attachment 19 *(Optional)* – Additional Legacy MAPD Plan Benefit Summary

Attachment 20 *(Optional)* – Additional Legacy MAPD Plan EOC

Attachment 21 *(Optional)* – Additional Legacy Pre-65 Managed Care Plan Design Summary

Attachment 22 *(Optional)* – Additional Legacy Pre-65 Managed Care Plan Benefit Summary

Attachment 23 – Sample ID Card

Should your firm need to include additional attachments with your application, please number them sequentially, beginning with “Attachment 24” and label each clearly. For electronic format submission purposes, please make sure that the file naming for each attachment begins with the attachment number in the following format convention: “Attachment 1 Insurance Certificate”.

**III-12. ADMINISTRATOR’s Representations and Authorizations**. By submitting its application, the ADMINISTRATOR understands, represents, and acknowledges that:

1. All of the ADMINISTRATOR’s information and representations in the application are material and important, and the Issuing Office may rely upon the contents of the application in approving the ADMINISTRATOR for award of a contract. The Commonwealth shall treat any misstatement, omission or misrepresentation as fraudulent concealment of the true facts relating to the application submission, punishable pursuant to 18 Pa. C.S. § 4904.
2. The ADMINISTRATOR has arrived at the price(s) and amounts in its applications independently and without consultation, communication, or agreement with any other ADMINISTRATOR or potential ADMINISTRATOR.
3. The ADMINISTRATOR has not disclosed the price(s), the amount proposed for any specific services, nor the approximate price(s) or amount(s) included in its application to any other firm or person who is an ADMINISTRATOR or potential ADMINISTRATOR for this contract, and the ADMINISTRATOR shall not disclose any of these items on or before the application submission deadline specified in the Calendar of Events for this contract.
4. The ADMINISTRATOR has not attempted, nor will it attempt, to induce any firm or person to refrain from submitting an application for this contract, or to submit an application higher than this application, or to submit any intentionally high or noncompetitive application or other form of complementary application.
5. The ADMINISTRATOR makes its application in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive application.
6. To the best knowledge of the person signing the application for the ADMINISTRATOR, the ADMINISTRATOR, its affiliates, subsidiaries, officers, directors, and employees are not currently under investigation by any governmental agency and have not in the last **four** years been convicted or found liable for any act prohibited by State or Federal law in any jurisdiction, involving conspiracy or collusion with respect to bidding or proposing on any public contract, except as ADMINISTRATOR has disclosed in this Application.
7. To the best of the knowledge of the person signing the application submission for the ADMINISTRATOR and except as the ADMINISTRATOR has otherwise disclosed in its application, the ADMINISTRATOR has no outstanding, delinquent obligations to the Commonwealth including, but not limited to, any state tax liability not being contested on appeal or other obligation of the ADMINISTRATOR that is owed to the Commonwealth.
8. The ADMINISTRATOR is not currently under suspension or debarment by the Commonwealth, any other state or the federal government, and if the ADMINISTRATOR cannot so certify, then it shall submit along with its application a written explanation of why it cannot make such certification.
9. The ADMINISTRATOR has not made, under separate contract with the Issuing Office, any recommendations to the Issuing Office concerning the need for the services described in its application or the specifications for the services described in the IFA.
10. The ADMINISTRATOR, by submitting its application, authorizes Commonwealth agencies to release to the Commonwealth information concerning the ADMINISTRATOR’s Pennsylvania taxes, unemployment compensation and workers’ compensation liabilities.

IN WITNESS WHEREOF, ADMINISTRATOR has caused this Application to be executed as of the \_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_.

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

ATTEST: Federal Tax Identification Number

ADMINISTRATOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name of firm)

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By:

Date Date

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:

**ATTACHMENT 3  
ACTIVE MAPD PLAN DESIGN SUMMARY**

**PLAN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| HOW MUCH PARTICIPANT WILL PAY | <Enter ADMINISTRATOR Name and Plan Name Here> | | |
| --- | --- | --- | --- |
| **MEDICAL** *[Use ‘NC’ to designate that a service is not covered]* | **In-Network** | **Out-of-Network** | |
|  | Check if deductible applies |
| Annual Deductible/Person |  |  | |
| Annual Out-of-Pocket Maximum/Person |  |  | |
| Doctor Visits | PCP-  Specialist- | PCP-  Specialist- |  |
| Preventive Care |  |  |  |
| Outpatient Surgery |  |  |  |
| Emergency Room  Waived if admitted? | Y□ N □ | Y□ N □ |  |
| Urgent Care |  |  |  |
| Diagnostic Testing |  |  |  |
| Outpatient Therapy |  |  |  |
| Durable Medical Equipment |  |  |  |
| Outpatient Mental Health |  |  |  |
| Hospitalization |  |  |  |
| Inpatient Mental Health |  |  |  |
| Routine Physical Exams |  |  |  |
| Ob/Gyn Exams |  |  |  |
| Mammograms |  |  |  |
| Skilled Nursing Facility |  |  |  |
| Vision Exams |  |  |  |
| Hearing Exams |  |  |  |
| Prescription Lenses  (Once every \_ months) |  |  |  |
| Hearing Aids  (Once every \_ months) |  |  |  |
| Dental Care |  |  |  |

| HOW MUCH PARTICIPANT WILL PAY | | <Enter ADMINISTRATOR Name and Plan Name Here> | | | |
| --- | --- | --- | --- | --- | --- |
| **PRESCRIPTION DRUGS** *[Use ‘NC’ to designate that a tier is not covered]* | | **Retail Pharmacy** *(up to a \_\_-day supply)* | | **Mail Order** | *(up to a \_\_-day supply)* |
|  | | Preferred Pharmacy | Non-Preferred Pharmacy | Preferred Pharmacy | Non-Preferred Pharmacy |
| Annual Deductible | |  |  |  |  |
| Initial Coverage | |  |  |  |  |
|  | Preferred generic drugs |  |  |  |  |
|  | Non-preferred generic drugs |  |  |  |  |
|  | Preferred brand drugs |  |  |  |  |
|  | Non-preferred brand drugs |  |  |  |  |
|  | Specialty drugs |  |  |  |  |
| Coverage Gap | |  |  |  |  |
|  | Preferred generic drugs |  |  |  |  |
|  | Non-preferred generic drugs |  |  |  |  |
|  | Preferred brand drugs |  |  |  |  |
|  | Non-preferred brand drugs |  |  |  |  |
|  | Specialty drugs |  |  |  |  |
| Catastrophic Coverage subject to minimums/maximums | |  |  |  |  |

**Note: If the plan does not distinguish between Preferred and Non-Preferred Pharmacies, please complete only the “Preferred Pharmacy” column, and include a note of confirmation that there is no distinction.**

**ATTACHMENT 6  
ORIGINAL LEGACY MAPD PLAN DESIGN SUMMARY**

**(Complete a Legacy Plan Design Summary for current Active Plan if applying for a New Active Plan and a second Legacy Plan Design Summary for current Legacy Plan, if any)**

**PLAN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| **HOW MUCH PARTICIPANT WILL PAY** | **<Enter ADMINISTRATOR Name and Plan Name Here>** | | |
| --- | --- | --- | --- |
| **MEDICAL** *[Use ‘NC’ to designate that a service is not covered]* | **In-Network** | **Out-of-Network** | |
|  | Check if deductible applies |
| Annual Deductible/Person |  |  | |
| Annual Out-of-Pocket Maximum/Person |  |  | |
| Doctor Visits | PCP-  Specialist- | PCP-  Specialist- |  |
| Preventive Care |  |  |  |
| Outpatient Surgery |  |  |  |
| Emergency Room  Waived if admitted? | Y□ N □ | Y□ N □ |  |
| Urgent Care |  |  |  |
| Diagnostic Testing |  |  |  |
| Outpatient Therapy |  |  |  |
| Durable Medical Equipment |  |  |  |
| Outpatient Mental Health |  |  |  |
| Hospitalization |  |  |  |
| Inpatient Mental Health |  |  |  |
| Routine Physical Exams |  |  |  |
| Ob/Gyn Exams |  |  |  |
| Mammograms |  |  |  |
| Skilled Nursing Facility |  |  |  |
| Vision Exams |  |  |  |
| Hearing Exams |  |  |  |
| Prescription Lenses  (Once every \_ months) |  |  |  |
| Hearing Aids  (Once every \_ months) |  |  |  |
| Dental Care |  |  |  |

| **HOW MUCH PARTICIPANT WILL PAY** | | **<Enter ADMINISTRATOR Name and Plan Name Here>** | | | |
| --- | --- | --- | --- | --- | --- |
| **PRESCRIPTION DRUGS** *[Use ‘NC’ to designate that a tier is not covered]* | | **Retail Pharmacy** *(up to a \_\_-day supply)* | | **Mail Order** | *(up to a \_\_-day supply)* |
|  | | Preferred Pharmacy | Non-Preferred Pharmacy | Preferred Pharmacy | Non-Preferred Pharmacy |
| Annual Deductible | |  |  |  |  |
| Initial Coverage | |  |  |  |  |
|  | Preferred generic drugs |  |  |  |  |
|  | Non-preferred generic drugs |  |  |  |  |
|  | Preferred brand drugs |  |  |  |  |
|  | Non-preferred brand drugs |  |  |  |  |
|  | Specialty drugs |  |  |  |  |
| Coverage Gap | |  |  |  |  |
|  | Preferred generic drugs |  |  |  |  |
|  | Non-preferred generic drugs |  |  |  |  |
|  | Preferred brand drugs |  |  |  |  |
|  | Non-preferred brand drugs |  |  |  |  |
|  | Specialty drugs |  |  |  |  |
| Catastrophic Coverage subject to minimums/maximums | |  |  |  |  |

**Note: If the plan does not distinguish between Preferred and Non-Preferred Pharmacies, please complete only the “Preferred Pharmacy” column, and include a note of confirmation that there is no distinction.**

**ATTACHMENT 9  
ACTIVE PRE-65 MANAGED CARE PLAN DESIGN SUMMARY**

**PLAN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| **HOW MUCH PARTICIPANT WILL PAY** | | **<Enter ADMINISTRATOR Name and Plan Name Here>** | | | |
| --- | --- | --- | --- | --- | --- |
| **MEDICAL** *[Use ‘NC’ to designate that a service is not covered]* | | **In-Network** | | **Out-of-Network** | |
|  | Check if deductible applies |  | Check if deductible applies |
| Annual Deductible | | Individual-  Family- | | Individual-  Family- | |
| Annual Out-of-Pocket Maximum | | Individual-  Family- | | Individual-  Family- | |
| Doctor Visits | | PCP-  Specialist- |  | PCP-  Specialist- |  |
| Preventive Care | |  |  |  |  |
| Outpatient Surgery | |  |  |  |  |
| Emergency Room  Waived if admitted? | | Y□ N □ |  | Y□ N □ |  |
| Urgent Care | |  |  |  |  |
| Diagnostic Testing | |  |  |  |  |
| Outpatient Therapy | |  |  |  |  |
| Durable Medical Equipment | |  |  |  |  |
| Outpatient Mental Health | |  |  |  |  |
| Hospitalization | |  |  |  |  |
| Inpatient Mental Health | |  |  |  |  |
| Routine Physical Exams | |  |  |  |  |
| Ob/Gyn Exams | |  |  |  |  |
| Mammograms | |  |  |  |  |
| Skilled Nursing Facility | |  |  |  |  |
| Vision Exam | |  |  |  |  |
| Hearing Exams | |  |  |  |  |
| Prescription Lenses  (Once every \_months) | |  |  |  |  |
| Hearing Aids  (Once every \_ months) | |  |  |  |  |
| Dental Care | |  |  |  |  |
| **PRESCRIPTION DRUGS** *[Use ‘NC’ to designate that a tier is not covered]* | | **In-Network** | | **Out-of-Network** | |
| Annual Deductible | | Individual-  Family- | | Individual-  Family- | |
| Annual Maximum | | Individual-  Family- | | Individual-  Family- | |
| **Retail Pharmacy**  *(up to a \_\_-day supply)* | |  | |  | |
|  | Generic drugs |  | |  | |
|  | Brand drugs |  | |  | |
| **Mail Order**  *(up to a \_\_-day supply)* | |  | |  | |
|  | Generic drugs |  | |  | |
|  | Brand drugs |  | |  | |

**ATTACHMENT 11  
ORIGINAL LEGACY PRE-65 MANAGED CARE PLAN DESIGN SUMMARY**

**PLAN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| **HOW MUCH PARTICIPANT WILL PAY** | | **<Enter ADMINISTRATOR Name and Plan Name Here>** | | | |
| --- | --- | --- | --- | --- | --- |
| **MEDICAL** *[Use ‘NC’ to designate that a service is not covered]* | | **In-Network** | | **Out-of-Network** | |
|  | Check if deductible applies |  | Check if deductible applies |
| Annual Deductible | | Individual-  Family- | | Individual-  Family- | |
| Annual Out-of-Pocket Maximum | | Individual-  Family- | | Individual-  Family- | |
| Doctor Visits | | PCP-  Specialist- |  | PCP-  Specialist- |  |
| Preventive Care | |  |  |  |  |
| Outpatient Surgery | |  |  |  |  |
| Emergency Room  Waived if admitted? | | Y□ N □ |  | Y□ N □ |  |
| Urgent Care | |  |  |  |  |
| Diagnostic Testing | |  |  |  |  |
| Outpatient Therapy | |  |  |  |  |
| Durable Medical Equipment | |  |  |  |  |
| Outpatient Mental Health | |  |  |  |  |
| Hospitalization | |  |  |  |  |
| Inpatient Mental Health | |  |  |  |  |
| Routine Physical Exams | |  |  |  |  |
| Ob/Gyn Exams | |  |  |  |  |
| Mammograms | |  |  |  |  |
| Skilled Nursing Facility | |  |  |  |  |
| Vision Exam | |  |  |  |  |
| Hearing Exams | |  |  |  |  |
| Prescription Lenses  (Once every \_ months) | |  |  |  |  |
| Hearing Aids  (Once every \_ months) | |  |  |  |  |
| Dental Care | |  |  |  |  |
| **PRESCRIPTION DRUGS** *[Use ‘NC’ to designate that a tier is not covered]* | | **In-Network** | | **Out-of-Network** | |
| Annual Deductible | | Individual-  Family- | | Individual-  Family- | |
| Annual Maximum | | Individual-  Family- | | Individual-  Family- | |
| **Retail Pharmacy**  *(up to a \_\_-day supply)* | |  | |  | |
|  | Generic drugs |  | |  | |
|  | Brand drugs |  | |  | |
| **Mail Order** *(up to a \_\_-day supply)* | |  | |  | |
|  | Generic drugs |  | |  | |
|  | Brand drugs |  | |  | |

**ATTACHMENT 14  
PERFORMANCE GUARANTEES**

Complete the shaded columns in following table with proposed annual performance guarantees. Indicate how your firm will measure and report each performance standard, the value you will put at risk (shown as a percent of overall premiums received, or as a discrete dollar amount), and whether the measurement will be client specific or based on your overall book of business. Performance against standards will be reported quarterly with annual settlement of guarantees.

| Performance Criteria | Performance Standard | How Measured | Dollar Amount at Risk | Client Specific? |
| --- | --- | --- | --- | --- |
| **1. Member Telephone Response Time (Average Speed to Answer)** | 45 Seconds or less |  | 45 sec or less 0%  46-55 seconds \_%  56-60 seconds \_%  >60 seconds \_% |  |
| **2. Member Call Abandonment Rate** | 2% or less |  | 2.00% or less 0%  2.01% - 3.00% \_%  3.01% - 4.00% \_%  >4.00% \_% |  |
| **3. Busy Signal Rate** | 5% or less |  | 5% or less 0%  5.1% - 6% \_%  6.1% - 7% \_%  >7% \_% |  |
| **4. Member First Call Resolution Rate** | 95% of member call questions are resolved as a result of the initial call. |  | 95% or more 0%  94% - 90% \_%  89% - 5% \_%  <85% \_% |  |
| **5. Member Written Inquiry Response Time** | 98% or more of all “normal” correspondence within 15 business days of receipt. |  | 98% or more 0%  90% - 97.9% \_%  80% - 89.9% \_%  <80% \_% |  |
| **6. Eligibility File Processing** | 98% or more of enrollment applications within 5 business days from receipt of CMS eligibility validation |  | 98% or more 0%  90% - 98% \_%  80% - 89% \_%  <80% \_% |  |
| **7. ID Card Turnaround** | 100% within 7 -10 Business Days after receipt of CMS eligibility validation (e.g., through the MARX system) |  | 10 or Less Business Days…………….0%  11 – 15 Business Days \_%  Greater than 15 Business Days \_% |  |
| **8. Claim Turnaround** | 95% of Clean claims paid within 30 days of receipt, all other claims will be paid within 60 days of receipt.  Clean claims are defined as claims that do not require additional information from outside the Administrator for processing. |  | 30 or Less Business Days 0%  31-45 Business Days \_%  Greater than 45 Business Days \_% |  |
| **9. Financial Payment Accuracy** | 99% of claims dollars submitted for payment will be accurately processed and paid. |  | 99% or greater 0% 98% to 99% \_%  97% to 98% \_%  Less than 97% \_% |  |
| **10. Claim Processing Accuracy** | 97% of all claims will be processed accurately. |  | 97% or Greater 0%  96% to 97% \_%  95% to 96% \_%  Less than 95% \_% |  |
| **11. Account Service Satisfaction** | 98% |  | 98% or more 0%  90% - 98% \_%  80% - 89% \_%  <80% \_% |  |

**ATTACHMENT 15**

**PREMIUM RATE PROPOSAL**

Please see excel document labeled PSERS IFA 2025 Attachment 15 and 16.

**ATTACHMENT 16  
OUT-OF-STATE REGION RATE TIER ASSIGNMENTS**

Please see excel document labeled PSERS IFA 2025 Attachment 15 and 16.

**ATTACHMENT 18 – *OPTIONAL*  
ADDITIONAL LEGACY PLAN DESIGN SUMMARY**

**PLAN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| **HOW MUCH PARTICIPANT WILL PAY** | **<Enter ADMINISTRATOR Name and Plan Name Here>** | | |
| --- | --- | --- | --- |
| **MEDICAL** *[Use ‘NC’ to designate that a service is not covered]* | **In-Network** | **Out-of-Network** | |
|  | Check if deductible applies |
| Annual Deductible/Person |  |  | |
| Annual Out-of-Pocket Maximum/Person |  |  | |
| Doctor Visits | PCP-  Specialist- | PCP-  Specialist- |  |
| Preventive Care |  |  |  |
| Outpatient Surgery |  |  |  |
| Emergency Room  Waived if admitted? | Y□ N □ | Y□ N □ |  |
| Urgent Care |  |  |  |
| Diagnostic Testing |  |  |  |
| Outpatient Therapy |  |  |  |
| Durable Medical Equipment |  |  |  |
| Outpatient Mental Health |  |  |  |
| Hospitalization |  |  |  |
| Inpatient Mental Health |  |  |  |
| Routine Physical Exams |  |  |  |
| Ob/Gyn Exams |  |  |  |
| Mammograms |  |  |  |
| Skilled Nursing Facility |  |  |  |
| Vision Exams |  |  |  |
| Hearing Exams |  |  |  |
| Prescription Lenses  (Once every \_ months) |  |  |  |
| Hearing Aids  (Once every \_ months) |  |  |  |
| Dental Care |  |  |  |

| **HOW MUCH PARTICIPANT WILL PAY** | | **<Enter ADMINISTRATOR Name and Plan Name Here>** | | | |
| --- | --- | --- | --- | --- | --- |
| **PRESCRIPTION DRUGS** *[Use ‘NC’ to designate that a tier is not covered]* | | **Retail Pharmacy** *(up to a \_\_-day supply)* | | **Mail Order** | *(up to a \_\_-day supply)* |
|  | | Preferred Pharmacy | Non-Preferred Pharmacy | Preferred Pharmacy | Non-Preferred Pharmacy |
| Annual Deductible | |  |  |  |  |
| Initial Coverage | |  |  |  |  |
|  | Preferred generic drugs |  |  |  |  |
|  | Non-preferred generic drugs |  |  |  |  |
|  | Preferred brand drugs |  |  |  |  |
|  | Non-preferred brand drugs |  |  |  |  |
|  | Specialty drugs |  |  |  |  |
| Coverage Gap | |  |  |  |  |
|  | Preferred generic drugs |  |  |  |  |
|  | Non-preferred generic drugs |  |  |  |  |
|  | Preferred brand drugs |  |  |  |  |
|  | Non-preferred brand drugs |  |  |  |  |
|  | Specialty drugs |  |  |  |  |
| Catastrophic Coverage subject to minimums/maximums | |  |  |  |  |

**Note: If the plan does not distinguish between Preferred and Non-Preferred Pharmacies, please complete only the “Preferred Pharmacy” column, and include a note of confirmation that there is no distinction.**

**ATTACHMENT 21 - *OPTIONAL*  
ADDITIONAL LEGACY PRE-65 MANAGED CARE PLAN DESIGN SUMMARY**

**PLAN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| **HOW MUCH PARTICIPANT WILL PAY** | | **<Enter ADMINISTRATOR Name and Plan Name Here>** | | | |
| --- | --- | --- | --- | --- | --- |
| **MEDICAL** *[Use ‘NC’ to designate that a service is not covered]* | | **In-Network** | | **Out-of-Network** | |
|  | Check if deductible applies |  | Check if deductible applies |
| Annual Deductible | | Individual-  Family- | | Individual-  Family- | |
| Annual Out-of-Pocket Maximum | | Individual-  Family- | | Individual-  Family- | |
| Doctor Visits | | PCP-  Specialist- |  | PCP-  Specialist- |  |
| Preventive Care | |  |  |  |  |
| Outpatient Surgery | |  |  |  |  |
| Emergency Room  Waived if admitted? | | Y□ N □ |  | Y□ N □ |  |
| Urgent Care | |  |  |  |  |
| Diagnostic Testing | |  |  |  |  |
| Outpatient Therapy | |  |  |  |  |
| Durable Medical Equipment | |  |  |  |  |
| Outpatient Mental Health | |  |  |  |  |
| Hospitalization | |  |  |  |  |
| Inpatient Mental Health | |  |  |  |  |
| Routine Physical Exams | |  |  |  |  |
| Ob/Gyn Exams | |  |  |  |  |
| Mammograms | |  |  |  |  |
| Skilled Nursing Facility | |  |  |  |  |
| Vision Exam | |  |  |  |  |
| Hearing Exams | |  |  |  |  |
| Prescription Lenses  (Once every \_months) | |  |  |  |  |
| Hearing Aids  (Once every \_ months) | |  |  |  |  |
| Dental Care | |  |  |  |  |
| **PRESCRIPTION DRUGS** *[Use ‘NC’ to designate that a tier is not covered]* | | **In-Network** | | **Out-of-Network** | |
| Annual Deductible | | Individual-  Family- | | Individual-  Family- | |
| Annual Maximum | | Individual-  Family- | | Individual-  Family- | |
| **Retail Pharmacy**  *(up to a \_\_-day supply)* | |  | |  | |
|  | Generic drugs |  | |  | |
|  | Brand drugs |  | |  | |
| **Mail Order**  *(up to a \_\_-day supply)* | |  | |  | |
|  | Generic drugs |  | |  | |
|  | Brand drugs |  | |  | |