# PART III – APPLICATION

# COMMONWEALTH CONTRACT REQUIREMENTS

# FOR

# GROUP MEDICARE ADVANTAGE PLANS
# AND
# PRE-65 MANAGED CARE PLANS

## ISSUING OFFICE: COMMONWEALTH OF PENNSYLVANIA, PUBLIC SCHOOL EMPLOYEES' RETIREMENT SYSTEM

## INVITATION FOR APPLICATION NUMBER: PSERS IFA 2018-01

## DATE OF ISSUANCE: March 30 2018

**COMMONWEALTH CONTRACT REQUIREMENTS**
**FOR**
**GROUP MEDICARE ADVANTAGE PLANS**
**AND COMPANION**
**PRE-65 MANAGED CARE PLANS**

**INVITATION FOR APPLICATION NUMBER: PSERS IFA 2018-01**

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# PART III

# APPLICATION

In accordance with the requirements of this IFA, _____ ("ADMINISTRATOR") hereby applies to offer a group Medicare Advantage and Prescription Drug plan 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.

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. Contact responsible for communication and coordination with PSERS' third party administrator regarding operational issues, enrollments, customer service and premium payment;

8. Federal Tax Identification Number for applicant firm;

9. Pennsylvania Tax Identification Number or business license number for applicant firm;

10. Address for ADMINISTRATOR notice, as follows:

    Name: _____

    Title: _____

    Company: _____

    Street: _____

    City, State, ZIP: _____

in accordance with Contract Document section 13.14; and

11. 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.

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

1. Provide the following information with respect to your organization:

    a. In what state and under what formal name is your organization incorporated?

    b. Is your company independently owned or affiliated either as a subsidiary or division of another organization? Identify all ownership entities.

    c. 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 | | |

3. Have there been any downgrades in your ratings in the past two years? If so, please disclose and explain.

4. Describe the type and amount of fidelity and surety insurance and bond coverage you carry to protect this plan in the event of loss.

5. 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**.

6. 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.

7. Disclose any sanctions or other limitations imposed on your Medicare or other programs by the Centers for Medicare and Medicaid Services. 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.

8. 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.

9. Provide your most recent audited financial statement as **Attachment 2**.

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

ADMINISTRATOR applies to provide coverage in the following PSERS regions:

1. ADMINISTRATOR applies to provide group Medicare Advantage plan with prescription drug benefits and group 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 Medicare Advantage and pre-65 plans must have identical coverage areas as your other offerings.**

2. Confirm that your firm is licensed and approved by CMS and the Commonwealth insurance regulatory authorities to offer and provide the Medicare Advantage products you are

proposing for each county in each Pennsylvania 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.

3. If you are applying to provide coverage for out-of-state Health Options Program 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 Medicare Advantage and pre-65 plans must have identical coverage areas as your other offerings.**

4. Confirm that your firm is licensed and approved by CMS and the appropriate state insurance regulatory authorities to offer and provide the proposed Medicare Advantage 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 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 | | | |

| Type of Medicare Plan | # of Group Plans | # of Covered Group Lives | # of Covered Individual Plan Lives |
|---|---|---|---|
| **Total All Medicare Advantage Plans** | | | |
| Medicare Supplement Plans | | | |
| **Total All Medicare Plans** | | | |

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

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

3. 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. MA-PPO Plans | | | |
| 2. MA-POS Plans | | | |
| 3. MA-HMO Plans | | | |
| 4. MA-PFFS Plans | | | |
| **5. Total All Medicare Advantage Plans** (total lines 1 through 4) | | | |
| 6. Medicare Supplement Plans | | | |
| **7. Total All Medicare Plans** (line 5 plus line 6) | | | |

4. If you are applying to provide out-of-state region Medicare Advantage plan coverage, complete the following table showing your group and individual Medicare Advantage plan coverage by state or territory.

| State/Territory | # of Group Medicare Advantage Plans | # of Covered Group Medicare Advantage Lives | # of Covered Individual Medicare Advantage Plan Lives |
|---|---|---|---|
| Alabama | | | |
| Alaska | | | |
| Arizona | | | |
| Arkansas | | | |
| California | | | |
| Colorado | | | |
| Connecticut | | | |
| Delaware | | | |
| District of Columbia | | | |
| Florida | | | |

| State/Territory | # of Group Medicare Advantage Plans | # of Covered Group Medicare Advantage Lives | # of Covered Individual Medicare Advantage Plan Lives |
|---|---|---|---|
| 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 | | | |

| State/Territory | # of Group Medicare Advantage Plans | # of Covered Group Medicare Advantage Lives | # of Covered Individual Medicare Advantage Plan Lives |
|---|---|---|---|
| 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** | | | |

5. 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 Medicare Advantage plan with Prescription Drug benefits that will be available for selection by eligible Health Options Program participants in the region(s) for which you are making application, provide the following attachments to this Application:

    a. **Attachment 3** – Plan design summary using the format provided.

    b. **Attachment 4** – Benefit summary of the plan design using your own format. Confirm that this benefit summary is fully consistent with Attachment 3.

    c. **Attachment 5** – Evidence of Coverage ("EOC") for the calendar year for which application is made. For the initial submission of this Application, provide a copy of the current EOC for this plan. If the proposed plan is new to PSERS, provide either a copy of the current year EOC for the plan offering or a draft EOC for the contract year. ADMINISTRATOR shall submit the final EOC as a replacement for this attachment within 10 days of publication, but not later than December 31, 2018.

2. For any group Medicare Advantage plan with Prescription Drug benefits currently maintained as a Legacy Benefit 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"):

a. **Attachment 6** – Plan design summary using the format provided.

b. **Attachment 7** – Benefit summary of the plan design using your own standard format. Confirm that this benefit summary is fully consistent with Attachment 6.

c. **Attachment 8** – Evidence of Coverage ("EOC") for the calendar year for which application is made. For the initial submission of this Application, provide a copy of the current EOC for this plan. ADMINISTRATOR shall submit the final EOC as a replacement for this attachment within 10 days publication, but not later than December 31, 2018.

3. If you wish to introduce a New Active group Medicare Advantage plan with Prescription Drug benefits, 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 New Active MA-PD Benefit Design Summary"):

   a. **Attachment 18** – Plan design summary using the format provided.

   b. **Attachment 19** – Benefit summary of the plan design using your own standard format. Confirm that this benefit summary is fully consistent with Attachment 18.

   c. **Attachment 20** – Evidence of Coverage ("EOC") for the calendar year for which application is made. For the initial submission of this Application, provide a copy of the current EOC for this plan. ADMINISTRATOR shall submit the final EOC as a replacement for this attachment within 10 days publication, but not later than December 31, 2018.

4. For the group pre-65 managed care plan with prescription drug benefits that will be available for selection by Health Options Program participants not eligible for Medicare in the region(s) for which you are making application, provide the following attachments to this Application:

   a. **Attachment 9** – Plan design summary using the format provided.

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

5. For any group pre-65 managed care plan with prescription drug benefits currently maintained as a Legacy Benefit 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"):

a. **Attachment 11** – Plan design summary using the format provided.

b. **Attachment 12** – Benefit summary of the plan design using your own format. Confirm that this benefit summary is fully consistent with Attachment 11.

6. If you wish to introduce a New Active pre-65 managed care plan with prescription drug benefits, 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 New Active pre-65 Plan Design Summary"):

   a. **Attachment 21** – Plan design summary using the format provided.

   b. **Attachment 22** – Benefit summary of the plan design using your own format. Confirm that this benefit summary is fully consistent with Attachment 21.

7. 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 Medicare Advantage 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.

8. 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.

9. Provide as **Attachment 13** the following provider and hospital network information:

   a. A list of website links to your current online provider directory for each Medicare Advantage 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.

   b. A list of hospitals covered in each PSERS region for each Medicare Advantage 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 Health Options Program 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.

## 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 Health Options Program participation (Medicare Advantage and Pre-65) of 5,000 or more participants, the Call Volume Report must be specific to the PSERS Health Options Program group account and is due within 15 days after the end of the calendar month. For an ADMINISTRATOR with less than 5,000 PSERS Health Options Program participants, the Call Volume Report may provide book of Medicare Advantage 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 Medicare Advantage Plan and each Legacy Medicare Advantage 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 Health Options Program enrollment for all Medicare Advantage 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:

a. Enrollment information;

b. Payments by claims type;

c. Utilization breakdown (e.g., inpatient, outpatient, professional and prescription drug);

d. Top inpatient and outpatient facilities;

e. High-cost claims summary by dollar levels (e.g., $10,000-$19,999; $20,000-$29,999, etc.);

f. Average number and cost of prescriptions per member;

g. Brand vs. generic analysis as percentage of prescriptions and as percentage of cost;

h. Top five prescription drugs by dollar;

i. Top therapeutic classes of drugs; and

j. 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.

5. 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.

6. 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 Medicare Advantage plan and for the companion pre-65 managed care plan proposed for the next calendar year using the tables contained in **Attachment 15**, and **Attachment 16**. If you are applying to continue offering a Legacy Benefit Plan, provide your proposed rates for the Legacy Benefit Plan on a separate Attachment 15 and Attachment 16 and clearly mark the additional attachments to reflect the plan name(s) they cover. If you are applying to offer a New Active Benefit Plan, provide your proposed rates for the New Active Benefit Plan on a separate Attachment 15 and Attachment 16 and clearly mark the additional attachments to reflect the plan name(s) they cover. **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, 2018*". When the completed rate Attachments are submitted, they will be substituted into the final Application documents.**

1. Instructions on Providing Proposed Rates.

    a. Medicare Advantage Plan. For the Medicare Advantage plan, provide a single per person rate that will apply throughout all counties in each PSERS Health Options Program region in Pennsylvania 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 Medicare Advantage 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, with the exception of the indicated states where only one per person rate will apply to each county in the state.

    b. 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.

2. 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 2019 as **Attachment 17**. The plan should include all work elements involved to set up the proposed MA and Pre-65 plans for PSERS to become effective January 1, 2019. For an ADMINISTRATOR approved and contracted for the 2018 calendar year, the 2019 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:

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

Attachment 2 – Audited financial statement

Attachment 3 – Medicare Advantage Plan Design Summary

Attachment 4 – Medicare Advantage Plan Benefit Summary

Attachment 5 – Medicare Advantage Plan Evidence of Coverage

Attachment 6 – Legacy Medicare Advantage Plan Design Summary

Attachment 7 – Legacy Medicare Advantage Plan Benefit Summary

Attachment 8 – Legacy Medicare Advantage Plan Evidence of Coverage

Attachment 9 – Pre-65 Managed Care Plan Design Summary

Attachment 10 – Pre-65 Managed Care Plan Benefit Summary

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

Attachment 12 – 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)* – New Active Medicare Advantage Plan Design Summary

Attachment 19 *(Optional)* – New Active Medicare Advantage Plan Benefit Summary

Attachment 20 *(Optional)* – New Active Medicare Advantage Plan Evidence of Coverage

Attachment 21 *(Optional)* – New Active Pre-65 Managed Care Plan Design Summary

Attachment 22 *(Optional)* – New Active Pre-65 Managed Care Plan Benefit Summary

Should your firm need to include additional attachments with your application, please number them sequentially, beginning with "Attachment 23" 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-11. 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.

11. Until the ADMINISTRATOR receives a fully executed contract from the Issuing Office, there is no legal and valid contract, in law or in equity, and the ADMINISTRATOR shall not begin to perform.

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
## MEDICARE ADVANTAGE PLAN DESIGN SUMMARY

| 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-<br>Specialist- | PCP-<br>Specialist- | |
| Outpatient Surgery | | | |
| Emergency Room<br>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 | | | |
| Vision Exams | | | |
| Hearing Exams | | | |
| Prescription Lenses<br>(Once every _ months) | | | |
| Hearing Aids<br>(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**
**LEGACY MEDICARE ADVANTAGE 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)**

| HOW MUCH PARTICIPANT WILL PAY | <Enter ADMINISTRATOR Name and Plan Name Here> | | |
|---|---|---|---|
| **MEDICAL**<br>*[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-<br>Specialist- | PCP-<br>Specialist- | |
| 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 | | | |
| 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
# PRE-65 MANAGED CARE PLAN DESIGN SUMMARY

| HOW MUCH PARTICIPANT WILL PAY | <Enter ADMINISTRATOR Name and Plan Name Here> | | | |
|---|---|---|---|---|
| **MEDICAL**<br>*[Use 'NC' to designate that a service is not covered]* | **In-Network** | Check if deductible applies | **Out-of-Network** | Check if deductible applies |
| Annual Deductible | Individual-<br>Family- | | Individual-<br>Family- | |
| Annual Out-of-Pocket Maximum | Individual-<br>Family- | | Individual-<br>Family- | |
| Doctor Visits | PCP-<br>Specialist- | | PCP-<br>Specialist- | |
| Outpatient Surgery | | | | |
| Emergency Room<br>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 | | | | |
| Vision Exam | | | | |
| Hearing Exams | | | | |
| Prescription Lenses<br>(Once every _months) | | | | |
| Hearing Aids<br>(Once every _ months) | | | | |
| Dental Care | | | | |
| **PRESCRIPTION DRUGS**<br>*[Use 'NC' to designate that a tier is not covered]* | **In-Network** | | **Out-of-Network** | |
| Annual Deductible | Individual-<br>Family- | | Individual-<br>Family- | |
| Annual Maximum | Individual-<br>Family- | | Individual-<br>Family- | |
| **Retail Pharmacy**<br>*(up to a __-day supply)* | | | | |
| Generic drugs | | | | |
| Brand drugs | | | | |
| **Mail Order**<br>*(up to a __-day supply)* | | | | |
| Generic drugs | | | | |
| Brand drugs | | | | |

# ATTACHMENT 11
# LEGACY PRE-65 MANAGED CARE PLAN DESIGN SUMMARY

| HOW MUCH PARTICIPANT WILL PAY | <Enter ADMINISTRATOR Name and Plan Name Here> | | | |
|---|---|---|---|---|
| **MEDICAL**<br>*[Use 'NC' to designate that a service is not covered]* | **In-Network** | Check if deductible applies | **Out-of-Network** | Check if deductible applies |
| Annual Deductible | Individual-<br>Family- | | Individual-<br>Family- | |
| Annual Out-of-Pocket Maximum | Individual-<br>Family- | | Individual-<br>Family- | |
| Doctor Visits | PCP-<br>Specialist- | | PCP-<br>Specialist- | |
| Outpatient Surgery | | | | |
| Emergency Room<br>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 | | | | |
| Vision Exam | | | | |
| Hearing Exams | | | | |
| Prescription Lenses<br>(Once every _ months) | | | | |
| Hearing Aids<br>(Once every _ months) | | | | |
| Dental Care | | | | |
| **PRESCRIPTION DRUGS**<br>*[Use 'NC' to designate that a tier is not covered]* | **In-Network** | | **Out-of-Network** | |
| Annual Deductible | Individual-<br>Family- | | Individual-<br>Family- | |
| Annual Maximum | Individual-<br>Family- | | Individual-<br>Family- | |
| **Retail Pharmacy**<br>*(up to a __-day supply)* | | | | |
| Generic drugs | | | | |
| Brand drugs | | | | |
| **Mail Order**<br>*(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%<br>46-55 seconds....._%<br>56-60 seconds....._%<br>>60 seconds....._% | |
| **2. Member Call Abandonment Rate** | 2% or less | | 2.00% or less.....0%<br>2.01% - 3.00%....._%<br>3.01% - 4.00%....._%<br>>4.00%..... _% | |
| **3. Busy Signal Rate** | 5% or less | | 5% or less.....0%<br>5.1% - 6%....._%<br>6.1% - 7%....._%<br>>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%<br>94% - 90%....._%<br>89% - 5%....._%<br><85%....._% | |
| **5. Member Written Inquiry Response Time** | 98% or more of all "normal" correspondence within 15 business days of receipt. | | 98% or more.....0%<br>90% - 97.9%....._%<br>80% - 89.9% ....._%<br><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%<br>90% - 98%....._%<br>80% - 89%....._%<br><80%....._% | |
| **7. ID Card Turnaround** | 7 -10 Business Days after receipt of CMS eligibility validation (e.g., through the MARX system) | | 10 or Less Business Days……0%<br>11 – 15 Business Days ....._%<br>Greater than 15 Business Days ....._% | |

| Performance Criteria | Performance Standard | How Measured | Dollar Amount at Risk | Client Specific? |
|---|---|---|---|---|
| **8. Claim Turnaround** | 95% of Clean claims paid within 30 days of receipt, all other claims will be paid within 60 days of receipt.<br>Clean claims are defined as claims that do not require additional information from outside the Administrator for processing. | | 30 or Less Business Days .....0%<br>31-45 Business Days ....._%<br>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%<br>98% to 99%....._%<br>97% to 98%....._%<br>Less than 97% ....._% | |
| **10. Claim Processing Accuracy** | 97% of all claims will be processed accurately. | | 97% or Greater....0%<br>96% to 97%....._%<br>95% to 96%....._%<br>Less than 95% ....._% | |
| **11. Account Service Satisfaction** | 98% | | 98% or more .....0%<br>90% - 98%....._%<br>80% - 89%....._%<br><80% ..... _% | |

**ATTACHMENT 15**
**PREMIUM RATE PROPOSAL**

1. In the following table, provide your proposed premium rates for the Medicare Advantage Plan with Prescription Drugs and for the Pre-65 managed care plan for the PSERS regions within Pennsylvania for which you are making application.
    a. If you are not making application for a particular region, enter "Not Applying" in the cells for that region.
    b. If you propose a Medicare Advantage Plan for a region, you must also offer a pre-65 managed care plan for retirees under age 65.
    c. All proposed rates should be the total per person rate for all benefit coverage, including both medical and prescription drug benefits. If rates are broken out by coverage type (e.g., MA and PDP), you must also show the total premium rate for all coverage types.
    d. If your two-person and/or three person rates for the Pre-65 Managed Care Plan are not exact multiples of the one person rate, please list each rate in the cell for that region.
    e. If you are also applying to continue providing a Legacy Benefit Plan, provide rates for the Legacy Benefit Plan(s) on a second copy of this table in the same attachment and clearly indicate "Legacy Benefit Plan" and the name of the plan just above the table.
    f. If you are also applying to provide a New Active Benefit Plan, provide rates for the New Active Plan on a third copy of this table in the same attachment and clearly indicate "New Active Benefit Plan" and the name of the plan just above the table.

| | **Monthly Premium Rate (per person)** | |
|---|---|---|
| **Region** | **Medicare Advantage Plan** | **Pre-65 Managed Care Plan** |
| **Pennsylvania** | | |
| Southeast Region | $ | $ |
| North and Central Region | $ | $ |
| Southwest Region | $ | $ |

2. In the following table, list your proposed monthly premiums to provide a Medicare Advantage Plan and a companion pre-65 managed care plan for Health Options Program participants who reside outside Pennsylvania.

    a. You may propose up to two rates for the Medicare Advantage Plan, which will be applied by state (or by county within state for Delaware, Florida, Maryland, New Jersey and New York) in **Attachment 16**.

    b. You must propose a single rate for your pre-65 managed care plan coverage that will apply for the benefit plan in every location.

c. All proposed rates should be the total per person rate for all benefit coverage, including both medical and prescription drug benefits. If rates are broken out by coverage type (e.g., MA and PDP), you must also show the total premium rate for all coverage types.

d. If your two-person and/or three person rates for the Pre-65 Managed Care Plan are not exact multiples of the one person rate, please list each rate in the cell provided.

e. If you are also applying to continue providing a Legacy Benefit Plan for the Out-of-State region, provide rates for the Legacy Benefit Plan(s) on a second copy of this table in the same attachment and clearly indicate "Legacy Benefit Plan" and the name of the plan just above the table.

f. If you are also applying to provide a New Active Benefit Plan for the Out-of-State region, provide rates for the New Active Plan on a third copy of this table in the same attachment and clearly indicate "New Active Benefit Plan" and the name of the plan just above the table.

| | **Monthly Premium Rate (per person)** | |
|---|---|---|
| **Rate Tier** | **Medicare Advantage Plan** | **Pre-65 Managed Care Plan** |
| **Out-of-State** | | |
| Tier 1 – High Tier | $ | $ |
| Tier 2 – Low Tier | $ | |

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

1. In the following table, list the Medicare Advantage Plan rate tier (e.g., "Tier 1") and rate (e.g., $xxx.xx) from Attachment 15 that applies to each county for the states listed for which you are applying to provide a Medicare Advantage Plan.

    a. If you are not approved to provide a group Medicare Advantage Plan in a particular county, mark the Rate Tier column for that county as "**Not offered**" and leave the Rate column blank.

    b. If you are <u>not</u> applying for a particular state, include a legend **in bold type** next to the state name "**Not applying for this state**" and leave both the Rate Tier and Rate columns blank for that state.

    c. <u>If you are also applying to continue providing a Legacy Benefit Plan in these states, provide the requested information on a second copy of this table in the same attachment and clearly indicate "Legacy Benefit Plan" and the name of the plan just above the table.</u>

    d. <u>If you are also applying to provide a New Active Benefit Plan in these states, provide the requested information on a third copy of this table in the same attachment and clearly indicate "New Active Benefit Plan" and the name of the plan just above the table.</u>

| State/County | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| **Delaware** | | |
| Kent | | $ |
| New Castle | | $ |
| Sussex | | $ |
| **Florida** | | |
| Alachua | | $ |
| Baker | | $ |
| Bay | | $ |
| Bradford | | $ |
| Brevard | | $ |

| State/County | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| Broward | | $ |
| Calhoun | | $ |
| Charlotte | | $ |
| Citrus | | $ |
| Clay | | $ |
| Collier | | $ |
| Columbia | | $ |
| DeSoto | | $ |
| Dixie | | $ |
| Duval | | $ |
| Escambia | | $ |
| Flagler | | $ |
| Franklin | | $ |
| Gadsden | | $ |
| Gilchrist | | $ |
| Glades | | $ |
| Gulf | | $ |
| Hamilton | | $ |
| Hardee | | $ |
| Hendry | | $ |
| Hernando | | $ |
| Highlands | | $ |
| Hillsborough | | $ |
| Holmes | | $ |

| State/County | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| Indian River | | $ |
| Jackson | | $ |
| Jefferson | | $ |
| Lafayette | | $ |
| Lake | | $ |
| Lee | | $ |
| Leon | | $ |
| Levy | | $ |
| Liberty | | $ |
| Madison | | $ |
| Manatee | | $ |
| Marion | | $ |
| Martin | | $ |
| Miami-Dade | | $ |
| Monroe | | $ |
| Nassau | | $ |
| Okaloosa | | $ |
| Okeechobee | | $ |
| Orange | | $ |
| Osceola | | $ |
| Palm Beach | | $ |
| Pasco | | $ |
| Pinellas | | $ |
| Polk | | $ |

| State/County | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| Putnam | | $ |
| Saint Johns | | $ |
| Saint Lucie | | $ |
| Santa Rosa | | $ |
| Sarasota | | $ |
| Seminole | | $ |
| Sumter | | $ |
| Suwanee | | $ |
| Taylor | | $ |
| Union | | $ |
| Volusia | | $ |
| Wakulla | | $ |
| Walton | | $ |
| Washington | | $ |
| **Maryland** | | |
| Alleghany | | $ |
| Anne Arundel | | $ |
| Baltimore County | | $ |
| Baltimore City | | $ |
| Calvert | | $ |
| Caroline | | $ |
| Carroll | | $ |
| Cecil | | $ |
| Charles | | $ |

| State/County | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| Dorchester | | $ |
| Frederick | | $ |
| Garrett | | $ |
| Harford | | $ |
| Howard | | $ |
| Kent | | $ |
| Montgomery | | $ |
| Prince George's | | $ |
| Queen Anne's | | $ |
| Saint Mary's | | $ |
| Somerset | | $ |
| Talbot | | $ |
| Washington | | $ |
| Wicomico | | $ |
| Worcester | | $ |
| **New Jersey** | | |
| Atlantic | | $ |
| Bergen | | $ |
| Burlington | | $ |
| Camden | | $ |
| Cape May | | $ |
| Cumberland | | $ |
| Essex | | $ |
| Gloucester | | $ |

| State/County | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| Hudson | | $ |
| Hunterdon | | $ |
| Mercer | | $ |
| Middlesex | | $ |
| Monmouth | | $ |
| Morris | | $ |
| Ocean | | $ |
| Passaic | | $ |
| Salem | | $ |
| Somerset | | $ |
| Sussex | | $ |
| Union | | $ |
| Warren | | $ |
| **New York** | | |
| Albany | | $ |
| Allegany | | $ |
| Bronx | | $ |
| Broome | | $ |
| Cattaraugus | | $ |
| Cayuga | | $ |
| Chautauqua | | $ |
| Chemung | | $ |
| Chenango | | $ |
| Clinton | | $ |

| State/County | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| Columbia | | $ |
| Cortland | | $ |
| Delaware | | $ |
| Duchess | | $ |
| Erie | | $ |
| Essex | | $ |
| Franklin | | $ |
| Fulton | | $ |
| Genesee | | $ |
| Greene | | $ |
| Hamilton | | $ |
| Herkimer | | $ |
| Jefferson | | $ |
| Kings | | $ |
| Lewis | | $ |
| Livingston | | $ |
| Madison | | $ |
| Monroe | | $ |
| Montgomery | | $ |
| Nassau | | $ |
| New York | | $ |
| Niagara | | $ |
| Oneida | | $ |
| Onondaga | | $ |

| State/County | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| Ontario | | $ |
| Orange | | $ |
| Orleans | | $ |
| Oswego | | $ |
| Otsego | | $ |
| Putnam | | $ |
| Queens | | $ |
| Rensselaer | | $ |
| Richmond | | $ |
| Rockland | | $ |
| St. Lawrence | | $ |
| Saratoga | | $ |
| Schenectady | | $ |
| Schoharie | | $ |
| Schuyler | | $ |
| Seneca | | $ |
| Steuben | | $ |
| Suffolk | | $ |
| Sullivan | | $ |
| Tioga | | $ |
| Tompkins | | $ |
| Ulster | | $ |
| Warren | | $ |
| Washington | | $ |

| State/County | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| Wayne | | $ |
| Westchester | | $ |
| Wyoming | | $ |
| Yates | | $ |

e. In the following table, indicate which of your proposed Medicare Advantage Plan rate tiers applies to each state or territory listed (e.g., "Tier 1") and enter the applicable rate (e.g., $xxx.xx). If you are not approved to provide a group Medicare Advantage Plan in a particular state or territory, mark the Rate Tier column for that state as "Not offered" and leave the Rate column blank. If you are also applying to continue providing a Legacy Benefit Plan in these states, provide the requested information on a second copy of this table in the same attachment and clearly indicate "Legacy Benefit Plan" and the name of the plan just above the table. If you are also applying to provide a New Active Benefit Plan in these states, provide the requested information on a third copy of this table in the same attachment and clearly indicate "New Active Benefit Plan" and the name of the plan just above the table.

2.

| State/Territory | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| Alabama | | $ |
| Alaska | | $ |
| Arizona | | $ |
| Arkansas | | $ |
| California | | $ |
| Colorado | | $ |
| Connecticut | | $ |
| District of Columbia | | $ |

| State/Territory | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| Georgia | | $ |
| Hawaii | | $ |
| Idaho | | $ |
| Illinois | | $ |
| Indiana | | $ |
| Iowa | | $ |
| Kansas | | $ |
| Kentucky | | $ |
| Louisiana | | $ |
| Maine | | $ |
| Massachusetts | | $ |
| Michigan | | $ |
| Minnesota | | $ |
| Mississippi | | $ |
| Missouri | | $ |
| Montana | | $ |
| Nebraska | | $ |
| Nevada | | $ |
| New Hampshire | | $ |
| New Mexico | | $ |
| North Carolina | | $ |
| North Dakota | | $ |
| Ohio | | $ |
| Oklahoma | | $ |

| State/Territory | Medicare Advantage Plan Rate Tier | Medicare Advantage Plan Rate |
|---|---|---|
| Oregon | | $ |
| Rhode Island | | $ |
| South Carolina | | $ |
| South Dakota | | $ |
| Tennessee | | $ |
| Texas | | $ |
| Utah | | $ |
| Vermont | | $ |
| Virginia | | $ |
| Washington | | $ |
| West Virginia | | $ |
| Wisconsin | | $ |
| Wyoming | | $ |
| Guam | | $ |
| Puerto Rico | | $ |
| U.S. Virgin Islands | | $ |

## ATTACHMENT 18 – *OPTIONAL*
## NEW ACTIVE MEDICARE ADVANTAGE PLAN DESIGN SUMMARY

| **HOW MUCH PARTICIPANT WILL PAY** | **<Enter ADMINISTRATOR Name and Plan Name Here>** | | |
|---|---|---|---|
| **MEDICAL**<br>*[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-<br>Specialist- | PCP-<br>Specialist- | |
| Outpatient Surgery | | | |
| Emergency Room<br>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 | | | |
| Vision Exams | | | |
| Hearing Exams | | | |
| Prescription Lenses<br>(Once every _ months) | | | |
| Hearing Aids<br>(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*
## NEW ACTIVE PRE-65 MANAGED CARE PLAN DESIGN SUMMARY

| HOW MUCH PARTICIPANT WILL PAY | <Enter ADMINISTRATOR Name and Plan Name Here> | | | |
|---|---|---|---|---|
| **MEDICAL**<br>*[Use 'NC' to designate that a service is not covered]* | **In-Network** | Check if deductible applies | **Out-of-Network** | Check if deductible applies |
| Annual Deductible | Individual-<br>Family- | | Individual-<br>Family- | |
| Annual Out-of-Pocket Maximum | Individual-<br>Family- | | Individual-<br>Family- | |
| Doctor Visits | PCP-<br>Specialist- | | PCP-<br>Specialist- | |
| Outpatient Surgery | | | | |
| Emergency Room<br>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 | | | | |
| Vision Exam | | | | |
| Hearing Exams | | | | |
| Prescription Lenses<br>(Once every _months) | | | | |
| Hearing Aids<br>(Once every _ months) | | | | |
| Dental Care | | | | |
| **PRESCRIPTION DRUGS**<br>*[Use 'NC' to designate that a tier is not covered]* | **In-Network** | | **Out-of-Network** | |
| Annual Deductible | Individual-<br>Family- | | Individual-<br>Family- | |
| Annual Maximum | Individual-<br>Family- | | Individual-<br>Family- | |
| **Retail Pharmacy**<br>*(up to a __-day supply)* | | | | |
| Generic drugs | | | | |
| Brand drugs | | | | |
| **Mail Order**<br>*(up to a __-day supply)* | | | | |
| Generic drugs | | | | |
| Brand drugs | | | | |