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 2020-01

DATE OF ISSUANCE: April 2, 2020

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

INVITATION FOR APPLICATION NUMBER: PSERS IFA 2020-01

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PART III

APPLICATION

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

12. 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 (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.

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 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.

2. 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.

3. 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.

4. 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			

Type of Medicare Plan	# of Group Plans	# of Covered Group Lives	# of Covered Individual Plan Lives
MA HMO Plans			
Total All MA 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 (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			

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. 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)			

4. 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			

State/Territory	# of Group MAPD Plans	# of Covered Group MAPD Lives	# of Covered Individual MAPD Plan Lives
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			

State/Territory	# of Group MAPD Plans	# of Covered Group MAPD Lives	# of Covered Individual MAPD Plan Lives
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 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:

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

    b. **Attachment 4** – Active 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, 2020.

    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.

2. 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"):

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

b. **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.

c. **Attachment 8** –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, 2020.

3. 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"):

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

b. **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.

c. **Attachment 20** –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, 2020.

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:

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

e. **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.

4. 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"):

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

   b. **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.

5. 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"):

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

   b. **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

6. 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.

7. 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.

8. 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 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.

    b. 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.

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:

   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 MAPD 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** 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 on a separate Attachment 15 and Attachment 16, for each Legacy Plan offered, 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 5, 2020*". When the completed rate Attachments are submitted, they will be substituted into the final Application documents.**

1. Instructions on Providing Proposed Rates.

    a. 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.

    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. The two-person and three person rates must be straight multiples of the single per person rate.

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 2021 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, 2021. For an ADMINISTRATOR approved and contracted for the 2020 calendar year, the 2021 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 – 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

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
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 Preventive Care	PCP- Specialist-	PCP- 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 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**	Check if deductible applies	**Out-of-Network**	Check if deductible applies
Annual Deductible	Individual- Family-		Individual- Family-	
Annual Out-of-Pocket Maximum	Individual- Family-		Individual- Family-	
Doctor Visits Preventive Care	PCP- Specialist-		PCP- 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 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**	Check if deductible applies	**Out-of-Network**	Check if deductible applies
Annual Deductible	Individual- Family-		Individual- Family-	
Annual Out-of-Pocket Maximum	Individual- Family-		Individual- Family-	
Doctor Visits Preventive Care	PCP- Specialist-		PCP- 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 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	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 ..... _%	

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. 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

1. In the following table, provide your proposed premium rates for the MAPD Plan and for the Pre-65 managed care plan for the PSERS regions within PA 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 MAPD 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. Two-person and/or family rates for the Pre-65 Managed Care Plan must be exact multiples of the one-person rate.
    e. If you are also applying to continue providing a Legacy Benefit Plan, provide rates for the Legacy Benefit Plan(s) on a second (or third) copy of this table in the same attachment and clearly indicate "Legacy Benefit Plan" and the name of the plan just above the table. At no time may the ADMINISTRATOR maintain more than two Legacy plans at one time.
    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	**MAPD Plan** **Plan Name:**	**Pre-65 Managed Care Plan** **Plan Name:**
Pennsylvania		
Southeast Region	$	$
North and Central Region	$	$
Southwest Region	$	$

2. In the following table, list your proposed monthly premiums to provide a MAPD Plan and a companion Pre-65 Managed Care Plan for HOP participants who reside outside PA.

    a. You may propose up to two rates for the MAPD 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. Two-person and/or family rates for the Pre-65 Managed Care Plan must be exact multiples of the one-person rate.

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 (or third) copy of this table in the same attachment and clearly indicate "Legacy Benefit Plan" and the name of the plan just above the table. At no time may the ADMINISTRATOR maintain more than two Legacy plans at one time.

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	**MAPD Plan** **Plan Name:**	**Pre-65 Managed Care Plan** **Plan Name:**
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 MAPD 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 MAPD Plan.

    a. If you are not approved to provide a group MAPD 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(s) in these states, provide the requested information on a second copy (or third) of this table in the same attachment and clearly indicate "Legacy Benefit Plan" and the name of the plan just above the table. At no time may an ADMINISTRATOR maintain more than two Legacy plans at one time.</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	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
Delaware		
Kent		$
New Castle		$
Sussex		$
Florida		
Alachua		$
Baker		$
Bay		$
Bradford		$
Brevard		$

State/County	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
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	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
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	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
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	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
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	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
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	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
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	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
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	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
Wayne		$
Westchester		$
Wyoming		$
Yates		$

e. In the following table, indicate which of your proposed MAPD 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 MAPD 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(s) in these states, provide the requested information on a second copy (or third) 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	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
Alabama		$
Alaska		$
Arizona		$
Arkansas		$
California		$
Colorado		$
Connecticut		$
District of Columbia		$
Georgia		$

State/Territory	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
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		$
Oregon		$

State/Territory	MAPD Plan Rate Tier	MAPD Plan Rate Plan Name:
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*
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 Preventive Care	PCP- Specialist-	PCP- 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 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**	Check if deductible applies	**Out-of-Network**	Check if deductible applies
Annual Deductible	Individual- Family-		Individual- Family-	
Annual Out-of-Pocket Maximum	Individual- Family-		Individual- Family-	
Doctor Visits Preventive Care	PCP- Specialist-		PCP- 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 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				