PART II –CONTRACT REQUIREMENTS AND VENDOR QUALIFICATION

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 2017-01

DATE OF ISSUANCE: March 31, 2017

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TABLE OF CONTENTS

PART II

CONTRACT REQUIREMENTS AND VENDOR QUALIFICATION

This Part sets forth the primary contract requirements and vendor qualification requirements to participate in offering a Medicare Advantage group plan and accompanying Pre-65 managed care plan for eligible Health Options Program participants.

II-1. Administrator Qualification

1. ADMINISTRATOR will make an annual application to participate in the Health Options Program for the following calendar year.

2. ADMINISTRATOR must apply by region to offer both a Medicare Advantage plan for Medicare eligible Health Options Program participants and a companion Pre-65 Managed Care Plan for Health Options Program participants not eligible for Medicare.

3. An ADMINISTRATOR making application only for a Medicare Advantage plan or a Pre-65 managed care plan will not be approved.

4. For the Out-of-State region, ADMINISTRATOR must indicate specifically each state in which ADMINISTRATOR is approved to offer both Medicare Advantage and Pre-65 Managed Care plans for this program.

5. PSERS reserves the right to approve an ADMINISTRATOR on a state by state and/or region by region basis, based on the ADMINISTRATOR's qualifications for each state or region, the number of eligible PSERS retirees residing in that state or region and on PSERS' judgment of the most advantageous plans to be offered to PSERS retirees and their dependents in that state or region. An ADMINISTRATOR will not be approved for a state or region with few PSERS retirees even if the ADMINISTRATOR is otherwise qualified to offer in that state or region, if PSERS determines that the number of PSERS retirees is not sufficient to support additional Medicare Advantage plan options.

6. PSERS reserves the right to request additional information necessary to assure that the ADMINISTRATOR's competence, number of qualified employees, business organization, financial resources and approved Medicare Advantage plans are adequate to provide the services under this agreement.

7. In the case of an ADMINISTRATOR that applies to offer a Medicare Advantage plan and to maintain an existing Legacy Benefit Plan, PSERS may approve an application to treat the Legacy Benefit Plan as the active Medicare Advantage Plan and to treat the active Medicare Advantage Plan as the Legacy Benefit Plan on a region by region basis.

II-2. Minimum Experience and Participation Standards

1. ADMINISTRATOR must demonstrate at least five years of providing continuous coverage of Medicare retirees in Medicare Advantage Plans with Prescription Drug benefits and at

least five (5) years of providing continuous coverage for pre-65 retirees in managed care plans in each region for which application is made.

2. ADMINISTRATOR must demonstrate current participation of at least 5,000 Medicare retirees in Pennsylvania in the proposed Medicare Advantage plan to be offered to PSERS.

3. ADMINISTRATOR must demonstrate current participation of at least 1,500 Medicare Advantage participants in the proposed Medicare Advantage plan in each region for which application is made.

4. ADMINISTRATOR must demonstrate current participation of at least 200 Health Options Program Medicare Advantage participants in the proposed Medicare Advantage plan in each region for which application is made. For the first two years of ADMINISTRATOR's participation, PSERS may waive this minimum number of participants requirement provided the ADMINISTRATOR demonstrates measurable progress toward attainment of 200 Health Options Program participants.

II-3. Plan Design

1. ADMINISTRATOR will provide a Centers for Medicare and Medicaid Services (CMS) approved group Medicare Advantage Plan that meets the following requirements:

    a. The plan must provide comprehensive coverage for Medicare eligible participants, including a CMS approved group Medicare Advantage Plan with Medicare Prescription Drug benefits (MA-PD).

    b. ADMINISTRATOR may offer only one MA-PD plan design for selection by eligible retirees across each region for which application is made.

    c. The plan design must maximize the ability for a participant who qualifies for the PSERS premium assistance subsidy to receive the maximum $100 per month reimbursement for premium payments.

2. ADMINISTRATOR will also provide a pre-65 group managed care plan as a companion plan to ADMINISTRATOR's group Medicare Advantage offering. The pre-65 group managed care plan must meet the following requirements:

    a. The plan must provide comprehensive coverage for medical and prescription drug benefits at least as generous as the HOP Pre-65 Medical Plan.

    b. The plan design for the pre-65 group managed care plan must be the same for each region for which application is made.

    c. The pre-65 group managed care plan must be offered in each and every location for which the ADMINISTRATOR is approved to offer its group Medicare Advantage plan.

3. ADMINISTRATOR may apply to continue providing coverage to eligible HOP participants who are grandfathered in a previously frozen group Medicare Advantage plan or pre-65

group managed care plan (collectively "Legacy Benefit Plans"). The following requirements apply to Legacy Benefit Plans:

a. ADMINISTRATOR may offer only one Legacy group Medicare Advantage plan and one Legacy pre-65 group managed care plan.

b. ADMINISTRATOR's Legacy group Medicare Advantage plan must provide comprehensive coverage for Medicare eligible participants, including Medicare Prescription Drug benefits (MA-PD), and maximize the ability for HOP participants eligible for premium assistance to obtain the full $100 per month subsidy.

c. ADMINISTRATOR's Legacy pre-65 group managed care plan must provide comprehensive coverage for medical and prescription drug benefits at least as generous as the HOP Pre-65 Medical Plan with prescription drug benefits.

d. Legacy Benefit Plans will remain frozen for new entrants.

e. Continuation of any Legacy Benefit Plan is contingent upon maintenance of at least 200 members in that program. PSERS reserves the right to withhold approval of a Legacy Benefit Plan, even if also approving the ADMINISTRATOR's active plan.

f. PSERS encourages ADMINISTRATOR to determine whether its Legacy Benefit Plan is continuing to provide a cost-effective marketplace alternative for the retirees who participate in that frozen plan and to voluntarily discontinue application for its Legacy Benefit Plan where ADMINISTRATOR believes its active plan option provides a better alternative program. PSERS also encourages ADMINISTRATOR discontinuing a Legacy Benefit Plan to conduct its own outreach to the affected participants to assure they understand the availability of ADMINISTRATOR's active plan offering.

g. Members participating in a discontinued Legacy Benefit Plan will have the option to select another plan from among all active offered plans during the next Option Selection Period.

4. ADMINISTRATOR must agree to extend the wellness and fitness programs it makes available to participants in its Medicare Advantage and pre-65 managed care plans to the participants in PSERS HOP Medical Plan and HOP Pre-65 Medical Plan, upon request by PSERS. Design and cost of the wellness and fitness program will be subject to separate negotiation should PSERS elect to exercise this option.

II-4. Provider Networks

1. ADMINISTRATOR's offered Medicare Advantage plans (including any Legacy Benefit Plans) must each include a provider network that meets CMS' requirements for Medicare Advantage plans. PSERS may accept approval by CMS of the Medicare Advantage Plan offered to PSERS as evidence of a sufficient provider network.

2. ADMINISTRATOR's offered Pre-65 Managed Care plans (including any Legacy Benefit Plans) must each include a provider network with sufficient capacity to handle PSERS' participation.

3. As part of its Application, ADMINISTRATOR must provide a list of hospitals covered for each plan in each PSERS region for which application is made.

4. ADMINISTRATOR shall provide in its application a website link to its list of providers for its Medicare Advantage Plan, Pre-65 Managed Care Plan and Legacy Benefit Plan networks. Upon request from PSERS, ADMINISTRATOR shall also provide a hard copy list of providers for these plans.

5. ADMINISTRATOR shall ensure that Negotiated Prices, as such term is defined in the Medicare Laws and Regulations and determined by PSERS, are offered to Medicare Advantage Plan Participants at all Medicare Advantage Plan Network Providers.

6. Upon PSERS' request, ADMINISTRATOR will intercede on PSERS' behalf to help resolve any dispute and/or resolve any issue regarding services provided by a network provider for ADMINISTRATOR's Medicare Advantage Plan or Pre-65 Managed Care Plan network, or by a non-network provider for a Health Options Program participant in ADMINISTRATOR's Medicare Advantage Plan or Pre-65 Managed Care Plan.

7. In no event shall ADMINISTRATOR or any network provider bill, charge, collect a deposit from, have any recourse against, or otherwise seek payment from any Medicare Advantage Plan Participant or Pre-65 Managed Care Plan Participant or Legacy Benefit Plan Participant for covered services, or any amounts due to ADMINISTRATOR from PSERS, other than copayments, returned checks and collection costs, and any similar fees in accordance with applicable Laws, including as required under Section 423.505(g)(i) of the Medicare Laws and Regulations. The provisions of this section shall not prevent ADMINISTRATOR from collecting fees in connection with a Medicare Advantage Plan, Pre-65 Managed Care Plan or Legacy Benefit Plan Participant's purchase of services that do not fall within the definition of services or covered services under this agreement.

II-5. Performance Measures and Guarantees

1. ADMINISTRATOR must agree to perform services in accordance with the following performance measures:

Performance Criteria	Performance Standard	How Measured
1. Member Telephone Response Time (Average Speed to Answer)	45 Seconds or less	Measured for all calls in the calendar quarter by dividing the total time in seconds to answer all calls, minus the total time in seconds for voice introductory messages, by the total number of calls offered.
2. Member Call Abandonment Rate	2% or less	For any calendar quarter, measured by dividing the total number of calls abandoned in that quarter by the total number of calls offered.
3. Busy Signal	5% or less	Measured for any calendar quarter by dividing the

Performance Criteria	Performance Standard	How Measured
Rate		total number of calls receiving a busy signal in that quarter by the total number of calls offered.
4. Member First Call Resolution Rate	95% of member call questions are resolved as a result of the initial call.	Reported by ADMINISTRATOR
5. Member Written Inquiry Response Time	98% or more of all "normal" correspondence within 15 business days of receipt.	"Normal" correspondence is defined as: • Coverage cancellation requests • Plan descriptive materials requests • Premium and/or coverage verification
6. Eligibility File Processing	98% or more of enrollment applications within 5 business days from receipt of CMS eligibility validation (e.g., through the MARX system).	Reported by ADMINISTRATOR
7. ID Card Turnaround	7 -10 Business Days after receipt of CMS eligibility validation	Reported by ADMINISTRATOR
8. Claim Turnaround	95% of Clean claims paid within 30 days of receipt, all other claims will be paid within 60 days of receipt.	➢ A claim is a request for a payment of a plan benefit by a plan participant or health care provider. ➢ A claim is deemed to have been received when it has been time-stamped by the vendor. ➢ Processing of a claim will be completed when it has been approved for payment, denied or pended with a request for further information. ➢ Clean claims are defined as claims that do not require additional information from outside the ADMINISTRATOR for processing.
9. Financial Payment Accuracy	99% of claims dollars submitted for payment will be accurately processed and paid.	The total of all overpayments and underpayments are subtracted from the dollar amount audited and then divided by the total paid dollars audited to determine the level of payment accuracy. Payments caused by the claimant's failure to provide adequate information that are corrected upon submission of the missing information shall not be counted as errors for the purpose of determining financial accuracy performance.
10. Claim Processing Accuracy	97% of all claims will be processed accurately.	Every claim that has a processing error shall be subtracted from the total number of claims audited and divided by total number of claims audited to determine the percentage of claim processing accuracy.
11. Account Service	98%	Measured by ADMINISTRATOR survey of Medicare Advantage and pre-65 managed care

Performance Criteria	Performance Standard	How Measured
Satisfaction		plan participants. Percentage of surveyed participants who rate ADMINISTRATOR as Positive/Favorable or above in account service.

2. ADMINISTRATOR will self-report performance against standards in item 1 above on a quarterly basis, with an additional annual performance report reflecting all four quarters. Reports will be in a format as prescribed or approved by PSERS. Reporting will be made on the ADMINISTRATOR's total book of Medicare Advantage business, until the calendar quarter in which ADMINISTRATOR reaches 5,000 total Health Options Program participants in its Medicare Advantage and companion Pre-65 Managed Care plans. For that quarter and thereafter for the remainder of the year, ADMINISTRATOR will also report results on a PSERS specific basis.

3. Each year ADMINISTRATOR must indicate in its Application for the following calendar year the amount of dollars it will put at risk for this program to meet the specified requirements.

4. Based on the self-reported performance results, ADMINISTRATOR will reimburse PSERS for any penalties due in accordance with the guarantees provided by ADMINISTRATOR in its Application. Penalties will be payable annually within 60 days of the end of the calendar year, based on performance against standards over the entire calendar year as reflected in the annual performance report.

II-6. Premium Rates

1. ADMINISTRATOR must propose a single rate tier for each of its group Medicare Advantage with Prescription Drug plans (active plan to be offered to participants and Legacy Benefit Plan) for each Pennsylvania region for which application is made. Plans with premium rates that differ by county within a region will not be approved.

2. If applying for the Out-of-State region, ADMINISTRATOR must propose no more than two rate tiers for its group Medicare Advantage with prescription drug plans (active plan to be offered to participants and Legacy Benefit Plan). Each state must be assigned only one of these two rate tiers, except Delaware, Florida, Maryland, New Jersey and New York, which may be assigned only one of the two rate tiers for each county.

3. ADMINISTRATOR must propose a single per person rate tier for its pre-65 group managed care plan that applies across every region for which application is made.

4. ADMINISTRATOR must propose calendar year rates with its Application and any final adjustment to the proposed rates upon review of the Application by PSERS. All rates must be submitted in accordance with the schedule established in Part I for the application process.

5. Premium rates for each accepted plan must remain in effect for the entire calendar year.

II-7. Reporting

1. ADMINISTRATOR agrees to provide PSERS with the following reports on the following schedule:

Report	Description	Due Date
Implementation Plan	Work elements involved to set up the proposed MA and Pre-65 plans for PSERS to become effective January 1. For an ADMINISTRATOR approved and contracted for the 2017 calendar year, the 2018 implementation plan must be submitted, but need only reflect changes to current administration to prepare for the new plan year.	Submitted with Application **(Attachment 17)**
Premium/Eligibility Reconciliation Report	Monthly report covering enrollments and terminations reconciled with premium payments	Submitted within 15 days after end of each month
Call Volume Report	Monthly report 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.	See specific reporting by enrollment level below:
	For ADMINISTRATOR with total PSERS HOP participation (Medicare Advantage and Pre-65) of 5,000 or more participants, Call Volume Report must be specific to PSERS Health Options Program group.	Within 15 days after the end of each calendar month.
	For ADMINISTRATOR with less than 5,000 PSERS HOP participants, Call Volume Report may provide book of Medicare Advantage business results, but must also identify the total number of calls reported for PSERS plans.	Within 45 days after the end of each calendar quarter, reflecting monthly, quarterly and year-to-date totals.
Medical Loss Ratio Report	Quarterly report of the medical loss ratio for each Medicare Advantage Plan and each Legacy Medicare Advantage Plan with Health Options Program retiree participation.	Within 45 days following the end of each calendar quarter

Report	Description	Due Date
Claims and Experience Report	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 a 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 j. Other supporting information as discussed and agreed. The format of this quarterly report may be proposed by ADMINISTRATOR at the time its participation reaches 1,000, but the format must include all identified data elements.	Within 45 days following the end of each calendar quarter
Final Annual Report	A summary of the year's activities and experience. ADMINISTRATOR may meet this requirement by including its final monthly or quarterly reports required above, provided such reports show the year-to-date activity for the entire calendar year.	Within 45 days following the end of the calendar year

Report	Description	Due Date
Appeals and Grievance Report	Listing of appeals and grievances sent by secure email message.	Due no later than 25 days following end of each month.

II-8. Customer Service

1. ADMINISTRATOR must provide an adequate number of customer service inquiry toll-free telephone lines to handle plan and claims inquiries from current Health Options Program participants and from PSERS' retirees interested in ADMINISTRATOR's Medicare Advantage and/or pre-65 managed care plans offered through the Health Options Program.

    a. ADMINISTRATOR's toll-free telephone lines must be open from 8:00 a.m. to 6:00 p.m., Eastern Time, Monday through Friday, for the first two weeks (typically October 1 through October 15) of the annual open enrollment or option selection period, and from 8:00 a.m. to 5:00 p.m., Eastern Time, for the remainder of the year.

    b. ADMINISTRATOR must provide an adequate number of customer service representatives to staff these customer service lines, especially during the first two weeks of the annual open enrollment or option selection period.

    c. ADMINISTRATOR must ensure that the customer service staff is fully trained and knowledgeable about the Health Options Program, and capable of addressing Medicare Advantage Plan Participant inquiries and/or issues including, but not limited to: plan provisions, copayments, enrollment status, claim status, preadmission certification program provisions, and grievances and appeals.

    d. ADMINISTRATOR must refer all questions and issues regarding Health Options Program retiree eligibility for benefits, enrollment options available, and application procedures to PSERS' TPA - the HOP Administration Unit.

2. ADMINISTRATOR must provide prompt mailing of requested plan informational materials and application forms.

3. ADMINISTRATOR must provide a web link specifically for PSERS Health Options Program participants that will be included in program materials provided by PSERS and in plan materials provided by ADMINISTRATOR to plan participants.

    a. The web link should connect to a welcome page for PSERS participants on ADMINISTRATOR's web site.

    b. The welcome page must include contact information and links to the HOP Administration Unit toll-free number for eligibility questions.

c. From the welcome page, a participant may be directed to ADMINISTRATOR's standard web site functions. ADMINISTRATOR is not required to provide links returning the participant to the Health Options Program welcome page.

4. In any year for which an ADMINISTRATOR's total PSERS Health Options Program participation in all plans exceeds 5,000, ADMINISTRATOR must provide a toll-free number and customer service function that is dedicated or specially designated to handle questions from PSERS Health Options Program participants.

II-9. Administration Requirements

ADMINISTRATOR agrees to provide its approved Medicare Advantage Plan, Pre-65 Managed Care Plan and Legacy Benefit Plans to all eligible Health Options Program Members in coordination with PSERS and its TPA. The following rules apply to such plan administration:

1. Implementation

   a. ADMINISTRATOR must coordinate with PSERS' TPA to set up required eligibility processes and financial transaction processes.

   b. ADMINISTRATOR must provide PSERS and its TPA a current list of ADMINISTRATOR's staff contacts for this program, including the account manager, the customer service manager, the financial contact, and the senior manager responsible for the account, as well as other ADMINISTRATOR staff members directly involved with the administration of this account. Any changes of personnel by ADMINISTRATOR in the listed categories must be reported to PSERS within 10 days of the change.

   c. ADMINISTRATOR must provide PSERS' TPA with plan related data and information exchange in a standard format on a pre-determined schedule to be agreed with PSERS' TPA.

   d. ADMINISTRATOR must establish a toll-free customer service unit to answer questions concerning the new plan beginning on October 1 and link its customer service unit with customer service representatives of the TPA's HOP Administration Unit.

   e. By September 14, ADMINISTRATOR must certify immediate readiness to receive telephone inquiries from Health Options Program participants and PSERS retirees on ADMINISTRATOR's approved plans.

   f. ADMINISTRATOR must offer PSERS' TPA electronic access to ADMINISTRATOR's plan eligibility, account, and utilization information. Ability to enroll participants on ADMINISTRATOR's system is not intended.

2. Enrollment and Termination

   a. PSERS shall retain complete and exclusive discretionary authority to determine participant eligibility under any plan approved and offered by ADMINISTRATOR.

PSERS acknowledges that ADMINISTRATOR must submit enrollments and disenrollments to CMS, which maintains final authority for acceptance of an eligible participant for coverage under ADMINISTRATOR's offered Medicare Advantage Plan or Legacy Medicare Advantage Plan.

b. PSERS' TPA will receive applications directly from Health Options Program participants who elect to participate in ADMINISTRATOR's Medicare Advantage Plan or Pre-65 Managed Care Plan, and will update participant's record and forward applications to ADMINISTRATOR for enrollment.

c. ADMINISTRATOR shall process enrollment and termination transactions as received from PSERS' TPA.

d. ADMINISTRATOR must provide enrollment and termination data records to PSERS' TPA on a regular basis and in a standard format and process.

e. ADMINISTRATOR must confirm all enrollments processed to PSERS' TPA.

f. ADMINISTRATOR must issue plan identification cards to individuals enrolling in its approved Medicare Advantage Plan or Pre-65 Managed Care Plan. Identification cards shall be issued on or before:
   1. December 31 for enrollments received in conjunction with the Option Selection Period (or Open Enrollment period, if approved by the Board).
   2. Thirty (30) days following receipt of enrollment records for eligible Health Options Program participants received outside of the Option Selection Period or Open Enrollment Period.
   3. The date required by CMS for issuance of identification cards following CMS' approval of a Medicare Advantage participant's enrollment.

3. Premium Administration and Reconciliation

a. PSERS, or its TPA, will provide ADMINISTRATOR with electronic eligibility data in PSERS' standard format for all eligible participants enrolled in ADMINISTRATOR's Medicare Advantage Plan, Pre-65 Managed Care Plan or Legacy Benefit Plans who are entitled to services or benefits.

b. ADMINISTRATOR must load correctly formatted participant eligibility updates or full files within seventy-two (72) business hours after receipt from PSERS or its TPA.

c. ADMINISTRATOR will accept premium payments from the TPA on behalf of plan enrollees. The Plan will be required to provide adjusted rates for those members who are Low-Income Subsidy eligible or who must incur a Late Enrollment Penalty, in compliance with Medicare Part D regulations, if applicable.

d. ADMINISTRATOR must coordinate all Health Options Program participant premium billing through PSERS' TPA. Premiums will be deducted from members' retirement benefit checks or the TPA will direct-bill members according to agreed-upon rates.

e. ADMINISTRATOR agrees to adjust rates at the member level for any members who are Low-Income Subsidy eligible or who must incur a Late Enrollment Penalty, in compliance with Medicare Part D regulations, if applicable.

f. ADMINISTRATOR must reconcile monthly enrollment and premium payment information with PSERS' TPA on or before 45 days following the beginning of the month.

4. Claims

ADMINISTRATOR shall be responsible for paying all claims for Health Options Program participants in ADMINISTRATOR's Medicare Advantage Plan, Pre-65 Managed Care Plan and Legacy Benefit Plans.

5. Communications and Enrollment Materials

a. PSERS will apprise participants in ADMINISTRATOR's Medicare Advantage Plan, Pre-65 Managed Care Plan, and Legacy Benefit Plans of the type, scope, restrictions, limitations, and duration of benefits to which its participants are entitled. PSERS will provide such information to participants as part of a regular option selection period or open enrollment participant statement or information package.

b. ADMINISTRATOR shall prepare customized communications materials regarding its approved Medicare Advantage Plan, Pre-65 Managed Care Plan and Legacy Benefit Plans for each plan year. Materials must be available for all plans no later than October 1.

c. ADMINISTRATOR must provide a supply of plan materials (including applications, brochures, Evidence of Coverage booklets and other related materials) to PSERS' TPA for use during the Option Selection Period or Open Enrollment and also for use with participants who request materials during the year.

d. PSERS' TPA will send ADMINISTRATOR's materials directly to the requesting participant, or arrange for ADMINISTRATOR to send such materials directly to the participant.

e. ADMINISTRATOR must provide to PSERS and its TPA sample current copies of its identification cards and materials that will be included in the identification card mailer for each plan. Where allowable, the cards should reflect customization for the PSERS Health Options Program account name and the HOP Administration Unit telephone number for eligibility questions.

f. ADMINISTRATOR must provide summary plan descriptions and other plan related information to members on a timely basis. All enrollment information, materials, and major member announcements, except Medicare required communications approved by CMS for ADMINISTRATOR's Medicare Advantage Plan, must be submitted to PSERS for approval in advance of release and must be coordinated with the TPA.

6. Prevention of Fraud, Waste and Abuse

a. ADMINISTRATOR shall use reasonable efforts to implement and maintain an effective Medicare Advantage compliance program as necessary to comply with the Medicare Laws and Regulations. PSERS shall, upon request, have the right to review the ADMINISTRATOR'S Medicare Advantage compliance program.

b. ADMINISTRATOR shall maintain fraud, waste and abuse policies and procedures for its Pre-65 Managed Care Plan and Legacy Benefit Plans covering non-Medicare eligible participants as required by the U.S. Department of Health and Human Services for the Early Retiree Reinsurance Program.

7. Appeals and Grievances

a. ADMINISTRATOR shall provide PSERS and the participants in its Medicare Advantage Plan, Pre-65 Managed Care Plan and Legacy Benefit Plans with its stated appeals and grievances services for the plans offered under the agreement in which the participant is enrolled.

b. ADMINISTRATOR shall be responsible for receiving, resolving and tracking all coverage, determinations, appeals and grievances, except grievances related to eligibility.

c. ADMINISTRATOR shall direct all grievances related to eligibility to PSERS in a timely manner. The provisions of the Agreement relating to appeals and grievance services may be revised as necessary to maintain compliance with the Medicare Laws and Regulations.

d. ADMINISTRATOR shall provide a monthly report to PSERS of all coverage determinations and appeals and grievance decisions regarding participants in ADMINISTRATOR's Medicare Advantage Plan, Pre-65 Managed Care Plan, or Legacy Benefit Plan. The report shall be provided monthly on or before the 25th day of the following month. The notice shall be sent by secure email to the Executive Director of PSERS (with a copy to Franca D'Agostino, Director, Health Insurance Office).

e. ADMINISTRATOR shall also provide a written response to the Medicare Advantage Plan, Pre-65 Managed Care Plan, or Legacy Benefit Plan participant for all grievances processed by ADMINISTRATOR that could not be satisfactorily resolved via a telephone conversation.

II-10. Cost Sharing for Enrollment Materials and Communications

1. ADMINISTRATOR must agree to share proportionally in PSERS' annual cost of the annual Option Selection Period (or Open Enrollment period, if approved by the Board).

2. The amount to be paid by ADMINISTRATOR will be based on the ADMINISTRATOR's current number of Health Options Program members participating in ADMINISTRATOR's plans and on the number of eligible Health Options Program members included in the Option Selection Period (or Open Enrollment, if authorized by the Board) in each region for which ADMINISTRATOR is approved to offer plans. This will reflect both the

ADMINISTRATOR's current proportional participation and the proportional opportunity offered to the ADMINISTRATOR' to gain new participants.

3. The ADMINISTRATOR's share of the cost will be the sum of the following formulas:

    a. Ratio 1 – Current Participation Allocation

        1) Number of Health Options Program participants in ADMINISTRATOR's Medicare Advantage Plan, pre-65 managed care plan, and Legacy Benefit Plans,

        2) Divided by the total of all Health Options Program participants in PSERS' Self-insured medical programs (HOP Medical Plan and Pre-65 HOP Medical Plan) and all ADMINISTRATORS' Medicare Advantage Plans, pre-65 managed care plans and Legacy Benefit Plans,

        3) Multiplied by the total allocable communication and enrollment cost, and

        4) Further multiplied by 60% weighting.

    b. Ratio 2 – Market Population Allocation

        1) Number of Health Options Program participants eligible to make plan selections during the Option Selection Period (or Open Enrollment, if authorized by the Board) in all regions for which ADMINISTRATOR is approved to offer plans,

        2) Divided by the sum of the number calculated in 1) for PSERS and for all ADMINISTRATORS approved to offer coverage for the year, and

        3) Multiplied by the total allocable communication and enrollment cost, and

        4) Further multiplied by 40% weighting.

    c. Sum of a. and b. equals ADMINISTRATOR's marketing and communication cost allocation for the year.

4. PSERS will bill ADMINISTRATOR directly for its proportional share of such costs. ADMINISTRATOR will pay its share of marketing expense within 45 days of receipt of billing.

II-11. Health Options Program Name and Mark Utilization and Meeting Requirements

1. ADMINISTRATOR must include PSERS Health Options Program branding on materials and member communications for the contracted plan, to the extent allowed under CMS marketing and communication rules.

2. ADMINISTRATOR agrees to have all member enrollment materials and communications outside of standard Medicare Advantage communications pre-approved by PSERS or its TPA.

3. In the event ADMINISTRATOR desires to hold participant enrollment meetings to promote its approved Medicare Advantage Plan and Pre-65 Managed Care Plan, the following guidelines describe the circumstances under which PSERS will allow its Health Options Program name and logo to be used for such enrollment meetings.

    a. Any enrollment meeting referencing the Health Options Program must be exclusive to Health Options Program participants and conducted by ADMINISTRATOR representatives familiar with the specific plan(s) offered to Health Options Program participants. The advertisement may say the meeting is authorized by the Health Options Program, but must make clear that the meeting will only cover information about the ADMINISTRATOR's plans and not other program options.

    b. ADMINISTRATOR must communicate in advance to PSERS the dates, times and locations of proposed meetings. The communication of this information must be completed at least two weeks in advance of the meeting or the beginning of the Option Selection Period (normally October 1) whichever is earlier.

    c. ADMINISTRATOR will only be allowed to market or discuss its PSERS-approved Medicare Advantage Plan and Pre-65 Managed Care Plan at the meetings. ADMINISTRATOR is strictly prohibited from presenting or marketing any non-Health Options Program individual or other group insurance plan product offered by ADMINISTRATOR or by any of its affiliate companies.

    d. ADMINISTRATOR may answer questions from meeting participants about its Legacy Benefit Plans, but may not market or promote such frozen plans. ADMINISTRATOR must represent to participants that they are open to select another available plan option, including the ADMINISTRATOR's approved plan, but will be frozen out of future participation in the Legacy Benefit Plan if a new plan is selected.

    e. All materials to be presented at the ADMINISTRATOR-sponsored meeting(s) must be reviewed and approved by PSERS in advance of the meeting.

    f. All signage or presentation materials (e.g., Power Point slides) bearing the PSERS Health Options Program logo or reference must be reviewed and approved by PSERS in advance of the meeting.

    g. The ADMINISTRATOR may advertise the meetings in general media, such as newspaper, radio, television, etc., and may send materials to Health Options Program members enrolled in one of the ADMINISTRATOR's plans based on addresses on file at the ADMINISTRATOR. PSERS will not provide a mailing list either of Health Options Program participants or of eligible PSERS retirees.

    h. ADMINISTRATOR agrees to provide PSERS a summary of each meeting within two weeks of the date of the meeting, with the summary to include the number of attendees, the materials presented and any questions raised by participating retirees that should be called to PSERS' attention.

    i. The ADMINISTRATOR will bear the full cost of any expenses associated with organizing or conducting the meeting(s).

j. PSERS reserves the right to have a staff member or designated representative attend the meetings to assure compliance with these rules.

k. PSERS will bear no responsibility or liability for any representations made by the ADMINISTRATOR at the meeting.

l. These guidelines must be adhered to strictly. PSERS will be the final authority on the interpretation of these guidelines.