# Exhibit 4

# HMO Plan Design

**[Supplier Name]**

**Plan Year 2023**

# Instructions

1. Benefits must conform to the Plan Design Description of Scope found at the end of this document.
2. All plan design options must correspond to Exhibit 5, HMO Premium Quotes.
3. Column “PY2023 No Plan Changes” is required for **all Bidders** and should list complete plan benefits.
   1. For Bidders with current contracts with the OEIBA Program, this column should list the Supplier’s current plan characteristics with no changes.
4. Only Bidders with current contracts have the option to also complete column “PY2023 with Proposed Plan Changes.”
   1. This column should include all PY2022 plan characteristics along with proposed plan changes for PY2023. **Proposed plan changes must be in bold**.
5. Plan design(s) must be from the member’s perspective.
6. No more than one (1) HMO plan proposed by the Supplier will be selected for PY2023.
7. HMO Plan Design must be signed by the Supplier’s President, Chief Executive Officer or authorized representative.

**Example**

|  |  |  |
| --- | --- | --- |
|  | **PY2023**  **No Plan Changes**  **(Required for all Bidders)** | **PY2023**  **With Proposed Plan Changes (Optional only for current suppliers)** |
| **PROFESSIONAL SERVICES**   * PCP (per visit) * Specialist (per visit with authorization) | $30 copay/PCP  $30 copay/specialist | $30 copay/PCP  **$50 copay/specialist** |

**HMO Plan Design Proposal(s)**

|  |  |  |
| --- | --- | --- |
|  | **PY2023**  **No Plan Changes**  **(Required)** | **PY2023**  **With Proposed Plan Changes**  **(Optional)** |
| **Calendar Year Deductible**  **Note:** Supplier’s HMO Plan cannot impose any type of an annual deductible. | No deductible | No deductible |
| **Calendar Year Out-of-Pocket Maximum** (Individual, Family)  This includes [medical and/or pharmacy] |  |  |
| **Office Visit** (PCP, Specialist, authorization) |  |  |
| **X-Ray and Lab** (routine X-ray and lab, MRI, CAT, MRA, PET, CT, EEG, ECG, MPS, etc.) |  |  |
| **Allergy Testing and Treatment** (PCP, Specialist, antigen and administration, testing per series.)  Serum and shots, including a six (6) week supply of antigen and administration. |  |  |
| **Preventive Services** (PCP, Specialist) Must conform to federal preventive care guidelines. |  |  |
| **Well-Child Care** |  |  |
| **Immunizations** |  |  |
| **Hearing Screening and Hearing Aid** |  |  |
| **Hospital Inpatient** (per day, maximum admission, preauthorization) |  |  |
| **Hospital Outpatient** |  |  |
| **Emergency Room**  (Physician, facility, waived if hospitalized) |  |  |
| **Urgent Care** (Include after-hours urgent care services). |  |  |
| **Maternity Pre and Postnatal Care** (visit, admission, max admission) |  |  |
| **Durable Medical Equipment** (initial device, repair and replacement) |  |  |
| **Mental Health or Substance Use Disorder Inpatient**  **NOTE:** The HMO is responsible for providing a benefit that conforms to Mental Health Parity regulations. |  |  |
| Mental Health or Substance Use Disorder **O**utpatient  **NOTE:** The HMO is responsible for providing a benefit that conforms to Mental Health Parity regulations. |  |  |
| **Occupational or Speech Therapy Visit** (inpatient, outpatient, limits) |  |  |
| **Physical Therapy or Physical Medicine Visit** (inpatient, outpatient, limits) |  |  |
| **Chiropractic and Manipulative Therapy Visit** (limits) |  |  |
| **BLOOD AND BLOOD PRODUCTS** |  |  |
| **MEDICAL TRANSPORTATION SERVICES** |  |  |
| **HOME HEALTH SERVICES** |  |  |
| **HOSPICE** |  |  |
| INFERTILITY SERVICES (Include diagnosis and some treatment including drug treatment) |  |  |
| Bariatric Surgery |  |  |
| CDC APPROVED nATIONAL Diabetes Prevention Program |  |  |
| **TELEHEALTH/TELEMEDICINE** |  |  |
| **BLOOD AND BLOOD PRODUCTS** |  |  |
| **MEDICAL TRANSPORTATION SERVICES** |  |  |
| HOME HEALTH SERVICES |  |  |
| HOSPICE |  |  |
| INFERTILITY SERVICES(Include diagnosis and some treatment including drug treatment) |  |  |
| SKILLED NURSING FACILITY |  |  |
| **TMD** (Lifetime non-surgical maximum of $1,500. Surgery is under medical.) |  |  |
| **TRANSPLANTS** |  |  |
| **DESCRIPTION OF ANY NETWORK VARIATION** |  |  |
| **Pharmacy Benefits**  Specify the following.  Retail 30-day Supply, Retail 90-day Supply, Mail-Order   * Preferred or Select Generic * Preferred brand * Non-preferred drugs * Specialty * Insulin |  |  |

**PROPOSED HMO PLAN DESIGN(S)**

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Signature Printed Name Date

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

Title Supplier Name

(To be signed by the Supplier’s President, Chief Executive

Officer or authorized representative.)

**PLAN DESIGN DESCRIPTION OF SCOPE**

**PREVENTIVE HEALTH SERVICES**

The Supplier must provide for preventative health services that are compliant with a non-grandfathered health plan as defined by PPACA.

**PROFESSIONAL SERVICES**

The Supplier must provide medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Coverage must include surgery, assistant surgery and anesthesia (inpatient or outpatient); non-dental related oral surgery; inpatient hospital and skilled nursing facility visits; professional office visits including visits for radiation therapy, chemotherapy, dialysis treatment, and home visits when medically necessary.

**HOSPITAL**

The Supplier must provide for inpatient and outpatient hospital services as defined below.

**Inpatient:** General hospital services, in a semi-private room, meals (including special diets as medically necessary), and general nursing care. Includes all medically necessary ancillary services such as use of operating room and related facilities; intensive care unit and services; prescribed drugs, medications, and biologicals; anesthesia and oxygen; diagnostic, laboratory and x-ray services; special duty nursing as medically necessary; respiratory therapy; radiation therapy; perfusion, delivery; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.

Includes inpatient hospital services in connection with dental procedures when hospitalization is required due to an underlying medical condition and clinical status or because of the severity of the dental procedure.

**Outpatient:** Services performed at a hospital or outpatient facility which shall include hospital services that can reasonably be provided on an ambulatory basis; and related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the individual’s stay at the facility.

Includes outpatient services in connection with dental procedures when the use of a hospital or outpatient facility is required due to an underlying medical condition and clinical status or because of the severity of the dental procedure.

**EMERGENCY HEALTH CARE SERVICES**

The Supplier must provide coverage for twenty-four hour emergency department screening and care to achieve stabilization as needed for conditions that reasonably appear to constitute a life or limb threatening emergency based on the presenting symptoms of the patient for both in and out of service area.

**MEDICAL TRANSPORTATION SERVICES**

The Supplier must provide emergency air or land ambulance transportation in connection with emergency services to the first hospital or urgent care center which actually accepts the individual for emergency care.

Subject to prior authorization, ambulance transportation for the transfer of an individual from a hospital to another hospital or facility or home when medically necessary and approved by the medical plan.

*Excludes transportation in the form of public conveyance such as airplane, passenger car, or taxi.*

**DIAGNOSTIC X-RAY AND LABORATORY SERVICES**

The Supplier must provide medically necessary diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services subject to plan protocols and preauthorization.

**PRESCRIPTION DRUGS**

The Supplier must provide benefits for prescription drugs as defined below.

Medically necessary drugs which are prescribed by a physician or dentist. Includes injectable medication, injectable and oral insulin, needles, ostomy bags, ostomy wafers, syringes necessary for the administration of the covered injectable medication, blood glucose testing strips and lancets, and oral contraceptives. Also includes prenatal vitamins and vitamins with fluoride which require a physician’s prescription.

Medically necessary drugs administered while member is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when provided through a participating pharmacy unless these charges are covered under the plan’s hospital or medical benefit.

*Excludes experimental or investigational drugs****, unless required by law****; accepted for use by the standards of the medical community; drugs or medications for cosmetic purposes; patent or over-the-counter medicines, or medicines not requiring a written prescription order; and dietary supplements, appetite suppressants or any other diet drugs or medications.*

The HMO is required to provide a definition for each of the three (3) tier categories based on the HMOs pharmaceutical formulary plan design. The definition for each of the three (3) tier categories as defined by the HMOs pharmaceutical formulary plan design shall remain unchanged and consistent throughout the term of the Plan Year. However, the HMO can change the formulary if such a change results in a less expensive copayment to members. HMOs are strictly prohibited from amending the definition of the three (3) tier categories at any time during the term of the contract.

The HMO can design its formulary to provide drugs to members at no cost during the Plan Year.

The HMO’s current pharmaceutical formulary must be provided with the HMO’s proposal.

Additional distribution of the pharmaceutical formulary must be provided pursuant to the requirements specified in this RFP.

If the cost of the prescribed medication(s) is less than the copayment, the HMO is prohibited from charging the member more than the cost of the prescribed medication(s).

**PHYSICAL AND MANIPULATIVE THERAPY**

The Supplier must provide physical, occupational, or speech therapy benefits provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or patient’s home. Benefits must also include chiropractic and manipulative therapy.

**MENTAL HEALTH**

The Supplier must provide benefits for the inpatient and outpatient treatment of mental illness. Benefits for the treatment of severe mental illness must also be included. The HMO is responsible for providing a benefit that conforms to Mental Health Parity regulations.

**SUBSTANCE ABUSE**

The Supplier must provide benefits for the treatment of substance abuse for both inpatient and outpatient settings. The HMO is responsible for providing a benefit that conforms to Mental Health Parity regulations.

**ALLERGY TREATMENT AND TESTING**

The Supplier must provide benefits for intradermal and percutaneous allergy testing including serum and allergy shots.

**DURABLE MEDICAL EQUIPMENT (DME)**

The Supplier must provide benefits for durable medical equipment.

**MATERNITY**

The Supplier must provide for medically necessary professional and hospital services related to maternity care including pre-natal and post-natal care, complications of pregnancy, and delivery. Includes any professional or hospital services related to a newborn adoption as required by law. Services for birth mother of newborn adoption are not covered unless the birth mother is a member of the plan.

**INFERTILITY SERVICES**

The Supplier must provide coverage for the diagnosis and some treatment for infertility.

**HOME HEALTH SERVICES**

The Supplier must provide coverage for home health services.

**HOSPICE**

The Supplier must provide for hospice care.

**SKILLED NURSING CARE**

The Supplier must provide for services prescribed by a plan physician and provided in a licensed skilled nursing facility when medically necessary.

**TRANSPLANTS**

The Supplier must provide coverage for medically necessary organ, tissue and bone marrow transplants which are not experimental or investigational in nature.

**BARIATRIC SURGERY**

The Supplier must provide coverage for bariatric surgery and any additional bariatric procedures.

**NATIONAL DIABETES PREVENTION PROGRAM**

The Supplier must provide coverage for the CDC-recognized Diabetes Prevention Program.