Choices Guide Page – General Instructions

Review these general instructions along with the sample *Choices* pages provided.

All plans must include coverage levels and enrollee costs for the following benefits:

Physician Services
Specialist Services
Radiology:
(X-rays, CAT scans, MRIs, ultrasounds)
Lab Tests
Pathology
EKG/EEG
Radiation
Chemotherapy
Pap Tests
Mammograms
Pre and Postnatal Visits
Bone Density Tests
Family Planning Services
Infertility Services
Contraceptive Drugs and Devices
Inpatient Hospital Surgery
Outpatient Surgery
Emergency Room
Urgent Care Facility
Ambulance (must note if airborne ambulance transportation is excluded)
Outpatient Mental Health (Individual and Group)
Inpatient Mental Health
Outpatient Drug/Alcohol Rehabilitation
Inpatient Drug/Alcohol Rehabilitation
Durable Medical Equipment
Prosthetic Devices
Orthotic Devices
Inpatient Rehabilitative Care:
(physical, speech & occupational therapy)
Outpatient Rehabilitative Care:
(physical, speech & occupational therapy)
Diabetic Supplies, Insulin & Oral Agents, Diabetic Shoes
Hospice
Skilled Nursing Facility
Prescription Drugs
Specialty Drugs
Dental
Vision
Hearing Aids
Out of Area Services
Home Health Care

In your electronic submission, you will be asked to specify the associated amount of out-of-pocket expense to the member for each benefit and the basis upon which the expense will be charged. For example: $/visit; $/1st - 10th visits then $/visit thereafter; $/item; % coinsurance.
If there is no out-of-pocket expense associated with a specific benefit, the appropriate response is “No copayment.” If the benefit is not covered, indicate “Not covered.”
You will be asked to enter the maximum number of visits, the maximum number of days or the number of days’ supply as appropriate.

The description of your prescription drug benefit must include:

- The type of Prescription Drug Formulary employed by your HMO (e.g., Closed or Incented Formulary).

You will be asked to indicate the applicable copayment per prescription and associated number of days for the prescription drug supply for the retail and mail order prescription drug benefit. (The copayment for self-injectable drugs, including fertility drugs, must be the same as the copayment for other covered drugs.) If your HMO has more than a single copayment benefit structure, include additional copayment lines as necessary. For example:

Retail, #-day supply
$$ Tier 1
$$ Tier 2
$$ Tier 3

Mail Order, #-day supply
$$ Tier 1
$$ Tier 2
$$ Tier 3

If your HMO has a web site for member viewing, you will be asked to include the web site address in HMO ePage, the electronic *Choices* Page interface you complete for the proposal.

Two additional pages will be allowed in *Choices* for HMOs that have a Medicare benefit that is substantially different from the benefit for non-Medicare primary individuals. Typically, these additional pages are used for Medicare Advantage products. HMOs that have a Medicare benefit identical to the non-Medicare primary benefit (those HMOs that coordinate coverage with Medicare) will have only two pages for listing benefits.

Sample Choices Pages:

HMO Name/Logo

Benefits	Enrollee Cost
Office Visits	$ per visit
Annual Adult Routine Physicals	$ per visit
Well Child Care	$ per visit
Specialty Office Visits	$ per visit
Diagnostic/Therapeutic Services	
Radiology	$ per visit
Lab Tests	$ per visit
Pathology	$ per visit
EKG/EEG	$ per visit
Radiation	$ per visit
Chemotherapy	$ per visit
Women's Health Care/OB GYN	
Pap Tests	$ per visit
Mammograms	$ per visit
Prenatal Visits	$ per visit
Postnatal Visits	$ per visit
Bone Density Tests	$ per visit
Family Planning Services	$ per visit
Infertility Services	$ per visit
Contraceptive Drugs	Applicable Rx copayment
Contraceptive Devices	Applicable Rx copayment
Inpatient Hospital Surgery	$ copayment
Outpatient Surgery	
Hospital	$ copayment
Physician's Office	$ copayment
Outpatient Surgery Facility	$copayment
Emergency Room	$ per visit
Urgent Care Facility	$ per visit
Ambulance	$ per trip
Outpatient Mental Health	
Individual	$ per visit
Group	$ per visit
Inpatient Mental Health max # days	No copayment

Benefits	Enrollee Cost
Outpatient Drug/Alcohol Rehab	
max # visits	$ per visit
Inpatient Drug/Alcohol Rehab	
max # days each	No copayment
Durable Medical Equipment	$ per item
Prosthetics	$ per item
Orthotics	$ per item
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient, max # days	No copayment
Outpatient, max # visits	$ per visit
Outpatient Speech Therapy	max # days
Diabetic Supplies	
Insulin and Oral Agents	$ per item
Diabetic Shoes, max # pairs	$ per pair
Hospice, max # days	No copayment
Skilled Nursing Facility	
max # days	No copayment
Prescription Drugs	
Retail, 30-day supply $ generic/$ formulary brand /$non-formulary	
Mail Order, 90-day supply $ generic/$ formulary brand/$ non-formulary	
Coverage includes fertility drugs, injectable/self injectable medications and enteral formulas.	
Specialty Drugs (Describe how drugs are obtained, including copayment/coinsurance amounts, coverage limits, exclusions, etc.)	

Sample Choices Pages:

Additional Benefits	Enrollee Cost
Annual Out-of-Pocket Maximum (In-Network Benefits)	per Individual per Family per year
Dental	$ per visit
Vision	$ per visit
Hearing Aids	$
Out of Area Describe coverage available to enrollees while traveling outside the HMO service area.	
HMO may also list other benefits not covered by the minimum benefit requirements. Examples: Wellness Services, Smoking Cessation	
Plan Highlights for 2016 (General marketing language or new highlights)	
Participating Physicians (Descriptive text)	
Affiliated Hospitals (Descriptive text – refer enrollees to customer services number if volume of hospitals is too extensive to list.)	
Pharmacies and Prescriptions (Descriptive text – include **Incented Formulary** or **Closed Formulary)**	
Medicare Coverage (Descriptive text – include **Medicare Advantage Plan** or **Coordinates Coverage with Medicare** as appropriate.)	

NYSHIP CODE NUMBER
(To be determined for new HMOs only).

A (model type) HMO serving
Individuals living or working in (HMO Service Area as approved by the Joint Labor Management Committees on Health Benefits).

HMO Name
HMO Address

For Information:
Customer Service: 800-XXX-XXXX
TTY: 800-XXX-XXXX
Web site: www.hmoname.com

Note: You will have approximately 3,000 characters to describe all benefits on this second page, not including the NYSHIP Code number section (See blue box above. The text in this box does not count toward the 3,000-character limit).
You may elaborate on the sections you choose, but bear in mind that there is an overall character limit.