SECTION 5: TECHNICAL PROPOSAL REQUIREMENTS

The purpose of Section 5 of the Specifications is to set forth the submissions required of the Offeror. The Offeror's Technical Proposal must contain responses to all required submissions from the Offeror in the format requested. Each Offeror's Technical Proposal will be evaluated based on the responses to the required submissions contained in Section 5 of these Specifications.

5.1 Plan Requirements

The Offeror must provide a copy of their current DOH Certificate of Authority to operate an HMO.

Please refer to Exhibit I for a copy of our Public Health Law Article 44.

In addition, the Offeror must:

1. Submit a copy of the draft NYSHIP Dependent Eligibility Rider that the organization will file with the DFS. A draft *2020 NYSHIP Dependent Eligibility Rider* (Attachment 19) provides the NYSHIP dependent eligibility requirements. The HMO must include this Rider, approved by the DFS, as part of its proposed benefit package.

   The NYSHIP Dependent Eligibility Rider form EXR-366 (Rev.1) is located in the Certificate and can be found in Exhibit II HMOBlue $25 with Drug and HMOBlue $25 without Drug Certificates as part of the proposed benefit package.

2. Indicate whether or not the HMO will be proposing a Medicare Advantage offering.

   Excellus BlueCross BlueShield (BCBS) will continue to offer the 2021 Medicare Advantage Plan offering in approved service area(s) with minimal changes.

3. Provide a list of Counties and associated rating region configuration for the HMO's proposed 2021 NYSHIP Service Area. Counties must be contiguous and listed for both Commercial Plan and Medicare Advantage Plan, if offered through NYSHIP. The Medicare Advantage Plan Service Area must be identical to the Commercial Plan and all counties must be CMS approved. However, additional participation in underserved counties is permissible during the term of the Contract. As of January 1, 2020, the Department, in consultation with the JLMC, considers Chemung, Schuyler, Rockland, Bronx, New York, Richmond, Queens, Kings, Nassau, and Suffolk counties in New York State to be underserved. The Department, in consultation with the JLMC currently defines an "underserved county" as a county in which, in addition to the Empire Plan, only one (1) NYSHIP HMO is offered. The definition of an "underserved county" is subject to change for any given plan year by the Department in consultation with the JLMC.

   Please refer to Exhibit III for a copy of the Excellus Health Plan, Inc. service area for both HMOBlue $25 and the Medicare Advantage (Medicare Blue Choice) plan.

Excellus BCBS service area for the HMOBlue $25 copay option plan consists of the following counties:

Broome, Cayuga, Chemung, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, St. Lawrence, Schuyler, Steuben, Tioga, and Tompkins counties.

There is no change in the service area from 2020 for the NYSHIP HMOBlue $25 copay option plan offering.

The service area for the Medicare Advantage (Medicare Blue Choice HMO) plan under NYSHIP Code Number 072 and 160 will consist of the following counties:

Broome, Cayuga, Chemung, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, St Lawrence, Schuyler, Steuben, Tioga, and Tompkins counties.

4. Provide a copy of your organization's most recent annual filing of Schedule M (Complaints).

Please refer to Exhibit IV for a copy of the Excellus Health Plan, Inc. Schedule M.

5. Describe the method that the Offeror uses to determine that all Members have reasonable access to Network Providers. For example, access to primary care physicians (PCP) should be within a 5-mile radius in an urban setting and 15 miles in a rural area. Provide the minimum standards that the Offeror uses to measure access. Submit a measurement of network access based on a "snapshot" of the network taken on March 31, 2020.

The access standard Excellus BCBS uses for the HMOBlue $25 participating provider network is as follows:

- **Primary care Physician: 2 providers within 10 miles**
- **Specialist: 2 providers within 15 miles**
- **Hospital: 1 provider within 20 miles**

The following is the snapshot access percentage for NYSHIP members using the Blue Choice provider network:

- **Primary Care Physicians: 93.3%**
- **Specialists: 100%**
- **Hospital: 93.3%**

6. Describe how the Offeror monitors if Network Providers are accepting new patients into their practices. Indicate whether the Offeror's proposed access standards take into account Provider availability. If yes, describe how.

   Excellus BCBS regularly informs providers of their obligation to notify us of a status change through fax blasts and banner messages on our web-based provider portal. Currently, we are making calls to a random sample of providers to validate their demographic data. We also have our Quality Office that performs "secret shopper" calls to evaluate adherence. Additionally, our Provider Relations representatives confirm whether providers are accepting new patients when visiting offices.

   We include information about whether providers are accepting new patients on our web based, member-facing, "Find a Doctor" tool and this is accounted for in our proposed access standards.

   Our access standards do not take into account provider availability.

7. Describe the Offeror's approach for credentialing Network Providers; specify if the Offeror utilizes an external credentialing verification organization. When was this process last completed? What is the Offeror's process for confirming continuing compliance with credentialing standards? How often does the Offeror conduct a complete review? Include a description of how the Offeror monitors disciplinary actions by licensing agencies

   A physician is only permitted in the HMO network after satisfying rigorous credentialing criteria. This includes reviewing pertinent performance criteria. We review and verify education and training, malpractice experience, license, board certification status, as well as any change in privileges at the hospitals where they admit patients. State licensing boards are queried at the time of initial credentialing and re-credentialing to identify any possible disciplinary actions. In addition, we receive notification directly from New York State for any disciplinary actions taken as they occur. To ensure that our information is up-to-date, our credentialing staff updates our systems in accordance with the details of the required action. In addition, the Credentialing staff monitors Office of the Medical Inspector General (OMIG), Office of the Inspector General (OIG) and Excluded Parties List System (EPLS) on a monthly basis to assure that we are complying with disciplinary actions.

   The Credentialing staff verifies all social security and NPI numbers during the processing of new and re-credentialing files. Physicians are re-credentialed every three years. Proof that 50 Continuing Medical Education credits (30 of which must be Category 1) are obtained annually, is also required. On an ongoing basis, we catalogue and evaluate member satisfaction, complaints and review in detail any quality issues that are raised.

We periodically conduct chart reviews to assess provider documentation against standards set by Excellus BCBS. In addition, Excellus BCBS monitors member feedback, medical record reviews, claims data, provider survey instruments, office site visits, to ensure that providers continually meet standards.

8. Explain the Offeror's approach to Network Provider fee schedules, including a description of the type(s) of financial arrangements that the Offeror has with each type of Provider (e.g., per diems, case rates, hourly rates, all-inclusive per diems covering Facility and Practitioner fees, etc.).

Professionals:
Excellus BCBS reimburses participating physicians based upon a fee schedule which is not subject to withholds. All participating providers agree to accept the Excellus BCBS fee schedule allowance for each professional service as payment in full, subject to applicable copayments and deductibles specified in the benefit plan. Using a fee schedule allows us to maximize discounts, which are passed back in the form of savings to the employer. Our fee schedules are based upon Medicare's Resource-Based Relative Value Scale (RBRVS) and are reviewed on an annual basis. Excellus BCBS uses multiple conversion factors which vary by CPT bodily system categories (i.e.: Integumentary vs. Musculoskeletal vs. Cardiology vs. Maternity, etc.). Conversion factors may vary by Excellus BCBS's geographic regions.

The non-participating providers are reimbursed based on what is in the Member contract.

Facilities:
Inpatient (in-network): Rates and reimbursement methodology are negotiated during the Hospital contracting process. The majority of inpatient claims are paid using APR DRG reimbursement methodology. A few providers are paid at Per Diems and one provider is paid at % of charges. Exempt units are currently paid at a negotiated per diem rate.

Inpatient (out of network): Out of network payments are dictated based on what is in the Member contract.

Outpatient (in-network): Rates and reimbursement methodology are negotiated during the Hospital contracting process. Outpatient is a mix of percent of charges and the Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) methodology. We continue to convert hospitals from a percent of charges to the APC methodology.

Outpatient (out of network): Out of network payments are dictated based on what is in the Member contract.

9. Indicate whether the Offeror ever incorporates pay-for-performance, shared savings, risk pools, risk sharing, and/or withholds into the payment methodologies for Network Providers. If yes, describe.

   Excellus BCBS has created arrangements to focus on quality and cost in a collaborative approach with providers called Accountable Cost and Quality Agreements (ACQA). Our ACQA arrangements and the complimentary initiatives within the health plan have saved over a billion dollars in five years. 62% of our total health plan membership sees a provider in an ACQA or similar arrangement. As these arrangements mature, we continue to see improvements in patient care and outcomes. Year after year member compliance with preventative screenings increases, consistently outperforming the results of providers not affiliated with an ACQA arrangement. In 2019, commercial ACQA attributed members had 19% more colorectal cancer screenings and $8.55 million less in emergency room spending compared to members who are not attributed to an ACQA provider. Since 2016, ACQA providers contributed to $28 million in prescription drug savings.

10. Describe any potential future plans to develop any of these care delivery models, including a timeline for implementation.

    Excellus BCBS is committed to the success of our ACQA arrangements. Our dedicated support model enables a full range of communication and resources for our ACQA partners. Our Account Management staff is dedicated by ACQA and is in constant contact, providing information and data, and coordinating clinical programs. The clinical support team, which includes pharmacists, registered nurses and a chief medical officer, work with the ACQA to find opportunities to improve care and create innovative ways to deliver care. This support team has greatly contributed to the success of these programs.

11. Provide an electronic copy of the most recent Health Plan Network (HPN) report submitted to the DOH indicating the HMO provider network in place at the time of submission. This electronic report must be provided for both the Commercial Plan and Medicare Advantage Plan, if offered through NYSHIP.

    Please refer to Exhibit V (USB) located within the sealed box envelope labeled Administrative Proposal as per the instructions provided on page 13 of 74 of the HMO Specifications. Please see number 5. Submission of Proposal, number a. iv. for a copy of the most recent Health Plan Network (HPN) report submitted to the Department of Health for the Blue Choice $25 and Medicare Advantage Plan (Medicare Blue Choice) offerings network in place at the time of submission.

12. Describe the utilization review procedures used when determining if care is medically necessary.

    - **Excellus BCBS prides itself in a comprehensive and mature medical benefit utilization management program. Decades of experience have resulted in a seasoned wholly owned internal utilization management program in terms of people, processes, and technology.**

- **At the highest level, a team of clinical data analysts, clinicians, medical directors and provider contracting resources continuously analyze claims data compared against national, regional and local utilization benchmarks. This team determines if healthcare services should be reviewed for medical necessity prior to services being rendered or post service pre-payment to compare a claim against actual provider medical records. Based on utilization trend analysis and resource capacity, Excellus BCBS's experienced medical policy team makes recommendations for what healthcare services should be added or subtracted from the prior-authorization list or post-service pre-payment claims pend list to review against medical records. To minimize disruption to its healthcare delivery system partners, Excellus BCBS typically makes two updates per year and provides 90-day advance notice for any changes.**

For healthcare service reviews that require a specialized skill, Excellus BCBS partners with companies to perform these utilization management functions.

1. **eviCore Healthcare, Inc.: Diagnostic Imaging (Radiology), Cardiac Device Implants, and Radiation Therapy and Musculoskeletal (Joint, Nerve, Spine) Services.**
2. **ProgenyHealth, Inc.: Neonatal Intensive Care Unit (NICU) or special care nursery as a result of premature birth or medically complex condition.**

Authorization request may come in through our web-based care management system, phone or fax into our Customer Service team.

We have a team of licensed health care professionals which includes a team of registered nurses, physical therapists and an experienced team of Medical Directors that review for medical appropriateness. In the Behavioral Health utilization management department; the team includes licensed master level/clinical social workers, certified alcohol and substance abuse counselors, registered nurses with psychiatric experience and a team of experienced psychiatric/addiction medicine medical directors.

Cases not meeting criteria or requiring further evaluation are referred to a Medical Director for review. Currently licensed, board certified physician consultants and licensed clinical peer reviewers representing major medical/surgical specialties, behavioral health practitioners and ancillary practitioners are available to assist the Medical Directors in determining medical necessity. Medical Directors, physician consultants, and clinical peer reviewers are the only individuals who can deny services as not medically necessary.

13. If the Offeror previously participated in NYSHIP, provide the total appeals filed by, or on behalf of NYSHIP Members for the previous plan year. Please provide the number of upheld, denied, and modified internal and external appeals. For internal appeals, HMOs must provide a breakdown of appeals by administrative and clinical categories.

Internal			
2019	Filed	Upheld Denied	Modified
Administrative	78	46	Not Reportable
Clinical	52	32	Not Reportable

External			
2019	Filed	Upheld Denied	Modified
Administrative	0	0	Not Reportable
Clinical	3	2	Not Reportable

14. State if the Offeror requires referrals to network specialists. If referrals are required, describe the procedure enrollees must follow for referrals to network specialists. This information should be provided for both the Commercial Plan and Medicare Advantage Plan, if one is proposed to be offered through NYSHIP.

- **HMOBlue $25 does not require referrals to network specialists.**
- **Medicare Advantage (Medicare Blue Choice) - does not require referrals to network specialists.**

15. Describe the procedure Enrollees must follow for referrals to non-network providers. This information must be provided for both the Commercial Plan and Medicare Advantage Plan, if one is proposed to be offered through NYSHIP.

    <u>HMOBlue $25</u> - Except in the case of an emergency, all requests to out-of-network providers should be preauthorized in advance by Excellus BCBS. To request an out-of-network referral for HMOBlue $25, the Primary Care Physician will contact Excellus BCBS prior to the enrollee seeing the out-of-network provider. Excellus BCBS will review the request and determine if there is an appropriate provider in its participating panel to treat the enrollee's condition in a reasonable amount of time. If Excellus BCBS determines that its participating panel of providers does not include a provider with appropriate training and experience to treat the enrollee's condition, we will approve a pre-authorization to a non-participating provider.

    <u>Medicare Advantage (Medicare Blue Choice)</u> - members can obtain services from non-network providers. Under this plan, members receive a point of service benefit for non-network providers that allows them to not have to obtain referrals. The member will be responsible for a coinsurance for those non-network providers. Any type of emergency and urgent care services will be covered worldwide at in network cost shares.

16. For HMOs proposing to offer both a Commercial Plan and a Medicare Advantage Plan (MAP) through NYSHIP, state if the provider networks for both plans are identical. If there are differences in the networks, describe any differences among the networks relative to provider type. For example, 95% of the primary care physicians in the Commercial Plan also participate in the Medicare Advantage Plan and 40% of the Specialty providers (HMO must define "Specialty providers") in the Commercial Plan also participate in the Medicare Advantage Plan.

    The provider networks for the commercial HMOBlue $25 and the Medicare Advantage (Medicare Blue Choice) plan are identical.

17. For HMOs proposing to offer a Medicare Advantage Plan through NYSHIP, provide the last three (3) years of CMS Star Ratings for the Medicare Advantage Plan that will be offered through NYSHIP. Indicate whether CMS has frozen enrollment any time during the last three (3) years.

    Excellus BCBS Medicare Advantage Plan (Medicare Blue Choice) had 4.5 for 2018 and 4.5 for 2019 and 4.0 for 2020. CMS has not frozen enrollment any time during the last three years.

18. Describe the Offeror's Medicare Enrollment reporting process. This description must include how changes to Medicare eligibility and enrollment/ disenrollment is identified and the proposed frequency and method these enrollment changes will be provided to the Department. Additionally, an Offeror is encouraged to suggest/identify a methodology of preference that will facilitate the most accurate and frequent sharing of information.

    Excellus BCBS receives a daily report from CMS with eligibility, enrollment, and disenrollment transactions. Enrollments and disenrollment's are processed from a weekly file sent by NYSHIP. Excellus BCBS also conducts a full monthly reconciliation and reports back any discrepancies directly to NYSHIP by the 15th of every month.

19. Describe the Offeror's process for Enrolling Members into their Medicare Advantage that conforms to the requirements set forth in Chapter 2 of the MMCM.

    Enrollments are processed within 7 days of receipt. Enrollments can also be pended due to missing information for 21 days or until the end of the month, whichever is greater.

20. Provide current status of the NCQA or URAC rating. Please provide the 5-point NCQA rating scale or the applicable URAC rating. The JLMC encourages an HMO to seek accreditation by nationally recognized organizations such as NCQA or URAC. If not currently accredited by NCQA or URAC, provide a detailed explanation why accreditation was not obtained.

    - **Excellus BCBS commercial (HMO/POS/PPO/EPO) – 4 Star**
    - **Excellus Medicare Advantage HMO – 4.5 Star**
    - **Excellus Medicare Advantage PPO – 4 Star**

    Note: On September 2020, they will change to 'accredited'. Given the pandemic, NCQA has cancelled NCQA Health Plan Ratings for 2020 (released in September 2020 for display until September 2021). I am attaching the link for https://www.ncqa.org/hedis/reports-and-research/ratings-2020/

CANCELLATION NOTICE

Due to COVID-19, NCQA will not release 2020–2021 Health Plan Ratings for any product line.

Accredited commercial and Medicaid plans must still submit the required HEDIS and CAHPS measures in order to meet annual reporting requirements; however, organizations **will not** be rated on measure results. A list of required measures for reporting is located under "Resources for Health Plans," below.

Health Plan Report Cards and Health Plan Ratings

Updated: April 3, 2020

Due to changes in HEDIS and CAHPS reporting outlined above:

- The September 2020 Health Plan Report Card update will list all plans with Interim, Accredited or Provisional status, as applicable, based on existing status or standards performance for surveys on the HPA 2020 Standards.
- There will be no Health Plan Ratings in 2020.

21. HMOs (charitable organizations) that are not for profit entities must provide a statement that the organization is exempt pursuant to one of the categories indicated on the Office of Attorney General's Request for Registration Exemption (Schedule E). The statement must identify the specific category under which the charitable organization is exempt.

    Please refer to Exhibit VI Excellus Health Plan, Inc. Not-for-Profit.

22. Outline what, if any, coverage is available to both Commercial and Medicare Members travelling outside of the United States. Please provide an overview for both Commercial and Medicare coverage as well as emergent, non-emergent and prescription drug services.

    Commercial
    Please See Page 131-134 in Exhibit II (HMO Blue with RX Contract) for details on how out-of-network services are covered

    Medicare Blue Choice
    Please See pages 36-39 in Exhibit VII (Medicare Blue Choice EOC) under Sections 2.4, 3.1, 3.2, and 3.3 for specific details on how out-of-network services are covered

23. Provide an overview of the current telemedicine/telehealth program available to NYSHIP Members in the HMO. Explain if there is an out-of-pocket cost to Members for these services and what the cost would be. Indicate if the program is administered in house or if the HMO uses a subcontractor. Describe when Members have access to telemedicine/telehealth services.

    The term "Telehealth" is applied to the use of electronic information and communication technologies by a [Participating] Provider to deliver Covered Services to a member while the member's location is different than the Provider's location.

The term "Telemedicine" is applied when referring to the delivery of healthcare services through the use of privacy compliant technology. Telemedicine visits allow members to connect with a doctor 24 hours a day, 365 days per year, including holidays, via secure two-way video, or telephone for the purposes of diagnosis, consultation and treatment; just as would be provided during a face-to-face office visit. The member is responsible for the applicable Deductible, Copayment, or Coinsurance.

Excellus BCBS partners with MDLIVE for Telemedicine and has recently expanded its acute medical service offerings to now include behavioral health services.

Telemedicine services will be covered in full beginning January 1, 2021.

Excellus BCBS' contract term with MDLIVE, our Telemedicine partner, is effective March 1, 2019 - March 1, 2022, a term of three years.

24. Provide confirmation that the HMO will cover the diagnosis and treatment of Gender Dysphoria. Please also provide any Member cost-sharing or prior authorizations that may apply.
Coverage is not excluded for Gender Dysphoria/Gender Identity Disorder and is coverable subject to our Corporate medical policies and Federal guidelines. Please refer to Exhibits VIII and IX for copies of the Medical Policies – Gender Reassignment/Gender Affirming Surgery and Treatments and Sex Specific Services for Transgender Individuals.

25. Complete the charts and answer the narrative questions as they appear on the *Prescription Drug Benefit Form* (Attachment 14).
Please refer to Exhibit X for response to the Prescription Drug Benefit Form (Attachment 14).

26. Certificate of Coverage (for Commercial Plan) and coverage riders. The proposed standard contract and riders should be available with prescription drug coverage and without prescription drug coverage. If the Certificate of Coverage is the same but for the prescription drug coverage, please submit only one copy of the Certificate and separate out the prescription drug coverage provisions.
Please refer to Exhibit II for a copy of the HMOBlue $25 with and without drug Certificate. Both Certificates have been supplied as they contain different language.

27. Evidence of Coverage (for Medicare Advantage Plans) and coverage riders, if offering a Medicare Advantage Plan. The proposed Medicare standard contract and riders should be available with prescription drug coverage and without prescription drug coverage. If the Evidence of Coverage is the same but for the prescription drug coverage, please submit only one copy of the Evidence of Coverage and separate out the prescription drug coverage provisions.

    Please refer to Exhibit VII for copies of the Medicare Advantage EOC (Medicare Blue Choice) with and without drug.

28. A completed *Commercial Benefits Chart* (Attachment 35) and *Medicare Benefits Chart* (Attachment 36) for both Commercial and Medicare Advantage Plans, as applicable, citing where each of the named benefits proposed for 2021 can be found in Contract or rider language. All Contracts and/or riders relating to the 2021 benefit offering must be listed. If there is no additional cost, indicate N/C in Projected Monthly Premium column. List the cost of the standard contract and riders for each rating region once, reference the citation in all other appropriate areas.

    Please refer to Exhibit XI for response to the Commercial (Attachment 35) Exhibit XII Medicare Advantage (Medicare Blue Choice) (Attachment 36) plan.

5.2 Member Communication Material Requirements

The Offeror must:

1. Submit drafts of the Cover Letter for the Member communications materials mailing to HMO Members, federally mandated Summary of Benefits and Coverage (SBC) and Schedule of Benefits, in both hard copies and PDF with their Proposals. In addition, those HMOs that participated in NYSHIP in 2020 are required to submit drafts of the Side by Side Comparison of Benefits in both hard copies and PDF with their Proposals. HMOs that did not participate in NYSHIP in 2020 will not be required to furnish the Side by Side Comparison with their Proposals.

    Please refer to Exhibit XIII for copies of the Cover Letter, Summary of Benefits and Coverage (SBC) and Schedule of Benefits and a Side by Side Comparison of Benefits of the Communication Materials to Enrollees for 2021.

2. The Offeror must provide a list of wellness programs/activities held or scheduled for 2020 and a summary of planned activities for 2021 using the Wellness Programs/Activities chart (Attachment 15).

    Please refer to Exhibit XIV for a copy of Attachment 15 response to Wellness Programs/Activities chart.

3. The Offeror must provide a list of its current five largest employer groups in descending order by number of contracts using the *Current Five Largest Employer Groups* chart (Attachment 16).

   Please refer to Exhibit XV for a copy of Attachment 16 response to the Current Five Largest Employer Groups.

4. Federally required Summary of Benefits and Coverage (SBC) for the proposed benefit package offered through NYSHIP. If the final 2021 SBC is not available for inclusion with this submission, please submit a draft version and advise when it is expected to be finalized. A finalized SBC must be submitted as soon as it is available, but no later than October 1, 2020.

   Please refer to Exhibit XIII HMOBlue $25 Summary of Benefits and Coverage (SBC).

5. Additional Member Communication Materials to Members for 2021 – Cover Letters, Marketing Materials. Refer to Section 3.6 of these Specifications for specific details. To ensure all Members have plan information prior to the NYSHIP Option Transfer Period, HMOs must submit confirmation to the Department that all Required Communications Materials have been mailed to Members by October 21, 2020.

   Please refer to Exhibit XIII and XVI for copies of Additional Communication Materials to Enrollees for 2021.

6. Choices Page, for both Commercial and Medicare Advantage Plans, as applicable. HMOs will have ten business days to complete their HMO e-page(s), after which time, access will be denied. All HMOs submitting Proposals will be required to access a Department online data interface (HMO ePage) through which plan benefit details will be electronically submitted to the Department. Additionally, HMOs are required to print a hard copy of their Choices page information from the database and submit it with their Proposal. This process will enable the Department to implement their online health benefit plan comparison tool. [**Note:** HMOs will ONLY be granted access to the Department's online data interface with their ePage if they have completed and submitted an affirmative *Notice of Intent* (Attachment 28) to participate in the 2021 NYSHIP plan year. The *Notice of Intent* will only be considered valid if it is sent to both the Department and the *JLMC Contact Members* (Attachment 13).]

   HMOs that participate in NYSHIP during 2020 will be able to edit selected fields of their 2021 Choices page content in the electronic templates to accurately describe plan benefits for the 2021 Plan Year. HMOs that did not participate in NYSHIP during 2020 will access blank electronic templates to electronically submit their Choices page information.

The Department's Communications Unit will use the electronic information submitted by each HMO to format a version of their pages for the Choices guide. HMOs will receive copies of their final Choices pages for sign off for accuracy via e-mail from the Communications Unit. Benefits described on an HMO's Choices pages will be binding upon such HMO, even in the event of erroneous oversight during such review.

Please refer to Exhibit XVII "Choices" Page for Active/Retiree (Commercial) and "Choices" Page for Second Retiree Medicare Advantage Plan (Medicare Blue Choice).

7. Schedule of Benefits required for Commercial Plan and Medicare Advantage Plan enrollees, if applicable. [**Note**: If this is part of the Offeror's Certificate of Coverage and/or Evidence of Coverage, indicate page numbers where this information can be found].

   Please refer to Exhibit XIII for a copy of the Schedule of Benefits of HMOBlue $25 and Medicare Advantage Plan (Medicare Blue Choice).

8. Side by Side Comparison of Benefit Changes 2020 to 2021 (document must be titled as such) identifying changes from 2020 (current year) to 2021 (upcoming year) for Commercial Plan and Medicare Advantage Plan Enrollees, if applicable. In the event there are no changes in the benefits offered, the HMO is required to mail an affirmative statement to Members confirming that there are no changes from the previous year; a copy of the statement of "no change" should be included in this submission, if applicable. This requirement is only for HMOs that participated in NYSHIP in 2020. See *SAMPLE Side-by-Side Comparison* (Attachment 25).

   Please refer to Exhibit XVIII for a copy of the Side by Side Comparisons of Benefit Changes from 2020 (current year) to 2021 (upcoming year) for HMOBlue $25 Active/Retiree (Commercial) and Medicare Advantage Plan (Medicare Blue Choice) Enrolled Retirees.

9. Listing of Certificate/Group Contract, Riders and/or Amendments (see *SAMPLE Contract and Rider* Summary (Attachment 30). Include both Commercial HMO and Medicare Advantage Plan documents.

   Please refer to Exhibit XIX for a copy of the HMOBlue $25 and Medicare Advantage (Medicare Blue Choice) Certificate/Group Contract/Rider and/or Amendment Summary.

5.3 Website Access

1. In accordance with Section 3.9 of these Specifications, the Offeror must provide the following:

   a. The website address to the online prescription drug formulary that the Offeror proposes for the NYSHIP plan;

      JLMC members may visit our website, ExcellusBCBS.com/member, they will then have to register in order to review the 3 tier formulary online.

   b. The process by which JLMC Members obtain the user IDs and passwords necessary to access the HMO website to view applications available to Members other than protected health information.

      JLMC members may use our website, ExcellusBCBS.com/member, to view applications available to them.

   c. For the Provider search, provide a copy of the message that would be returned if a Member entered a zip code outside of the HMOs approved NYSHIP service area.

      When a NYSHIP member accesses the Excellus BCBS website it will only reflect providers within our 31-county service area. If a member uses a zip code of our 31-county service area they will receive the following message:

      "There were no results for the specialty selected, please search again for another related specialty.

      Records 0 - 0 of 0 "

      Note: NYSHIP members must live within the six counties but will also have full access to the HMOBlue $25 participating provider network, which consists of the additional 25 counties, for a total of 31 counties.