ATTACHMENT 36

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Medicare Benefits Charts
"Health Maintenance Organizations
Specifications for the New York State Health Insurance Program"

Offeror name: Excellus BlueCross BlueShield

HMO BENEFITS FOR 2021 - Medicare Advantage Plan

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Office Visit		page 81			$5 copayment	Unlimited	No	Medical $568.50 RX $167.50
Specialty Office Visit		page 81			$20 copayment	Unlimited	No	
Chiropractic Care		page 52			$5 copayment	We cover only manual manipulation of the spine to correct subluxation	No	
Inpatient Hospital Care	Not subject to deductibles, copays or coinsurance	page 65			$0 copayment	Prior Authorization is required by your doctor or other network provider.	No	
Surgery (include all settings - Physician-Inpatient , Physician-Outpatient (at a hospital, facility or surgery center), Physician's Office, Outpatient Surgery Facility		page 81			$50 copayment	Prior authorization is required for some services by your doctor or other network provider.	No	
Skilled Nursing Facilities		page 90			Days 1-20: $0 copayment per day. Days 21-100: $25 copayment per day.	Covered for up to 100 days. A 3 day inpatient stay is not required. Prior authorization is required by your doctor or other network provider.	No	
Hospice Benefits		page 62			When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Medicare Blue Choice (HMO-POS).	Must enroll in a Medicare-certified hospice program	No	

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Emergency Room		page 57			$50 copayment	Worldwide coverage. Copayment waived if admitted to the hospital within 23 hours.	No	
Urgent Care Facility		page 94			$50 copayment	Worldwide coverage	No	
Ambulance indicate both Non-airborne & Airborne		page 48			$35 copayment	Prior authorization is required for some services by your doctor or other network provider.	No	
Diagnostic/Therapeutic Services: Cite both Hospital and Medical/Surgical Settings								
Radiology		page 69			$20 copayment	Prior authorization is required for some services by your doctor or other network provider.	No	
Lab Tests		page 68			$0 copayment	Unlimited	No	
Pathology		page 68			$0 copayment	Unlimited	No	
EKG/EEG		page 68			$20 Copayment for each service	Prior authorization is required for some services by your doctor or other network provider.	No	
Radiation/ Chemotherapy		page 69			$20 Copayment for each service 20% coinsurance for treatment considered to be a Medicare Part B prescription drug	Unlimited	No	
Women's Health Care/OB GYN								
Pap Tests		page 52			$0 copayment	Covered in full once every 24 months.	No	
Mammograms		page 50			$0 copayment	Covered in full for a diagnostic or routine mammogram every 12 months (for women age 40 or over)	No	
Bone Mineral Density Measurements & Tests		page 50			$0 copayment	Covered in full once per calendar year (or more frequent if medically necessary)	No	

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Pre- and Post Natal Visits	Covered as required by Federal and NYS law and/or regulation	NA			The benefit is not specifically mentioned in the contract. $5 PCP $20 Specialist	Unlimited	No	
Family Planning	Routine examinations; laboratory tests; birth control counseling; pregnancy testing; genetic counseling	page 104			Not covered	Not covered	No	
Infertility Services	Covered as required by Federal and NYS law and/or regulation	page 104			Not covered	Not covered	No	
Contraceptive Drugs and Devices		page 104			Covered under the Part D prescription drug benefit.	Please refer to Chapter 6 of the contract for coverage details. Please refer to the formulary (drug list) for specific drug information.	No	
Rehabilitative Care, Physical, Speech & Occupational Therapy								
Inpatient Rehabilitative Care		page 65			$0 Copayment for physical, occupational, and speech language therapy for inpatient hospital care each time you are admitted to the hospital.	Covered services include: physical therapy, occupational therapy, and speech language therapy. Prior authorization is required for some services by your doctor or other network provider.	No	
Outpatient Rehabilitative Care		page 80			$20 copayment	Prior authorization is required for some services by your doctor or other network provider.	No	
Mental Health/Substance Abuse								
Outpatient Mental Health	Covered as required by Federal and NYS law and/or regulation	page 80			20% coinsurance	Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	No	

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Inpatient Mental Health	Covered as required by Federal and NYS law and/or regulation	page 67			$0 copayment	There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.	No	
Coverage for Autism Spectrum Disorder	In compliance with NYS Autism legislation including Habilitative Services, Applied Behavior Analysis (ABA)	NA			Not covered	Not covered	No	
Alcohol and Substance Abuse Detoxification	Covered as required by Federal and NYS law and/or regulation	page 67			$0 copayment	Unlimited	No	
Outpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation	page 80			20% coinsurance	Prior authorization is required for some services by your doctor or other network provider.	No	
Inpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation	page 67			$0 copayment	For inpatient hospital care, the cost-sharing applies each time you are admitted to the hospital.	No	
Prescription Drugs: *Medically necessary federal legend and state restricted drugs, compounded medications and injectable insulin. Coverage must include contraceptive drugs and devices, fertility drugs and enteral formulas. (The copayment for injectable drugs, including fertility drugs, must be the same as the copayment for other covered drugs except drugs limited to 30 days supply at dispensing.) No annual or lifetime maximum permitted.*								
Prescription Drugs		page 134			30 day supply: Tier 1: $10 Tier 2: $25 Tier 3: $40 90-day supply: Tier 1: $20 Tier 2: $50 Tier 3: $80	Please refer to Chapter 6 of the contract for coverage details. Please refer to the formulary (drug list) for specific drug information.	No	
Other								
Diabetic Supplies		page 55			$5 Copayment	Per item for a 30 day supply from a preferred provider.	No	
Oral Agents and Insulin		NA			$5 Copayment per item for a 30 day supply from a preferred provider.	Please refer to Chapter 6 of the contract for coverage details. Please refer to the formulary (drug list) for specific drug information.	No	

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Diabetic Shoes		page 55			20% coinsurance	For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	No	
Durable Medical Equipment (DME)	Medically necessary DME which can with- stand repeated use and primarily used to serve a medical purpose must be covered. Examples include but not limited to: wheelchairs, walkers, respiratory equip, oxygen supplies, replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.	page 56			20% coinsurance	Prior authorization is required for some services by your doctor or other network provider.	No	
Prosthetic Devices	Medically necessary prosthetic devices that aid body functioning or replace a limb or body part in order to correct a defect of body form or function must be covered. Examples of prosthetic devices include but are not limited to: artificial limbs, pacemakers, heart valve replacements, artificial joints, external breast prostheses and Ostomy Supplies. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.	page 85			20% coinsurance	Prior authorization is required for some services by your doctor or other network provider.	No	

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Orthotic Devices	Medically Necessary custom-made orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot must be covered. Orthopedic shoes and other supportive devices for treatment of weak, strained, flat, unstable or unbalanced feet should not be included for coverage. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.	Page 100			Not covered	Except for orthopedic or therapeutic shoes for people with diabetic foot disease		
Additional Benefits	Health and wellness education programs Silver&Fit® Fitness Program	Page 57			$25 annual fee for gym membership $10 fee for up to 2 home fitness kits $150 allowance for out-of-network gym membership	Cannot enroll in a in network and out-of-network gym in the same month.	Yes- For 2020 had to choose either gym membership or in home kits. For 2021, can have both at the same time. For 2020, paid fees to the gym. For 2021, will pay fees directly to Silver&Fit.	
Additional Benefits	Hearing Aids	Page 60			$699 copayment per aid for Advanced Aids $999 copayment per aid for Premium Aids	For routine hearing exams and hearing aids, you must contact TruHearing to schedule an appointment prior to visiting the provider.	Yes - For 2021, option for $50 additional cost per aid for optional hearing aid rechargeability.	
Additional Benefits	Acupuncture	Page 48			50% coinsurance	Covered for 10 visits per calendar year.	Yes- For 2021, the Plan covers up to 20 visits per calendar year for chronic low back pain and an additional 10 visits per calendar year for all other diagnosis.	