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: BlueCross BlueShield of Western New York

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	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 85			$10 PCP/visit, ($0 for follow-up visits after any inpatient discharge or observation discharge within 14 days.) $30 Specialist/visit	Unlimited	No	$675.35
Specialty Office Visit	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 85			$30/visit	Unlimited	No	$675.35
Chiropractic Care	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 63			$20/visit	Unlimited	No	$675.35
Inpatient Hospital Care	Not subject to deductibles, copays or coinsurance. Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 73, and 74			$0 copay	Unlimited	No	$675.35
Surgery (include all settings - Physician-Inpatient , Physician-Outpatient (at a hospital, facility or surgery center), Physician's Office, Outpatient Surgery Facility	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 84, and 85			$75/visit for each visit to an ambulatory surgical center or hospital outpatient facility. $10 PCP/$30 Specialist/visit for surgery services furnished in a physicians office.	Unlimited	No	$675.35
Skilled Nursing Facilities	Not subject to deductibles, copays or coinsurance. Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 91 and 92			$0 copay	Plan covers up to 100 days each benefit period.	No	$675.35
Hospice Benefits	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 71, and 72 With Part D Drug Plan Only : Chapter 5, Section 9.4 Page 122			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.	Original Medicare	No	$675.35
Emergency Room	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 67			$65/visit, waived if admitted to the hospital within one day.	Unlimited	No	$675.35
Urgent Care Facility	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 94			$35/visit, waived if admitted to the hospital within one day.	Unlimited	No	$675.35

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Ambulance indicate both Non-airborne & Airborne	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 60			$100 per trip for Non-airborne & Airborne transports.	Unlimited	No	$675.35
Diagnostic/Therapeutic Services: Cite both Hospital and Medical/Surgical Settings								
Radiology	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 81			$30/test	Unlimited	No	$675.35
Lab Tests	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 81			$0 copay	Unlimited	No	$675.35
Pathology	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 81			$0 copay	Unlimited	No	$675.35
EKG/EEG	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 81, and 96			$0 copay for EKG's performed in conjunction with your "Welcome to Medicare" (IPPE) Visit. For all other EKG and EEG tests $30/test.	EEGs are unlimited EKGs performed with your IPPE are limited to 1 per lifetime. All others are unlimited.	No	$675.35
Radiation/ Chemotherapy	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 79 and 81 With Part D Drug Plan Only : Chapter 5, Section 1.1, Page 105 Chapter 6, Section 5.2, Page 133 & 134			$0 copay for Part B physician administered injectable drugs and Part B oral chemotherapy drugs. $0 copay for chemotherapy administration. $30/visit for Radiation Therapy. With Part D Drug Plan Only: See formulary (drug list) for Part D drugs. $0/$15/$30/$50/$50	No limits on outpatient visits Part B Drugs: Due to the amount of drugs that are represented within this category, please contact the plan for specific limitations on a particular item. Part D Drug Plan Only Part D Drugs: Limitations indicated on formulary (drug list)	No	$675.35
Women's Health Care/OB GYN								
Pap Tests	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 63			$0 copay	Preventive Pap exams are covered once every 24 months. If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months. Additional diagnostic tests; Unlimited	No	$675.35
Mammograms	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 61, and 81			$0 for Medicare-covered preventive screenings. Additional diagnostic tests $30/test	Preventive screenings: One baseline mammogram between the ages of 35 and 39. One screening mammogram every plan year age 40 and older. Additional diagnostic tests; Unlimited	No	$675.35

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		EOC	Rider					Individual
Bone Mineral Density Measurements & Tests	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 61, and 81			$0 for Medicare-covered preventive screenings. Additional diagnostic tests $30/test	Preventive screenings: 1 every 24 months Additional diagnostic tests; Unlimited	No	$675.35
Pre- and Post Natal Visits	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 85			First visit to confirm pregnancy $10 copay. All additional maternity OBGYN visits $0.	Unlimited	No	$675.35
Family Planning	Routine examinations; laboratory tests; birth control counseling; pregnancy testing; genetic counseling	Chapter 4, Page 63, 81, and 85			$0 copay lab tests (including Genetic testing). $30/test for all other diagnostic tests. $0 copay for Preventive Pap smear, Pelvic Exam, and Clinical Breast Examinations. $10/visit with PCP $10/diagnostic vists with OBGYN $30/visit for all other specialists.	Unlimited	No	$675.35
Infertility Services	N/C	N/C			N/C	N/C	No	$675.35
Contraceptive Drugs and Devices	Coverage as required by CMS and/or NYS laws and/or regulations.	Medicare Part B Prescription Drugs: Chapter 4 page 79 With Part D Drug Plan Only: Chapter 6, Section 5.2, Page 133 & 134. See formulary (drug list) for applicable tier.			No copayment for the device when supplied by your physician. In this scenario the device is covered under your Medicare Part B medical coverage. An office copay may apply. With Part D Drug Plan Only: You pay the applicable Rx Tier copayment when filling a script at the pharmacy for drugs or devices. $0/$15/$30/$50/$50	<u>Part B Drugs:</u> Devices may vary, please contact the plan for specific limitations on a particular item. <u>Part D Drug Plan Only</u> <u>Part D Drugs:</u> Limitations indicated on formulary (drug list)	No	$675.35
Rehabilitative Care, Physical, Speech & Occupational Therapy								
Inpatient Rehabilitative Care	Not subject to deductibles, copays or coinsurance. Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 73, and 74			$0 copay	Unlimited	No	$675.35
Outpatient Rehabilitative Care	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 84			$20/visit	Unlimited	No	$675.35

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Mental Health/Substance Abuse								
Outpatient Mental Health	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 83			$40/visit	Unlimited	No	$675.35
Inpatient Mental Health	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 75			$0 copay	190 day lifetime maximum in a psychiatric hospital	No	$675.35
Coverage for Autism Spectrum Disorder	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 83			$40/visit	Unlimited	No	$675.35
Alcohol and Substance Abuse Detoxification	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 73, 74 and 75			$0 copay	190 day lifetime maximum in a psychiatric hospital	No	$675.35
Outpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 84			$40/visit	Unlimited	No	$675.35
Inpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 73, 74 and 75			$0 copay	190 day lifetime maximum in a psychiatric hospital	No	$675.35
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	Coverage as required by CMS and/or NYS laws and/or regulations.	Medicare Part B Prescription Drugs: Chapter 4, page 66 and 79 With Part D Drug Plan Only: Chapters 5 and 6			Part B Drugs: $0 copay for Part B Diabetic supplies. $0 copay for Part B oral anti-cancer drugs. $0 copay for Part B injectable drugs that aren't self-administered. $0 copay for Part B Immunosuppressive drugs. 20% coinsurance for Part B Nebulizer drugs. 20% coinsurance for all other Part B drugs. Part D Drug Plan Only Part D Drugs: $0/$15/$30/$50/$50	Part B Drugs: Due to the amount of drugs that are represented within this category, please contact the plan for specific limitations on a particular item. Part D Drug Plan Only Part D Drugs: Limitations indicated on formulary (drug list)	No	$675.35

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Other								
Diabetic Supplies	Coverage as required by CMS and/or NYS laws and/or regulations.	Part B Drugs: Chapter 4, page 66 With Part D Drug Plan Only: Chapters 5 and 6			Part B Drugs: $0 copay for Part B Diabetic supplies. Part D Drug Plan Only Part D Drugs: $0/$15/$30/$50/$50	Part B Drugs: Due to the amount of supplies that are represented within this category, please contact the plan for specific limitations on a particular item. Part D Drug Plan Only Part D Drugs: Limitations indicated on formulary (drug list)	No	$675.35
Oral Agents and Insulin	Coverage as required by CMS and/or NYS laws and/or regulations.	Medicare Part B Prescription Drugs: Chapter 4, page 66 and 79 With Part D Drug Plan Only: Chapters 5 and 6			Part B Drugs: $0 copay for Part B Diabetic supplies. $0 copay for Part B oral anti-cancer drugs. $0 copay for Part B Immunosuppressive drugs. 20% coinsurance for Part B Nebulizer drugs. 20% coinsurance for all other Part B drugs. Part D Drug Plan Only Part D Drugs: $0/$15/$30/$50/$50	Part B Drugs: Due to the amount of drugs that are represented within this category, please contact the plan for specific limitations on a particular item. Part D Drug Plan Only Part D Drugs: Limitations indicated on formulary (drug list)	No	BlueCross BlueShield of Western New York: $675.35 BlueShield of Northeastern New York: $755.00
Diabetic Shoes	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 66			$0 copay	For people with diabetes who have severe diabetic foot disease: One pair per calender year of therapeutic custom molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or 1 pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	No	$675.35
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. Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Page 66			$0 compression stockings; 20% coinsurance on all other items	Due to the amount of items that are represented within this category, please contact the plan for specific limitations on a particular item.	No	$675.35

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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. Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Diabetic shoes/inserts page 66 Prosthetic Devices, page 87			$0 diabetic shoes/inserts; 20% coinsurance on all other items	Due to the amount of items that are represented within this category, please contact the plan for specific limitations on a particular item.	No	$675.35
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. Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4, Diabetic shoes/inserts page 66 Prosthetic Devices, page 87			$0 diabetic shoes/inserts; 20% coinsurance on all other items	Due to the amount of items that are represented within this category, please contact the plan for specific limitations on a particular item.	No	$675.35
Additional Benefits	Coverage as required by CMS and/or NYS laws and/or regulations.	Chapter 4: Page 68 for fitness membership/health & wellness programs. Page 95, Vision Allowance/Routine eye exam Page 64, Dental Allowance Page 69-70, Hearing Services Page 94, Telemedicine Meals (Post Discharge)- Chapter 4			$0 SilverSneakers Fitness Club Membership $0 health & wellness programs $200 vision allowance, $0 Routine Eye Exam $200 dental allowance Hearing aid: $699 copayment per aid for Advanced hearing aid. $999 copayment per aid for Premium hearing aid. $50 additional cost per aid for optional hearing aid rechargeability. Hearing aid purchases includes: • 3 provider visits within first year of hearing aid purchase • 45 day trial period • 3 year extended warranty • 48 batteries per aid Telemedicine; Range $0 copay- office visit copay Meals (Post-Discharge): $0 copay, 1 meal per day/7days	SilverSneakers: Members get one fitness club membership per year at any participating SilverSneakers fitness center location. Vision Allowance: This annual allowance can be used towards glasses, contacts, lenses and frames. Allowance does not cover Sick/Well visit vision copays. Cannot combine with any promotional offers. Enrollees must use allowance with an In-network Davis provider. Routine eye exam is limited to 1 per year with a Davis provider. Dental Allowance: Annual dental allowance to use towards preventive dental services. Hearing aid: Our plan will cover up to two (2) TruHearing hearing aids every year (one per ear per year). Must contact TruHearing to schedule an appointment. $0 Telemedicine- must use specified vendor-Doctor On Demand Telemedicine Expansion: If provider has the ability to host telemedicine visits the member pays the same cost as they would for an in-office visit. Eligible benefits include Medicare covered: Primary Care Physician Services, Occupational Therapy Services, Physician Specialist Services, Individual Sessions for Mental Health Specialty Services, Group Sessions for Mental Health Specialty Services, Podiatry Services, Other Health Care Professional, Individual Sessions for Psychiatric Services, Group Sessions for Psychiatric Services, Physical Therapy and Speech-Language Pathology Services, Individual Sessions for Outpatient Substance Abuse, Group Sessions for Outpatient Substance Abuse, Kidney Disease Education Services, Diabetes Self-Management Training, Eye Exams, and Hearing Exams. Meal (Post-Discharge): Only discharges from inpatient hospitals or SNFs will qualify for the meals benefit. Meal requests must be made to our healthcare services team. Our healthcare representatives will coordinate the meal delivery to the member. Please see EOC for full details.	Yes, made updates to vision allowance, routine eye exam, added updated vision vendor, updated dental allowance, updated cost for rechargeability to premium hearing aid, revised Telemedicine, and Meals addition	$675.35