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: MVP Health Plan

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		Chapter 4, pages 76 East, 74 West		Pending	$10 copay/visit		No	East $756.11, Central $855.67, Mid-Hudson $841.10, Rochester
Specialty Office Visit		Chapter 4, pages 56 East, 53 West		Pending	$15 copay/visit		No	MA RX124AB &MRX130AB 2020 - N/C
Chiropractic Care		Chapter 4, pages 76 East, 74 West		Pending	$15 copay/visit		No	Preferred Gold Eyewear 2020 MR002 - N/C
Inpatient Hospital Care	Not subject to deductibles, copays or coinsurance	Chapter 4, pages 66 East, 64 West		Pending	No copay		No	Preferred Gold Hearing Services Rider 2020 - N/C
Surgery (include all settings - Physician-Inpatient , Physician-Outpatient (at a hospital, facility or surgery center), Physician's Office, Outpatient Surgery Facility		Chapter 4, pages 74, 75, 76 East, 71, 73, 74 West		Pending	Physician Inpatient - No copay Physician Outpatient - No copay Physician Office - $10 copay PCP or $15 copay Specialist		No	See above
Skilled Nursing Facilities		Chapter 4, pages 82 East, 80 West		Pending	No copay days 1-20 $135 copay/day, days 21-100	100 days of coverage per benefit period	No	See above
Hospice Benefits		Chapter 4, pages 64 East, 63 West		Pending	Covered by Medicare		No	See above
Emergency Room		Chapter 4, pages 59 East, 57 West		Pending	$65 copay/visit		No	See above
Urgent Care Facility		Chapter 4, pages 85 East, 83 West		Pending	$15 copay/visit		No	See above
Ambulance indicate both Non-airborne & Airborne		Chapter 4, pages 53 East, 51 West		Pending	$50 copay/trip - both		No	See above

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		EOC	Rider					Individual
Diagnostic/Therapeutic Services: Cite both Hospital and Medical/Surgical Settings								
Radiology		Chapter 4, pages 67&73 East, 64 &71 West		Pending	$0 Inpatient/$15 Outpatient per visit		No	See above
Lab Tests		Chapter 4, Section 2.1, pages 71&73 East, 69&71 West		Pending	No Copay		No	See above
Pathology				Pending	No Copay		No	See above
EKG/EEG		Chapter 4, pages 55 East, 53 West		Pending	No Copay		No	See above
Radiation/ Chemotherapy		Chapter 4, 68, 71, 92 East, 68, 69, 90 West		Pending	No copay - Radiation $15 copay/visit for physician-administered chemotherapy		No	See above
Women's Health Care/OB GYN								
Pap Tests		Chapter 4, pages 55 East, 54 West		Pending	No Copay		No	See above
Mammograms		Chapter 4, pages 54 East, 52 West		Pending	No Copay		No	See above
Bone Mineral Density Measurements & Tests		Chapter 4, pages 54 East, 52 West		Pending	No Copay		No	See above
Pre- and Post Natal Visits	Covered as required by Federal and NYS law and/or regulation			Pending	$10 copay/visit PCP, $15 copay/visit Specialist (initial visit only) /		No	See above
Family Planning	Routine examinations; laboratory tests; birth control counseling; pregnancy testing; genetic counseling			Pending	N/A		No	See above
Infertility Services	Covered as required by Federal and NYS law and/or regulation			Pending	N/A		No	See above
			Rider Enhanced					

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Contraceptive Drugs and Devices			Rider Enhanced Prescription Drug $0 / $10 / $30 / $60 / $60	Pending	$0 / $10 / $30 / $60 / $60		No	See above

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Rehabilitative Care, Physical, Speech & Occupational Therapy								
Inpatient Rehabilitative Care		Chapter 4, pages 66 East, 64 West		Pending	No Copay		No	See above
Outpatient Rehabilitative Care		Chapter 4, pages 74 East, 72 West		Pending	$15 copay/visit	Combined limit of $2,040 (in 2019)	No	See above
Mental Health/Substance Abuse								
Outpatient Mental Health	Covered as required by Federal and NYS law and/or regulation	Chapter 4, pages 74 East, 72 West		Pending	$15 copay/visit		No	See above
Inpatient Mental Health	Covered as required by Federal and NYS law and/or regulation	Chapter 4, pages 67 East, 65 West		Pending	No Copay		No	See above
Coverage for Autism Spectrum Disorder	In compliance with NYS Autism legislation including Habilitative Services, Applied Behavior Analysis (ABA)			Pending	$15 copay/visit		No	See above
Alcohol and Substance Abuse Detoxification	Covered as required by Federal and NYS law and/or regulation	Chapter 4, pages 79 East, 77 West		Pending	$15 copay/visit		No	See above
Outpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation	Chapter 4, pages 71, 74 East, 69, 72 West		Pending	$15 copay/visit		No	See above
Inpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation	Chapter 4, pages 66 East, 64 West		Pending	No Copay		No	See above
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.*								

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Prescription Drugs		Chapter 6 page 108 West, 110 East	RX $0 / $10 / $30 / $60 / $60	Pending		If your total drug costs (paid by both you and MVP Health Plan, Inc) reach $4,130, you will pay either the copayments as listed above or less. You will continue to pay $0 for Tier 1 drugs. Catastropic Coverage Stage: when you have paid $6,550 out of pocket, your cost for prescriptions is reduced to 5% or $3.70 for generics and $9.20 for all other drugs, whichever is greater you will never pay more in Catastropic Coverage than you did in the Inital Coverage stage.	Yes	See above

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Other								
Diabetic Supplies		hapter page 57 East, 55 West		Pending	$0-10% coinsurance		No	See above
Oral Agents and Insulin		Chapter 6 page 108 West, 110 East	$0 / $10 / $30 / $60 / $60	Pending	$0 / $10 / $30 / $60 / $60		No	See above
Diabetic Shoes		Chapter page 57 East, 55 West		Pending	20% coinsurance for diabetic related therapeutic shoes.	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. Inserts purchased separately must be used with diabetic custom molded shoes or depth shoes.	yes	
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.	Chapter 4 page 58 East, 56 West		Pending	20% coinsurance		No	See above
	Medically necessary prosthetic devices that aid body functioning or replace a							

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Prosthetic Devices	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.	Chapter 4 page 79 East, 77 West		Pending	20% coinsurance		No	See above

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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.	Chapter 4 page 68 East, 66 West		Pending	20% Coinsurance		No	See above
Additional Benefits	Telemedicine	Chapter 4 page 84 East, 82 West		Pending	No copay for general office visit/urgent care/behavioral health visit		No	See above