BlueCross BlueShield of New Mexico

New Mexico Retiree Health Care Authority (NMRHCA)

Summary of Benefits

Blue Cross Group Medicare Advantage (HMO)SM

January 1, 2021 – December 31, 2021

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage Benefits Insert."

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INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2021 – December 31, 2021

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
You have choices about how to get your Medicare prescription drug benefits	• One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. • Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Cross Group Medicare Advantage Plan I (HMO)** or **Blue Cross Group Medicare Advantage Plan II (HMO)**).	
Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what **Blue Cross Group Medicare Advantage Plan I (HMO)** or **Blue Cross Group Medicare Advantage Plan II (HMO)** covers and what you pay. • If you want to compare our plans with other Medicare Health Plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov. • If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.	
Sections in this booklet	• Things to Know About **Blue Cross Group Medicare Advantage Plan I (HMO)** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Prescription Drug Benefits	• Things to Know About **Blue Cross Group Medicare Advantage Plan II (HMO)** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Prescription Drug Benefits
Hours of Operation	• From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. – 8:00 p.m. local time. • From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. – 8:00 p.m. local time.	

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
Phone Numbers	• Call toll-free 1-877-299-1008. (TTY users should call 711).	
Who can join?	To join **Blue Cross Group Medicare Advantage Plan I (HMO)** or **Blue Cross Group Medicare Advantage Plan II (HMO)**, you must be enrolled in Medicare Part A and B, and be a retiree, or Medicare-eligible dependent of a retiree, of New Mexico Retiree Health Care Authority (NMRHCA).	
	Our service area includes the state of New Mexico.	
Which doctors, hospitals, and pharmacies can I use?	**Blue Cross Group Medicare Advantage (HMO)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. • You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. • You can see our plan's *Provider Directory* and/or *Pharmacy Directory* at www.bcbsnm.com/retiree-medicare-tools.	
What do we cover?	Like all Medicare health plans, we cover everything that Original Medicare covers—and *more*. **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less. **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the plan formulary (list of Part D prescription drugs) and any restrictions at www.bcbsnm.com/retiree-medicare-tools. Call us and we will send you a copy of the formulary.	
How will I determine my drug costs?	Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage, Coverage Gap, and Catastrophic Coverage.	

SUMMARY OF BENEFITS

January 1, 2021 – December 31, 2021

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium?	For information concerning the actual premiums you will pay, please contact your employer or your employer group benefits plan administrator. In addition, you must keep paying your Medicare Part B premium.	
How much is the deductible?	These plans do not have a medical deductible.	
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. **Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.**	
	Your yearly limit(s) in this plan: $3,000 for services you receive from in-network providers.	Your yearly limit(s) in this plan: $6,700 for services you receive from in-network providers.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain supplemental benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain supplemental benefits. Contact us for the services that apply.

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
INPATIENT CARE		
Inpatient Hospital Care*	• $1,250 out-of-pocket limit every year $125 copay per day for days 1-5 $0 copay per day for days 6-90	• $500 copay per stay
OUTPATIENT CARE AND SERVICES		
Outpatient Hospital Care/Surgery*	**Outpatient hospital** • $175 copay **Ambulatory surgical center** • $175 copay	**Outpatient hospital** • $300 copay **Ambulatory surgical center** • $300 copay
Doctor's Office Visits*	**Primary care physician visit** • $10 copay **Specialist visit** • $30 copay	**Primary care physician visit** • $10 copay **Specialist visit** • $40 copay

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
Preventive Care*	• $0 copay	• $0 copay
	Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit **Any additional preventive services approved by Medicare during the contract year will be covered.**	
Emergency Care	• $65 copay If admitted to the hospital within 24-hour(s) for the same condition, $0 copay for emergency room visit. See the "Inpatient Hospital Care" section of this booklet for other costs.	• $90 copay If admitted to the hospital within 24-hour(s) for the same condition, $0 copay for emergency room visit. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services	• $25 copay	• $50 copay

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
Diagnostic Tests, Lab and Radiology Services, and X-Rays*	**Diagnostic radiology services (such as MRIs, CT scans)** • $50 copay **Diagnostic tests and procedures** • $0 copay **Lab services** • $0 copay **Outpatient X-rays** • $0 copay **Therapeutic radiology services (such as radiation treatment for cancer)** • $0 copay	**Diagnostic radiology services (such as MRIs, CT scans)** • $200 copay **Diagnostic tests and procedures** • $0 copay **Lab services** • $0 copay **Outpatient X-rays** • $0 copay **Therapeutic radiology services (such as radiation treatment for cancer)** • $0 copay
Hearing Services*	**Exam to diagnose and treat hearing and balance issues** • $20 copay **Routine hearing exam** • $30 copay for 1 routine hearing exam every year **Hearing aids** • $300 allowance toward hearing aids every year	**Exam to diagnose and treat hearing and balance issues** • $20 copay **Routine hearing exam** • $30 copay for 1 routine hearing exam every year **Hearing aids** • $300 allowance toward hearing aids every year

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
Dental Services*	**Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)**	
	• $20 copay	• $20 copay
Vision Services*	**Exam to diagnose and treat diseases and conditions of the eye**	
	• $35 copay **Yearly glaucoma screening** • $0 copay **Eyeglasses or contact lenses after cataract surgery** • $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery **Routine eye exam** • $10 copay for 1 routine eye exam every calendar year **Routine eye wear** • $150 allowance toward routine eyewear (frames and contact lenses) every year	• $35 copay **Yearly glaucoma screening** • $0 copay **Eyeglasses or contact lenses after cataract surgery** • $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery **Routine eye exam** • $10 copay for 1 routine eye exam every calendar year **Routine eye wear** • $150 allowance toward routine eyewear (frames and contact lenses) every year

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
Mental Health Care*	**Inpatient visit** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.	
	• $1,250 out-of-pocket limit every year $125 copay per day for days 1-5 $0 copay per day for days 6-90	• $500 copay per stay
	Outpatient individual and group therapy visit with a mental health specialist • $40 copay	**Outpatient individual and group therapy visit with a mental health specialist** • $30 copay
Skilled Nursing Facility (SNF)*	**Our plans cover up to 100 days in a SNF.** • $0 copay per day for days 1-20 $75 copay per day for days 21-100	**Our plans cover up to 100 days in a SNF.** • $0 copay per day for days 1-20 $50 copay per day for days 21-100

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
Outpatient Rehabilitation*	**Cardiac (heart) rehab services** • $10 copay for cardiac rehabilitation services. • $10 copay for intensive cardiac rehabilitation services. **Supplemental cardiac rehab services** • $10 copay for an unlimited number of supplemental cardiac rehabilitation services **Occupational therapy visit** • $10 copay **Physical therapy and speech and language therapy visit** • $10 copay	**Cardiac (heart) rehab services** • $10 copay for cardiac rehabilitation services. • $10 copay for intensive cardiac rehabilitation services. **Supplemental cardiac rehab services** • $10 copay for an unlimited number of supplemental cardiac rehabilitation services **Occupational therapy visit** • $40 copay **Physical therapy and speech and language therapy visit** • $40 copay
Ambulance* ***(Medicare-covered ground and air transportation services)***	**Medicare-covered ground and air transportation services** • $100 copay for each one-way trip	**Medicare-covered ground and air transportation services** • $200 copay for each one-way trip

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
Transportation*	• $0 copay for up to 4 one-way trips every year to plan-approved locations	• $0 copay for up to 4 one-way trips every year to plan-approved locations
Medicare Part B Drugs*	**Part B chemotherapy drugs** • 20% of the total cost **Other Part B drugs** • 20% of the total cost	**Part B chemotherapy drugs** • 20% of the total cost **Other Part B drugs** • 20% of the total cost

PRESCRIPTION DRUG BENEFITS		
	Blue Cross Group Medicare Advantage (HMO)SM Plan I	**Blue Cross Group Medicare Advantage (HMO)SM Plan II**
Stage 1: Part D Deductible	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you.	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you.
Stage 2: Initial Coverage	You pay the following (see table(s) below) until your total yearly drug costs reach $4,130. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	You pay the following (see table(s) below) until your total yearly drug costs reach $4,130. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Cost Shares During the Initial Coverage Stage

Initial Coverage Stage: Standard Retail Pharmacy		
Standard Retail	**Blue Cross Group Medicare Advantage (HMO)℠ Plan I**	**Blue Cross Group Medicare Advantage (HMO)℠ Plan II**
Tier 1: Preferred Generic	**One-month supply:** $5	**One-month supply:** $5
	Three-month supply: $15	**Three-month supply:** $15
Tier 2: Generic	**One-month supply:** $10	**One-month supply:** $12
	Three-month supply: $30	**Three-month supply:** $36
Tier 3: Preferred Brand	**One-month supply:** $45	**One-month supply:** $45
	Three-month supply: $135	**Three-month supply:** $135
Tier 4: Non-Preferred Drug	**One-month supply:** $95	**One-month supply:** $95
	Three-month supply: $285	**Three-month supply:** $285
Tier 5: Specialty Tier	**One-month supply:** 33%	**One-month supply:** 25%
	Three-month supply: 33%	**Three-month supply:** 25%

Initial Coverage Stage: Preferred Retail Pharmacy		
Preferred Retail	**Blue Cross Group Medicare Advantage (HMO)SM Plan I**	**Blue Cross Group Medicare Advantage (HMO)SM Plan II**
Tier 1: Preferred Generic	**One-month supply:** $0	**One-month supply:** $0
	Three-month supply: $0	**Three-month supply:** $0
Tier 2: Generic	**One-month supply:** $5	**One-month supply:** $7
	Three-month supply: $15	**Three-month supply:** $21
Tier 3: Preferred Brand	**One-month supply:** $40	**One-month supply:** $40
	Three-month supply: $120	**Three-month supply:** $120
Tier 4: Non-Preferred Drug	**One-month supply:** $90	**One-month supply:** $90
	Three-month supply: $270	**Three-month supply:** $270
Tier 5: Specialty Tier	**One-month supply:** 33%	**One-month supply:** 25%
	Three-month supply: 33%	**Three-month supply:** 25%

Initial Coverage Stage: Standard Mail Order Pharmacy		
Standard Mail Order	**Blue Cross Group Medicare Advantage (HMO)℠ Plan I**	**Blue Cross Group Medicare Advantage (HMO)℠ Plan II**
Tier 1: Preferred Generic	**One-month supply:** $5	**One-month supply:** $5
	Three-month supply: $15	**Three-month supply:** $15
Tier 2: Generic	**One-month supply:** $10	**One-month supply:** $12
	Three-month supply: $30	**Three-month supply:** $36
Tier 3: Preferred Brand	**One-month supply:** $45	**One-month supply:** $45
	Three-month supply: $135	**Three-month supply:** $135
Tier 4: Non-Preferred Drug	**One-month supply:** $95	**One-month supply:** $95
	Three-month supply: $285	**Three-month supply:** $285
Tier 5: Specialty Tier	**One-month supply:** 33%	**One-month supply:** 25%
	Three-month supply: 33%	**Three-month supply:** 25%

Initial Coverage Stage: Preferred Mail Order Pharmacy		
Preferred Mail Order	**Blue Cross Group Medicare Advantage (HMO)SM Plan I**	**Blue Cross Group Medicare Advantage (HMO)SM Plan II**
Tier 1: Preferred Generic	**One-month supply:** $0	**One-month supply:** $0
	Three-month supply: $0	**Three-month supply:** $0
Tier 2: Generic	**One-month supply:** $5	**One-month supply:** $7
	Three-month supply: $15	**Three-month supply:** $21
Tier 3: Preferred Brand	**One-month supply:** $40	**One-month supply:** $40
	Three-month supply: $120	**Three-month supply:** $120
Tier 4: Non-Preferred Drug	**One-month supply:** $90	**One-month supply:** $90
	Three-month supply: $270	**Three-month supply:** $270
Tier 5: Specialty Tier	**One-month supply:** 33%	**One-month supply:** 25%
	Three-month supply: 33%	**Three-month supply:** 25%

Initial Coverage Stage: Long-term Care and Out-of-network Pharmacies (one-month supply)		
	Blue Cross Group Medicare Advantage (HMO)SM Plan I	**Blue Cross Group Medicare Advantage (HMO)SM Plan II**
Long-term Care Tiers 1-5	If you reside in a long-term facility, you pay the same as at a retail pharmacy.	
Out-of-network Tiers 1-5	You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. You generally must use a network pharmacy to fill your prescription.	

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
Stage 3: Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. See the table(s) below for your costs during this stage. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $6,550.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. See the table(s) below for your costs during this stage. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $6,550.

Coverage Gap Stage: Standard Retail Pharmacy		
Standard Retail	**Blue Cross Group Medicare Advantage (HMO)℠ Plan I**	**Blue Cross Group Medicare Advantage (HMO)℠ Plan II**
Tier 1: Preferred Generic	**One-month supply:** $5	**One-month supply:** $5
	Three-month supply: $15	**Three-month supply:** $15
Tier 2: Generic	**One-month supply:** $10	**One-month supply:** $12
	Three-month supply: $30	**Three-month supply:** $36
Tier 3: Preferred Brand	**One-month supply:** $45	**One-month supply:** $45
	Three-month supply: $135	**Three-month supply:** $135
Tier 4: Non-Preferred Drug	**One-month supply:** $95	**One-month supply:** $95
	Three-month supply: $285	**Three-month supply:** $285
Tier 5: Specialty Tier	**One-month supply:** 15%	**One-month supply:** 15%
	Three-month supply: 15%	**Three-month supply:** 15%

Coverage Gap Stage: Preferred Retail Pharmacy		
Preferred Retail	**Blue Cross Group Medicare Advantage (HMO)SM Plan I**	**Blue Cross Group Medicare Advantage (HMO)SM Plan II**
Tier 1: Preferred Generic	**One-month supply:** $0	**One-month supply:** $0
	Three-month supply: $0	**Three-month supply:** $0
Tier 2: Generic	**One-month supply:** $5	**One-month supply:** $7
	Three-month supply: $15	**Three-month supply:** $21
Tier 3: Preferred Brand	**One-month supply:** $40	**One-month supply:** $40
	Three-month supply: $120	**Three-month supply:** $120
Tier 4: Non-Preferred Drug	**One-month supply:** $90	**One-month supply:** $90
	Three-month supply: $270	**Three-month supply:** $270
Tier 5: Specialty Tier	**One-month supply:** 15%	**One-month supply:** 15%
	Three-month supply: 15%	**Three-month supply:** 15%

Coverage Gap Stage: Standard Mail Order Pharmacy		
Standard Mail Order	**Blue Cross Group Medicare Advantage (HMO)SM Plan I**	**Blue Cross Group Medicare Advantage (HMO)SM Plan II**
Tier 1: Preferred Generic	**One-month supply:** $5	**One-month supply:** $5
	Three-month supply: $15	**Three-month supply:** $15
Tier 2: Generic	**One-month supply:** $10	**One-month supply:** $12
	Three-month supply: $30	**Three-month supply:** $36
Tier 3: Preferred Brand	**One-month supply:** $45	**One-month supply:** $45
	Three-month supply: $135	**Three-month supply:** $135
Tier 4: Non-Preferred Drug	**One-month supply:** $95	**One-month supply:** $95
	Three-month supply: $285	**Three-month supply:** $285
Tier 5: Specialty Tier	**One-month supply:** 15%	**One-month supply:** 15%
	Three-month supply: 15%	**Three-month supply:** 15%

Coverage Gap Stage: Preferred Mail Order Pharmacy		
Preferred Mail Order	**Blue Cross Group Medicare Advantage (HMO)SM Plan I**	**Blue Cross Group Medicare Advantage (HMO)SM Plan II**
Tier 1: Preferred Generic	**One-month supply:** $0	**One-month supply:** $0
	Three-month supply: $0	**Three-month supply:** $0
Tier 2: Generic	**One-month supply:** $5	**One-month supply:** $7
	Three-month supply: $15	**Three-month supply:** $21
Tier 3: Preferred Brand	**One-month supply:** $40	**One-month supply:** $40
	Three-month supply: $120	**Three-month supply:** $120
Tier 4: Non-Preferred Drug	**One-month supply:** $90	**One-month supply:** $90
	Three-month supply: $270	**Three-month supply:** $270
Tier 5: Specialty Tier	**One-month supply:** 15%	**One-month supply:** 15%
	Three-month supply: 15%	**Three-month supply:** 15%

	Blue Cross Group Medicare Advantage (HMO)SM Plan I	Blue Cross Group Medicare Advantage (HMO)SM Plan II
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $6,550, you pay the greater of: • 5% of the total cost, or • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copayment for all other drugs	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $6,550, you pay the greater of: • 5% of the total cost, or • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copayment for all other drugs

	Blue Cross Group Medicare Advantage Plan I (HMO)SM	Blue Cross Group Medicare Advantage Plan II(HMO)SM
ADDITIONAL MEMBER BENEFITS		
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
Acupuncture	**Acupuncture for chronic low back pain (Medicare-covered)** • In-network: $0 copay **Acupuncture (non-Medicare-covered)** • $15 copay per visit up to 20 visit(s) for acupuncture and other alternative therapies every year	**Acupuncture for chronic low back pain (Medicare-covered)** • In-network: $0 copay **Acupuncture (non-Medicare-covered)** • $15 copay per visit up to 20 visit(s) for acupuncture and other alternative therapies every year
Chiropractic Care*	**Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)**	
	• $20 copay **Routine care visits** • $20 copay for up to 36 supplemental routine chiropractic visit(s) every year	• 20% of the total cost **Routine care visits** • 20% of the total cost for up to 36 supplemental routine chiropractic visit(s) every year
Diabetes Supplies and Services*	**Diabetes monitoring supplies** • $0 copay **Diabetes self-management training** • $0 copay	**Diabetes monitoring supplies** • $0 copay **Diabetes self-management training** • $0 copay
Durable Medical Equipment *(wheelchairs, oxygen, etc.)**	• 0% - 20% of the cost (0% for safety medical devices only)	• 20% of the total cost

	Blue Cross Group Medicare Advantage Plan I (HMO)SM	Blue Cross Group Medicare Advantage Plan II (HMO)SM
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
Wellness Programs	$0 copay for SilverSneakers®† Fitness Program This benefit includes SilverSneakers instructor-led group fitness classes. At participating locations, you can take classes plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms. SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and a mobile app, SilverSneakers GO™. †SilverSneakers, SilverSneakers FLEX, SilverSneakers On-Demand, and SilverSneakers GO are registered trademarks or trademarks of Tivity Health, Inc.	
Foot Care *(podiatry services)**	**Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions**	
	• $20 copay	• $35 copay
Home Health Care*	• $0 copay	• $0 copay
Opioid Treatment Program Services*	• $0 copay	• $0 copay
Outpatient Substance Abuse Services*	**Group therapy visit** • $40 copay **Individual therapy visit** • $40 copay	**Group therapy visit** • $100 copay **Individual therapy visit** • $100 copay
Over-the-Counter Items	$20 allowance every month for specific over-the-counter drugs and other health-related products. Unused monthly allowance will rollover to the next month but does not rollover to the next year.	Not Covered

	Blue Cross Group Medicare Advantage Plan I (HMO)SM	Blue Cross Group Medicare Advantage Plan II (HMO)SM
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
Prosthetic Devices ***(braces, artificial limbs, etc.)**** *	**Prosthetic devices** • 20% of the total cost **Related medical supplies** • 20% of the total cost	**Prosthetic devices** • 20% of the total cost **Related medical supplies** • 20% of the total cost
Meals	• 3 occurrences per year after an inpatient stay	• 3 occurrences per year after an inpatient stay
Renal Dialysis*	• $0 copay	• $0 copay
Telehealth Services	• $10 copay for urgent care; $40 copay for outpatient mental health; $40 copay for outpatient mental health psychiatric visit through MDLive.	• $10 copay for urgent care; $30 copay for outpatient mental health; $30 copay for outpatient mental health psychiatric visit through MDLive.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	

BlueCross BlueShield of New Mexico

Blue Cross and Blue Shield of New Mexico complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of New Mexico does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of New Mexico:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator

If you believe that Blue Cross and Blue Shield of New Mexico has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-299-1008 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-299-1008 (TTY: 711).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-877-299-1008 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-299-1008 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-299-1008 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-299-1008 (TTY: 711) 。

ملحوظ: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل رقم 1-877-299-1008
(رقم هاتف الصم والبكم: 711)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-299-1008 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-299-1008 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-299-1008 (TTY: 711) まで、お電話にてご連絡ください。

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-299-1008 (ATS: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-299-1008 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-299-1008 (телетайп: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-299-1008 (TTY: 711) पर कॉल करें।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی به صورت رایگان برای شما فراهم می باشد. با 1-877-299-1008 (TTY: 711) تماس بگیرید.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-299-1008 (TTY: 711).

BlueCross BlueShield of New Mexico

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Medicare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services

This information is not a complete description of benefits. Call 1-877-299-1008 (TTY: 711) for more information.

HMO plans provided by Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.