

2018 Blue Cross Blue Shield HMO of New Mexico - Post 65 (Medicare Eligible)*

Medicare Eligible / Over 65 Only	Blue Cross / Blue Shield of New Mexico HMO**	
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Plan changes are in orange.	2018 In-Network	2018 Comments
General Information		
Lifetime Maximum Benefit	Not Applicable	
Annual Maximum Benefit	Not Applicable	
Coinsurance Percentage	Not Applicable	
Precertification Requirements	PET scans, MRI, MRA, Hospital admissions(non-emergency), Hospice, Home Healthcare, Surgery, Outpatient Rehabilitation, DME, Safety Devices	
Precertification Penalty	Services may not be covered	
Health Savings Account (HSA)	Not Applicable	
Health Reimbursement Account (HRA)	Not Applicable	
R & C	Not Applicable	
Deductibles		
Individual Annual Deductible	Not Applicable	
Family Annual Deductible	Not Applicable	
Applies to Out-of-Pocket Maximum	Not Applicable	
Prescription benefits are covered under medical deductible	No	
Out-of-Pocket Mx per Plan Year		
Individual Out-of-Pocket Maximum Per Year	\$2,500.00	
Family Out-of-Pocket Maximum Per Year	Not Applicable	
Outpatient Services		
Primary Care Physician Visits	\$5 copay per visit	
Specialist Visit	\$20 copay per visit	
Lab tests and X-ray	Covered at 100%	
Specialized Imaging	\$50 copay	
Outpatient Surgery	\$50 copay	
Allergy Injections	Covered under office visit copay	
Preventive Care		
Well Child Care Office Visit	Not applicable	
Well Child Age limit	Not applicable	
Adult Routine Physical Exams	\$0 copay	
Adult Immunizations	Covered at 100%	
Routine Mammogram	Covered at 100%	
Pap Smear	Covered at 100%	
Prostate Screening (PSA)	Covered at 100%	
Colon Cancer Screenings	Covered at 100%	
Cardiovascular screenings	\$0. Covered under preventive services.	
Hearing Evaluations	\$30 copay covered every 1 year	
Inpatient Hospital		
Deductible per Confinement	Not applicable	
Deductible per Day	Not applicable	
Hospital Services	\$200 copay per admission	
Physicians and Surgeons' Services	Covered under admission copayment	
Emergency Services		
Emergency Room Treatment	\$50 copay	
Non-emergency or non-urgent use of ER	\$50 copay	
Ambulance	\$75 copay	
Urgent Care Facility Services	\$20-\$50 copay per ben grid	
Physician Office Visit	\$5 copay for PCP, \$20 copay for specialist	
After Hours	\$5 copay for PCP, \$20 copay for specialist	
Maternity Care		
Physician Office Visit	\$5 copay per visit	
Maternity Care - Inpatient Delivery	Not applicable	

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Midwife delivery services	Not applicable	
Mental Health		
Deductible per Confinement	Not applicable	
Deductible per Day	Not applicable	
Mental Health Inpatient	\$200 copay per admission	
Mental Health-Inpatient Plan Maximums	Not applicable	
Mental Health Outpatient	\$0 copay for partial hospitalization; \$20 copay for Group/Individual Therapy	
Mental Health - Group Therapy	\$20 copayment	
Mental Health-Outpatient Plan Maximums	Not applicable	
Severe Mental Illness	\$0 copay for partial hospitalization; \$20 copay for Group/Individual Therapy; \$200 copay per inpatient admission	
Substance Abuse		
Deductible per Confinement	Not applicable	
Deductible per Day	Not applicable	
Detoxification	\$200 copay for inpatient admission	
Substance Abuse - Inpatient Treatment	\$200 copay per admission	
Substance Abuse-Inpatient Plan Maximums	Not applicable	
Substance Abuse-Outpatient	\$20 copay for Group/Individual Therapy; \$20 for outpatient	
Substance Abuse-Outpatient Plan Maximums	Not applicable	
Rehabilitation Therapy		
Inpatient Rehabilitation	For SNF, it is \$0 copay per day for days 1-100.	
Outpatient Physical, Occupational, and Speech Therapy	\$10 copay	
Alternative Care		
Chiropractic Care	\$20 copay (36 visits per calendar yr)	
Acupuncture	Not Covered	
Acupressure	Not covered	
Massage Therapy	Not covered	
Other Services		
Private-Duty Nursing Care	Not covered	
Durable Medical Equipment	\$0 copay	
Prosthetic and Orthotic Appliances	\$0 copay	
Smoking Cessation	covered \$0 copay	
Weight control program	Healthy Weight program available	SilverSneakers included
Bariatric surgery	If Medicare covered.	
TMJ	Not covered	
Podiatry Services	\$20 copay (medically necessary)	
Home Health Care	\$0 copay	
Skilled Nursing Facility Care	\$0 copay days 1-100.	
Hospice Care	Member must get care from a Medicare-certified hospice. Member must consult with plan before selecting hospice.	
Rewards and Incentives	\$25 for up to 4 times a year	
Hearing Aids	\$300 plan coverage limit for hearing aids every year.	

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Family Planning		
Tubal ligation	Not covered	
Vasectomy	Not covered	
Contraceptive Drugs	Not covered	
Contraceptive Devices	Not covered	
Infertility Testing	Not covered	
Infertility Treatments - Office Visit	Not covered	
Infertility Treatments - Surgery	Not covered	
In Vitro Fertilization	Not covered	
Infertility Treatments - Lifetime Maximum	Not covered	
Vision Care		
Eye Examination	\$0 copay for routine eye exam, limited to 1 exam every calendar year.	
Lenses	\$150 eyewear allowance towards glasses every calendar yr)	Contacts are covered per Medicare guidelines after cataract surgery
Frames	\$150 eyewear allowance towards glasses every calendar yr)	Contacts are covered per Medicare guidelines after cataract surgery
Contact lenses- necessary	\$150 eyewear allowance towards glasses every calendar yr)	Contacts are covered per Medicare guidelines after cataract surgery
Contact lenses-elective	\$150 eyewear allowance towards glasses every calendar yr)	Contacts are covered per Medicare guidelines after cataract surgery
Lasik Eye Surgery	Not covered	
Organ and Tissue Transplants		
Organ Transplant -Inpatient	yes with PA through our contracted vendor	
Organs covered	yes	
Transplant Travel	If Medicare-covered	
Transplant donor expenses	Not applicable; not listed in benefit plan.	
Lifetime Maximum	If Medicare-covered	
Prescription Drug Coverage		
Annual Prescription Deductible - Family	Not applicable	
Annual Prescription Deductible - Individual	Not applicable	
Out-of-Pocket Maximums - Individual	\$5,000 in 2018	
Out-of-Pocket Maximums - Family	Not applicable	
Annual Maximum Benefit	\$5,000 in 2018	
Lifetime Maximum Benefit	Not applicable	
Generic Substitution	Not required	
Retail Refill Penalty	Not applicable	
Prescription Drug Retail		
30 day supply:		
Tier 1- Retail - Preferred Generic	\$0 Preferred Pharmacy \$5 Non-Preferred Pharmacy	
Tier 2- Retail Non Preferred Generic	\$5 Preferred Pharmacy \$10 Non-Preferred Pharmacy	
Tier 3 -Retail - Preferred Brand	\$30 Preferred Pharmacy \$35 Non-Preferred Pharmacy	
Tier 4 - Retail -Non Preferred Brand	\$50 Preferred Pharmacy \$55 Non-Preferred Pharmacy	
Tier 5 - Specialty	10% coinsurance to max of \$150	
Injectable Medications	Depends on where it falls in the formulary list	
Prescription Drug Mail Order		
90 day supply:		
Tier 1- Retail - Preferred Generic	\$15 copay	
Tier 2- Retail Non Preferred Generic	\$30 copay	

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Tier 3 -Retail - Preferred Brand	\$105 copay	
Tier 4 - Retail -Non Preferred Brand	\$165 copay	
Tier 5 - Specialty	\$450 copay	
Injectable Medications	Depends on where it falls in the formulary list	
Day Supply	N/A	
Other Services - Prescription Drugs		
Over the Counter	Not covered	
Prenatal Vitamins	Not covered	
Diabetic Supplies	\$0 copay	
Lifestyle Drugs	See formulary listing	
Contraceptives - Injectable	See formulary listing	
Fertility Drugs	Not covered	
Smoking Cessation	See formulary listing	
Cosmetic Medications	Not covered	
Nutritional Supplements	Not covered	