Medicare Eligibile / Over 65 Only	Blue Cross / Blue Shield of New Mexico HMO**	
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Plan changes are in orange.	**2019 In-Network**	**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	
Midwife delivery services	Not applicable	

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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 for Medicare-covered occupational therapy visits**	Benefit Clarification
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.	
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	

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Vision Care		
Eye Examination	$20 copay medicare covered; $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	**$5,100 in 2019**	
Out-of-Pocket Maximums - Family	Not applicable	
Annual Maximum Benefit	**$5,100 in 2019**	
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	

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Prescription Drug Mail Order	90 day supply	
Tier 1- Retail - Preferred Generic	$0 Preferred Pharmacy $15 Non-Preferred Pharmacy	
Tier 2- Retail Non Preferred Generic	$15 Preferred Pharmacy $30 Non-Preferred Pharmacy	
Tier 3 -Retail - Preferred Brand	$90 Preferred Pharmacy $105 Non-Preferred Pharmacy	
Tier 4 - Retail -Non Preferred Brand	$150 Preferred Pharmacy $160 Non-Preferred Pharmacy	
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	

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