Medicare Eligibile / Over 65 Only	Blue Cross / Blue Shield of New Mexico HMO**	
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Plan changes are in orange.	**2020 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	
Mental Health		
Deductible per Confinement	Not applicable	
Deductible per Day	Not applicable	
Mental Health Inpatient	$200 copay per admission	

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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.	

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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	$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	$6,350 in 2020	
Out-of-Pocket Maximums - Family	Not applicable	
Annual Maximum Benefit	$6,350 in 2020	
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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