Medicare Eligible / Over 65 Only

Blue Cross / Blue Shield of New Mexico HMO*

*Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits Department.

file in the Aerospace Employee Benefits Department.				
Plan Changes are in Orange	2026 In-Network	2026 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), Home Healthcare, Surgery, Outpatient			
	Rehabilitation, DME, Safety Devices, Allergy care,			
	including tests and serums, Blepharoplasty, Botox			
	injections, Chemotherapy and Radiation Therapy,			
	Dental Care, Fixed wing air ambulance, Implantable			
	devices Nutritional Counseling			
Precertification Penalty	Services may not be covered			
Health Savings Account (HSA)	Not Applicable			
Health Reimbursement Account (HRA)	Not Applicable			
R & C	Not Applicable			
Deductibles	Not Applicable			
Individual Annual Deductible	Not Applicable			
Family Annual Deductible	Not Applicable			
Applies to Out-of-Pocket Maximum	Not Applicable			
Prescription benefits are covered under medical	Not covered			
deductible Out-of-Pocket Mx per Plan Year				
Individual Out-of-Pocket Maximum Per Year	\$2,500.00			
Family Out-of-Pocket Maximum Per Year				
Outpatient Services	Not Applicable			
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			
·	\$50 copay			
Outpatient Surgery Allergy Injections	Covered under office visit copay			
OP Blood Services	Covered under office visit copay			
Coverage begins with the first Pint of Blood	\$0 copay			
Preventive Care				
Well Child Care Office Visit	Not applicable			
Well Child Age limit	Not applicable			
Adult Routine Physical Exams	\$0 copay			
Adult Immunizations	Part B vaccines covered at 100%; Part D vaccines			
, , , , , , , , , , , , , , , , , , , ,	vary based on tier			
Routine Mammogram	Covered at 100%			
Pap Smear	Covered at 100%			
Prostate Screening (PSA)	Covered at 100%			
Colon Cancer Screenings	Covered at 100%			
Cardiovascular screenings	Covered at 100%			
Hearing Evaluations	\$20 copay - diagnostic hearing exam			
	\$30 copay - 1 routine hearing exam every 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. Worldwide coverage. Cost share waived if	CMS language clarification; no benefit change		
	admitted within 3 days of the same condition			
Non-emergency or non-urgent use of ER	\$50 copay			
Ambulance	\$75 copay			
Urgent Care Facility Services	\$20 copay for Medicare-covered	Virtual Visits solution has been added to support		
	urgently-needed-care visits	urgent issues 24/7.		
	Worldwide coverage.			
Disserting Office Vitalia	(\$10 copay Virtual Visits)			
Physician Office Visit	\$5 copay for PCP, \$20 copay for specialist			
After Hours	\$5 copay for PCP, \$20 copay for specialist			
Maternity Care	0.5			
Physician Office Visit	\$5 copay per visit			
Maternity Care - Inpatient Delivery	Not applicable			
Midwife delivery services	Not applicable			
Mental Health	Mar and Back In			
Deductible per Confinement	Not applicable			
Deductible per Day	Not applicable			
Mental Health Inpatient	\$200 copay per admission	CMC standard		
Mental Health-Inpatient Plan Maximums	Limited to 190 lifetime days	CMS standard		

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Severe Mental Illness Silbstance Abuse	Mental Health - Group Therapy	\$20 copay	The state of the s		
Severe Mental Illness Silbstance Abuse	Mental Health-Outpatient Plan Maximums	Not applicable			
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Substance Abuse-Outpatient Plan Maximums Not applicable Rehabilitation For SNF, it is 30 copay per day for days 1-100.	·	\$20 copay for Group/Individual Therapy; \$0 for Opioid Treatment Services			
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	,	eye exam, limited to 1 exam every calendar year			
Lenses \$0 copay Medicare covered	Lenses				
1 pair of eyeglasses (lenses and frames)			Į l		
contact lenses after cataract surgery			Į		
\$150 allowance		\$150 allowance	ı i		
on evewear every year.		· ·	1		

Medicare Eligible / Over 65 Only	Blue Cross / Blue Shield of	Blue Cross / Blue Shield of New Mexico HMO*		
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Plan Changes are in Orange	2026 In-Network	2026 Comments		
Frames	\$0 copay Medicare covered			
	1 pair of eyeglasses (lenses and frames)			
	contact lenses after cataract surgery			
	\$150 allowance			
	on evewear every year.			
Contact lenses- necessary	\$0 copay Medicare covered			
	1 pair of eyeglasses (lenses and frames)			
	contact lenses after cataract surgery			

	\$150 allowance	
	on evewear every year.	
Contact lenses- necessary	\$0 copay Medicare covered	
	1 pair of eyeglasses (lenses and frames)	
	contact lenses after cataract surgery	
	\$150 allowance	
	on evewear every year.	
Contact lenses-elective	\$0 copay Medicare covered	
	1 pair of eyeglasses (lenses and frames)	
	contact lenses after cataract surgery	
	\$150 allowance	
	on evewear every year.	
Lasik Eye Surgery	Not covered	
Organ and Tissue Transplants		
Organ Transplant -Inpatient	\$200 copay per admission	
Organs covered	Yes, covered	
Transplant Travel	Yes, covered	
Transplant donor expenses	Yes, covered	
Lifetime Maximum	Not applicable	
Prescription Drug Coverage		
Annual Prescription Deductible - Family	Not applicable	
Annual Prescription Deductible - Individual	Not applicable	
Out-of-Pocket Maximums - Individual	\$2,100	CMS mandated change
Out-of-Pocket Maximums - Family	Not applicable	
Annual Maximum Benefit	Not applicable	
Lifetime Maximum Benefit	Not applicable	
Generic Substitution	Not required	
Retail Refill Penalty	Not applicable	
Prescription Drug Retail		
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	

Medicare Eligible / Over 65 Only Blue Cross / Blue Shield of New Mexico HMO*

*Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits Department.

file in the Aerospace Employee Benefits Department.			
Plan Changes are in Orange	2026 In-Network	2026 Comments	
Prescription Drug Mail Order			
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 \$165 Non-Preferred		
	Pharmacy		
Tier 5 - Specialty	\$450 copay		
Injectable Medications	Depends on where it falls in the formulary list		
Day Supply	90 day supply		
Other Services - Prescription Drugs			
Over the Counter	Not covered		
Prenatal Vitamins	Not covered		
Diabetic Supplies	0-20% coinsurance for diabetic supplies and services	No change from 2021: 0%-20% 0% cost sharing limited to diabetic testing supplies (meters, strips and lancets) obtained through the pharmacy for a LifeScan branded product (OneTouch Verio Flex, OneTouch Verio Reflect, OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra 2). 20% cost sharing for plan approved non-preferred diabetic testing supplies (meters, strips and lancets). 20% cost sharing for all other diabetic supplies in this category. All test strips will also be subject to a quantity limit of 204 per 30 days. Continuous Glucose Monitoring (CGM) products obtained through the	
Lifestyle Drugs	Not covered		
Contraceptives - Injectable	See formulary listing		
Fertility Drugs	Not covered		
Smoking Cessation	See formulary listing		
Cosmetic Medications	Not covered		
Nutritional Supplements	Not covered		