



**BlueCross BlueShield  
of New Mexico**

# Summary of Benefits

Blue Cross Medicare Advantage Saver Plus (PPO)<sup>SM</sup>

**January 1, 2023 – December 31, 2023**

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."

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## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-774-8592 (TTY/TDD: 711). We are open from 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

## Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [getbluenm.com/mapd](https://getbluenm.com/mapd) or call 1-877-774-8592 to view a copy of the EOC.
- Review the *Provider Finder* (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the *Pharmacy Directory* to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

## Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. **In addition, you will pay a higher copay for services received by non-contracted providers.**

# 2023 Summary of Benefits

## Blue Cross Medicare Advantage Saver Plus (PPO)

January 1, 2023 - December 31, 2023

**Blue Cross Medicare Advantage Saver Plus (PPO)** is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-877-774-8592 (TTY 711) and request the “Evidence of Coverage” or access it online at [getbluenm.com/mapd](http://getbluenm.com/mapd).

To join **Blue Cross Medicare Advantage Saver Plus (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in New Mexico: Bernalillo, Catron, Chaves, Cibola, Colfax, Curry, De Baca, Doña Ana, Grant, Guadalupe, Harding, Lincoln, Los Alamos, Luna, McKinley, Mora, Otero, Quay, Rio Arriba, Roosevelt, San Juan, San Miguel, Sandoval, Santa Fe, Sierra, Socorro, Taos, Torrance, and Valencia.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services unless otherwise noted in your Evidence of Coverage (EOC).

For coverage and costs of Original Medicare, look in your current **“Medicare & You”** handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.

For more information, please call us at 1-877-774-8592 (TTY users should call 711). Hours are 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays, or visit us at [getbluenm.com/mapd](http://getbluenm.com/mapd).

| Premiums and Benefits  | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>  |
|--|---|
| Monthly Plan Premium ( <i>includes both medical and drugs</i> )                            | You pay \$0 per month. In addition, you must keep paying your Medicare Part B premium.  |
| Part B Premium Buy-down (if applicable)  | \$40.00   |
| Deductible   | This plan does not have a deductible.   |
| Maximum Out-of-Pocket Responsibility ( <i>does not include Part D prescription drugs</i> ) | <p>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.</p> <p><b>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</b></p>   |
|  | <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>• \$5,500 for services you receive from in-network providers.</li> <li>• \$8,950 for services you receive from out-of-network providers.</li> <li>• \$8,950 for services you receive from any provider. Your limit for services received from in-network providers and your limit for services received from out-of-network providers will count toward this limit.</li> </ul> |
| Inpatient Hospital   | <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$370 copay per day for days 1-6 and \$0 copay per day for days 7-90</li> <li>• \$0 copay per day for days 91 and beyond</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$500 copay per day</li> </ul>  |
| Outpatient Hospital  | <p><b>In-Network:</b> \$375 copay</p> <p><b>Out-of-Network:</b> \$400 copay</p>   |

| Premiums and Benefits  | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>   |
|--|--|
| Ambulatory Surgical Center (ASC)   | <b>In-Network:</b> \$300 copay<br><b>Out-of-Network:</b> \$350 copay   |
| Doctor Visits <ul style="list-style-type: none"> <li>◦ Primary care provider</li> <li>◦ Specialists</li> </ul> | <b><u>Primary care provider visit</u></b> <ul style="list-style-type: none"> <li>◦ <b>In-Network:</b>\$0 copay</li> <li>◦ <b>Out-of-Network:</b> \$30 copay</li> </ul><br><b><u>Specialists</u></b> <ul style="list-style-type: none"> <li>◦ <b>In-Network:</b>\$45 copay</li> <li>◦ <b>Out-of-Network:</b>\$75 copay</li> </ul>   |
| Preventive Care<br><br>(e.g., flu vaccine, diabetic screenings)  | <b>In-Network:</b> \$0 copay<br><b>Out-of-Network:</b> \$0 copay<br><b>Important Message About What You Pay for Vaccines</b><br>Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.<br><br>*Other preventive services are available. There are some covered services that have a cost. Please reference EOC for more detail. |
| Emergency Care   | \$90 copay per visit<br><br>Copay is waived if you are admitted to the hospital within 3 days for the same condition. See the "Inpatient Hospital" section of this booklet for other costs.  |
| Urgently Needed Services   | \$30 copay per visit   |

| Premiums and Benefits  | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>   |
|--|--|
| Diagnostic Services/Labs/Imaging <ul style="list-style-type: none"> <li>◦ MRI, CAT Scan<br/>X-Rays</li> <li>◦ Diagnostic tests and procedures</li> <li>◦ Lab services</li> </ul> | <p><b><u>Diagnostic radiology services (such as MRIs, CT scans)</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$250 copay at a free-standing clinic, \$300 copay for services in an outpatient hospital setting</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$400 copay</li> </ul> <p><b><u>Diagnostic tests and procedures</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$100 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$200 copay</li> </ul> <p><b><u>Lab services</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$50 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$200 copay</li> </ul> <p><b><u>Outpatient X-rays</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$5 - \$100 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$200 copay</li> </ul> |

| Premiums and Benefits | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>  |
|-----------------------|---|
|                       | <p data-bbox="753 233 1892 269"><b><u>Therapeutic radiology services (such as radiation treatment for cancer)</u></b></p> <p data-bbox="753 289 951 321"><b>In-Network:</b></p> <ul data-bbox="806 342 989 378" style="list-style-type: none"><li data-bbox="806 342 989 378">• \$60 copay</li></ul> <p data-bbox="753 412 1020 444"><b>Out-of-Network:</b></p> <ul data-bbox="806 466 1142 501" style="list-style-type: none"><li data-bbox="806 466 1142 501">• 50% of the total cost</li></ul> |

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|--|---|
| <p>Hearing Services</p> <ul style="list-style-type: none"> <li>◦ Medicare-covered hearing exam</li> <li>◦ Routine hearing exam</li> <li>◦ Hearing aid</li> </ul> | <p><b><u>Exam to diagnose and treat hearing and balance issues</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$40 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay</li> </ul> <p><b><u>Routine hearing exam</u></b></p> <p><b>In-Network</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for 1 routine hearing exam each year</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• 50% of the total cost for 1 routine hearing exam each year</li> </ul> <p><b><u>Hearing aid fitting/evaluation</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay</li> <li>• Purchase includes unlimited provider visits for fitting and adjustments within 12 months of purchase of hearing aids.</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• 50% of the total cost for 1 hearing aid fitting and evaluation visit every three years</li> </ul> <p><b><u>Hearing Aids</u></b></p> <ul style="list-style-type: none"> <li>• There is a \$1,000 maximum plan coverage limit for hearing aids (both ears combined) purchased in- or out-of-network every three years.</li> </ul> |



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|---|---|
| <p>Dental Services</p> <ul style="list-style-type: none"> <li>◦ Medicare-covered dental</li> <li>◦ Preventive Dental</li> <li>◦ Supplemental Dental Services</li> </ul> | <p><b><u>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$35 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay</li> </ul> <p><b><u>Preventive dental services</u></b></p> <p><b><u>Cleanings</u></b></p> <p><b>In-Network and Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for up to 2 cleaning(s) per year</li> </ul> <p><b><u>Dental X-rays</u></b></p> <p><b>In-Network and Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for up to 1 bitewing X-ray per year</li> </ul> <p><b><u>Oral exams</u></b></p> <p><b>In-Network and Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for up to 2 oral exam(s) per year</li> </ul> <p><b><u>Comprehensive dental services</u></b></p> <p><b>In-Network and Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$1,000 annual maximum coverage. For more details on benefits and benefit limitations regarding your dental coverage, please see your Evidence of Coverage.</li> </ul> |

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|---|---|
| <p>Vision Services</p> <ul style="list-style-type: none"> <li>◦ Medicare-covered eye exam</li> <li>◦ Medicare-covered eyewear</li> <li>◦ Routine eye exam</li> <li>◦ Routine eyewear</li> </ul> | <p><b><u>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for Medicare-covered eye exam; \$0 copay for one vision specialist exam</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay</li> </ul> <p><b><u>Routine eye exam</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for 1 routine eye exam every year</li> </ul> <p><b>Out-of-Network</b></p> <ul style="list-style-type: none"> <li>• \$40 allowance for 1 routine eye exam every year</li> </ul> <p><b><u>Eyeglasses or contact lenses after cataract surgery</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery</li> </ul> |

| Premiums and Benefits | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>   |
|-----------------------|--|
|                       | <p><b><u>Routine eye wear</u></b></p> <p><b>Contact lenses</b></p> <p><b>In-Network and Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay</li> </ul> <p><b>Eyeglass frames</b></p> <p><b>In-Network and Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for 1 pair of eyeglass frames every year</li> </ul> <p><b>Eyeglass lenses</b></p> <p><b>In-Network and Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for 1 pair of eyeglass lenses every year (Standard lenses only. Progressive lenses excluded)</li> </ul> <p>\$100 maximum plan coverage limited in-network and out-of-network for routine eye wear every year (including eyeglass frames, lenses, and contact lenses)</p> |

| Premiums and Benefits   | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>   |
|---|--|
| <p>Mental Health Services</p> <ul style="list-style-type: none"> <li>◦ Inpatient mental health</li> <li>◦ Outpatient group therapy/ individual therapy visit</li> </ul> | <p><b><u>Inpatient visit</u></b></p> <p>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.</p> <p>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.</p> <hr/> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$290 copay per day for days 1-6 and a \$0 copay per day for days 7-90</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$500 copay per day</li> </ul> <p><b><u>Outpatient group therapy visit</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$40 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$50 copay</li> </ul> |

| Premiums and Benefits          | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>  |
|--------------------------------|---|
|                                | <p><b><u>Outpatient individual therapy visit</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$40 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$50 copay</li> </ul>  |
| Skilled Nursing Facility (SNF) | <p><b>Our plan covers up to 100 days in a SNF.</b></p> <p>Inpatient hospital stay is not required prior to admission.</p> <p><b>In-Network:</b> \$0 copay per day for days 1-20. \$196 copay per day for days 21-49. \$0 copay per day for days 50-100.</p> <p><b>Out-of-Network:</b> \$250 copay per day</p> |
| Physical Therapy               | <p><b>In-Network:</b> \$40 copay</p> <p><b>Out-of-Network:</b> \$75 copay</p>   |

| Premiums and Benefits     | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>  |
|---------------------------|---|
| Outpatient Rehabilitation | <p><b><u>Cardiac (heart) rehab services</u></b> (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks)</p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$30 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay</li> </ul> <p><b><u>Occupational therapy visit</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$40 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay</li> </ul> |
| Ambulance                 | <p><b>In-Network:</b> \$250 copay for each one-way ground transportation trip, 20% of the total cost for each one-way air transportation trip.</p> <p><b>Out-of-Network:</b> \$250 copay for each one-way ground transportation trip, 20% of the total cost for each one-way air transportation trip.</p>   |
| Transportation            | Not Covered   |
| Medicare Part B Drugs     | <p><b>In-Network:</b> 20% of the total cost for chemotherapy drugs. 20% of the total cost for other Part B drugs</p> <p><b>Out-of-Network:</b> 50% of the total cost for chemotherapy drugs. 50% of the total cost for other Part B drugs</p>   |

| Premiums and Benefits         | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>   |                                     |  |  |
|-------------------------------|--|-------------------------------------|--|--|
| Outpatient Prescription Drugs |  |                                     |  |  |
| Deductible                    | <p>\$505 per year for Part D prescription drugs except for drugs listed on Tier 1 Preferred Generic and Tier 2 Generic which are excluded from the deductible.</p> <p>Once you have paid \$505 for your Tiers 3, 4 and 5 drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.</p> <p><b>Important Message About What You Pay for Insulin</b></p> <p>You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.</p> |                                     |  |  |
|                               | Preferred Retail Rx<br>30-day supply   | Standard Retail Rx<br>30-day supply | Preferred Mail<br>Order<br>90-day supply                 | Standard Mail<br>Order<br>90-day supply                  |
| Initial Coverage              |  |                                     |  |  |
| Tier 1: Preferred Generic     | \$0 copay  | \$15 copay                          | \$0 copay  | \$45 copay   |
| Tier 2: Generic               | \$5 copay  | \$20 copay                          | \$15 copay   | \$60 copay   |
| Tier 3: Preferred Brand       | \$44 copay   | \$47 copay                          | \$132 copay  | \$141 copay  |
| Tier 4: Non-Preferred Drug    | \$85 copay   | \$100 copay                         | \$255 copay  | \$300 copay  |
| Tier 5: Specialty Tier        | 25% of the total cost  | 25% of the total cost               | A long-term supply is not available for drugs in Tier 5. | A long-term supply is not available for drugs in Tier 5. |
|                               | *If you reside in a long-term facility, you pay the same as at a standard retail pharmacy.   |                                     |  |  |
| Coverage Gap                  | During this phase you will pay 25% for generic or brand-name drugs.  |                                     |  |  |

| Premiums and Benefits   | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>  |
|---|---|
| <b>Outpatient Prescription Drugs</b>  |   |
| Catastrophic Coverage ( <i>after you or others on your behalf pay \$7,400</i> ) <ul style="list-style-type: none"> <li>◦ Generic Drugs</li> <li>◦ Brand-Name Drugs</li> </ul> | <b>Generic Drugs:</b> <ul style="list-style-type: none"> <li>• You pay \$4.15 or 5% (whichever costs more)</li> </ul> <b>Brand-Name Drugs:</b> <ul style="list-style-type: none"> <li>• You pay \$10.35 or 5% (whichever costs more)</li> </ul> |
| Cost-Sharing may change depending on the pharmacy you choose.   |   |



| Additional Member Benefits  | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>   |
|---|--|
| Acupuncture for Chronic Low Back Pain   | <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$45 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay</li> </ul>  |
| Chiropractic Care   | <p><b><u>Medicare-covered manipulation of the spine to correct a subluxation</u></b> (when 1 or more of the bones of your spine move out of position)</p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$20 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay</li> </ul>  |
| <p>Diabetes Supplies and Services</p> <ul style="list-style-type: none"> <li>- Diabetes Monitoring Supplies</li> <li>- Diabetes self-management training</li> <li>- Therapeutic shoes or inserts</li> </ul> | <p><b><u>Diabetes monitoring supplies</u></b></p> <p><b>In-Network:</b> 0% or 20% of the total cost</p> <p><b>Out-of-Network:</b> 20% of the total cost</p> <p><b><u>Diabetes self-management training</u></b></p> <p><b>In-Network:</b> \$0 copay</p> <p><b>Out-of-Network:</b> \$0 copay</p> <p><b><u>Therapeutic shoes or inserts</u></b></p> <p><b>In-Network:</b> 20% of the total cost</p> <p><b>Out-of-Network:</b> 20% of the total cost</p> |

| Additional Member Benefits                                      | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>  |
|---|---|
| Durable Medical Equipment<br><i>(wheelchairs, oxygen, etc.)</i> | <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• 20% of the total cost</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• 20% of the total cost</li> </ul> |

| Additional Member Benefits | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>  |
|----------------------------|---|
| Wellness Programs          | <p data-bbox="758 235 1436 272">\$0 copay for SilverSneakers<sup>®</sup> † Fitness Program</p> <p data-bbox="758 289 1976 667">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<sup>®</sup> 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<sup>™</sup> and a mobile app, SilverSneakers GO<sup>™</sup>. Plus, you get access to GetSetUp3, with thousands of live online classes to ignite your interests in topics like cooking, technology and art. All you need to get started is your personal SilverSneakers ID number. Go to <a href="http://SilverSneakers.com">SilverSneakers.com</a> to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET.</p> <p data-bbox="758 688 1724 725">Always talk with your doctor before starting an exercise program.</p> <ol data-bbox="800 743 1976 1101" style="list-style-type: none"> <li data-bbox="800 743 1976 857">1. Participating locations (“PL”) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.</li> <li data-bbox="800 865 1976 938">2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.</li> <li data-bbox="800 946 1976 1101">3. GetSetUp is a third-party service provider and is not owned or operated by Tivity Health, Inc. (“Tivity”) or its affiliates. Users must have internet service to access GetSetUp service. Internet service charges are responsibility of user. Charges may apply for access to certain GetSetUp classes or functionality.</li> </ol> <p data-bbox="758 1133 1976 1247">Blue Cross<sup>®</sup>, Blue Shield<sup>®</sup> and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.</p> <p data-bbox="758 1268 1976 1336">†SilverSneakers, SilverSneakers FLEX, SilverSneakers On-Demand, and SilverSneakers GO are registered trademarks or trademarks of Tivity Health, Inc.</p> |

| Additional Member Benefits             | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>  |
|--|---|
| Foot Care ( <i>podiatry services</i> ) | <p><b><u>Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$40 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay</li> </ul> |
| Home Health Care                       | <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• 50% of the total cost</li> </ul>   |
| Opioid Treatment Program Services      | <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$50 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay</li> </ul>   |

| Additional Member Benefits                                   | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>  |
|--|---|
| Outpatient Substance Abuse Services                          | <p><b><u>Group therapy visit</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$100 copay</li> </ul> <p><b><u>Individual therapy visit</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$75 copay</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• \$100 copay</li> </ul>  |
| Over-the-Counter Items                                       | Not Covered   |
| Prosthetic Devices ( <i>braces, artificial limbs, etc.</i> ) | <p><b><u>Prosthetic devices</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• 20% of the total cost</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• 20% of the total cost</li> </ul> <p><b><u>Related medical supplies</u></b></p> <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• 20% of the total cost</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• 20% of the total cost</li> </ul> |

| Additional Member Benefits | Blue Cross Medicare Advantage Saver Plus (PPO) <sup>SM</sup>   |
|----------------------------|--|
| Meals                      | Not Covered  |
| Renal Dialysis             | <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• 20% of the total cost</li> </ul> <p><b>Out-of-Network:</b></p> <ul style="list-style-type: none"> <li>• 50% of the total cost</li> </ul>                    |
| Telehealth Services        | <p><b>In-Network:</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for urgent care visits through MDLive</li> </ul>  |
| Hospice                    | <p>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.</p> |

| <b>Optional Supplemental Benefits</b>   | <b>Blue Cross Medicare Advantage Saver Plus (PPO)<sup>SM</sup></b>   |
|---|--|
| OSB Package <ul style="list-style-type: none"><li>◦ Monthly Premium</li></ul> | <ul style="list-style-type: none"><li>• You pay additional \$35.30 per month<ul style="list-style-type: none"><li>◦ Dental</li></ul></li></ul> |



**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 a 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., 35<sup>th</sup> floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960. You can file a grievance by phone, mail, or fax. If you need help filing a grievance, a 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>.



English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-774-8592 (TTY/TDD: 711). Someone who speaks English/Language can help you. This is a free service.

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Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-774-8592 (TTY/TDD: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

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Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-774-8592 (TTY/TDD: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

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Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-774-8592 (TTY/TDD: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

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Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-774-8592 (TTY/TDD: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

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French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-774-8592 (TTY/TDD: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

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Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-774-8592 (TTY/TDD: 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

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German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-774-8592 (TTY/TDD: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-774-8592 (TTY/TDD: 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-774-8592 (TTY/TDD: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

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Arabic: سيقوم شخص ما يتحدث العربية إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول (TTY/ 1-877-774-8592) TDD: 711). بمساعدتك. هذه خدمة مجانية على مترجم فوري، ليس عليك سوى الاتصال بنا على

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Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-774-8592 (TTY/TDD: 711). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

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Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-774-8592 (TTY/TDD: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

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Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-774-8592 (TTY/TDD: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

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French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-774-8592 (TTY/TDD: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

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Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-774-8592 (TTY/TDD: 711). Ta usługa jest bezpłatna.

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Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご利用になるには、1-877-774-8592 (TTY/TDD: 711). にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

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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 1-877-774-8592 (TTY: 711) for more information.

HMO and PPO plans provided by Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). PPO plan provided by HCSC Insurance Services Company (HISC). HCSC and HISC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and HISC are Medicare Advantage organizations with a Medicare contract. Enrollment in these plans depends on contract renewal.

Premium, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.