



BlueCross BlueShield
of New Mexico

New Mexico Retiree Health Care Authority (NMRHCA)

Summary of Benefits

Blue Cross Group Medicare Advantage (HMO)SM

January 1 – December 31, 2024

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 Benefits Insert."

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Blue Cross Group Medicare Advantage (HMO)

Blue Cross Group Medicare Advantage (HMO) is a Medicare Advantage HMO MAPD 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 1-877-299-1008 (TTY 711) and request the “Evidence of Coverage” or access it online at www.bcbsnm.com/retiree-medicare-tools.

To join Blue Cross Group Medicare Advantage (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and be a retiree, or Medicare-eligible dependent of a retiree, of New Mexico Retiree Health Care Authority.

Our service area includes the state of New Mexico

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 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 1-877-299-1008 (TTY users should call 711), 7 days a week, 8 a.m. to 8 p.m. or visit us at www.bcbsnm.com/retiree-medicare-tools.

Understanding the Benefits

Blue Cross Group Medicare Advantage (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can see our plan's Provider Directory and/or Pharmacy Directory at www.bcbsnm.com/retiree-medicare-tools.

NOTE: Services with a * may require prior authorization or a referral from your doctor.

	Blue Cross Group Medicare Advantage (HMO) SM HMO I	Blue Cross Group Medicare Advantage (HMO) SM HMO II
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium? (includes both medical and drugs)	For information concerning the actual premiums you will pay, please contact your employer or your employer group benefits plan administrator. In addition, you must keep paying your Medicare Part B premium.	
Deductible	This plan does not have a deductible for medical services.	This plan does not have a deductible for medical services.
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	
	Your yearly limit(s) in this plan: <ul style="list-style-type: none"> • \$3,000 combined for services you receive from in-network and out of network providers. • \$0 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. 	Your yearly limit(s) in this plan: <ul style="list-style-type: none"> • \$6,700 combined for services you receive from in-network and out of network providers. • \$0 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.
Inpatient Hospital Care*	Our plan covers an unlimited number of days for an inpatient hospital stay. \$1,250 out-of-pocket limit each year. <u>In-network:</u> \$125 copay per day for days 1-5 \$0 copay per day for days 6+	Our plan covers an unlimited number of days for an inpatient hospital stay. <u>In-network:</u> \$500 copay
Outpatient Hospital*	<u>In-network:</u> \$175 copay	<u>In-network:</u> \$300 copay

	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Ambulatory Surgical Center (ASC)*	<u>In-network:</u> \$175 copay	<u>In-network:</u> \$300 copay
Doctor Visits* <ul style="list-style-type: none"> • Primary care provider • Specialists 	<ul style="list-style-type: none"> • <u>In-network:</u> \$10 copay • <u>In-network:</u> \$30 copay 	<ul style="list-style-type: none"> • <u>In-network:</u> \$10 copay • <u>In-network:</u> \$40 copay
Preventive Care* (e.g., flu vaccine, diabetic screenings)	<p><u>In-network:</u> \$0 copay</p> <p>Important Message About What You Pay for Vaccines Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.</p> <p>*Other preventive services are available. There are some covered services that may have a cost.</p>	<p><u>In-network:</u> \$0 copay</p> <p>Important Message About What You Pay for Vaccines Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.</p> <p>*Other preventive services are available. There are some covered services that may have a cost.</p>
Emergency Care	<p><u>In-network:</u> \$65 copay</p> <p>Cost share waived if admitted within 3 days for the same condition.</p>	<p><u>In-network:</u> \$90 copay</p> <p>Cost share waived if admitted within 3 days for the same condition.</p>
Urgently Needed Services	<p><u>In-network:</u> \$25 copay</p> <p>Cost share waived if admitted within 3 days for the same condition.</p>	<p><u>In-network:</u> \$50 copay</p> <p>Cost share waived if admitted within 3 days for the same condition.</p>

	Blue Cross Group Medicare Advantage (HMO) SM HMO I	Blue Cross Group Medicare Advantage (HMO) SM HMO II
Diagnostic Tests, Lab and Radiology Services, and X-Rays* <ul style="list-style-type: none"> • Diagnostic tests and procedures • Lab services • MRI, CAT Scan • X-Rays 	<ul style="list-style-type: none"> • <u>In-network</u>: \$0 copay • <u>In-network</u>: \$0 copay • <u>In-network</u>: \$50 copay • <u>In-network</u>: \$0 copay 	<ul style="list-style-type: none"> • <u>In-network</u>: \$0 copay • <u>In-network</u>: \$0 copay • <u>In-network</u>: \$200 copay • <u>In-network</u>: \$0 copay
Hearing Services* <ul style="list-style-type: none"> • Medicare covered hearing exam • Routine hearing exam • Hearing aid 	<ul style="list-style-type: none"> • <u>In-network</u>: \$20 copay • <u>In-network</u>: \$30 copay for 1 routine hearing exam each year • <u>In-network</u>: \$300 allowance toward hearing aids every 12 months 	<ul style="list-style-type: none"> • <u>In-network</u>: \$20 copay • <u>In-network</u>: \$30 copay for 1 routine hearing exam each year • <u>In-network</u>: \$300 allowance toward hearing aids every 12 months
Dental Services* <ul style="list-style-type: none"> • Medicare covered dental • Preventive Dental 	<ul style="list-style-type: none"> • <u>In-network</u>: \$20 copay • Not Covered 	<ul style="list-style-type: none"> • <u>In-network</u>: \$20 copay • Not Covered

	Blue Cross Group Medicare Advantage (HMO) SM HMO I	Blue Cross Group Medicare Advantage (HMO) SM HMO II
<ul style="list-style-type: none"> • Supplemental Dental Services 	<ul style="list-style-type: none"> • Not Covered 	<ul style="list-style-type: none"> • Not Covered
Vision Services* <ul style="list-style-type: none"> • Medicare covered vision exam • Medicare covered eyewear • Routine vision exam • Routine eyewear 	<ul style="list-style-type: none"> • <u>In-network:</u> \$35 copay • <u>In-network:</u> \$0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery • <u>In-network:</u> \$10 copay for 1 routine eye exam each year • <u>In-network:</u> \$150 contact lens allowance OR \$0 copay standard eyeglass lens AND \$150 frame allowance every year. 	<ul style="list-style-type: none"> • <u>In-network:</u> \$35 copay • <u>In-network:</u> \$0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery • <u>In-network:</u> \$10 copay for 1 routine eye exam each year • <u>In-network:</u> \$150 contact lens allowance OR \$0 copay standard eyeglass lens AND \$150 frame allowance every year.
Mental Health Care* <ul style="list-style-type: none"> • Inpatient mental health 	<ul style="list-style-type: none"> • <u>In-network:</u> \$1,250 out-of-pocket limit each year • <u>In-network:</u> \$125 copay per day for days 1-5 • \$0 copay for days 6+ 	<ul style="list-style-type: none"> • <u>In-network:</u> \$500 per day for days 1-5

	Blue Cross Group Medicare Advantage (HMO) SM HMO I	Blue Cross Group Medicare Advantage (HMO) SM HMO II
<ul style="list-style-type: none"> • Psychiatric Services • Outpatient group therapy/ individual therapy visit 	<p>Individual</p> <ul style="list-style-type: none"> • <u>In-network:</u> \$40 copay <p>Group</p> <ul style="list-style-type: none"> • <u>In-network:</u> \$40 copay 	<p>Individual</p> <ul style="list-style-type: none"> • <u>In-network:</u> \$30 copay <p>Group</p> <ul style="list-style-type: none"> • <u>In-network:</u> \$30 copay
Skilled Nursing Facility (SNF)*	<u>In-network:</u> \$0 copay per day for days 1-20. \$75 copay per day for days 21-100.	<u>In-network:</u> \$0 copay per day for days 1-20. \$50 copay per day for days 21-100.
<p>Outpatient Rehabilitation*</p> <ul style="list-style-type: none"> • Cardiac Rehabilitation Services • Physical therapy and speech and language therapy visit • Pulmonary Rehabilitation Therapy 	<p><u>In-network:</u> \$10 copay for cardiac rehabilitation services</p> <p><u>In-network:</u> \$10 copay</p> <p><u>In-network:</u> \$0 copay limit up to 36 sessions per year</p>	<p><u>In-network:</u> \$10 copay for cardiac rehabilitation services</p> <p><u>In-network:</u> \$40 copay</p> <p><u>In-network:</u> \$0 copay limit up to 36 sessions per year</p>

	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
<ul style="list-style-type: none"> • Supervised Exercise Therapy for PAD 	<u>In-network:</u> \$0 copay limit up to 36 sessions in 12 weeks	<u>In-network:</u> \$0 copay limit up to 36 sessions in 12 weeks
Ambulance* <ul style="list-style-type: none"> • Ground services • Air services 	<ul style="list-style-type: none"> • <u>In-network:</u> \$100 copay • <u>In-network:</u> \$100 copay 	<ul style="list-style-type: none"> • <u>In-network:</u> \$200 copay • <u>In-network:</u> \$200 copay
Transportation*	<ul style="list-style-type: none"> • \$0 copay for up to 4 one-way trips every year to plan-approved locations 	<ul style="list-style-type: none"> • \$0 copay for up to 4 one-way trips every year to plan-approved locations
Medicare Part B Drugs* <ul style="list-style-type: none"> • Chemotherapy drugs • Other Part B drugs 	<ul style="list-style-type: none"> • <u>In-network:</u> 20% of the total cost • <u>In-network:</u> 20% of the total cost 	<ul style="list-style-type: none"> • <u>In-network:</u> 20% of the total cost • <u>In-network:</u> 20% of the total cost

	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
PRESCRIPTION DRUG BENEFITS		
Stage 1: Part D Deductible	<p>Because there is no prescription drug deductible for the plan, this payment stage does not apply to you.</p> <p>Important Message About What You Pay for Insulin</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.</p>	<p>Because there is no prescription drug deductible for the plan, this payment stage does not apply to you.</p> <p>Important Message About What You Pay for Insulin</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.</p>
Stage 2: Initial Coverage	<p>Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p>	<p>Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p>

Cost Shares During the Initial Coverage Stage

Initial Coverage Stage: Standard Retail Pharmacy		
Standard Retail	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Tier 1: Preferred Generic	One-month supply: \$5	One-month supply: \$5
	Three-month supply: \$15	Three-month supply: \$15
Tier 2: Generic	One-month supply: \$10	One-month supply: \$12
	Three-month supply: \$30	Three-month supply: \$36
Tier 3: Preferred Brand	One-month supply: \$45	One-month supply: \$45
	Three-month supply: \$135	Three-month supply: \$135
Tier 4: Non-Preferred Drug	One-month supply: \$95	One-month supply: \$95
	Three-month supply: \$285	Three-month supply: \$285
Tier 5: Specialty Tier	One-month supply: 33%	One-month supply: 25%
	Three-month supply: 33%	Three-month supply: 25%

Initial Coverage Stage: Preferred Retail Pharmacy		
Preferred Retail	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Tier 1: Preferred Generic	One-month supply: \$0	One-month supply: \$0
	Three-month supply: \$0	Three-month supply: \$0
Tier 2: Generic	One-month supply: \$5	One-month supply: \$7
	Three-month supply: \$15	Three-month supply: \$21
Tier 3: Preferred Brand	One-month supply: \$40	One-month supply: \$40
	Three-month supply: \$120	Three-month supply: \$120
Tier 4: Non-Preferred Drug	One-month supply: \$90	One-month supply: \$90
	Three-month supply: \$270	Three-month supply: \$270
Tier 5: Specialty Tier	One-month supply: 33%	One-month supply: 25%
	Three-month supply: 33%	Three-month supply: 25%

Initial Coverage Stage: Standard Mail Order Pharmacy		
Standard Mail Order	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Tier 1: Preferred Generic	One-month supply: \$5	One-month supply: \$5
	Three-month supply: \$15	Three-month supply: \$15
Tier 2: Generic	One-month supply: \$10	One-month supply: \$12
	Three-month supply: \$30	Three-month supply: \$36
Tier 3: Preferred Brand	One-month supply: \$45	One-month supply: \$45
	Three-month supply: \$135	Three-month supply: \$135
Tier 4: Non-Preferred Drug	One-month supply: \$95	One-month supply: \$95
	Three-month supply: \$285	Three-month supply: \$285
Tier 5: Specialty Tier	One-month supply: 33%	One-month supply: 25%
	Three-month supply: 33%	Three-month supply: 25%

Initial Coverage Stage: Preferred Mail Order Pharmacy		
Preferred Mail Order	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Tier 1: Preferred Generic	One-month supply: \$0	One-month supply: \$0
	Three-month supply: \$0	Three-month supply: \$0
Tier 2: Generic	One-month supply: \$5	One-month supply: \$7
	Three-month supply: \$15	Three-month supply: \$21
Tier 3: Preferred Brand	One-month supply: \$40	One-month supply: \$40
	Three-month supply: \$120	Three-month supply: \$120
Tier 4: Non-Preferred Drug	One-month supply: \$90	One-month supply: \$90
	Three-month supply: \$270	Three-month supply: \$270
Tier 5: Specialty Tier	One-month supply: 33%	One-month supply: 25%
	Three-month supply: 33%	Three-month supply: 25%

Initial Coverage Stage: Long-term Care and Out-of-network Pharmacies (one-month supply)		
	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Long-term Care Tiers 1-5	If you reside in a long-term facility, you pay the same as at a standard retail pharmacy.	
Out-of-network Tiers 1-5	You may get drugs from an out-of-network pharmacy in specific situations. You generally must use a network pharmacy to fill your prescription.	

	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Stage 3: Coverage Gap	<p>Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$5,030.</p> <p>See the table(s) below for your costs during this stage. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$8,000.</p>	

Coverage Gap Stage: Standard Retail Pharmacy		
Standard Retail	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Tier 1: Preferred Generic	One-month supply: \$5	One-month supply: \$5
	Three-month supply: \$15	Three-month supply: \$15
Tier 2: Generic	One-month supply: \$10	One-month supply: \$12
	Three-month supply: \$30	Three-month supply: \$36
Tier 3: Preferred Brand	One-month supply: \$45	One-month supply: \$45
	Three-month supply: \$135	Three-month supply: \$135
Tier 4: Non-Preferred Drug	One-month supply: \$95	One-month supply: \$95
	Three-month supply: \$285	Three-month supply: \$285
Tier 5: Specialty Tier	One-month supply: 15%	One-month supply: 15%
	Three-month supply: 15%	Three-month supply: 15%

Coverage Gap Stage: Preferred Retail Pharmacy		
Preferred Retail	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Tier 1: Preferred Generic	One-month supply: \$0	One-month supply: \$0
	Three-month supply: \$0	Three-month supply: \$0
Tier 2: Generic	One-month supply: \$5	One-month supply: \$7
	Three-month supply: \$15	Three-month supply: \$21
Tier 3: Preferred Brand	One-month supply: \$40	One-month supply: \$40
	Three-month supply: \$120	Three-month supply: \$120
Tier 4: Non-Preferred Drug	One-month supply: \$90	One-month supply: \$90
	Three-month supply: \$270	Three-month supply: \$270
Tier 5: Specialty Tier	One-month supply: 15%	One-month supply: 15%
	Three-month supply: 15%	Three-month supply: 15%

Coverage Gap Stage: Standard Mail Order Pharmacy		
Standard Mail Order	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Tier 1: Preferred Generic	One-month supply: \$5	One-month supply: \$5
	Three-month supply: \$15	Three-month supply: \$15
Tier 2: Generic	One-month supply: \$10	One-month supply: \$12
	Three-month supply: \$30	Three-month supply: \$36
Tier 3: Preferred Brand	One-month supply: \$45	One-month supply: \$45
	Three-month supply: \$135	Three-month supply: \$135
Tier 4: Non-Preferred Drug	One-month supply: \$95	One-month supply: \$95
	Three-month supply: \$285	Three-month supply: \$285
Tier 5: Specialty Tier	One-month supply: 15%	One-month supply: 15%
	Three-month supply: 15%	Three-month supply: 15%

Coverage Gap Stage: Preferred Mail Order Pharmacy		
Preferred Mail Order	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Tier 1: Preferred Generic	One-month supply: \$0	One-month supply: \$0
	Three-month supply: \$0	Three-month supply: \$0
Tier 2: Generic	One-month supply: \$5	One-month supply: \$7
	Three-month supply: \$15	Three-month supply: \$21
Tier 3: Preferred Brand	One-month supply: \$40	One-month supply: \$40
	Three-month supply: \$120	Three-month supply: \$120
Tier 4: Non-Preferred Drug	One-month supply: \$90	One-month supply: \$90
	Three-month supply: \$270	Three-month supply: \$270
Tier 5: Specialty Tier	One-month supply: 15%	One-month supply: 15%
	Three-month supply: 15%	Three-month supply: 15%

	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs reach \$8,000, you pay nothing for covered Part D drugs.	After your yearly out-of-pocket drug costs reach \$8,000, you pay nothing for covered Part D drugs.

	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
ADDITIONAL MEMBER BENEFITS		
NOTE: Services with a * may require prior authorization or a referral from your doctor.		
Acupuncture	<p><u>Acupuncture for chronic low back pain (Medicare-covered)</u></p> <ul style="list-style-type: none"> • \$0 copay <p><u>Routine Acupuncture (non-Medicare-covered)</u></p> <ul style="list-style-type: none"> • \$15 copay per visit up to 20 visit(s) for acupuncture and other alternative therapies every year 	<p><u>Acupuncture for chronic low back pain (Medicare-covered)</u></p> <ul style="list-style-type: none"> • \$0 copay <p><u>Routine Acupuncture (non-Medicare-covered)</u></p> <ul style="list-style-type: none"> • \$15 copay per visit up to 20 visit(s) for acupuncture and other alternative therapies every year
Chiropractic Care*	<p><u>Medicare-covered manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)</u></p> <ul style="list-style-type: none"> • \$20 copay <p><u>Routine care visits</u></p> <ul style="list-style-type: none"> • \$20 copay for up to 36 supplemental routine chiropractic visit(s) every year 	<p><u>Medicare-covered manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)</u></p> <ul style="list-style-type: none"> • 20% of the total cost <p><u>Routine care visits</u></p> <ul style="list-style-type: none"> • 20% of the total cost for up to 36 supplemental routine chiropractic visit(s) every year
Diabetes Supplies and Services*	<p><u>Diabetes monitoring supplies</u></p> <ul style="list-style-type: none"> • 0% of the total cost • for preferred testing supplies; for non-preferred testing supplies; for all other supplies. <p><u>Diabetes self-management training</u></p> <ul style="list-style-type: none"> • \$0 copay 	<p><u>Diabetes monitoring supplies</u></p> <ul style="list-style-type: none"> • 0% of the total cost <p><u>Diabetes self-management training</u></p> <ul style="list-style-type: none"> • \$0 copay

	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Durable Medical Equipment (wheelchairs, oxygen, etc.)*	<ul style="list-style-type: none"> • 20% of the total cost 	<ul style="list-style-type: none"> • 20% of the total cost
Wellness Programs	<p>\$0 copay for SilverSneakers[†] Fitness Program</p> <p>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[†] 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-DemandTM and a mobile app, SilverSneakers GOTM.</p> <p>[†]SilverSneakers, SilverSneakers FLEX, SilverSneakers On-Demand, and SilverSneakers GO are registered trademarks or trademarks of Tivity Health, Inc.</p>	<p>\$0 copay for SilverSneakers[†] Fitness Program</p> <p>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[†] 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-DemandTM and a mobile app, SilverSneakers GOTM.</p> <p>[†]SilverSneakers, SilverSneakers FLEX, SilverSneakers On-Demand, and SilverSneakers GO are registered trademarks or trademarks of Tivity Health, Inc.</p>
Foot Care (podiatry services)*	<p><u>Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions</u></p> <ul style="list-style-type: none"> • \$20 copay 	<p><u>Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions</u></p> <ul style="list-style-type: none"> • \$35 copay
Home Health Care*	<ul style="list-style-type: none"> • \$0 copay 	<ul style="list-style-type: none"> • \$0 copay
Opioid Treatment Program Services*	<ul style="list-style-type: none"> • \$0 copay 	<ul style="list-style-type: none"> • \$0 copay

	Blue Cross Group Medicare Advantage (HMO)SM HMO I	Blue Cross Group Medicare Advantage (HMO)SM HMO II
Outpatient Substance Abuse Services*	<p><u>Group therapy visit</u></p> <ul style="list-style-type: none"> • \$40 copay <p><u>Individual therapy visit</u></p> <ul style="list-style-type: none"> • \$40 copay 	<p><u>Group therapy visit</u></p> <ul style="list-style-type: none"> • \$100 copay <p><u>Individual therapy visit</u></p> <ul style="list-style-type: none"> • \$100 copay
Over-the-Counter Items	<ul style="list-style-type: none"> • \$20 allowance every month for specific over-the-counter drugs and other health-related products. Unused monthly allowance will rollover to the next month but does not rollover to the next year. 	Not Covered
Prosthetic Devices (braces, artificial limbs, etc.)*	<p><u>Prosthetic devices</u></p> <ul style="list-style-type: none"> • 20% of the total cost <p><u>Related medical supplies</u></p> <ul style="list-style-type: none"> • 20% of the total cost 	<p><u>Prosthetic devices</u></p> <ul style="list-style-type: none"> • 20% of the total cost <p><u>Related medical supplies</u></p> <ul style="list-style-type: none"> • 20% of the total cost
Meals	14 meals/7days Max 3 times per year (Authorization required after inpatient stay)	14 meals/7days Max 3 times per year (Authorization required after inpatient stay)
Renal Dialysis*	<ul style="list-style-type: none"> • \$0 copay 	<ul style="list-style-type: none"> • \$0 copay
Supplemental Telehealth Services	<ul style="list-style-type: none"> • \$10 copay for urgent care; \$40 copay for Outpatient Mental Health; \$40 copay for Outpatient Mental Health Psychiatric visit through MDLive. 	<ul style="list-style-type: none"> • \$10 copay for urgent care; \$30 copay for Outpatient Mental Health; \$30 copay for Outpatient Mental Health Psychiatric visit through MDLive.
Hospice	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.	



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 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., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, 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>.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-299-1008** (TTY/TDD: **711**).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-299-1008** (TTY/TDD: **711**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-299-1008** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-299-1008** (TTY/TDD : **711**) 。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-299-1008** (TTY/TDD: **711**) 번으로 전화해 주십시오

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-299-1008** (TTY/TDD: **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-299-1008** (رقم هاتف الصم والبكم: **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-299-1008** (телетайп: **711**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-299-1008** (TTY: **711**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں **1-877-299-1008** (TTY: **711**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-299-1008** (TTY/TDD: **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-299-1008** (TTY/TDD: **711**).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-299-1008** (TTY/TDD: **711**) पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-299-1008** (ATS : **711**).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-299-1008** (TTY: **711**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-299-1008** (TTY/TDD: **711**).



**BlueCross BlueShield
of New Mexico**

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 1-877-299-1008 (TTY: 711) for more information.

HMO plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.