BlueCross BlueShield of New Mexico

Blue Cross Group Medicare Advantage (HMO)[SM] offered by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC)

Annual Notice of Changes for 2023

You are currently enrolled as a member of Blue Cross Group Medicare Advantage (HMO)[SM] through the University of New Mexico (UNM). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium***.

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the Evidence of Coverage, which is located on our Blue Access for Members (BAM) portal www.bluememberNM.com. You may also call Customer Service to ask us to mail you an Evidence of Coverage.

- **During your Group's open enrollment period, you may make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital)
- Review the changes to our drug coverage, including authorization requirements and costs
- Think about how much you will spend on premiums, deductibles, and cost sharing

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan, you will stay in Blue Cross Group Medicare Advantage (HMO).
   - To change to a **different plan**, contact your Employer Group Plan Benefit Administrator.

Additional Resources

- This document is available for free in Spanish.
- ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call Customer Service at 1-877-299-1008 (TTY only, call: 711) for more information.
- ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio al Cliente al 1-877-299-1008 (TTY: 711) para recibir más información.
- Please contact our Customer Service number at 1-877-299-1008 for additional information. (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.
- Para obtener más información por favor póngase en contacto con nuestro número de servicio al cliente en 1-877-299-1008. (Usuarios de TTY deben llamar al 711.) El horario es de 8:00 – 20:00, hora de local, 7 días a la semana. Si usted está llamando desde el 1 de abril hasta el 30 de septiembre, tecnologías alternativas (por ejemplo, correo de voz) se utilizarán los fines de semana y festivos.
- Please contact Blue Cross Group Medicare Advantage (HMO) if you need this information in another language or format (Spanish, braille, large print or alternate formats).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Blue Cross Group Medicare Advantage (HMO)

- HMO plans provided by Blue Cross and Blue Shield of New Mexico, a Division of 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.
- When this document says "we," "us," or "our," it means Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). When it says "plan" or "our plan," it means Blue Cross Group Medicare Advantage (HMO).

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Blue Cross Group Medicare Advantage (HMO) in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	**You can get information regarding your premium by going through your employer group.**	
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	**HMO I –** $2,500 **HMO II –** $5,000	**HMO I –** $2,500 **HMO II –** $5,000
Doctor office visits	**HMO I –** **Primary care visits:** $10 copay per visit **Specialist visits:** $30 copay per visit **HMO II –** **Primary care visits:** $10 copay per visit **Specialist visits:** $40 copay per visit	**HMO I –** **Primary care visits:** $10 copay per visit **Specialist visits:** $30 copay per visit **HMO II –** **Primary care visits:** $10 copay per visit **Specialist visits:** $40 copay per visit

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays	**HMO I –** $100 copay per day for days 1-5 and $0 copay for days 6+ **HMO II –** $100 copay per day for days 1-5 and $0 copay for days 6+	**HMO I –** $100 copay per day for days 1-5 and $0 copay for days 6+ **HMO II –** $100 copay per day for days 1-5 and $0 copay for days 6+
Part D prescription drug coverage (See Section 1.5 for details.)	**HMO I –** **Deductible:** $0 Copayment/Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** Preferred – $4 Standard – $9 **Drug Tier 2:** Preferred – $10 Standard – $15 **Drug Tier 3:** Preferred – $42 Standard – $47 **Drug Tier 4:** Preferred – $95 Standard – $100 **Drug Tier 5:** Preferred – 33% (max of $250) Standard – 33% (max of $250)	**HMO I –** **Deductible:** $0 Copayment/Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** Preferred – $4 Standard – $9 **Drug Tier 2:** Preferred – $10 Standard – $15 **Drug Tier 3:** Preferred – $42 Standard – $47 **Drug Tier 4:** Preferred – $95 Standard – $100 **Drug Tier 5:** Preferred – 33% ($250 max) Standard – 33% ($250 max)

Cost	2022 (this year)	2023 (next year)
	HMO II – **Deductible:** $0 Copayment/Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** Preferred – $4 Standard – $9 **Drug Tier 2:** Preferred – $10 Standard – $15 **Drug Tier 3:** Preferred – $42 Standard – $47 **Drug Tier 4:** Preferred – $95 Standard – $100 **Drug Tier 5:** Preferred – 33% (max of $250) Standard – 33% (max of $250)	**HMO II –** **Deductible:** $0 Copayment/Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** Preferred – $4 Standard – $9 **Drug Tier 2:** Preferred – $10 Standard – $15 **Drug Tier 3:** Preferred – $42 Standard – $47 **Drug Tier 4:** Preferred – $95 Standard – $100 **Drug Tier 5:** Preferred – 33% ($250 max) Standard – 33% ($250 max)

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**You can get information regarding your premium by going through your employer group.**	

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay "out-of-pocket" for the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**HMO I –** $2,500 **HMO II –** $5,000	**HMO I –** $2,500 Once you have paid $2,500 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year. **HMO II –** $5,000 Once you have paid $5,000 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our Blue Access for Members (BAM) portal www.bluememberNM.com. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a *directory*.

There are changes to our network of providers for next year. **Please review the 2023 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Rx: Initial Coverage Limit	$4,430	$4,660
Rx: TrOOP Amount	$7,050	$7,400
Rx: TrOOP Threshold	$7,050	$7,400
Rx: Catastrophic Percentage of the total cost, or copayment for generic (including brand drugs treated as generic), or copayment for all other drugs	5%, $3.95 or $9.85 whichever is greater	5%, $4.15 or $10.35 whichever is greater

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically. The Drug List we provide includes many – but not all – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling Customer Service (see the back cover) or visiting our Blue Access for Members (BAM) portal www.bluememberNM.com.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), the information about costs for Part D prescription drugs may not apply to you. We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages."

The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

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.

Important Message About What You Pay for Insulin

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.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your drugs until you have reached the yearly deductible.	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage **Plan I and Plan II:** During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in your *Evidence of Coverage Benefits Insert*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic:** • *Standard cost sharing:* **HMO I:** You pay $9 per prescription. **HMO II:** You pay $9 per prescription. • *Preferred cost sharing:* **HMO I:** You pay $4 per prescription. **HMO II:** You pay $4 per prescription. **Tier 2: Generic:** • *Standard cost sharing:* **HMO I:** You pay $15 per prescription. **HMO II:** You pay $15 per prescription. • *Preferred cost sharing:* **HMO I:** You pay $10 per prescription. **HMO II:** You pay $10 per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic:** • *Standard cost sharing:* **HMO I:** You pay $9 per prescription. **HMO II:** You pay $9 per prescription. • *Preferred cost sharing:* **HMO I:** You pay $4 per prescription. **HMO II:** You pay $4 per prescription. **Tier 2: Generic:** • *Standard cost sharing:* **HMO I:** You pay $15 per prescription. **HMO II:** You pay $15 per prescription. • *Preferred cost sharing:* **HMO I:** You pay $10 per prescription. **HMO II:** You pay $10 per prescription.

Stage	2022 (this year)	2023 (next year)
be in a different tier, look them up on the Drug List.	**Tier 3: Preferred Brand:** • *Standard cost sharing:* **HMO I:** You pay $47 per prescription. **HMO II:** You pay $47 per prescription. • *Preferred cost sharing:* **HMO I:** You pay $42 per prescription. **HMO II:** You pay $42 per prescription. **Tier 4: Non-Preferred Drug:** • *Standard cost sharing:* **HMO I:** You pay $100 per prescription. **HMO II:** You pay $100 per prescription. • *Preferred cost sharing:* **HMO I:** You pay $95 per prescription. **HMO II:** You pay $95 per prescription. **Tier 5: Specialty:** • *Standard cost sharing:* **HMO I:** You pay 33% (max of $250) per prescription. **HMO II:** You pay 33% (max of $250) per prescription.	**Tier 3: Preferred Brand:** • *Standard cost sharing:* **HMO I:** You pay $47 per prescription. **HMO II:** You pay $47 per prescription. • *Preferred cost sharing:* **HMO I:** You pay $42 per prescription. **HMO II:** You pay $42 per prescription. **Tier 4: Non-Preferred Drug:** • *Standard cost sharing:* **HMO I:** You pay $100 per prescription. **HMO II:** You pay $100 per prescription. • *Preferred cost sharing:* **HMO I:** You pay $95 per prescription. **HMO II:** You pay $95 per prescription. **Tier 5: Specialty:** • *Standard cost sharing:* **HMO I:** You pay 33% ($250 max) per prescription. **HMO II:** You pay 33% ($250 max) per prescription.

Stage	2022 (this year)	2023 (next year)
	• *Preferred cost sharing:* **HMO I:** You pay 33% (max of $250) per prescription. **HMO II:** You pay 33% (max of $250) per prescription. Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	• *Preferred cost sharing:* **HMO I:** You pay 33% ($250 max) per prescription. **HMO II:** You pay 33% ($250 max) per prescription. Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.** For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your Evidence of Coverage Benefits Insert.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Blue Cross Group Medicare Advantage (HMO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by the open enrollment timeframe as defined by your employer, you will automatically be enrolled in our Blue Cross Group Medicare Advantage (HMO).

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,

- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

Step 2: Change your coverage

- If you no longer wish to be covered by Blue Cross Group Medicare Advantage (HMO), please contact your employer/union benefits administrator.
- If you want to enroll in an Individual (retail) Medicare Advantage plan, the Centers for Medicare and Medicaid Services (CMS) will automatically disenroll you from your Blue Cross Group Medicare Advantage (HMO) plan.
- If you want to **change to Original Medicare without a prescription drug plan**, you must either:
  - Contact your current employer or former employer or union.
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it during your Group's specified Open Enrollment period. Contact your Employer Group Plan Benefit Administrator to understand what happens if you disenroll from the group plan. The change will take effect on January 1, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2023, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023. Your coverage is provided through a contract with your current employer or former employer or union. Please contact your employer/union benefits administrator for more information.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In New Mexico, the SHIP is called New Mexico Aging and Long-Term Services Department.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. New Mexico Aging and Long-Term Services Department counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call New Mexico Aging and Long-Term Services Department at 1-800-432-2080. You can learn more about New Mexico Aging and Long-Term Services Department by visiting their website (http://www.nmaging.state.nm.us/). If you need assistance in another state please visit www.bcbsnm.com/retiree-medicare-tools for a listing of SHIP's in every state.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
  - Your State Medicaid Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New Mexico Department of Health, 1190 S. St. Francis Dr., Suite 1200, Santa Fe, NM 87502; https://www.nmhealth.org/about/phd/idb/hats/. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-505-476-3628. If you need assistance in another state please visit www.bcbsnm.com/retiree-medicare-tools for a listing of ADAP's in every state.

SECTION 6 Questions?

Section 6.1 – Getting Help from Blue Cross Group Medicare Advantage (HMO)

Questions? We're here to help. Please call Customer Service at 1-877-299-1008. (TTY only, call 711). We are available for phone calls 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. Calls to these numbers are free.

Read your 2023 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the 2023 *Evidence of Coverage Benefits Insert* for Blue Cross Group Medicare Advantage (HMO). The *Evidence of Coverage Benefits Insert* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. The *Evidence of Coverage* and the *Evidence of Coverage Benefits Insert* is located on our Blue Access for Members (BAM) portal (www.bluememberNM.com) or you may call Customer Service to ask us to mail you a copy.

Visit our Website

You can also visit our website at www.bluememberNM.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Group Medicare Advantage (HMO) members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage Benefits Insert* for more information, including the cost sharing that applies to out-of-network services.

BlueCross BlueShield of New Mexico

University of New Mexico (UNM)

Evidence of Coverage Benefits Insert

January 1, 2023 – December 31, 2023

2023 Evidence of Coverage Benefits Insert

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Chapter 3. Using the plan for your medical services

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.2 What is your cost sharing for oxygen benefits? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment coverage is:

Cost for Oxygen Benefits	
HMO Plan I	**HMO Plan II**
$20 copay every month	20% of the total cost every month

After 5 years of enrollment you will begin a new cost-sharing cycle.

If prior to enrolling in Blue Cross Group Medicare Advantage (HMO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Blue Cross Group Medicare Advantage (HMO) is the same as shown in the chart above.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

Section 1.2 What is your plan deductible?

This plan does not have a deductible for medical services.

Section 1.3 What is the most you will pay for covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered by our plan (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

2023 Maximum Out-of-Pocket Amount	
HMO Plan I	**HMO Plan II**
For calendar year 2023 this amount is **$2,500**. The amounts you pay for deductibles, copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of $2,500, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered services. However, you must continue to pay your plan premium, if applicable and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).	For calendar year 2023 this amount is **$5,000**. The amounts you pay for deductibles, copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of $5,000, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered services. However, you must continue to pay your plan premium,if applicable and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

See also Section 2.1 of Chapter 4 in the Evidence of Coverage document for more information.

You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.	**In-network** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.	**In-network** $0 copay for each Medicare-covered visit.	**In-network** $0 copay for each Medicare-covered visit.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Acupuncture for chronic low back pain (continued) Treatment must be discontinued if the patient is not improving or is regressing. ***Authorization rules may apply***		
Acupuncture (supplemental)	**In-network** $15 copay per visit up to 20 visit(s) for acupuncture and other alternative therapies every year.	**In-network** $15 copay per visit up to 20 visit(s) for acupuncture and other alternative therapies every year.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. ***Authorization rules may apply***	Cost sharing applies to each one-way trip. **In-network** $75 copay for each one-way Medicare-covered ground transportation service. $75 copay for each one-way Medicare-covered air transportation service.	Cost sharing applies to each one-way trip. **In-network** $75 copay for each one-way Medicare-covered ground transportation service. $75 copay for each one-way Medicare-covered air transportation service.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Annual physical exam The routine physical examination is a comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, hands on examination, anticipatory guidance/risk factor reduction interventions. ***Authorization rules may apply***	**In-network** $0 copay for an annual routine physical exam.	**In-network** $0 copay for an annual routine physical exam.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the annual wellness visit.	**In-network** There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality,	**In-network** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.	**In-network** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Bone mass measurement (continued) including a physician's interpretation of the results. ***Authorization rules may apply***		
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for covered screening mammograms.	**In-network** There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. ***Authorization rules may apply***	**In-network** $10 copay for Medicare-covered cardiac rehabilitation services. $0 copay for Medicare-covered intensive cardiac rehabilitation services. $10 copay for an unlimited number of supplemental cardiac	**In-network** $10 copay for Medicare-covered cardiac rehabilitation services. $0 copay for Medicare-covered intensive cardiac rehabilitation services. $10 copay for an unlimited number of supplemental cardiac

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Cardiac rehabilitation services (continued)		
	rehabilitation services.	rehabilitation services.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.	**In-network** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.	**In-network** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include:	**In-network** There is no coinsurance,	**In-network** There is no coinsurance,

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Cervical and vaginal cancer screening (continued) • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months ***Authorization rules may apply***	copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation ***Authorization rules may apply***	**In-network** $20 copay for each Medicare-covered visit. $20 copay for up to 36 supplemental routine chiropractic visit(s) every year.	**In-network** $20 copay for each Medicare-covered visit. $20 copay for up to 36 supplemental routine chiropractic visit(s) every year.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years	**In-network** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. $0 copay for each Medicare-covered barium enema.	**In-network** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. $0 copay for each Medicare-covered barium enema.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Colorectal cancer screening (continued) For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy ***Authorization rules may apply***		
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. ***Authorization rules may apply***	**In-network** $20 copay for Medicare-covered services.	**In-network** $40 copay for Medicare-covered services.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for an annual depression screening visit.	**In-network** There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.	**In-network** There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	**In-network** Medicare-covered diabetic supplies: 0% of the total cost 0% of the total cost for Medicare-covered diabetic therapeutic shoes or inserts. $0 copay for Medicare-covered	**In-network** Medicare-covered diabetic supplies: 0% of the total cost 0% of the total cost for Medicare-covered diabetic therapeutic shoes or inserts. $0 copay for Medicare-covered

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Diabetes self-management training, diabetic services and supplies (continued) • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. ***Authorization rules may apply***	diabetes self-management training services.	diabetes self-management training services.
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 as well as Chapter 3, Section 7 of the *Evidence of Coverage* document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you	**In-network** $20 copay for Medicare-covered durable medical equipment and supplies. **Authorization required if cost is greater than $2,500**	**In-network** 20% of the total cost for Medicare-covered durable medical equipment and supplies. **Authorization required if cost is greater than $2,500**

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Durable medical equipment (DME) and related supplies (continued) may ask them if they can special order it for you. If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9 of the *Evidence of Coverage* document, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*) ***Authorization rules may apply***		
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.	**In-network** $65 copay for Medicare-covered emergency room visits. Cost share is waived if admitted within three days for the same condition. **Worldwide Coverage** $65 copay for Worldwide emergency services. No annual limit. If you receive emergency care at	**In-network** $75 copay for Medicare-covered emergency room visits. Cost share is waived if admitted within three days for the same condition. **Worldwide Coverage** $75 copay for Worldwide emergency services. No annual limit. If you receive emergency care at

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Emergency care (continued) Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **Worldwide emergency/urgent care services are covered.**	an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered.	an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered.
Health and wellness education programs SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations1. You have access to instructors who lead specially designed group exercise classes[2]. At participating locations nationwide[1], you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and our mobile app, SilverSneakers GO™. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about	**In-network** $0 copay for this wellness program.	**In-network** $0 copay for this wellness program.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Health and wellness education programs (continued) your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. **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. **2.** Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc.		
Hearing services Diagnostic hearing and balance evaluations performed by your PCP to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. We cover:	***Medicare-Covered Services:*** **In-network** $20 copay for each Medicare-covered hearing exam.	***Medicare-Covered Services:*** **In-network** $40 copay for each Medicare-covered hearing exam.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Hearing services (continued) • Medicare-covered Services • Supplemental Hearing Exam (non-Medicare-covered) • Supplemental Hearing Aids (non-Medicare-covered) ***Authorization rules may apply***	***Supplemental Hearing Exam Coverage:*** **In-network** $20 copay for 1 routine hearing exam every year. ***Supplemental Hearing Aids Coverage:*** **In-network** $900 allowance toward hearing aids every 3 years.	***Supplemental Hearing Exam Coverage:*** **In-network** $40 copay for 1 routine hearing exam every year. ***Supplemental Hearing Aids Coverage:*** **In-network** $900 allowance toward hearing aids every 3 years.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.	**In-network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.	**In-network** $0 copay for Medicare-covered services.	**In-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Home health agency care (continued) Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies ***Authorization rules may apply***		
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring	**In-network** $0 copay for Medicare-covered professional services. $20 copay for Medicare-covered supplies. 0% of the total cost for Medicare-covered home infusion drugs.	**In-network** $0 copay for Medicare-covered professional services. 20% of the total cost for Medicare-covered supplies. 0% of the total cost for Medicare-covered home infusion drugs.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Home infusion therapy (continued) • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier ***Authorization rules may apply***		
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan)	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Blue Cross Group Medicare Advantage (HMO).	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Blue Cross Group Medicare Advantage (HMO).

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Hospice care (continued) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by Blue Cross Group Medicare Advantage (HMO) but are not covered by Medicare Part A or B: Blue Cross Group Medicare Advantage (HMO) will continue to cover plan-covered services that are not covered under Part A or B whether or not		

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Hospice care (continued) they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see the *Evidence of Coverage* document Chapter 5, Section 9.4 (*What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.		
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine	**In-network** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.	**In-network** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Immunizations (continued) • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit. ***Authorization rules may apply***		
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Plan covers an unlimited number of days per benefit period. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy	**In-network** $100 copay per day for days 1-5 and $0 copay for days 6+ If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.	**In-network** $100 copay per day for days 1-5 and $0 copay for days 6+ If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Inpatient hospital care (continued) • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/ multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Blue Cross Group Medicare Advantage (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services		

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Inpatient hospital care (continued) **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. ***Authorization rules may apply***		
Inpatient services in a psychiatric hospital • Covered services include mental health care services that require a hospital stay. 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 health services provided in a general hospital. ***Authorization rules may apply***	**In-network** $100 copay per day for days 1-5 and $0 copay for days 6+	**In-network** $100 copay per day for days 1-5 and $0 copay for days 6+

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	**In-network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the MDPP benefit.	**In-network** There is no coinsurance, copayment, or deductible for the MDPP benefit.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Medicare Part B prescription drugs		
These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	Part B drugs ***may*** be subject to step therapy requirements. **<u>In-network</u>** $10 copay for Medicare-covered Part B chemo drugs. 0% of the total cost for other Medicare Part B drugs. ***Prior authorization and/or step therapy may be required***	Part B drugs ***may*** be subject to step therapy requirements. **<u>In-network</u>** $10 copay for Medicare-covered Part B chemo drugs. 0% of the total cost for other Medicare Part B drugs. ***Prior authorization and/or step therapy may be required***

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Medicare Part B prescription drugs (continued) For a list of Part B Drugs that may be subject to Step Therapy, contact Customer Service. We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 in the *Evidence of Coverage* document explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.		
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	**In-network** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include:	**In-network** $0 copay for Medicare-covered opioid treatment program services.	**In-network** $0 copay for Medicare-covered opioid treatment program services.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Opioid treatment program services (continued) • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing ***Authorization rules may apply***		
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests ***Authorization rules may apply***	**In-network** **Medicare-covered outpatient X-ray services**: $0 copay **Medicare-covered outpatient therapeutic radiology services** (such as radiation treatment for cancer): $10 copay **Medicare-covered medical supplies:** $20 copay **Medicare-covered outpatient lab services:** $0 copay **Medicare-covered outpatient blood services:** $0 copay **Medicare-covered diagnostic**	**In-network** **Medicare-covered outpatient X-ray services**: $0 copay **Medicare-covered outpatient therapeutic radiology services** (such as radiation treatment for cancer): $10 copay **Medicare-covered medical supplies:** 20% of the total cost **Medicare-covered outpatient lab services:** $0 copay **Medicare-covered outpatient blood services:** $0 copay **Medicare-covered diagnostic**

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Outpatient diagnostic tests and therapeutic services and supplies (continued)		
	procedures/tests: $0 copay	**procedures/tests:** $0 copay
	Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans): $50 copay	**Medicare-covered outpatient diagnostic radiology services** (such as MRIs and CT scans): $100 copay
Outpatient hospital observation		
Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.	**In-network** $0 copay for Medicare-covered observation services.	**In-network** $0 copay for Medicare-covered observation services.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Outpatient hospital observation (continued) You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. ***Authorization rules may apply***		
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts	**In-network** $150 copay for Medicare-covered outpatient hospital services. $150 copay for Medicare-covered ambulatory surgical services.	**In-network** $175 copay for Medicare-covered outpatient hospital services. $175 copay for Medicare-covered ambulatory surgical services.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Outpatient hospital services (continued) • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. ***Authorization rules may apply***		
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-network** $30 copay for Medicare-covered individual visits with a psychiatrist. $30 copay for each virtual visit with a psychiatrist through MDLive.	**In-network** $40 copay for Medicare-covered individual visits with a psychiatrist. $40 copay for each virtual visit with a psychiatrist through MDLive.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Outpatient mental health care (continued)		
Authorization rules may apply	$30 copay for Medicare-covered group visits with a psychiatrist. $20 copay for Medicare-covered individual visits with a mental health specialist. $20 copay for each virtual visit with a mental health specialist through MDLive. $20 copay for Medicare-covered group visits with a mental health specialist.	$40 copay for Medicare-covered group visits with a psychiatrist. $20 copay for Medicare-covered individual visits with a mental health specialist. $20 copay for each virtual visit with a mental health specialist through MDLive. $20 copay for Medicare-covered group visits with a mental health specialist.
Outpatient rehabilitation services		
Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). ***Authorization rules may apply***	**In-network** $20 copay for Medicare-covered occupational therapy services. $20 copay for Medicare-covered physical, language and speech therapy services.	**In-network** $20 copay for Medicare-covered occupational therapy services. $20 copay for Medicare-covered physical, language and speech therapy services.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Outpatient substance abuse services		
Coverage under Medicare Part B is available for treatment services that are provided in the outpatient department of a hospital to patients who for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. ***Authorization rules may apply***	**In-network** $30 copay for Medicare-covered individual outpatient substance abuse treatment. $30 copay for Medicare-covered group outpatient substance abuse treatment. $0 copay for Medicare-covered partial hospitalization services.	**In-network** $40 copay for Medicare-covered individual outpatient substance abuse treatment. $40 copay for Medicare-covered group outpatient substance abuse treatment. $0 copay for Medicare-covered partial hospitalization services.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers		
Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." ***Authorization rules may apply***	**In-network** $150 copay for Medicare-covered outpatient hospital services. $150 copay for Medicare-covered ambulatory surgical services. $0 copay for Medicare-covered observation services.	**In-network** $175 copay for Medicare-covered outpatient hospital services. $175 copay for Medicare-covered ambulatory surgical services. $0 copay for Medicare-covered observation services.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered partial hospitalization services.	**In-network** $0 copay for Medicare-covered partial hospitalization services.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare	**In-network** $10 copay for Medicare-covered physician services with a PCP. $30 copay for Medicare-covered specialist services. $10 copay for services performed with a PCP and a $30 copay for services performed with a Specialist for Medicare-covered services provided by other health care professionals	**In-network** $10 copay for Medicare-covered physician services with a PCP. $40 copay for Medicare-covered specialist services. $10 copay for services performed with a PCP and a $40 copay for services performed with a Specialist for Medicare-covered services provided by other health care professionals

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Physician/Practitioner services, including doctor's office visits (continued)		
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation	such as nurse practitioners, physician assistants, etc.	such as nurse practitioners, physician assistants, etc.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Physician/Practitioner services, including doctor's office visits (continued) and follow-up by your doctor within 24 hours **if**: ◦ You're not a new patient **and** ◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Supplemental telehealth for urgent care and behavioral services available through MDLive. Please refer to Telehealth section for additional information. ***Authorization rules may apply***		

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered services.	**In-network** $0 copay for Medicare-covered services.
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for an annual PSA test. $0 copay for an annual Medicare-covered digital rectal exam.	**In-network** There is no coinsurance, copayment, or deductible for an annual PSA test. $0 copay for an annual Medicare-covered digital rectal exam.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also	**In-network** $20 copay for Medicare-covered prosthetic devices. $20 copay for Medicare-covered medical supplies. ***Authorization required if cost is greater than $2,500***	**In-network** 20% of the total cost for Medicare-covered prosthetic devices. 20% of the total cost for Medicare-covered medical supplies.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Prosthetic devices and related supplies (continued) includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. ***Authorization rules may apply***		***Authorization required if cost is greater than $2,500***
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered pulmonary rehabilitation services. $0 copay for an unlimited number of supplemental pulmonary rehabilitation services.	**In-network** $0 copay for Medicare-covered pulmonary rehabilitation services. $0 copay for an unlimited number of supplemental pulmonary rehabilitation services.
Rewards Program *Rewards Program for Healthy Activities* You can earn rewards for completing selected screenings, managing chronic conditions, or seeing your physician for a physical. Members can potentially receive rewards for completing eligible health activities during the calendar year (January 1 - December 31). The amount of the reward is up to a maximum of $100 annually and will be triggered by submission of a claim. Most Healthy Action completions reward	Earn up to $100 annually for completing healthy activities* such as the examples below: • Welcome to Medicare/ Annual Physical or Qualified Wellness Visits	Earn up to $100 annually for completing healthy activities* such as the examples below: • Welcome to Medicare/ Annual Physical or Qualified Wellness Visits

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Rewards Program (continued)		
members $25 in the form of a gift card. The Annual Wellness Visit will reward members $50 upon completion. These rewards can be redeemed for a variety of gift cards that can be used at select pharmacies or national retailers. Members can opt to obtain a gift card for the completion of each individually completed healthy activity or they can opt to pool their reward amounts for numerous completed healthy activities. A maximum of one payment for each specific healthy activity per year will be rewarded until you reach the $100 maximum. ***Authorization rules may apply***	• Annual Flu Vaccine • Colorectal Screening • Retinal Exam • Mammogram Additional healthy activities may be identified and provided to members after the beginning of the plan year via mail, email, or through the member portal. *This list is subject to change. The Rewards Program offers the above healthy activities for all members as well as additional healthy activities based on your unique needs. To register and determine the current list of healthy activities, go to www.BlueRewardsNM.com. You will need your member ID card, date of birth and email address to register online if	• Annual Flu Vaccine • Colorectal Screening • Retinal Exam • Mammogram Additional healthy activities may be identified and provided to members after the beginning of the plan year via mail, email, or through the member portal. *This list is subject to change. The Rewards Program offers the above healthy activities for all members as well as additional healthy activities based on your unique needs. To register and determine the current list of healthy activities, go to www.BlueRewardsNM.com. You will need your member ID card, date of birth and email address to register online if

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Rewards Program (continued)		
	you have not already. You can also call the number on the back of your member ID card to learn more about the program and register. Customer Service will take your information to begin the process to set up your account. **REGISTRATION IS REQUIRED**	you have not already. You can also call the number on the back of your member ID card to learn more about the program and register. Customer Service will take your information to begin the process to set up your account. **REGISTRATION IS REQUIRED**
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.	**In-network** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime	**In-network** $0 copay for Medicare-covered dialysis services. $0 copay for Medicare-covered kidney disease education.	**In-network** $0 copay for Medicare-covered dialysis services. $0 copay for Medicare-covered kidney disease education.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Services to treat kidney disease (continued) • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible of the Evidence of Coverage document) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs." ***Authorization rules may apply***		
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this document. Skilled nursing facilities are sometimes called "SNFs.") Plan covers 100 days per benefit period. Covered services include but are not limited to:	**In-network** $0 copay per day for days 1-20 $0 copay per day for days 21-100	**In-network** $0 copay per day for days 1-20 $0 copay per day for days 21-100

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Skilled nursing facility (SNF) care (continued) • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.		

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Skilled nursing facility (SNF) care (continued) • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital ***Authorization rules may apply***		
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered supervised exercise therapy.	**In-network** $0 copay for Medicare-covered supervised exercise therapy.
Supplemental telehealth services Covered services include: • Certain telehealth services, including: urgent care and behavioral health services.	**In-network** $5 copay for urgent care;	**In-network** $5 copay for urgent care;

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Supplemental telehealth services (continued) ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ◦ This telehealth service is offered through MDLive. Members will need to complete registration and be directed to complete a medical questionnaire upon first visit to the MDLive portal. Please contact MDLive at 1-888-680-8646 or visit the MDLive website at www.mdlive.com. Access to telehealth service can be completed through computer, tablet, smartphone, traditional phone and can include web-based video.	$20 copay for Outpatient Mental Health; $30 copay for Outpatient Mental Health Psychiatric visit through MDLive.	$20 copay for Outpatient Mental Health; $40 copay for Outpatient Mental Health Psychiatric visit through MDLive.
Transportation services We cover plan approved transportation services to plan approved locations(s). Contact the plan for details on how to access this benefit. ***Authorization rules may apply***	**In-network** $0 copay for up to 4 one-way trips every year to plan-approved locations.	**In-network** $0 copay for up to 4 one-way trips every year to plan-approved locations.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not	**In-network** $10 copay for Medicare-covered services.	**In-network** $10 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Urgently needed services (continued)		
possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network. ***Worldwide emergency/urgent care services are covered.***	$5 copay for each virtual visit through MDLive. **Worldwide coverage** $10 copay for each visit.	$5 copay for each virtual visit through MDLive. **Worldwide coverage** $10 copay for each visit.
Vision care		
Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older	***Medicare-Covered Services:*** **In-network** $20 copay for Medicare-covered services. $0 copay for an annual glaucoma screening. $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery.	***Medicare-Covered Services:*** **In-network** $40 copay for Medicare-covered services. $0 copay for an annual glaucoma screening. $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery.

Services that are covered for you	What you must pay when you get these services	
	HMO Plan I	**HMO Plan II**
Vision care (continued) • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Supplemental vision services (non-Medicare-covered) ◦ Routine eye exam ◦ Routine eye wear ***Authorization rules may apply***	***Supplemental Vision Services:*** **In-network** $0 copay for 1 routine eye exam every calendar year. $0 copay standard eyeglass lens and $150 material allowance	***Supplemental Vision Services:*** **In-network** $0 copay for 1 routine eye exam every calendar year. $0 copay standard eyeglass lens and $150 material allowance
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	**In-network** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.	**In-network** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

Section 2.2 Getting care using our plan's optional visitor/traveler benefit

When you are continuously absent from the Blue Cross Group Medicare Advantage (HMO) service area for more than six (6) months, we are required to disenroll you from our plan. However, we offer a supplemental benefit that will not disenroll you for a six-month period, and will allow you to remain enrolled in Blue Cross Group Medicare Advantage (HMO) when you are outside of our service area, due to travel, secondary residency or visiting family/friends, for up to six (6) months.

Under the visitor/traveler program you may receive all services covered under Blue Cross Group Medicare Advantage (HMO) at in-network cost sharing for up to 6 months if you use a pre-approved provider. Please contact Blue Cross Group Medicare Advantage (HMO) at 1-877-299-1008 for assistance in locating a provider when using the visitor/traveler benefit. The program will include Blue Cross Group Medicare Advantage (HMO) network coverage of all Part A, Part B, and supplemental benefits offered by your plan outside your service area; you must notify the plan of your travel. (NOTE: To ensure coverage, you will be required to notify Blue Cross Group Medicare Advantage (HMO) approximately seven (7 days) in advance of your travel.)

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in the *Evidence of Coverage* document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information of the *Evidence of Coverage* document on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Full-time nursing care in your home.	✓	
Custodial care. (Care that helps with activities of daily living that does not require professional skills or training e.g. bathing and dressing.)	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Fees charged for care by your immediate relatives or members of your household.	✓	
Cosmetic surgery or procedures		✓ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as fillings or dentures.	✓	
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines e.g., if you have diabetes.
Orthopedic shoes or supportive devices for the feet		✓ Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with, diabetic foot disease.
Radial keratotomy, LASIK surgery, and other low vision aids.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Acupuncture		✓ Available for people with chronic low back pain only when medically necessary or as a supplemental benefit.
Naturopath services (uses natural or alternative treatments).	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

Chapter 6. What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for Blue Cross Group Medicare Advantage (HMO) members?

There are four "drug payment stages" for your prescription drug coverage under Blue Cross Group Medicare Advantage (HMO). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

SECTION 4 There is no deductible for Blue Cross Group Medicare Advantage (HMO)

There is no deductible for Blue Cross Group Medicare Advantage (HMO). You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs, and you pay your share

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see the *Evidence of Coverage* booklet Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier		**Retail (standard and preferred) cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see the *Evidence of Coverage* Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	**Plan I**	**Standard:** $9 **Preferred:** $4	$4	$9	$9
	Plan II	**Standard:** $9 **Preferred:** $4	$4	$9	$9
Cost-Sharing Tier 2 (Generic)	**Plan I**	**Standard:** $15 **Preferred:** $10	$10	$15	$15
	Plan II	**Standard:** $15 **Preferred:** $10	$10	$15	$15

Tier		Retail (standard and preferred) cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; see the *Evidence of Coverage* Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 3 (Preferred Brand)	**Plan I**	**Standard:** $47 **Preferred:** $42	$42	$47	$47
	Plan II	**Standard:** $47 **Preferred:** $42	$42	$47	$47
Cost-Sharing Tier 4 (Non-Preferred Drug)	**Plan I**	**Standard:** $100 **Preferred:** $95	$95	$100	$100
	Plan II	**Standard:** $100 **Preferred:** $95	$95	$100	$100

Tier		Retail (standard and preferred) cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; see the *Evidence of Coverage* Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 5 (Specialty)	**Plan I**	**Standard:** 33% ($250 max) **Preferred:** 33% ($250 max)	33% ($250 max)	33% ($250 max)	33% ($250 max)
	Plan II	**Standard:** 33% ($250 max) **Preferred:** 33% ($250 max)	33% ($250 max)	33% ($250 max)	33% ($250 max)

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier		Retail (standard and preferred) cost sharing (in-network) (up to a 90-day supply)	Mail-order (standard and preferred) cost sharing (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	**Plan I**	**Standard:** $27 **Preferred:** $12	$8
	Plan II	**Standard:** $27 **Preferred:** $12	$8
Cost-Sharing Tier 2 (Generic)	**Plan I**	**Standard:** $45 **Preferred:** $30	$20
	Plan II	**Standard:** $45 **Preferred:** $30	$20
Cost-Sharing Tier 3 (Preferred Brand)	**Plan I**	**Standard:** $141 **Preferred:** $126	$84
	Plan II	**Standard:** $141 **Preferred:** $126	$84

Tier		Retail (standard and preferred) cost sharing (in-network) (up to a 90-day supply)	Mail-order (standard and preferred) cost sharing (up to a 90-day supply)
Cost-Sharing Tier 4 (Non-Preferred Drug)	**Plan I**	**Standard:** $300 **Preferred:** $285	$190
	Plan II	**Standard:** $300 **Preferred:** $285	$190
Cost-Sharing Tier 5 (Specialty)	**Plan I**	**Standard:** 33% ($250 max) **Preferred:** 33% ($250 max)	33% ($250 max)
	Plan II	**Standard:** 33% ($250 max) **Preferred:** 33% ($250 max)	33% ($250 max)

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,660

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$4,660 limit for the Initial Coverage Stage**.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf for your drugs during the year. Many people do not reach the $4,660 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

The tables below show what you pay for prescription drugs during the Coverage Gap Stage.

Coverage Gap Stage **Tier**		**Retail (standard and preferred) cost sharing (in-network)** (30-day supply)	**Retail (standard and preferred) cost sharing (in-network)** (90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	**Plan I**	**Standard:** $9 **Preferred:** $4	**Standard:** $27 **Preferred:** $12
	Plan II	**Standard:** $9 **Preferred:** $4	**Standard:** $27 **Preferred:** $12
Cost-Sharing Tier 2 (Generic)	**Plan I**	**Standard:** $15 **Preferred:** $10	**Standard:** $45 **Preferred:** $30
	Plan II	**Standard:** $15 **Preferred:** $10	**Standard:** $45 **Preferred:** $30
Cost-Sharing Tier 3 (Preferred Brand)	**Plan I**	**Standard:** $47 **Preferred:** $42	**Standard:** $141 **Preferred:** $126
	Plan II	**Standard:** 25% **Preferred:** 25%	**Standard:** 25% **Preferred:** 25%

Coverage Gap Stage **Tier**		**Retail (standard and preferred) cost sharing (in-network)** (30-day supply)	**Retail (standard and preferred) cost sharing (in-network)** (90-day supply)
Cost-Sharing Tier 4 (Non-Preferred Drug)	**Plan I**	**Standard:** $100 **Preferred:** $95	**Standard:** $300 **Preferred:** $285
	Plan II	**Standard:** 25% **Preferred:** 25%	**Standard:** 25% **Preferred:** 25%
Cost-Sharing Tier 5 (Specialty)	**Plan I**	**Standard:** 15% ($250 max) **Preferred:** 15% ($250 max)	**Standard:** 15% ($250 max) **Preferred:** 15% ($250 max)
	Plan II	**Standard:** 25% **Preferred:** 25%	**Standard:** 25% **Preferred:** 25%

Coverage Gap Stage **Tier**		**Mail-order cost sharing (in-network)** (30-day supply)	**Mail-order cost sharing** (90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	**Plan I**	$4	$8
	Plan II	$4	$8
Cost-Sharing Tier 2 (Generic)	**Plan I**	$10	$20
	Plan II	$10	$20

Coverage Gap Stage **Tier**		**Mail-order cost sharing (in-network)** (30-day supply)	**Mail-order cost sharing** (90-day supply)
Cost-Sharing Tier 3 (Preferred Brand)	**Plan I**	$42	$84
	Plan II	**Standard:** 25%	**Standard:** 25%
		Preferred: 25%	**Preferred:** 25%
Cost-Sharing Tier 4 (Non-Preferred Drug)	**Plan I**	$95	$190
	Plan II	**Standard:** 25%	**Standard:** 25%
		Preferred: 25%	**Preferred:** 25%
Cost-Sharing Tier 5 (Specialty)	**Plan I**	15% ($250 max)	15% ($250 max)
	Plan II	**Standard:** 25%	**Standard:** 25%
		Preferred: 25%	**Preferred:** 25%

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of $7,400, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $7,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs. You will pay:

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  - – *either* – coinsurance of 5% of the cost of the drug
  - – *or* – $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs.

HMO plans provided by Blue Cross and Blue Shield of New Mexico, a Division of 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.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Group Medicare Advantage (HMO) members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage Benefits Insert* for more information, including the cost sharing that applies to out-of-network services.

BlueCross BlueShield of New Mexico

University of New Mexico (UNM)

Summary of Benefits

Blue Cross Group Medicare Advantage (HMO)[SM]

January 1, 2023 – December 31, 2023

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 University of New Mexico.

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.

Premiums and Benefits	Blue Cross Group Medicare Advantage (HMO)[SM] HMO I	Blue Cross Group Medicare Advantage (HMO)[SM] HMO II
Monthly Plan 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: • $2,500 for services you receive from in-network providers. • $2,500 for services you receive from out-of-network providers.	Your yearly limit(s) in this plan: • $5,000 for services you receive from in-network providers. • $5,000 for services you receive from out-of-network providers.
Inpatient Hospital Care*	Our plan covers an unlimited number of days for an inpatient hospital stay. $100 copay per day for days 1-5 and $0 copay for days 6+	Our plan covers an unlimited number of days for an inpatient hospital stay. $100 copay per day for days 1-5 and $0 copay for days 6+
Outpatient Hospital*	**In-network:** $150 copay	**In-network:** $175 copay
Ambulatory Surgical Center (ASC)*	**In-network:** $150 copay	**In-network:** $175 copay

Premiums and Benefits	Blue Cross Group Medicare Advantage (HMO)[SM] HMO I	Blue Cross Group Medicare Advantage (HMO)[SM] HMO II
Doctor Visits* • Primary care provider • Specialists	• **In-network:** $10 copay • **In-network:** $30 copay	• **In-network:** $10 copay • **In-network:** $40 copay
Preventive Care* (e.g., flu vaccine, diabetic screenings)	**In-network:** $0 copay **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. *Other preventive services are available. There are some covered services that may have a cost.	**In-network:** $0 copay **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. *Other preventive services are available. There are some covered services that may have a cost.
Emergency Care	**In-network:** $65 copay Cost share waived if admitted within 3 days for the same condition.	**In-network:** $75 copay Cost share waived if admitted within 3 days for the same condition.
Urgently Needed Services	**In-network:** $10 copay	**In-network:** $10 copay
Diagnostic Tests, Lab and Radiology Services, and X-Rays* • Diagnostic tests and procedures • Lab services • MRI, CAT Scan	• **In-network:** $0 copay • **In-network:** $0 copay • **In-network:** $50 copay	• **In-network:** $0 copay • **In-network:** $0 copay • **In-network:** $100 copay

Premiums and Benefits	Blue Cross Group Medicare Advantage (HMO)[SM] HMO I	Blue Cross Group Medicare Advantage (HMO)[SM] HMO II
• X-Rays	• **In-network:** $0 copay	• **In-network:** $0 copay
Hearing Services* • Medicare covered hearing exam • Routine hearing exam • Hearing aid	• **In-network:** $20 copay • **In-network:** $20 copay for 1 routine hearing exam each year • **In-network:** $900 allowance toward hearing aids every 3 years	• **In-network:** $40 copay • **In-network:** $40 copay for 1 routine hearing exam each year • **In-network:** $900 allowance toward hearing aids every 3 years
Dental Services* • Medicare covered dental • Preventive Dental • Supplemental Dental Services	• **In-network:** $20 copay • Not Covered • Not Covered	• **In-network:** $40 copay • Not Covered • Not Covered
Vision Services* • Medicare covered vision exam • Medicare covered eyewear	• **In-network:** $20 copay • **In-network:** $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery	• **In-network:** $40 copay • **In-network:** $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery

Premiums and Benefits	Blue Cross Group Medicare Advantage (HMO)[SM] HMO I	Blue Cross Group Medicare Advantage (HMO)[SM] HMO II
• Routine vision exam • Routine eyewear	• **In-network:** $0 copay for 1 routine eye exam each year • **In-network:** $0 copay standard eyeglass lens and $150 material allowance	• **In-network:** $0 copay for 1 routine eye exam each year • **In-network:** $0 copay standard eyeglass lens and $150 material allowance
Mental Health Care* • Inpatient mental health • Outpatient group therapy/ individual therapy visit	• **In-network:** $100 copay per day for days 1-5 and $0 copay for days 6+ **Individual** • **In-network:** $20 copay **Group** • **In-network:** $20 copay	• **In-network:** $100 copay per day for days 1-5 and $0 copay for days 6+ **Individual** • **In-network:** $20 copay **Group** • **In-network:** $20 copay
Skilled Nursing Facility (SNF)*	$0 copay per day for days 1-20 and $0 copay per day for days 21-100.	$0 copay per day for days 1-20 and $0 copay per day for days 21-100.
Outpatient Rehabilitation* • Physical therapy and speech and language therapy visit	**In-network:** $20 copay	**In-network:** $20 copay

Premiums and Benefits	Blue Cross Group Medicare Advantage (HMO)[SM] HMO I	Blue Cross Group Medicare Advantage (HMO)[SM] HMO II
Ambulance* • Ground services • Air services	• **In-network:** $75 copay for each one-way trip • **In-network:** $75 copay for each one-way trip	• **In-network:** $75 copay for each one-way trip • **In-network:** $75 copay for each one-way trip
Transportation*	• $0 copay for up to 4 one-way trips every year to plan-approved locations	• $0 copay for up to 4 one-way trips every year to plan-approved locations
Medicare Part B Drugs* • Chemotherapy drugs • Other Part B drugs	• **In-network:** $10 copay • **In-network:** 0% of the total cost	• **In-network:** $10 copay • **In-network:** 0% 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	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you.	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you.
Stage 2: Initial Coverage	You pay the following (see table(s) below) until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	You pay the following (see table(s) below) until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

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:** $9	**One-month supply:** $9
	Three-month supply: $27	**Three-month supply:** $27
Tier 2: Generic	**One-month supply:** $15	**One-month supply:** $15
	Three-month supply: $45	**Three-month supply:** $45
Tier 3: Preferred Brand	**One-month supply:** $47	**One-month supply:** $47
	Three-month supply: $141	**Three-month supply:** $141
Tier 4: Non-Preferred Drug	**One-month supply:** $100	**One-month supply:** $100
	Three-month supply: $300	**Three-month supply:** $300
Tier 5: Specialty Tier	**One-month supply:** 33% ($250 max)	**One-month supply:** 33% ($250 max)
	Three-month supply: 33% ($250 max)	**Three-month supply:** 33% ($250 max)

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:** $4	**One-month supply:** $4
	Three-month supply: $12	**Three-month supply:** $12
Tier 2: Generic	**One-month supply:** $10	**One-month supply:** $10
	Three-month supply: $30	**Three-month supply:** $30
Tier 3: Preferred Brand	**One-month supply:** $42	**One-month supply:** $42
	Three-month supply: $126	**Three-month supply:** $126
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% ($250 max)	**One-month supply:** 33% ($250 max)
	Three-month supply: 33% ($250 max)	**Three-month supply:** 33% ($250 max)

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:** $4	**One-month supply:** $4
	Three-month supply: $8	**Three-month supply:** $8
Tier 2: Generic	**One-month supply:** $10	**One-month supply:** $10
	Three-month supply: $20	**Three-month supply:** $20
Tier 3: Preferred Brand	**One-month supply:** $42	**One-month supply:** $42
	Three-month supply: $84	**Three-month supply:** $84
Tier 4: Non-Preferred Drug	**One-month supply:** $95	**One-month supply:** $95
	Three-month supply: $190	**Three-month supply:** $190
Tier 5: Specialty Tier	**One-month supply:** 33% ($250 max)	**One-month supply:** 33% ($250 max)
	Three-month supply: 33% ($250 max)	**Three-month supply:** 33% ($250 max)

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 retail pharmacy.	
Out-of-network Tiers 1-5	You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. 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	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 $4,660. 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 $7,400.	

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:** $9	**One-month supply:** $9
	Three-month supply: $27	**Three-month supply:** $27
Tier 2: Generic	**One-month supply:** $15	**One-month supply:** $15
	Three-month supply: $45	**Three-month supply:** $45
Tier 3: Preferred Brand	**One-month supply:** $47	**One-month supply:** 25%
	Three-month supply: $141	**Three-month supply:** 25%
Tier 4: Non-Preferred Drug	**One-month supply:** $100	**One-month supply:** 25%
	Three-month supply: $300	**Three-month supply:** 25%
Tier 5: Specialty Tier	**One-month supply:** 15% ($250 max)	**One-month supply:** 25%
	Three-month supply: 15% ($250 max)	**Three-month supply:** 25%

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:** $4	**One-month supply:** $4
	Three-month supply: $12	**Three-month supply:** $12
Tier 2: Generic	**One-month supply:** $10	**One-month supply:** $10
	Three-month supply: $30	**Three-month supply:** $30
Tier 3: Preferred Brand	**One-month supply:** $42	**One-month supply:** 25%
	Three-month supply: $126	**Three-month supply:** 25%
Tier 4: Non-Preferred Drug	**One-month supply:** $95	**One-month supply:** 25%
	Three-month supply: $285	**Three-month supply:** 25%
Tier 5: Specialty Tier	**One-month supply:** 15% ($250 max)	**One-month supply:** 25%
	Three-month supply: 15% ($250 max)	**Three-month supply:** 25%

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:** $4	**One-month supply:** $4
	Three-month supply: $8	**Three-month supply:** $8
Tier 2: Generic	**One-month supply:** $10	**One-month supply:** $10
	Three-month supply: $20	**Three-month supply:** $20
Tier 3: Preferred Brand	**One-month supply:** $42	**One-month supply:** 25%
	Three-month supply: $84	**Three-month supply:** 25%
Tier 4: Non-Preferred Drug	**One-month supply:** $95	**One-month supply:** 25%
	Three-month supply: $190	**Three-month supply:** 25%
Tier 5: Specialty Tier	**One-month supply:** 15% ($250 max)	**One-month supply:** 25%
	Three-month supply: 15% ($250 max)	**Three-month supply:** 25%

	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 (including drugs purchased through your retail pharmacy and through mail-order) reach $7,400, you pay the greater of: • 5% of the total cost, or • $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $7,400, you pay the greater of: • 5% of the total cost, or • $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs

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., 35th 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 1-877-299-1008 (TTY/TDD: 711). Someone who speaks English/Language can help you. This is a free service.

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 1-877-299-1008 (TTY/TDD: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

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 1-877-299-1008 (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。

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 1-877-299-1008 (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。

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 1-877-299-1008 (TTY/TDD: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

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 1-877-299-1008 (TTY/TDD: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

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 quí vị cần thông dịch viên xin gọi 1-877-299-1008 (TTY/TDD: 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phi.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-299-1008 (TTY/TDD: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-299-1008 (TTY/TDD: 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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 1-877-299-1008 (TTY/TDD: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: سيقوم شخص ما يتحدث العربية إإننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول 1-877-299-1008 (TTY/TDD: 711). بمساعدتك. هذه خدمة مجانية على مترجم فوري، ليس عليك سوى الاتصال بنا على

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 1-877-299-1008 (TTY/TDD: 711). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

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 1-877-299-1008 (TTY/TDD: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-877-299-1008 (TTY/TDD: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

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 1-877-299-1008 (TTY/TDD: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

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 1-877-299-1008 (TTY/TDD: 711). Ta usługa jest bezpłatna.

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ございます。通訳をご用命になるには、1-877-299-1008 (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。

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 Blue Cross and Blue Shield of New Mexico, a Division of 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.