



**BlueCross BlueShield
of New Mexico**

Lovelace Employer Group Medicare Plan

Annual Notice of Changes for 2016

You are currently enrolled as a member of Lovelace Employer Group Medicare Plan through your employer. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

To remain with your Group's current plan for your Insurance for CY2016 you can make any adjustments during your Group's specified Open Enrollment period. If you want to change to another Medicare Plan, you have from October 15 until December 7 to make changes to your Medicare coverage for next year.

Additional Resources

- ◆ This information is available for free in other languages.
- ◆ Please contact our Customer Service number at 1-888-731-7503 for additional information. (TTY/TDD users should call 711.) Hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Customer Service also has free language interpreter services available for non-English speakers.
- ◆ Esta información está disponible en otros idiomas de forma gratuita. Por favor comuníquese a nuestro número de Servicio al Cliente llamando al 1-888-731-7503 para obtener información adicional. (Los usuarios de TTY/TDD deberán llamar al 711). El horario es de 8:00 a.m. a 8:00 p.m., hora local, los siete días de la semana. Si llama del 15 de febrero al 30 de septiembre, se utilizarán tecnologías alternativas (por ejemplo, correo de voz) durante los fines de semana y días festivos. El Servicio al Cliente también tiene a la disposición los servicios de intérpretes para aquellas personas que no hablan inglés.
- ◆ Please contact Lovelace Medicare Plan if you need this information in another language or format (Spanish or Large Print).

About Lovelace Employer Group Medicare Plan

- ◆ 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 booklet says “we,” “us,” or “our,” it means Blue Cross and Blue Shield of New Mexico. When it says “plan” or “our plan,” it means Lovelace Employer Group Medicare Plan.

Think about Your Medicare Coverage for Next Year

Each fall, your group allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 2.1 - 2.5 for information about benefit and cost changes for our plan.
- Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 2.6 for information about changes to our drug coverage.
- Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Sections 2.3 – 2.4 for information about our Provider/Pharmacy Directory.
- Think about your overall health care costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.**

Summary of Important Costs for 2016

The table below compares the 2015 costs and 2016 costs for Lovelace Employer Group Medicare Plan HMO in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2015 (this year)	2016 (next year)
<p>Monthly plan premium*</p> <p>* Your premium may be higher or lower than this amount. See Section 2.1 for details.</p>	<p>You can get information regarding your premium by going through your employer group.</p>	
<p>Maximum out-of-pocket amount</p> <p>This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)</p>	\$1,500	\$1,500
<p>Doctor office visits</p>	<p>Primary care visits: \$10 copay per visit</p> <p>Specialist visits: \$30 copay per visit</p>	<p>Primary care visits: \$10 copay per visit</p> <p>Specialist visits: \$30 copay per visit</p>
<p>In-patient hospital stays</p>	\$175 per day (days 1-3) for each Medicare-covered hospital stay	\$175 per day (days 1-3) for each Medicare-covered hospital stay
<p>Part D prescription drug coverage</p> <p>(See Section 2.6 for details.)</p>	<p>Deductible: \$0</p> <p>Copays during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> ♦ Drug Tier 1: \$4 ♦ Drug Tier 2: \$12 ♦ Drug Tier 3: \$20 ♦ Drug Tier 4: \$40 ♦ Drug Tier 5: 25% coinsurance of the total for a 30-day supply 	<p>Deductible: \$0</p> <p>Copays during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> ♦ Drug Tier 1: \$4 ♦ Drug Tier 2: \$12 ♦ Drug Tier 3: \$20 ♦ Drug Tier 4: \$40 ♦ Drug Tier 5: 25% coinsurance of the total for a 30-day supply

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Lovelace Employer Group Medicare Plan in 2016

If you have not done anything to change your Medicare coverage by December 7, 2015, we will automatically enroll you in our Lovelace Employer Group Medicare Plan. This means starting January 1, 2016, you will be getting your medical and prescription drug coverage through Lovelace Employer Group Medicare Plan. You have choices about how to get your Medicare coverage. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare.

The information in this document tells you about the differences between your current benefits in Lovelace Employer Group Medicare Plan and the benefits you will have on January 1, 2016 as a member of Lovelace Employer Group Medicare Plan.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2015 (this year)	2016 (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 late enrollment penalty.
- ◆ 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.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2015 (this year)	2016 (next year)
Maximum out-of-pocket amount	\$1,500	\$1,500
Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	Once you have paid \$1,500 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.	Once you have paid \$1,500 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year.

You may call Customer Service for updated provider information or to ask us to mail you a Provider Directory. Please review the 2016 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- ◆ Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- ◆ When possible we will provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.
- ◆ We will assist you in selecting a new qualified provider to continue managing your health care needs.
- ◆ If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- ◆ If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.

- ◆ If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 2.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within the network.

There are changes to our network of pharmacies for next year.

You may call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2016 Pharmacy Directory to see which pharmacies are in our network.**

Section 2.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2016 Evidence of Coverage*.

There are no changes for 2016.

Section 2.6 – 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 in this envelope.

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.**

If you are affected by a change in drug coverage you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
 - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.

- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary in the first 90 days of coverage of the plan year or coverage. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Current formulary exceptions may still be covered, depending on the circumstance. You can call Customer Service to confirm coverage duration.

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 coverage. If you get “Extra Help” and didn’t receive this insert with this packet, please call Customer Service and ask for the “LIS Rider.” Phone numbers for Customer Service are in Section 7.1 of this booklet.

There are four “drug payment stages.” How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year 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. To get information about your costs in these stages, look at Chapter 6, Sections 4 and 5, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

	2015 (this year)	2016 (next year)
Stage 1: Yearly Deductible Stage	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

	2015 (this year)	2016 (next year)
<p>Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a Standard Network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p>	Your cost for a one-month supply at a network pharmacy:	Your cost for a one-month supply at a network pharmacy:
	Tier 1 - Preferred Generic: You pay \$4 per prescription	Tier 1 - Preferred Generic: You pay \$4 per prescription
	Tier 2 – Generic: You pay \$12 per prescription	Tier 2 – Generic: You pay \$12 per Prescription
	Tier 3 - Preferred Brand: You pay \$20 per prescription	Tier 3 - Preferred Brand: You pay \$20 per Prescription
	Tier 4 – Non-Preferred Brand: You pay \$40 per Prescription	Tier 4 – Non-Preferred Brand: You pay \$40 per prescription
	Tier 5 – Specialty Tier: 25% coinsurance of the total for a 30-day supply	Tier 5 – Specialty Tier: 25% coinsurance of the total for a 30-day supply
	Once you have paid \$4,700 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Once you have paid \$4,850 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage 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*.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Lovelace Medicare Plan

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 December 7, you will automatically stay enrolled as a member of our plan for 2016.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2016 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 and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2016*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to <http://www.medicare.gov> and click “Find health & drug plans.” **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Health Care Services Corporation offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Blue Cross Medicare Advantage.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Blue Cross Medicare Advantage.
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).

- – *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 4 Deadline for Changing Plans

To remain with your Group’s current plan for your Insurance for CY2016 you can make any adjustments during your Group’s specified Open Enrollment period. If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2016.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2016, and don’t like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2016. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

New Mexico Aging and Long-Term Services Department is independent (not connected with any insurance company or health plan). 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 1-866-451-2901. You can learn more about New Mexico Aging and Long-Term Services Department by visiting their website (www.nmaging.state.nm.us).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

“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. Many people are eligible and don't even know it. 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 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications);
- **Prescription Cost-sharing Assistance for Person 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: Infectious Disease Bureau. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-505-827-2435.

SECTION 7 Questions?

Section 7.1 – Getting Help from Lovelace Medicare Plan

Questions? We're here to help. Please call Customer Service at 1-888-731-7503. (TTY/TDD only, call 711.) We are available for phone calls 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Calls to these numbers are free.

Read your 2016 *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 2016. For details, look in the 2016 *Evidence of Coverage* for Lovelace Employer Group Medicare Plan. The *Evidence of Coverage* 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. A copy of the *Evidence of Coverage* was included in this envelope.

Section 7.2 – 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

You can visit the Medicare website (<http://www.medicare.gov>). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <http://www.medicare.gov> and click on “Find health & drug plans”).

Read *Medicare & You 2016*

You can read the *Medicare & You 2016* Handbook. Every year in the 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 booklet, you can get it at the Medicare website (<http://www.medicare.gov>) 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.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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**BlueCross BlueShield
of New Mexico**

**2016 Sandia National Laboratories
Group Medicare Plan
Evidence of Coverage Benefit Insert**

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Chapter 4, Section 1.2 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. The most you will have to pay out-of-pocket for covered in-network services is listed in this EOC Benefits Insert.

Copays and coinsurance are applicable to the maximum out-of-pocket expense.

2016 Maximum Out-of-pocket	
	HMO
	\$1,500

Chapter 4, Section 2.1 Your medical benefits and costs as a member of the plan

 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	
<p> Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” preventive visit.</p> <p><i>Authorization rules may apply</i></p>	<p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.</p>
<p>Ambulance services</p> <ul style="list-style-type: none"> 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 are contraindicated (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 are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required. <p><i>Authorization rules may apply</i></p>	<p>\$75 copay for Medicare-covered services</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p> Annual wellness visit</p> <p>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.</p> <p>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.</p> <p>Authorization rules may apply</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>
<p> Bone mass measurement</p> <p>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, including a physician's interpretation of the results.</p> <p>Authorization rules may apply</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 <p>Authorization rules may apply</p>	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Cardiac rehabilitation services</p> <p>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.</p> <p>Authorization rules may apply</p>	<p>\$10 copay for Medicare-covered cardiac rehabilitation services</p> <p>\$10 copay for Medicare-covered intensive cardiac rehabilitation services</p> <p>\$0 copay for Medicare-covered pulmonary rehabilitation services</p> <p>\$10 copay for supplemental cardiac rehabilitation services</p> <p>\$0 copay for supplemental pulmonary rehabilitation services</p> <p>No limit on the number of supplemental cardiac rehabilitation services</p> <p>No limit on the number of supplemental pulmonary rehabilitation services</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover 1 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 well.</p> <p>Authorization rules may apply</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p> <p>Authorization rules may apply</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months <p>Authorization rules may apply</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • We cover only manual manipulation of the spine to correct subluxation (when 1 or more of the bones of your spine move out of position) <p>Authorization rules may apply</p>	<p>\$30 copay for each Medicare-covered chiropractic visit</p> <p>\$30 copay for up to 36 supplemental routine chiropractic visit(s) every year</p>
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy <p>Authorization rules may apply</p>	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p>
<p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.</p>	<p>Limited dental services (this does not include services in connection with care, treatment, filing, removal, or replacement of teeth): \$30 - \$100</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p> Depression screening</p> <p>We cover 1 screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</p> <p>Authorization rules may apply</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>
<p> Diabetes screening</p> <p>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.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p> <p>Authorization rules may apply</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p>
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • 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. • 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. <p>Authorization rules may apply</p>	<p>\$0 copay for Medicare-covered Diabetes self-management training</p> <p>\$0 copay for the total cost for preferred Medicare-covered diabetes monitoring supplies.</p> <p>\$0 copay for Medicare-covered Therapeutic shoes or inserts</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Durable medical equipment and related supplies</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p> <p>We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.</p> <p><i>Authorization required if cost is greater than \$2,500</i></p>	<p>\$0 copay for Medicare-covered equipment</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>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, 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.</p> <p><i>Worldwide coverage</i></p>	<p>\$50 copay for Medicare-covered emergency services.</p> <p>Worldwide coverage.</p> <p>Admitted within 24-hour(s) for the same condition, \$0 copay for emergency room visit.</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p> Health and wellness education programs</p> <p>The Silver Sneakers Fitness program is designed to focus on health conditions such as high blood pressure, cholesterol, asthma, and special diets, also to enrich the health and lifestyles of members include weight management, fitness, and stress management.</p> <p>Healthways SilverSneakers® Fitness Program is a wellness program owned and operated by Healthways, Inc, an independent company.</p>	<p>In-network for all plans</p> <p>Healthways SilverSneakers® Fitness Program is the nation’s leading wellness program designed exclusively for Medicare beneficiaries. Eligible members receive a basic fitness membership with access to amenities and fitness classes including the signature SilverSneakers classes designed to improve muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination. For more information and to find a SilverSneakers participating locations, visit silversneakers.com or call 1-888-423-4632 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. EST.</p> <p>SilverSneakers® Steps is available as an alternative for members who can’t get to a SilverSneakers participating location. SilverSneakers Steps is a self-directed physical activity program that allows members to choose one of four available kits to use at home or on the go – general fitness, strength, walking or yoga. Eligible plan members should visit silversneakers.com for more information and to get started.</p>
<p>Hearing services</p> <p>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.</p> <p><i>Authorization rules may apply</i></p>	<p>\$20 copay - diagnostic hearing exam</p> <p>\$30 copay - 1 supp routine hearing exam every year</p> <p>\$300 plan coverage limit for hearing aid every year</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy <p><i>Authorization rules may apply</i></p>	<p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care</p> <p>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.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 <p><i>Authorization rules may apply</i></p>	<p>\$0 copay for Medicare-covered services</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include:</p> <ul style="list-style-type: none">• Drugs for symptom control and pain relief• Short-term respite care• Home care <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal condition:</u> Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal condition:</u> 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 condition, your cost for these services depends on whether you use a provider in our plan's network:</p> <ul style="list-style-type: none">• If you obtain the covered services from a network provider, 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) <p><u>For services that are covered by <i>Blue Cross Medicare Advantage</i> but are not covered by Medicare Part A or B:</u> <i>Blue Cross Medicare Advantage</i> will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your plan cost-sharing amount for these services.</p> <p><u>For drugs that may be covered by the plan's Part D benefit:</u> drugs are never covered by both hospice and our plan at the same time.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not <i>Blue Cross Medicare Advantage</i>.</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We also cover some vaccines under our Part D prescription drug benefit.</p> <p><i>Authorization rules may apply</i></p>	<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.</p>
<p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, 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.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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 • 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. 	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <p>For Medicare-covered hospital stay: \$175/day (days 1-3)</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Inpatient hospital care (continued)</p> <ul style="list-style-type: none">• Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered by the plan. If <i>Blue Cross Medicare Advantage</i> provides transplant services at a distant location (outside of the service area) and you chose 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 only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.• Physician services <p>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.</p> <p>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 2 at http://www.medicare.gov/Publications/Pubs/pdf/1143_5.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</p>	

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Inpatient mental health care</p> <p>Covered services include mental health care services that require a hospital stay. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra days, your inpatient hospital coverage will be limited to 90 days.</p>	<p>For Medicare-covered hospital stays: \$175/day (days 1-3)</p>
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</p> <p>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.</p> <p><i>Authorization rules may apply</i></p>	<p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Medicare Part B prescription drugs</p> <p>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:</p> <ul style="list-style-type: none"> • 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 	<p>\$0 copay for Medicare-covered Part B drugs.</p>
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>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.</p> <p><i>Authorization rules may apply</i></p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. Coverage begins with the fourth pint of blood that you need – you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. Coverage of storage and administration begins with the first pint of blood that you need. • Other outpatient diagnostic tests <p><i>Authorization may be required</i></p>	<p>\$0 copay for Medicare-covered Advanced Imaging (MRI, MRA, CT Scan, PET)</p> <p>\$0 copay for Medicare-covered lab services</p> <p>\$0 copay for Medicare-covered for Medicare-covered diagnostic radiology services and outpatient x-rays</p> <p>\$0 copay for Medicare-covered Therapeutic radiology services</p> <p>\$0 copay for Medicare-covered Diagnostic test and procedures</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Outpatient hospital services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself <p>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.</p> <p>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 http://www.medicare.gov/Publications/Pubs/pdf/1143_5.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.</p> <p>Authorization rules may apply</p>	<p>\$150 copay for Medicare-covered outpatient hospital services</p> <p>\$150 copay for Medicare-covered Ambulatory surgical center services</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Outpatient mental health care</p> <p>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.</p> <p><i>Authorization rules may apply</i></p>	<p>\$20 copay for Medicare-covered outpatient individual therapy visit</p> <p>\$20 copay for Medicare-covered group therapy visit</p> <p>\$20 copay for Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$20 copay for Medicare-covered group therapy visit with a psychiatrist</p>
<p>Outpatient rehabilitation services</p> <p>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).</p> <p><i>Authorization rules may apply</i></p>	<p>\$10 copay for Medicare-covered occupational therapy visit</p> <p>\$10 copay for physical therapy and speech language therapy visit</p>
<p>Outpatient substance abuse services</p> <p>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.</p> <p><i>Authorization rules may apply.</i></p>	<p>\$20 copay for Medicare-covered individual therapy visit</p> <p>\$20 copay for Medicare-covered group therapy visit</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>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.”</p> <p>Authorization rules may apply</p> <p>Note: Applies to all plans</p>	<p>\$150 copay for Medicare-covered outpatient hospital services</p> <p>\$150 copay for Medicare-covered Ambulatory surgical center services</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting 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.</p> <p>Authorization rules may apply</p>	<p>\$0 copay for Medicare-covered services</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare. • 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) <p>Authorization rules may apply</p>	<p>\$10 copay for Medicare-covered Primary care visit</p> <p>\$30 copay for Medicare-covered Specialist visit</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 <p>Authorization rules may apply</p>	<p>\$25 copay for Medicare-covered Podiatry services</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test <p>Authorization rules may apply</p>	<p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Prosthetic devices and related supplies</p> <p>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 includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p> <p><i>Authorization is required if the cost is greater than \$2,500.</i></p>	<p>\$0 copay for Medicare-covered Prosthetic devices</p>
<p>Pulmonary rehabilitation services</p> <p>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.</p> <p><i>Authorization rules may apply</i></p>	<p>\$10 copay for Medicare-covered pulmonary rehabilitation services</p> <p>\$0 copay for supplemental pulmonary rehabilitation services</p> <p>No limit on the number of supplemental pulmonary rehabilitation services</p>
<p> Screening and counseling to reduce alcohol misuse</p> <p>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.</p> <p><i>Authorization rules may apply</i></p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>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.</p> <p>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.</p> <p><i>Authorization rules may apply</i></p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.</p>
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area • 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) <p>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 below, “Medicare Part B prescription drugs.”</p> <p><i>Authorization rules may apply</i></p>	<p>\$0 copay for Medicare-covered Renal Dialysis services</p> <p>\$0 copay for Medicare-covered kidney disease education services</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p>Skilled nursing facility (SNF) care (Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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 only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. 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 <p>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.</p> <ul style="list-style-type: none"> • 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. <p><i>Authorization rules may apply</i></p>	<p>The plan covers up to 100 days in SNF</p> <p>\$0/day (days 1-20) \$75/day (days 21-100)</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> 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.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> 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.</p> <p><i>Authorization rules may apply</i></p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p>Transportation Services</p> <p>Plan approved transportation services to plan approved location(s). Contact the plan for details on how to access this benefit.</p> <p><i>Authorization rules may apply</i></p>	<p>\$0 copay for up to 4 one-way trip(s) to plan-approved location every year.</p>
<p>Urgently needed care</p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p><i>Worldwide coverage</i></p>	<p>\$30 - \$50 copay for Medicare-covered urgently-needed-care visits.</p> <p>Worldwide coverage.</p>

Services that are covered for you	What you must pay when you get these services
HMO	
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening 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.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. 	<p>Eye Exams: \$0-\$20 copay for Medicare-covered exam to diagnose and treat diseases and conditions of the eye including yearly glaucoma screening.</p> <p>\$0 copay for one routine eye exam limited to 1 per year.</p> <p>Eye Wear: \$0 copay for 1 pair of eyeglasses (lenses and frames), contact lenses after cataract surgery.</p> <p>\$150 allowance towards frames and contact lenses.</p>
<p> “Welcome to Medicare” Preventive Visit</p> <p>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.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p>

This section tells you what services are “excluded” from Medicare coverage and therefore, are not covered by this plan. If a service is “excluded,” it means that this plan doesn’t cover the service.

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. We won’t pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found 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.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart 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.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and 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 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 is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	
Cosmetic surgery or procedures		<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • 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 cleanings, fillings or dentures.	✓	
Non-routine dental care.		<p style="text-align: center;">✓</p> <p>Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</p>
Routine chiropractic care		<p style="text-align: center;">✓</p> <p>Manual manipulation of the spine to correct a subluxation is covered.</p>
Routine foot care		<p style="text-align: center;">✓</p> <p>Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.</p>
Orthopedic shoes		<p style="text-align: center;">✓</p> <p>If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.</p>

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Supportive devices for the feet		<p style="text-align: center;">✓</p> Orthopedic or therapeutic shoes for people with diabetic foot disease.
Routine hearing exams, hearing aids, or exams to fit hearing aids.	✓	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids.		<p style="text-align: center;">✓</p> Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Acupuncture	✓	
Naturopath services (uses natural or alternative treatments).	✓	

Chapter 6, Section 2.1 What are the drug payment stages for Blue Cross Medicare Advantage members?

Stage 1 <i>Yearly Deductible Stage</i>	Stage 2 <i>Initial Coverage Stage</i>	Stage 3 <i>Coverage Gap Stage</i>	Stage 4 <i>Catastrophic Coverage Stage</i>
<p>Because there is no deductible for these plans, this payment stage does not apply to you.</p>	<p>You begin in this stage when you fill your first prescription of the year.</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total \$3,310 for HMO.</p>	<p>You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$4,850. This amount and rules for counting costs toward this amount have been set by Medicare.</p>	<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2016).</p>

Chapter 6, Section 3.1 We send you a monthly report called the “Part D Explanation of Benefits” (the “Part D EOB”)

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

	Standard retail cost-sharing (in-network) (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 Chapter 5 for details.) (up to a 29-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	\$4	\$4	\$4
Cost-Sharing Tier 2 (Generic)	\$12	\$12	\$12
Cost-Sharing Tier 3 (Preferred Brand)	\$20	\$20	\$20
Cost-Sharing Tier 4 (Non-Preferred Brand)	\$40	\$40	\$40
Cost-Sharing Tier 5 (Specialty)	25%	25%	25%

Chapter 6, Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day supply) of a drug

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

	Standard retail cost-sharing (in-network) (up to a 90-day supply)	Mail-order cost-sharing (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	\$8	\$8
Cost-Sharing Tier 2 (Generic)	\$24	\$24
Cost-Sharing Tier 3 (Preferred Brand)	\$40	\$40
Cost-Sharing Tier 4 (Non-Preferred Brand)	\$80	\$80
Cost-Sharing Tier 5 (Specialty)	25%	25%

Chapter 6, Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,850

You receive coverage for all drugs in Tiers 1, 2, 3, 4 and 5.

Tier 1: Preferred Generic Drugs

\$4 copay for a one-month (30-day) supply of all drugs covered in this tier from a Standard Retail network pharmacy

\$8 copay for a three-month (90-day) supply of all drugs covered in this tier from a Standard Retail network pharmacy

Tier 2: Generic Drugs

\$12 copay for a one-month (30-day) supply of all drugs covered in this tier from a Standard Retail network pharmacy

\$24 copay for a three-month (90-day) supply of all drugs covered in this tier from a Standard Retail network pharmacy

Tier 3: Preferred Brand Drugs

\$20 copay for a one-month (30-day) supply of all drugs covered in this tier from a Standard Retail network pharmacy

\$40 copay for a three-month (90-day) supply of all drugs covered in this tier from a Standard Retail network pharmacy

Tier 4: Non-Preferred Brand Drugs

\$40 copay for a one-month (30-day) supply of all drugs covered in this tier from a Standard Retail network pharmacy

\$80 copay for a three-month (90-day) supply of all drugs covered in this tier from a Standard Retail network pharmacy

Tier 5: Specialty Tier Drugs

25% coinsurance for a one-month (30-day) supply of select drugs covered in this tier from a Standard Retail network pharmacy

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year.

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.