



Los Alamos National Labs

Plan Highlights – Medicare Retirees

National EPO Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges Preferred Provider (In-Network) ^{1,2}
Calendar Year Deductible ¹ (Family deductible is an aggregate of three times individual amount and may be met by three or more family members.) ¹	\$150 Individual \$450 Family
Calendar Year Out-of-Pocket Limit ² (Includes deductible, copayments, drug plan copayments and percentage coinsurance amounts. Family limit may be met by three or more family members.)	\$2,000 Individual \$6,000 Family
Lifetime Maximum Benefit Limit (per member)	Unlimited
Office Visit/Exam Charge Office Visits/Exams or Consultations (Other office services received during the visit, unless specified otherwise, are subject to deductible and/or coinsurance provisions as listed in the rest of the summary. Includes initial visit to OB/Gyn or midwife to confirm pregnancy; pre-natal and post-natal care is listed under "Hospital/Other Facility: Inpatient" as part of global delivery fee.) Sterilization/surgery (reversal not covered); other related services in office Allergy Injections (only) and Immunizations (only) Other Allergy Care (such as allergy testing; extract preparation) Therapeutic Injections: Office Surgery and Supplies Lab, X-Ray, and Other diagnostic Tests (Nonroutine/nonpreventive) Nutritional Counseling (3sessions/lifetime for certain conditions)	\$20/visit (deductible waived) 10% after deductible No Charge 10% after deductible 10% after deductible ⁴ 10% after deductible ⁴ \$20/visit (deductible waived)
PREVENTIVE SERVICES	
Routine/Preventive Well-Baby Care (Through Age 2): Including check-ups, routine screening; routine laboratory tests; immunizations	No Charge
Routine/Preventive Adult Care (Ages 3 and Older): Including routine physicals and gynecological exams; well-child care, vision/hearing screenings; routine mammograms, routine colonoscopies; immunizations; routine pap tests, cholesterol tests, urinalysis.	No Charge
Family Planning (including devices, insertion, Depo-Provera, etc.)	No Charge
OTHER MEDICAL/SURGICAL SERVICES	
Acupuncture Treatment (limited to 20 visits/year)	\$20/visit (deductible waived)
Ambulance: Emergency Transport (Ground and Emergency Air, as needed)	10% after deductible ³
Ambulance: NonEmergency Ground Transport (between facilities)	10% after deductible ⁴
Ambulance: Nonemergency Air Transfer (between facilities)	10% after deductible ⁴
Cancer/Congenital Heart Disease Care (Blue distinction programs only include a lodging per diem benefit of \$50 per person, or \$100/day for 2-3 persons. Travel and the above per diem allowances combined are limited to \$10,000 per lifetime for each program utilized. If program is not used, benefits are same as for any other service, per place of treatment, provider contract and type of service.)	10% after deductible ^{4,5}
Cardiac Rehabilitation, Outpatient/Office	\$20/visit (deductible waived) ⁴
Chemotherapy, Dialysis, and Radiation -Office or Freestanding Clinic -Outpatient Hospital	\$20/visit (deductible waived) ⁴ 10% after deductible ⁴
Dental/Facial Accident³, Oral Surgery, and TMJ/CMJ Services (for limited, non-dental medical conditions; see a benefits booklet for details)	Usual benefit based on type/place of service ⁴
Emergency Room Visit (emergency condition only)	\$75/visit (deductible waived) ³
Physician and Other Professional Provider Charges	10% after deductible ³

Blue Cross and Blue Shield of New Mexico (BCBSNM) is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

National EPO Medical Program Cost-Sharing Features, covered Services, and Limitations	Member's Share of Covered Charges Preferred Provider ¹ (In-Network)
Hearing-Related Services for members 21 years & younger: -Office exams and evaluations: cochlear implant; auditory testing -Hearing aid services (maximum total benefit of two hearing aids every three years, including fitting of hearing aid and ear molds)	10% after deductible
Hearing-Related Services for members 22 years & older: -Office exams and evaluations: cochlear implant; auditory testing -Hearing aid services (maximum total benefit of \$2,200 during any 3-year period, including fitting of hearing aid and ear molds)	10% after deductible
Home Health Care/Home I.V. Services (Private duty nursing not covered; care must be from a licensed home health care agency): Home Health care agency services and home I.V. services	10% after deductible ⁴
Hospice Services including bereavement counseling when such services are provided by hospice (Respite care limited to 10 days for each 6-month benefit period)	10% (deductible waived) ⁴
Hospital/Other Facility: Inpatient	
-Medical/Surgical Acute Care, Observation, Medical Detox, Maternity-Related (including routine newborn nursery charges), and Extended Stay (Nonroutine) for Covered Newborn: Room/Board, and Covered Ancillaries -Birthing Center -Skilled Nursing Facility and Inpatient Physical Rehabilitation (max. 100 days per calendar year) -Inpatient Physician's Medical visit or Consultation; Routine Inpatient OB/Gyn Global Delivery Fee (includes pre-natal/post-natal care); Inpatient Newborn Male Circumcision -Inpatient Surgeon, Anesthesiologist, Radiologist, Pathologist, and Assistant Surgeon (including maternity services that are not part of OB/Gyn global delivery fee and complications of pregnancy)	10% after deductible ⁵ 10% after deductible 10% after deductible ⁵ No Charge 10% after deductible ⁴
Hospital/Other Facility: Outpatient/Ambulatory Surgery Center (includes covered services, whether billed by facility or professional provider, including surgery, diagnostic test, chemotherapy, dialysis, and radiation treatment.)	10% after deductible ⁴
Lab, X-ray, and Other Diagnostic Tests (nonpreventive) Including MRI, CT Scans, and PET Scans; Sleep Studies; EKGs, etc. -Office or Freestanding/Independent Facility or Outpatient Hospital	10% after deductible ⁴
Short-Term Rehabilitation; Outpatient and Office (Includes Physical, Occupational, and Speech therapy services, each are limited to 20 visits /calendar year. Speech therapy is limited to specified medical conditions; see a benefit booklet for details.)	\$20/visit (deductible waived) ⁴
Spinal/Osteopathic Manipulation/Naprapathy (limited to 20 visits /calendar year combined)	\$20/visit (deductible waived)
Supplies, Durable Medical Equipment, Prosthetics, Orthotics (Includes insulin pumps and pump supplies; support hose limited to 6 pair/year; mastectomy bras limited to 3/year; For diabetic supplies such as needles, test strips, glucagon, etc., see drug plan provision)	10% after deductible ^{4,6}
Surgery: Outpatient Hospital/Ambulatory Surgery Facility (including facility charges and related physician and other professional charges, such as surgeon, pathologist, radiologist, etc.)	10% after deductible ⁴
Surgery: Office (including casts, splints, dressings, and diagnostic tests done in office on same day and billed by surgeon)	\$20/visit (deductible waived) ⁴
Therapy: Chemotherapy, Dialysis, and Radiation -Office or Freestanding Clinic -Outpatient Hospital	\$20/visit (deductible waived) ⁴ 10% after deductible ⁴

National EPO Medical Program Cost-Sharing Features, covered Services, and Limitations		Member's Share of Covered Charges Preferred Provider ¹ (In-Network)		
Transplant Services: Limitations apply to donor charges and travel and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.		10% after deductible ^{4,5}		
Travel and Lodging: Benefits are available when these services are related to case-managed Cancer Services or Congenital Heart Disease if patient is receiving treatment from a Blue Distinction Center for Specialty Care or case-managed transplants (excluding cornea). Travel for more than 50 miles must be necessary in order to be eligible for coverage under this provision. For each of the three benefit programs, the benefits are as follows: `				
-Travel to and from health care facility plus per diem payments listed below		\$10,000/lifetime after deductible ⁴		
-Lodging per diem for patient and/or companion(s)		\$50/Individual or \$100 for 2-3 persons after deductible ⁴		
Urgent Care Facility		\$20/visit (deductible waived)		
-Ancillary Services (lab, x-rays, supplies, etc.)		10% after deductible		
BEHAVIORAL HEALTH: Mental Health and Chemical Dependency				
Mental Health Services		\$20/visit (deductible waived)		
-Office				
-Other Outpatient Treatments; Intensive Outpatient Programs; Partial Hospitalization		10% after deductible		
-Inpatient		10% after deductible ⁵		
-Related Physician Claims		10% after deductible		
Chemical Dependency Rehabilitation		\$20/visit (deductible waived)		
-Office				
-Other Outpatient Treatments; Intensive Outpatient Programs; Partial Hospitalization; Outpatient Suboxone		10% after deductible		
-Inpatient		10% after deductible ⁵		
-Related Physician Claims		10% after deductible		
-Residential Treatment Center for Chemical Dependency and Mental Health Includes Physician		10% after deductible ^{5,7}		
DRUG PLAN: Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Specified Vaccines⁸				
Members must use a participating pharmacy. Enteral nutritional products, compounded medications, special medical foods, and other drugs require preauthorization or benefits will be denied.	Generic Drug	Brand-Name Drug⁸		
		If a generic equivalent is available and you order the brand-name drug, you pay:	On Drug List	Not on Drug List
Retail Pharmacy Program (up to a 30-day supply or 180 units, whichever is less) benefits include Flu, Pneumococcal, and Zostavax vaccines, for which no copayment is required.	\$15	\$15 plus difference in covered charge between the brand-name and the generic equivalent	\$30	\$45
Mail-Order Service (up to a 60-or 90-day supply or 540 units, whichever is less)	\$30	\$30 plus difference in covered charge between the brand-name and the generic equivalent	\$60	\$90
Nonprescription enteral nutritional products and special medical foods (up to a 30-day supply pre 30-day period; requires preauthorization)	\$45 retail/\$90 mail-order			

FOOTNOTES:

1 All services – excluding items covered under the drug plan – are subject to deductible unless otherwise indicated in the *Summary of Benefits* (i.e., “deductible waived”). When applicable, the deductible must be met before benefit payments are made.

2 After a member (or family) reaches the applicable out-of-pocket limit, the Medical Program pays 100 percent of that member’s (or family’s) covered charges for the rest of the calendar year

3 Initial treatment of a medical emergency is paid at the Preferred Provider benefit level. Follow-up treatment from a Nonpreferred Provider and treatment that is not for an emergency is not covered unless listed as an exception in the “NOTE” at the bottom of the page.

4 Certain services are **not covered** if preauthorization is not obtained from BCBSNM (or the BCBSNM Behavioral Health Unit). A list of services requiring preauthorization and a description of when obtaining preauthorization is **your** responsibility is in Section 4. Some services may require a written request for preauthorization in order to be covered. (Nonemergency ambulance services are covered **only** when it is medically necessary to transfer the patient from one facility to another.)

5 Preauthorization is required for inpatient admissions. You pay a **\$300 penalty** for covered facility services if preauthorization is your responsibility and is not obtained.

6 Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

7 LANS has authorized the Claims Administrator to approve, when used as a cost-effective alternative to inpatient hospitalization, residential treatment center services for patients being treated for chemical dependency and mental health.

8 Prescription drugs and other items covered under the drug plan must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy or Mail-Order Programs. (BCBSNM has contracted with a separate program for administration of your outpatient drug plan benefits.) Some prescription drugs require preauthorization before coverage will be available. If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the generic drug copayment.

NOTE: Nonpreferred provider services may be covered in the following cases only: emergency care; transition of care (up to 90 days); pathologist, anesthesiologist, and radiologist services when member is receiving covered services at a preferred facility; and when a provider belongs to a type that is “unsolicited” (i.e., a type that is not offered a Preferred Provider contract). Also, if you must travel more than 30 miles to find a Preferred Provider and a Nonpreferred Provider is closer, the Medical Program will cover the Nonpreferred Provider services, if eligible. If the providers are essentially equal in distance from your home or office (i.e., within 5 miles of each other), the exception does not apply and you must use a Preferred Provider. This exception also does not apply to members living or residing outside the United States. In any case, to receive Preferred Provider benefits for nonemergency services of a Nonpreferred Provider, you must first obtain prior approval from BCBSNM. **It is YOUR responsibility to determine if a provider is in the national/worldwide BCBS PPO network or not. See Section 3 for details.**