



## Medicare (Part A) Hospital Services — Per Benefit Period\*

SERVICES	MEDICARE PAYS	THIS PLAN PAYS	YOU PAY**
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,216	\$1,216 (Part A deductible)	\$0
61st through 90th day	All but \$304 a day	\$304 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$608 a day	\$608 a day	\$0
• Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare eligible expenses	\$0
– Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$152 a day	Up to \$152 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respice care	\$0	Balance

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

## Medicare (Parts A and B)

SERVICES	MEDICARE PAYS	THIS PLAN PAYS	YOU PAY**
<b>Home Health Care</b>			
Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable Medical Equipment			
• First \$147 of Medicare-approved amounts	\$0	\$147 (Part B deductible)	\$0
• Remainder of Medicare-approved amounts	80%	20%	\$0

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## Medicare (Part B) Medical Services — Per Calendar Year\*

SERVICES	MEDICARE PAYS	THIS PLAN PAYS	YOU PAY**
<b>Medical Expenses</b>			
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$147 of Medicare-approved amounts*	\$0	\$147 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Medicare-covered preventive services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$147 of Medicare-approved amounts*	\$0	\$147 Part B deductible	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services</b>			
Blood tests for diagnostic services	100%	\$0	\$0
<b>Immunosuppressive Drug Therapy</b>			
	80%	20%	\$0
<b>Mammography Screening</b>			
As required by your physician	80%	20%	\$0

### Other Benefits — Services Not Covered by Medicare

SERVICES	THIS PLAN PAYS	YOU PAY**
<b>Preventive Services Not Covered by Medicare</b>	100% of the BCBSNM maximum allowable fee.	Amounts above the BCBSNM maximum allowable fee.
<b>Hearing/Vision Exams</b>	100% of the BCBSNM maximum allowable fee; one exam per year.	Amounts above the BCBSNM maximum allowable fee.
<b>Care Outside Medicare Territorial Limits (see "NOTE" below)</b>		
<b>Nonemergency Care</b>	\$0	All expenses
<b>Emergency Care</b>	100% of the BCBSNM maximum allowable fee.	Amounts above the BCBSNM maximum allowable fee.

\*Once you have been billed \$147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\* "\$0" indicates your liability for covered charges. You are responsible for all other **non-covered** charges.

**NOTE:** The Medicare territorial limits are defined by Medicare as the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

**Note: add page 3 here “Other Benefits – OP Rx Drug Plan**