Effective January 1 – December 31, 2020

2020 Summary of Benefits

Blue Shield 65 Plus Choice Plan (HMO)

Medicare Advantage Prescription Drug Plan

San Bernardino County/
Riverside County

blue california

blueshieldca.com/medicare

H0504_19_402A_040_M Accepted 09012019

2020 Summary of Benefits
Blue Shield 65 Plus Choice Plan
San Bernardino County/ Riverside County

January 1, 2020 – December 31, 2020

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please refer to the ***Evidence of Coverage* (EOC) at blueshieldca.com/medMAPD2020 or by calling** Member Services at **(800) 776-4466** [TTY: **711**], 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m., Saturday and Sunday), from April 1 through September 30. **Note: The EOC will be available on our website by October 15.**

Blue Shield 65 Plus℠ Choice Plan includes Medicare health care (Part C) and prescription drug (Part D) coverage and may offer supplemental benefits in addition to Part C and Part D benefits, offering you the convenience of having both your medical and prescription drugs covered through one plan.

To join **Blue Shield 65 Plus Choice Plan**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. **Our service area includes San Bernardino and Riverside counties.**

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at http://www.medicare.gov or get a copy 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.

Our plan Provider Directory is located on our website at **blueshieldca.com/find-a-doctor**.

Our plan Pharmacy Directory is located on our website at **blueshieldca.com/med_pharmacy2020**.

To get the most complete and current information about which drugs are covered, you can visit our website at **blueshieldca.com/med_formulary2020**.

Summary of benefits

Effective January 1 through December 31, 2020

Premiums and benefits	You pay	What you should know
Monthly plan premium	$0	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Deductible	$0	
Maximum out-of-pocket	$999	Does not include Part D prescription drugs. This is the most you would pay for the year for covered Medicare Parts A and B services.
Inpatient hospital care	$0 copay per admission	Our plan covers an unlimited number of days for each Medicare-covered stay in a network hospital.
Outpatient hospital services • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	$85 copay for each visit to an emergency room (this copay is waived if you are admitted to the hospital within one day for the same condition) $150 copay for each visit to an outpatient hospital facility $0 copay for observation services	Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
Outpatient surgery	$0 copay for each visit to an ambulatory surgical center $150 copay for each visit to an outpatient hospital facility	
Doctor visits • Primary care physician • Specialists	 $0 copay per visit $0 copay per visit	 **A referral from your doctor may be required for Specialist visits.**
Preventive services	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care	$85 copay per visit $85 copay and no combined annual limit for covered emergency care and urgently needed services outside the United States and its territories	This copay is waived if you are admitted to a hospital within one day for the same condition. Worldwide coverage.
Urgently needed services	$0 copay for each visit to a network urgent care center within your plan service area. $0 copay for each visit to an urgent care center or physician office outside your plan service area but within the United States and its territories.	

Summary of benefits (cont'd)

Effective January 1 through December 31, 2020

Premiums and benefits	You pay	What you should know
Urgently needed services (cont'd)		
	$85 copay for each visit to an emergency room outside of your plan service area but within the United States and its territories. $85 copay for each visit to an emergency room, urgent care center, or physician office that is outside of the United States and its territories.	The $85 copay for each visit to an emergency room that is outside of the plan service area or outside of the United States and its territories is waived if you are admitted to the hospital within one day for the same condition. There is no combined annual limit for covered emergency care or urgently needed services outside the United States and its territories. Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit. Worldwide coverage.
Diagnostic services, labs, and imaging		**A referral from your doctor may be required for diagnostic services, labs and imaging services.**
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$0 copay for each diagnostic radiology service	Covered according to Medicare guidelines.
• Lab services	$0 copay	
• Diagnostic tests and procedures	$0 copay	
• Outpatient X-rays	$0 copay	
• Therapeutic radiology services (such as radiation treatment for cancer)	You pay 20% of the Medicare-allowed amount	While you pay 20% for therapeutic radiology services, you will never pay more than your $999 total out-of-pocket maximum for the year.
Hearing services		**A referral from your doctor may be required for hearing services.**
• Hearing exam (Medicare-covered)	$0 copay for each Medicare-covered visit	Routine hearing exams are unlimited if provided by your doctor but are limited to one exam every 12 months with network hearing aid provider.
• Routine (non-Medicare covered) hearing exam	$0 copay for one routine hearing exam every year through the network hearing aid provider	

Summary of benefits (cont'd)

Effective January 1 through December 31, 2020

Premiums and benefits	You pay	What you should know
Hearing services (cont'd)		
• Hearing aids	$499 copay for each Vista 610 hearing aid or $799 copay for each Vista 810 hearing aid from the network provider Coverage is limited to 2 hearing aids per year.	• Hearing aid instrument – Choice of the Vista 610 model or Vista 810 model – Up to two hearing aids every year available in the following styles: o In the ear o In the canal o Invisible in canal o Behind the ear o Receiver in the ear – Hearing aid fittings, counseling, and adjustments – Ear impressions & molds – Hearing aid device checks – Two-year supply of batteries per hearing aid – Three-year extended warranty on some models
Dental services		
• Cleaning	$20 copay per visit	One visit every 6 months
• Dental X-ray(s)	$0-$10 copay, depending on the service/type	One series of bitewing X-rays every 6 months. One series of full mouth X-rays every 24 months.
• Fluoride treatment	$5 copay per visit	Two visits in 12 months for fluoride treatment.
• Oral exam	$5-$16 copay per visit, depending on the service	See optional supplemental dental HMO and PPO plans for more information about dental services for an extra plan premium.
Vision services		
• Exam to diagnose and treat diseases and conditions of the eye	$0 copay for each Medicare-covered visit	**A referral from your doctor may be required for an exam and treat diseases and conditions of the eye.**
• Yearly glaucoma screening	$0 copay	**A referral from your doctor may be required for yearly glaucoma screenings.**
• Routine eye exam, including refraction	$0 copay	One exam every 12 months with network provider. Some coverage at non-network providers included; see the plan EOC for details.

Summary of benefits (cont'd)

Effective January 1 through December 31, 2020

Premiums and benefits	You pay	What you should know
Vision services (cont'd)		
• Eyeglass frames or contact lenses	$0 copay	Once every 24 months with network provider. Our plan pays up to $150 every 24 months for either eyeglass frames or for contact lenses. Some coverage at non-network providers included; see the plan EOC for details.
• Eyeglass lenses	$0 copay	One pair every 12 months with network provider. Some coverage at non-network providers included; see the plan EOC for details.
Mental health services		
• Inpatient mental health care	$900 copay per Medicare-covered stay	**A referral from your doctor may be required for mental health services.**
• Outpatient group therapy visit	$30 copay per visit	You are covered for 150 days each benefit period, up to the 190-day lifetime limit.
• Outpatient individual therapy visit	$30 copay per visit	A benefit period starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.
Skilled nursing facility (SNF) care	$0 copay per day for days 1 through 20 $55 copay per day for days 21 through 100	**A referral from your doctor may be required for skilled nursing facility care.** 100 days per benefit period; no prior hospitalization required with network provider. A benefit period starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.
Rehabilitation services		
• Occupational therapy services	$0 copay per visit	**A referral from your doctor may be required for rehabilitation services.**
• Physical therapy and speech and language therapy services	$0 copay per visit	
Ambulance	$150 copay per trip (each way)	
Transportation	$0 copay	Limited to 24 one-way trips to plan-approved health-related locations every 12 months.

Summary of benefits (cont'd)

Effective January 1 through December 31, 2020

Premiums and benefits	You pay	What you should know
Medicare Part B Drugs	20% of the Medicare-allowed amount for chemotherapy drugs 20% of the Medicare-allowed amount for other Part B drugs	
Opioid treatment program services	$0 copay	
Over-the-counter items	$0 copay	You have $80 per quarter to spend on covered items. You can place one order per quarter and cannot roll over your unused allowance into the next quarter.
Telehealth services	$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication. See the plan EOC for more information.
Foot care (podiatry services)		**A referral from your doctor may be required for foot care services.**
• Foot exams and treatment	$0 copay for each Medicare-covered visit	
• Routine foot care	You will be reimbursed up to $1,000 every year for routine foot care.	You may obtain routine foot care at the provider of your choice.
Medical equipment/supplies		**A referral from your doctor may be required for medical equipment/supplies.** Prior authorization from the plan may be required for durable medical equipment. See the plan EOC for more information.
• Durable medical equipment (e.g., wheelchairs, oxygen)	20% of the Medicare-allowed amount	
• Blood glucose monitors	$0 copay for ACCU-CHEK® blood glucose monitors and 20% of the Medicare-allowed amount for blood glucose monitors from all other manufacturers	
• Prosthetics (e.g., braces, artificial limbs)	$0 copay	
• Diabetes self-management training, diabetic services and supplies	$0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	
Health and Wellness programs		
• Basic gym access through SilverSneakers Fitness	$0 copay	
• NurseHelp 24/7℠ (telephone and online support)	$0 copay	
• Personal Emergency Response System (PERS) (24/7 medical alert)	$0 copay	

Prescription drug coverage

You pay the following:

Part D prescription drug benefit				
Stage 1: Annual Deductible	**$0** This stage does not apply because there is no deductible for this plan.			
Stage 2: Initial Coverage	**Preferred retail cost-sharing (in-network)**		**Standard retail cost-sharing (in-network)**	
	30-day supply	**90-day supply*,NDS**	**30-day supply**	**90-day supplyNDS**
Tier 1: Preferred Generic Drugs	$0 copay	$0 copay	$5 copay	$5 copay
Tier 2: Generic Drugs	$5 copay	$7.50 copay	$12 copay	$36 copay
Tier 3: Preferred Brand Drugs	$35 copay	$87.50 copay	$47 copay	$141 copay
Tier 4: Non-Preferred Drugs	$90 copay	$225 copay	$100 copay	$300 copay
Tier 5: Specialty Tier Drugs	33% coinsurance	Not covered	33% coinsurance	Not covered
Tier 6: Select Care Drugs	$5 copay	$5 copay	$10 copay	$10 copay

If you reside in a long-term care facility, you pay the same as at a standard retail cost-sharing pharmacy. There are limited situations where you may get drugs from an out-of-network pharmacy at the same cost as an in network standard retail cost sharing pharmacy.

For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC.

*** 90-day supply cost-sharing also applies to Blue Shield's mail service pharmacy. Tier 5 drugs are limited to a 30-day supply for mail service.**

NDS A long-term (up to a 90-day) supply is not available for select drugs. We limit the amount select drugs that can be filled at one time for **your protection**. The drugs that are not available for a long-term supply are marked with the symbol NDS in our Drug List.

Prescription drug coverage (cont'd)

You pay the following:

Stage 3: Coverage Gap	Coverage for outpatient prescription drugs after the total yearly drug costs paid by both you and Blue Shield reach $4,020, until your yearly out-of-pocket drug costs reach $6,350	Tier 1: Preferred Generic Drugs, Tier 2: Generic Drugs and Tier 6: Select Care Drugs are covered at the copays described above. For all other tiers, you pay 25% of the price for brand-name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs until your costs total $6,350, which is the end of the coverage gap.
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through mail service) reach $6,350, you pay the greater of: • 5% of the cost, or • $3.60 copay for a generic drug (including brand drugs treated as generic) and an $8.95 copay for all other drugs (This stage **protects** you from any additional costs once you have paid your yearly out-of-pocket drug costs.)	

Mail Service Pharmacy

CVS Caremark is our network mail service pharmacy where you may obtain a 90-day supply of maintenance drugs at a lower cost. They will be delivered to your home or office with no charge for shipping or delivery. Sign up at caremark.com or call (866) 346-7200 [TTY: 711].

Network pharmacies that offer preferred cost-sharing

You may pay less when you fill your prescriptions at one of our network pharmacies that offer preferred cost-sharing. Here's just a few:

• CVS/pharmacy (including CVS pharmacy at Target)	(888) 607-4287 [TTY: 711]	CVS/pharmacy®
• Safeway and Vons pharmacies	(877) 723-3929 [TTY: 711]	VONS Pharmacy
• Albertsons/Sav-on/Osco pharmacies	(877) 932-7948 [TTY: 711]	Albertsons Sav-on
• Costco	(800) 955-2292 [TTY: 711]	COSTCO PHARMACY
• Ralphs, Walmart, and many more.		

You do not have to be a Costco member to use Costco Pharmacies.

Other pharmacies are available in our network.

Optional supplemental dental HMO and PPO plans

You pay the following:

	Blue Shield 65 Plus Choice Plan	Optional supplemental dental HMO	Optional supplemental dental PPO	
Network access	**Participating dentists only**	**Participating dentists only**	**Participating dentists**	**Non-participating dentists**
Monthly optional supplemental dental plan premium	None	$11.60	$37.90	
Calendar-year deductible per member (not applicable to diagnostic and preventive services)	$0	$0	You pay $50	
Calendar-year maximum per member	None	*$1,000 for covered endodontic, periodontic, and oral surgery services when performed by a network dental specialist.	$1,500 for covered preventive and comprehensive dental services combined, no matter if the services are performed by a participating general dentist or a dental specialist. Up to $1,000 of this maximum amount may be used for covered preventive and comprehensive dental services performed by non-participating dentists in a calendar year. You pay any amount above the $1,500 calendar-year benefit maximum.	
Waiting Periods – Major Services Only	No waiting period	No waiting period	No waiting period for preventive and diagnostic services. Six-month waiting period for major services. See the plan EOC for more information.	

* All services must be performed, prescribed or authorized by your network dentist. If you need to see a specialist, you must get a referral from your primary dentist to receive covered specialist services. Plan pays a maximum of $1,000 per calendar year for covered specialist services. You are responsible for amounts above $1,000. If you are enrolled in the optional supplemental dental PPO plan and you need to see a specialist, you may go directly to the specialist.

Optional supplemental dental HMO and PPO plans (cont'd)

	Blue Shield 65 Plus Choice Plan	Optional supplemental dental HMO	Optional supplemental dental PPO	
	Participating dentists only	Participating dentists only	Participating dentists	Non-participating dentists
Summary list of services covered (ADA code)†				
	You pay	**You pay**	**You pay**	**You pay**
Diagnostic services				
Comprehensive oral exam (D0150)	$16 copay	$5 copay (2 visits in 12 months)	0% (2 visits in 12 months)	20% (2 visits in 12 months)
Complete X-rays (D0210)	$5 copay (1 series every 24 months)	$0 copay (1 series every 24 months)	0% (1 series every 36 months)	20% (1 series every 36 months)
Preventive care				
Prophylaxis – adult (D1110)	$20 copay (1 cleaning every 6 months)	$5 copay (1 cleaning every 6 months)	0% (1 cleaning every 6 months)	20%
Restorative services				
One surface composite resin restoration – anterior (D2330)	$40 copay	$11 copay	20%	30%
Crown (porcelain fused to noble metal) (D2750)	$430 copay	$275 copay‡	50%	50%
Periodontics	**For the optional supplemental dental HMO plan, your copayment will be higher if these services are performed by a specialist.**			
Periodontal scaling & root planing/four or more teeth per quadrant (D4341)	$80 copay	$45 copay	50%	50%
Endodontics	**For the optional supplemental dental HMO plan, your copayment will be higher if these services are performed by a specialist.**			
Anterior root canal therapy (D3310)	$240 copay	$195 copay	50%	50%
Molar tooth therapy (D3330)	$373 copay	$335 copay	50%	50%

† ADA codes are procedure codes established by the American Dental Association for efficient processing and reporting of dental claims.

‡ You pay the copayment plus the cost of precious or semi-precious metals. Porcelain on molar crowns is not a covered benefit.

We're here to help

Contact Blue Shield at **(888) 534-4263** [TTY: **711**]

8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays, from April 1 through September 30.

Blue Shield of California is an HMO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.

This information is not a complete description of benefits. Call **(800) 776-4466** [TTY: **711**] for more information.

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California cumple con las leyes estatales y las leyes federales de derechos civiles vigentes, y no discrimina por motivos de raza, color, país de origen, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad.

Blue Shield of California 遵循適用的州法律和聯邦公民權利法律，並且不以種族、膚色、原國籍、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡或殘障為由而進行歧視。