Effective January 1 – December 31, 2019

2019 Summary of Benefits

Blue Shield 65 Plus (HMO)

Medicare Advantage Prescription Drug Plan

San Bernardino County (partial)

blue california

blueshieldca.com/medicare

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2019 Summary of Benefits
Blue Shield 65 Plus
San Bernardino County (partial)

January 1, 2019 – December 31, 2019

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/medMAPD 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.

Blue Shield 65 Plus[SM] includes Part D coverage, which provides prescription drug coverage, offering you the convenience of having both your medical and prescription drugs covered through one plan.

To join **Blue Shield 65 Plus**, 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 County*.** The service area for San Bernardino County includes **only the ZIP codes listed below**. You must live in one of these ZIP codes to join the plan:

91701, 91708, 91709, 91710, 91729, 91730, 91737, 91739, 91743, 91758, 91759, 91761, 91762, 91763, 91764, 91784, 91785, 91786, 91798, 92301, 92305, 92307, 92308, 92311, 92312, 92313, 92314, 92315, 92316, 92317, 92318, 92321, 92322, 92324, 92325, 92326, 92327, 92329, 92333, 92334, 92335, 92336, 92337, 92339, 92340, 92341, 92342, 92344, 92345, 92346, 92347, 92350, 92352, 92354, 92356, 92357, 92358, 92359, 92368, 92369, 92371, 92372, 92373, 92374, 92375, 92376, 92377, 92378 92382, 92385, 92386, 92391, 92392, 92393, 92394, 92395, 92397, 92399, 92401, 92402, 92403, 92404, 92405, 92406, 92407, 92408, 92410, 92411, 92412, 92413, 92414, 92415, 92418, 92420, 92424, and 92427.

* Denotes partial county.

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_pharmacy**.

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

Summary of benefits

Effective January 1 through December 31, 2019

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	$2,799	Does not include prescription drugs. This is the most you would pay for the year for Medicare Parts A and B services.
Inpatient hospital coverage	$0 copay per admission	Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient hospital coverage • 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 $0 copay	 **A referral from your doctor may be required for Specialist visits.**
Preventive care	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.

Summary of benefits (cont'd)

Effective January 1 through December 31, 2019

Premiums and benefits	You pay	What you should know
Emergency care	$85 copay per visit $85 copay and $50,000 combined annual limit for 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	$5 copay for each visit to a network urgent care center within your plan service area. $5 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. $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. You have a $50,000 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.)	$40 copay for each diagnostic radiology service	Covered according to Medicare guidelines; prior authorization is required.
• Lab services	$0 copay	

Summary of benefits (cont'd)

Effective January 1 through December 31, 2019

Premiums and benefits	You pay	What you should know
Diagnostic services, labs, and imaging (cont'd)		
• 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 $2,799 total out-of-pocket maximum for the year.
Hearing services		**A referral from your doctor may be required for hearing services.**
• Hearing exam	$0 copay	
• Hearing aids	You will be reimbursed up to $500 every two years for hearing aids	Applies to both ears combined; costs for hearing aids do not apply to your $2,799 out-of-pocket maximum.
Dental services	Covered with additional plan premium	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	**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 and refraction	$0 copay	Once every 12 months with network provider. Some coverage at non-network providers included; see the plan EOC for details.
• Eyeglass frames or contact lenses	$20 copay	Once every 24 months with network provider. Our plan pays up to $100 every 24 months for either eyeglass frames or for contact lenses. Some coverage at non-network providers included; see the plan EOC for details.

Summary of benefits (cont'd)

Effective January 1 through December 31, 2019

Premiums and benefits	You pay	What you should know
Vision services (cont'd)		
• Eyeglass lenses	$20 copay	Once 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 stay	**A referral from your doctor may be required for mental health services.**
• Outpatient group therapy visit	$30 copay per visit	
• Outpatient individual therapy visit	$30 copay per visit	
Skilled nursing facility (SNF)	$0 copay per day for days 1 through 20 $75 copay per day for days 21 through 100	**A referral from your doctor may be required for skilled nursing facility.** 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 do into the hospital after one benefit period has ended, a new benefit period begins.
Rehabilitation Services		
• Occupational therapy visit	$0 copay	**A referral from your doctor may be required for rehabilitation services.**
• Physical therapy and speech and language therapy visit	$0 copay	
Ambulance	$150 copay per trip (each way)	
Transportation	Not covered	

Summary of benefits (cont'd)

Effective January 1 through December 31, 2019

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	
Foot care (podiatry services) • Foot exams and treatment	$0 copay for each Medicare-covered visit	**A referral from your doctor may be required for foot care services.**
Medical equipment/ supplies		**A referral from your doctor may be required for medical equipment/supplies.**
• Durable medical equipment (e.g., wheelchairs, oxygen)	20% of the Medicare-allowed amount	Prior authorization from the plan may be required for durable medical equipment. See the plan EOC for more information.
• 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)	Prior authorization from the plan may be required for diabetes self-management training. See the plan EOC for more information.
Health and Wellness programs		
• Basic gym access through SilverSneakers Fitness	$0 copay	
• NurseHelp 24/7℠ (telephone and online support)	$0 copay	

Prescription drug coverage

You pay the following:

Part D prescription drug benefit				
Stage 1: Annual Prescription Deductible	**$0** This stage does not apply because there is no deductible.			
Stage 2: Initial Coverage	**Preferred retail**		**Standard retail**	
	30-day supply	**90-day supply***	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic Drugs	$0 copay	$0 copay	$7 copay	$21 copay
Tier 2: Generic Drugs	$10 copay	$15 copay[NDS]	$18 copay	$54 copay[NDS]
Tier 3: Preferred Brand Drugs	$40 copay	$100 copay[NDS]	$47 copay	$141 copay[NDS]
Tier 4: Non-Preferred Drugs	$95 copay	$237.50 copay[NDS]	$100 copay	$300 copay[NDS]
Tier 5: Injectable Drugs	28% coinsurance	28% coinsurance[NDS]	28% coinsurance	28% coinsurance[NDS]
Tier 6: Specialty Tier Drugs	33% coinsurance	Not offered	33% coinsurance	Not offered

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.

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 $3,820, until your yearly out-of-pocket drug costs reach $5,100	Tier 1: Preferred Generic Drugs, Tier 2: Generic Drugs and partial Tier 3: Preferred Brand Drugs (diabetes drugs only) are covered at the copays described above. For Tiers 3 (excludes diabetes drugs) through 6, you pay 25% of the price for brand-name drugs (plus a portion of the dispensing fee) and 37% of the price for generic drugs until your costs total $5,100, which is the end of the coverage gap. Whether a drug is considered generic or brand can be determined using the plan formulary.
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 $5,100, you pay the greater of: • 5% of the cost, or • $3.40 copay for a generic drug (including brand drugs treated as generic) and an $8.50 copay for all other drugs (This stage **protects** you from any additional costs once you have paid your yearly out-of-pocket drug costs.)	

Network pharmacies that offer preferred cost-sharing

You may pay less when you visit 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 Savon
• 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.

‡ Accepts e-prescribing.

Optional supplemental dental HMO and PPO plans

You pay the following:

Network access	Optional supplemental dental HMO	Optional supplemental dental PPO	
	Participating dentists only	Participating dentists	Non-participating dentists
Monthly optional supplemental dental plan premium	$12.40	$34.90	
Calendar-year deductible per member (not applicable to diagnostic and preventive services)	$0	You pay $50 before major services begin	
Calendar-year maximum per member*	$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 for preventive and diagnostic services. Six-month waiting period for major services	

* 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)

	Optional supplemental dental HMO	Optional supplemental dental PPO	
	Participating dentists only	Participating dentists	Non-participating dentists
Summary list of services covered (ADA code)†			
	You pay	**You pay**	**You pay**
Diagnostic services			
Comprehensive oral exam (D0150)	$5 copay (2 visits in 12 months)	0% (2 visits in 12 months)	20% (2 visits in 12 months)
Complete X-rays (D0210)	$0 copay (1 series every 24 months)	0% (1 series every 36 months)	20% (1 series every 36 months)
Preventive care			
Prophylaxis – adult (D1110)	$5 copay (1 cleaning every 6 months)	0% (1 cleaning every 4 months)	20%
Restorative services			
One surface composite resin restoration – anterior (D2330)	$11 copay	20%	30%
Crown (porcelain fused to noble metal) (D2750)	$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)	$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)	$195 copay	50%	50%
Molar tooth therapy (D3330)	$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 **(800) 488-8000** [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.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-776-4466 (TTY: 711).

ATENCIÓN: Si no habla inglés, tiene a su disposición gratis el servicio de asistencia en idiomas. Llame al 1-800-776-4466 (TTY: 711).

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。