blue california

2024 Summary of Benefits

Blue Shield 65 Plus Choice Plan (HMO)

Medicare Advantage Prescription Drug Plan
for San Bernardino and Riverside Counties

Effective January 1, 2024 – December 31, 2024

blueshieldca.com/medicare

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2024 Summary of Benefits
Blue Shield 65 Plus Choice Plan
San Bernardino and Riverside Counties

Effective January 1, 2024 – December 31, 2024

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/MAPDdocuments2024** or by calling Customer Service at **(800) 776-4466** [TTY: **711**], 8 a.m. to 8 p.m., seven days a week. **Note: The *EOC* will be available on our website by October 15, 2023.**

Blue Shield 65 Plus Choice Plan 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 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 **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/medicare/providerdirectory**.

Our plan ***Pharmacy Directory*** is located on our website at **blueshieldca.com/medpharmacy2024**.

To get the most complete and current information about which drugs are covered, you can visit our website at **blueshieldca.com/medformulary2024**.

Summary of benefits

Effective January 1, 2024 - December 31, 2024

Blue Shield 65 Plus Choice Plan (HMO)
San Bernardino and Riverside Counties

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.
Health plan deductible	$0	
Annual out-of-pocket maximum amount	$899	Does not include Part D prescription drugs. This is the most you would pay for the year for in-network covered Medicare Part A and Part B services.
Inpatient hospital care	$0 copay per admission	**Prior authorization and a referral from your doctor may be required for inpatient hospital care.** Our plan covers an unlimited number of days for a Medicare-covered inpatient hospital stay in a network hospital.
Outpatient hospital services • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	$150 copay for each visit to an outpatient hospital facility $0 copay for observation services $125 copay for each visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition)	**A referral and/or prior authorization may be required for outpatient hospital facility and 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	**A referral and prior authorization from your doctor may be required.**
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 care	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.

Premiums and benefits	You pay	What you should know
Emergency care • Worldwide coverage	$125 copay per visit No 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 the hospital within one day for the same condition.
Urgently needed services • Worldwide coverage	$0 copay for each visit to a network urgent care center within the plan service area $0 copay for each visit to an urgent care center outside of the plan service area but within the United States and its territories $125 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories $125 copay for each visit to an emergency room or urgent care center that is outside of the United States and its territories No combined annual limit for emergency care and urgently needed services outside the United States and its territories	These copays are waived if you are admitted to the hospital within one day for the same condition.

Premiums and benefits	You pay	What you should know
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	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)	20% coinsurance for each therapeutic radiology service	While you pay 20% coinsurance for therapeutic radiology services, you will never pay more than your $899 total out-of-pocket maximum for the year.
Hearing services		**A referral from your doctor may be required for Medicare-covered hearing services.**
• Hearing exam (Medicare-covered)	$0 copay per visit	
• Routine (non-Medicare covered) hearing exam	$0 copay per 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.
• Hearing aids	$449 copay for each Silver Technology level hearing aid or $699 copay for each Gold Technology level hearing aid	Coverage is limited to 2 hearing aids per year.
Dental services (Medicare-covered)	$0 copay per visit if performed by your PCP or a specialist	

Premiums and benefits	You pay	What you should know
Dental services (non-Medicare covered)		
• Prophylaxis (cleaning)	$0 copay	Two visits every 12 months.
• Dental X-rays	$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	$5 copay	One visit every 6 months
• Oral exam	$0 - $16 copay, depending on the service	See the "Optional Supplemental Dental HMO and PPO plans" section for more information about dental services for an additional plan premium.
Vision services		**A referral from your doctor may be required for an exam to diagnose and treat diseases and conditions of the eye.**
• Exam to diagnose and treat diseases and conditions of the eye	$0 copay for each Medicare-covered visit	
• Routine (non-Medicare covered) eye exam and refraction	$0 copay per visit	One visit every 12 months with network provider. Some coverage at non-network providers included; see the plan EOC for details.
• Eyeglass frames	$0 copay	Our plan pays for one pair of eyeglass frames (priced up to a regular retail value of $300) every 24 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.
• Eyeglass lenses or contact lenses	$0 copay	Our plan pays for either one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses (priced up to $300 for contact lens service and materials) every 12 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.

Premiums and benefits	You pay	What you should know
Mental health services		**A referral and/or prior authorization from your doctor may be required for mental health services.**
• Inpatient services in a psychiatric hospital	$900 copay per Medicare-covered stay for days 1-150	If you go over the 150-day limit, you will be responsible for all costs. See EOC for more information.
• Outpatient individual therapy visit	$30 copay per visit	
• Outpatient group therapy visit	$30 copay per visit	
Skilled nursing facility (SNF) care	$0 copay per day for days 1 - 20 $75 copay per day for days 21 – 100	**A referral and prior authorization from your doctor may be required for skilled nursing facility care.** If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.
Rehabilitation Services		
• Occupational therapy	$0 copay per visit	**A referral and prior authorization from your doctor may be required for rehabilitation services.**
• Physical therapy	$0 copay per visit	
• Speech and language therapy	$0 copay per visit	
Ambulance services	Medicare-covered ground ambulance services: $200 copay per trip (each way) Medicare-covered air ambulance services: 20% coinsurance per trip (each way)	
Transportation services (non-Medicare covered)	$0 copay	Limited to 16 one-way trips to plan-approved health-related locations every year.
Medicare Part B Prescription Drugs	0% to 20% coinsurance	Some Part B drugs may require a prior authorization from your doctor. Members may pay 0% to 20% coinsurance for select Medicare Part B drugs which can change each quarter as established by CMS. Insulin obtained under Part B (when taken with an insulin pump) should not exceed a $35 copay for a one-month supply.

Additional benefits included in your plan

Premiums and benefits	You pay	What you should know
Annual Physical Exam	$0 copay	One every 12 months.
Opioid Treatment Program Services	$0 copay	**A referral and prior authorization from your doctor may be required for Opioid Treatment Program Services.**
Additional telehealth services	$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication.
Foot care (podiatry services)		**A referral from your doctor may be required for Medicare-covered foot care services.**
• Foot exams and treatment	$0 copay for each Medicare-covered visit	
• Routine (non-Medicare covered) foot care	$0 copay for each routine (non-Medicare covered) visit	
Diabetic Supplies & Services		Prior authorization from the plan may be required for diabetic supplies and services (including blood glucose monitors). See the plan EOC for more information.
• Blood glucose monitors	$0 copay for ACCU-CHEK blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers	
• Diabetes self-management training, diabetic services and supplies	$0 copay for all training, services and supplies except glucose monitors (see "Blood glucose monitors" above)	
Durable Medical Equipment (DME) and Related Supplies		
• Durable medical equipment (e.g., wheelchairs, oxygen)	20% coinsurance	Prior authorization from the plan may be required for DME. See the plan EOC for more information.

Premiums and benefits	You pay	What you should know
Prosthetics/Medical Supplies		**Prior authorization from your doctor may be required for prosthetics/medical supplies.**
• Prosthetics (e.g., braces, artificial limbs)	20% coinsurance	
• Medical supplies (e.g., splints, casts)	$0 copay	
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	
Over-the-Counter (OTC) Items	You have a $90 allowance per quarter to spend on covered items.	You can place two orders per quarter and cannot roll over your unused allowance into the next quarter.
Routine chiropractic services (non-Medicare covered)	$0 copay per visit	Limited to 12 visits per year.

Prescription drug coverage

Effective January 1, 2024 - December 31, 2024

Blue Shield 65 Plus Choice Plan (HMO)
San Bernardino and Riverside Counties

You pay the following:

Part D prescription drug benefit						
Stage 1: Annual Deductible Stage	This stage does not apply because there is no deductible.					
Stage 2: Initial Coverage Stage	**Preferred retail cost-sharing (in-network)**			**Standard retail cost-sharing (in-network)^**		
	30-day supply	**90-day supply*NDS**	**100-day supplyNDS**	**30-day supply**	**90-day supplyNDS**	**100-day supplyNDS**
Tier 1: Preferred Generic Drugs	$0 copay	See 100-day supply	$0 copay	$5 copay	See 100-day supply	$5 copay
Tier 2: Generic Drugs	$3 copay	$4.50 copay	Not Covered	$10 copay	$30 copay	Not Covered
Tier 3: Preferred Brand Drugs	$35 copay	$87.50 copay	Not Covered	$47 copay	$141 copay	Not Covered
Tier 3: Covered Insulins**	$25 copay	$75 copay	Not Covered	$35 copay	$105 copay	Not Covered
Tier 4: Non-Preferred Drugs	$95 copay	$237.50 copay	Not Covered	$100 copay	$300 copay	Not Covered
Tier 4: Covered Insulins**	$35 copay	$105 copay	Not Covered	$35 copay	$105 copay	Not Covered
Tier 5: Specialty Tier Drugs	33% coinsurance	Not Covered	Not Covered	33% coinsurance	Not Covered	Not Covered

** Covered Insulins are marked with the symbol INS on the drug list. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").

^If you reside in a long-term care facility, you pay the same as at an in-network standard retail cost-sharing pharmacy. There are limited situations where you may be able to 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- and 100-day supply cost-sharing also applies to Blue Shield's mail service pharmacy.

NDS A long-term (up to a 90- or 100-day) supply is not available for select drugs. The drugs that are not available for a long-term supply are marked with the symbol NDS in our Drug List.

Part D prescription drug benefit		
Stage 3: Coverage Gap Stage	Coverage for outpatient prescription drugs after the total yearly drug costs paid by both you and Blue Shield reach $5,030, until your yearly out-of-pocket drug costs reach $8,000.	Tier 1: Preferred Generic Drugs, Tier 2: Generic Drugs, Tier 3: Covered Insulins and Tier 4: Covered Insulins 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 year-to-date out-of-pocket drug costs total $8,000, which is the end of the coverage gap stage. 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 $8,000, the plan pays the full cost for your covered Part D drugs. For excluded drugs covered under our enhanced benefit, you pay Tier 2: Generic Drugs copayment listed in the table shown above. (This stage **protects** you from any additional costs once you have paid your yearly out-of-pocket drug costs.)	
Important Message About What You Pay for Vaccines: Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.		

Mail Service Pharmacy

CVS Caremark® is our network mail service pharmacy where you can get a 90- or 100-day supply of maintenance drugs at a lower cost share. Your order will be delivered to your home or office with no charge for standard shipping. See plan EOC for more information.

Tier 5 drugs are limited to a 30-day supply by mail service.

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]
- Safeway and Vons pharmacies‡ (877) 723-3929 [TTY: 711]
- Albertsons/Sav-on/Osco pharmacies‡ (877) 932-7948 [TTY: 711]
- Costco‡ (800) 955-2292 [TTY: 711]
- 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.

‡Accepts e-prescribing

Optional supplemental dental HMO and PPO plans

Effective January 1, 2024 - December 31, 2024

You pay the following:

	Optional supplemental dental HMO plan	Optional supplemental dental PPO plan	
	Participating dentists only	Participating dentists	Non-participating dentists
Monthly optional supplemental dental plan premium	$15.00	$45.00	
Calendar year deductible (not applicable to diagnostic and preventive services)	$0	You pay $50 before coverage for major services begins.	
Calendar year benefit maximum	None	$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 Period	No waiting period	No waiting period	

*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)

Effective January 1, 2024 - December 31, 2024

	Optional supplemental dental HMO plan	Optional supplemental dental PPO plan	
	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 (1 visit every 6 months)	0% coinsurance (1 visit every 6 months)	20% coinsurance (1 visit every 6 months)
Comprehensive X-rays (D0210)	$0 copay (1 series every 24 months)	0% coinsurance (1 series every 24 months)	20% coinsurance (1 series every 24 months)
Preventive care			
Prophylaxis – adult (D1110)	$5 copay (1 cleaning every 6 months)	0% coinsurance (1 cleaning every 6 months)	20% coinsurance (1 cleaning every 6 months)
Restorative services			
One surface composite resin restoration – anterior (D2330)	$11 copay	20% coinsurance	30% coinsurance
Crown (porcelain fused to noble metal) (D2750)	$275 copay‡	50% coinsurance	50% coinsurance
Periodontics			
Periodontal scaling & root planing/four or more teeth per quadrant (D4341)	$45 copay	50% coinsurance	50% coinsurance
Endodontics			
Anterior root canal therapy (D3310)	$195 copay	50% coinsurance	50% coinsurance
Surgical placement of implant services body: endosteal implant (D6010)	Not covered	50% coinsurance	50% coinsurance
Molar tooth therapy (D3330)	$335 copay	50% coinsurance	50% coinsurance

† 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.

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

The company complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability, or physical disability.
La compañía cumple con las leyes de derechos civiles federales y estatales aplicables, y no discrimina, ni excluye ni trata de manera diferente a las personas por su raza, color, país de origen, identificación con determinado grupo étnico, condición médica, información genética, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad, ni discapacidad física ni mental. 本公司遵守適用的州法律和聯邦民權法律，並且不會以種族、膚色、原國籍、族群認同、醫療狀況、遺傳資訊、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡、精神殘疾或身體殘疾而進行歧視、排斥或區別對待他人。

Blue Shield of California is an independent member of the Blue Shield Association MA040-SOB-SR-1023