Effective January 1 – December 31, 2020

2020 Summary of Benefits

Blue Shield Medicare (PPO)

Medicare Advantage Prescription Drug Plan

Alameda County

blue california

blueshieldca.com/medicare

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Blue Shield Medicare
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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 Medicare 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 Medicare**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. **Our service area includes Alameda 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.

Summary of benefits

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Monthly plan premium	$126		You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Maximum out-of-pocket	$6,700 in-network and $10,000 in- and out-of-network combined.		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.
Premiums and benefits	**In-Network You pay**	**Out-of-Network You pay**	**What you should know**
Deductible	$0	$750 per year	
Inpatient hospital care	$175 copay each day for days 1-7 $0 copay each day for days 8 and over	40% coinsurance per stay after you meet your plan deductible	Our plan covers an unlimited number of days for each Medicare-covered stay in a hospital.
Outpatient hospital services • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	$90 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) $250 copay for each visit to an outpatient hospital facility $10 copay for observation services	$90 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) 40% coinsurance for each visit to an outpatient hospital facility after you meet your plan deductible. 40% coinsurance for observation services after you meet your plan deductible.	Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Prior authorization may be required and is the responsibility of your provider.
Outpatient surgery	$100 copay for each visit to an ambulatory surgical center $250 copay for each visit to an outpatient hospital facility	40% coinsurance for each visit to an ambulatory surgical center or an outpatient hospital facility after you meet your plan deductible.	Prior authorization may be required and is the responsibility of your provider.
Doctor visits • Physician of choice • Specialists	$10 copay per visit $35 copay per visit	40% coinsurance for each Medicare-covered visit after you meet your plan deductible	
Preventive services	$0 copay	40% coinsurance	A plan deductible does not apply to Medicare-covered preventive services when obtained out of network. 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, 2020

Premiums and benefits	In-Network You pay	Out-of-Network You pay	What you should know
Emergency care	$90 copay per visit $90 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	$30 copay for each visit to a network urgent care center within your plan service area. $30 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. $90 copay for each visit to an emergency room outside of your plan service area but within the United States and its territories. $90 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 $90 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			**Prior authorization may be required for diagnostic services and is the responsibility of your provider.**
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$100 copay for each diagnostic radiology service	40% coinsurance after you meet your plan deductible	Covered according to Medicare guidelines; prior authorization is required.
• Lab services	$40 copay	40% coinsurance after you meet your plan deductible	
• Diagnostic tests and procedures	$40 copay	40% coinsurance after you meet your plan deductible	
• Outpatient X-rays	$40 copay	40% coinsurance after you meet your plan deductible	
• Therapeutic radiology services (such as radiation treatment for cancer)	You pay 20% of the Medicare-allowed amount	40% coinsurance after you meet your plan deductible	For therapeutic radiology services, you will never pay more than your total out-of-pocket maximum for the year: $6,700 in-network and $10,000 in- and out-of-network combined.

Summary of benefits (cont'd)

Effective January 1 through December 31, 2020

Premiums and benefits	In-Network You pay	Out-of-Network You pay	What you should know
Hearing services • Hearing exam	$0 copay per visit for Medicare-covered and routine hearing exam	40% coinsurance after you meet your plan deductible	**Prior authorization may be required and is the responsibility of your provider.**
Dental services	Covered with additional plan premium		See optional supplemental dental PPO plan for more information about dental services for an extra plan premium.
Vision services			
• Exam to diagnose and treat diseases and conditions of the eye	$35 copay for each Medicare-covered visit	40% coinsurance after you meet your plan deductible	
• Yearly glaucoma screening	$0 copay	40% coinsurance after you meet your plan deductible	
• Routine eye exam, including refraction	$20 copay	You are reimbursed up to $30 for one exam every 12 months.	One exam every 12 months is covered.
• Eyeglass frames or contact lenses	$0 copay	You are reimbursed up to $35 for either one pair of frames or for contact lenses every 24 months. You are reimbursed up to $35 for one pair of medically necessary uncoated plastic eyeglass lenses, regardless of size or power, every 12 months.	Once every 24 months is covered. Our plan pays up to $75 every 24 months for either eyeglass frames or for contact lenses.
• Eyeglass lenses	$20 copay	You are reimbursed up to $32 for one pair of medically necessary standard anti-reflective coated lenses every 12 months.	One pair every 12 months is covered.

Summary of benefits (cont'd)

Effective January 1 through December 31, 2020

Premiums and benefits	In-Network You pay	Out-of-Network You pay	What you should know
Mental health services			**Prior authorization may be required and is the responsibility of your provider.** You are covered for 150 days each benefit period, up to the 190-day lifetime limit. 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.
• Inpatient mental health care	$1,660 copay per benefit period	40% coinsurance after you meet your plan deductible	
• Outpatient group therapy visit	$20 copay per visit	40% coinsurance after you meet your plan deductible	
• Outpatient individual therapy visit	$20 copay per visit	40% coinsurance after you meet your plan deductible	
Skilled nursing facility (SNF) care	$0 copay per day for days 1 through 20 $178 copay per day for days 21 through 100	40% coinsurance after you meet your plan deductible	**Prior authorization may be required and is the responsibility of your provider.** 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	$25 copay per visit	40% coinsurance after you meet your plan deductible	
• Physical therapy and speech and language therapy services	$25 copay per visit	40% coinsurance after you meet your plan deductible	
Ambulance	$300 copay per trip (each way)	$300 copay per trip (one way)	**A plan deductible does not apply to ambulance services when obtained out-of-network.** **Prior authorization is required for non-emergency transportation by fixed-wing aircraft.**
Transportation	Not covered	Not covered	
Medicare Part B Drugs	20% of the Medicare-allowed amount for chemotherapy drugs 20% of the Medicare-allowed amount for other Part B drugs	40% coinsurance after you meet your plan deductible	

Summary of benefits (cont'd)

Effective January 1 through December 31, 2020

Premiums and benefits	In-Network You pay	Out-of-Network You pay	What you should know
Opioid treatment program services	$0 copay	40% coinsurance	**Referral and Prior Authorization may be required and is the responsibility of your provider.**
Telehealth services	$0 copay	Not covered	
Foot care (podiatry services)			
• Foot exams and treatment	$35 copay for each Medicare-covered visit	40% coinsurance after you meet your plan deductible	
Medical equipment/supplies			
• Durable medical equipment (e.g., wheelchairs, oxygen)	20% of the Medicare-allowed amount	40% coinsurance after you meet your plan deductible	**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	40% coinsurance after you meet your plan deductible	
• Prosthetics (e.g., braces, artificial limbs)	20% coinsurance	40% coinsurance after you meet your plan deductible	**Prior authorization may be required and is the responsibility of your provider.**
• Diabetes self-management training	$0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	40% coinsurance	**Prior authorization from the plan may be required for diabetes self-management training. See the plan EOC for more information.**
• Diabetic services and supplies		20% coinsurance	
Health and Wellness programs			
• Basic gym access through SilverSneakers Fitness	$0 copay	$0 copay	
• NurseHelp 24/7℠ (telephone and online support)	$0 copay	$0 copay	

Prescription drug coverage

You pay the following:

Part D prescription drug benefit				
Stage 1: Annual Deductible	**$400 (does not apply to drugs on Tier 1, Tier 2, or Tier 6)**			
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	$15 copay	$22.50 copay	$20 copay	$60 copay
Tier 3: Preferred Brand Drugs	$40 copay	$100 copay	$47 copay	$141 copay
Tier 4: Non-Preferred Drugs	$95 copay	$237.50 copay	$100 copay	$300 copay
Tier 5: Specialty Tier Drugs	25% coinsurance	Not covered	25% 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 is 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 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 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.
Other pharmacies are available in our network.

Optional supplemental dental PPO plan

You pay the following:

	Optional supplemental dental PPO	
Network access	**Participating dentists**	**Non-participating dentists**
Monthly optional supplemental dental plan premium	$37.90	
Calendar-year deductible per member (not applicable to diagnostic and preventive services)	You pay $50	
Calendar-year maximum per member	$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 for preventive and diagnostic services. Six-month waiting period for major services	

Optional supplemental dental PPO plan (cont'd)

	Optional supplemental dental PPO	
	Participating dentists	**Non-participating dentists**
Summary list of services covered (ADA code)†		
	You pay	**You pay**
Diagnostic services		
Comprehensive oral exam (D0150)	0% (2 visits in 12 months)	20% (2 visits in 12 months)
Complete X-rays (D0210)	0% (1 series every 36 months)	20% (1 series every 36 months)
Preventive care		
Prophylaxis – adult (D1110)	0%	20%
	(1 cleaning every 6 months)	
Restorative services		
One surface composite resin restoration – anterior (D2330)	20%	30%
Crown (porcelain fused to noble metal) (D2750)	50%	50%
Periodontics		
Periodontal scaling & root planing/four or more teeth per quadrant (D4341)	50%	50%
Endodontics		
Anterior root canal therapy (D3310)	50%	50%
Molar tooth therapy (D3330)	50%	50%

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