

2021 Summary of Benefits

Blue Shield 65 Plus (HMO)

Medicare Advantage Prescription Drug Plan

San Diego County

Summary of benefits

Blue Shield 65 Plus (HMO)
San Diego County

Effective January 1, 2021 - December 31, 2021

| 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 | |
| Annual out-of-pocket maximum amount | \$3,399 | 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 | \$295 each day for days 1 – 7 \$0 each day for days 8 and over | Our plan covers an unlimited number of days for a Medicare-covered inpatient hospital stay in a network hospital. |
| Outpatient hospital services <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery | \$350 copay for each visit to an outpatient hospital facility \$0 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) | 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 | \$200 copay for each visit to an ambulatory surgical center \$350 copay for each visit to an outpatient hospital facility | |
| Doctor visits <ul style="list-style-type: none"> • Primary care physician • Specialists | \$15 copay per visit \$35 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. |
| Emergency care | \$90 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 a hospital within one day for the same condition. Worldwide coverage. |

Summary of benefits (cont'd)

Blue Shield 65 Plus (HMO)
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| Premiums and benefits | You pay | What you should know |
|---|---|--|
| <p>Urgently needed services</p> | <p>\$30 copay for each visit to a network urgent care center within your plan service area</p> <p>\$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</p> <p>\$90 copay for each visit to an emergency room outside of your plan service area but within the United States and its territories</p> <p>\$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</p> <p>No combined annual limit for emergency care and urgently needed services outside the United States and its territories</p> | |
| <p>Diagnostic services, labs, and imaging</p> <ul style="list-style-type: none"> • Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.) • Lab services • Diagnostic tests and procedures • Outpatient X-rays • Therapeutic radiology services (such as radiation treatment for cancer) | <p>\$85 copay for each diagnostic radiology service</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>20% coinsurance for each therapeutic radiology service</p> | <p>A referral from your doctor may be required for diagnostic services, labs and imaging services.</p> <p>Covered according to Medicare guidelines</p> <p>While you pay 20% coinsurance for therapeutic radiology services, you will never pay more than your \$3,399 total out-of-pocket maximum for the year.</p> |

Summary of benefits (cont'd)

Blue Shield 65 Plus (HMO)
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| Premiums and benefits | You pay | What you should know |
|---|--|---|
| <p>Hearing services</p> <ul style="list-style-type: none"> • Hearing exam (Medicare-covered) • Routine (non-Medicare covered) hearing exam • Hearing aids | <p>\$15 copay per visit if performed at your PCP's office</p> <p>\$35 copay per visit if performed at a specialist's office</p> <p>\$0 - \$35 copay, depending on the provider of service</p> <p>\$449 copay for each Basic Technology behind-the-ear hearing aid or \$699 copay for each Reserve Technology hearing aid</p> | <p>A referral from your doctor may be required for hearing services.</p> <p>Routine hearing exams are unlimited if provided by your doctor but are limited to one exam every 12 months with network hearing aid provider.</p> <p>Coverage is limited to 2 hearing aids per year.</p> |
| <p>Dental services</p> <ul style="list-style-type: none"> • Prophylaxis (cleaning) • Dental X-rays • Fluoride treatment • Oral exam | <p>\$20 copay</p> <p>\$0 - \$10 copay, depending on the service/type</p> <p>\$5 copay</p> <p>\$5 - \$16 copay, depending on the service</p> | <p>One visit every 6 months.</p> <p>One series of bitewing X-rays every 6 months.</p> <p>One series of full mouth X-rays every 24 months.</p> <p>Two visits every 12 months for fluoride treatment.</p> <p>See optional supplemental dental HMO and PPO plans for more information about dental services for an extra plan premium.</p> |

Summary of benefits (cont'd)

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|---|---|--|
| Vision services <ul style="list-style-type: none"> • Exam to diagnose and treat diseases and conditions of the eye • Routine eye exam and refraction • Eyeglass frames • Eyeglass lenses or contact lenses | <p>\$35 copay for each Medicare-covered visit</p> <p>\$0 copay per visit</p> <p>\$0 copay</p> <p>\$0 copay</p> | <p>A referral from your doctor may be required for an exam to diagnose and treat diseases and conditions of the eye.</p> <p>One visit every 12 months with network provider. Some coverage at non-network providers included; see the plan EOC for details.</p> <p>Our plan pays up to \$200 for eyeglass frames every 24 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p> <p>Our plan pays for either one pair of prescription eyeglass lenses or up to \$200 for contact lenses every 12 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p> |
| Mental health services <ul style="list-style-type: none"> • Inpatient mental health care • Outpatient group therapy visit • Outpatient individual therapy visit | <p>\$250 copay per day for days 1 – 7</p> <p>\$0 copay per day for days 8 - 150</p> <p>\$20 copay per visit</p> <p>\$20 copay per visit</p> | <p>A referral from your doctor may be required for mental health services.</p> <p>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.</p> <p>If you go into the hospital after one benefit period has ended, a new benefit period begins.</p> |

Summary of benefits (cont'd)

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| Premiums and benefits | You pay | What you should know |
|--|--|---|
| Skilled nursing facility (SNF) care | \$0 copay per day for days 1 - 20 \$160 copay per day for days 21 - 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 • Physical therapy and speech and language therapy | \$40 copay per visit \$40 copay per visit | A referral from your doctor may be required for rehabilitation services. |
| Ambulance | \$250 copay per trip (each way) | |
| Transportation | \$0 copay | Limited to 24 one-way trips to plan-approved health-related locations every year. |
| Medicare Part B Drugs | 20% coinsurance for chemotherapy/radiation drugs and other Part B drugs | Some Part B drugs may require a prior authorization from your provider. |

Summary of benefits (cont'd)

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Additional benefits included in your plan

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|---|--|--|
| Annual Physical Exam | \$0 copay | One every 12 months. |
| Opioid Treatment Program Services | \$0 copay | |
| Additional telehealth services | \$0 copay | Teladoc Physicians can diagnose and treat basic medical conditions, and can also prescribe certain medication. |
| Foot care (podiatry services) <ul style="list-style-type: none"> • Foot exams and treatment • Routine foot care | \$35 copay for each Medicare-covered visit You will be reimbursed up to \$1,000 every year for routine foot care | A referral from your doctor may be required for foot care services. You may obtain routine foot care at the provider of your choice. |
| Diabetic Supplies & Services <ul style="list-style-type: none"> • Blood glucose monitors • Diabetes self-management training, diabetic services and supplies | \$0 copay for ACCU-CHEK blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers \$0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above) | A referral from your doctor may be required for diabetic supplies & services. Prior authorization from the plan may be required for durable medical equipment, blood glucose monitors and test strips. See the plan EOC for more information. |
| Durable Medical Equipment (DME) and Related Supplies <ul style="list-style-type: none"> • Durable medical equipment (e.g., wheelchairs, oxygen) | 20% coinsurance | A referral from your doctor may be required for DME and related supplies. Prior authorization from the plan may be required for DME. See the plan EOC for more information. |
| Prosthetics/Medical Supplies <ul style="list-style-type: none"> • Prosthetics (e.g., braces, artificial limbs) • Medical supplies (e.g., splints, casts) | 20% coinsurance \$0 copay | A referral from your doctor may be required for prosthetics/medical supplies. |

Summary of benefits (cont'd)

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Effective January 1, 2021 - December 31, 2021

| Premiums and benefits | You pay | What you should know |
|---|--|---|
| Health and Wellness programs <ul style="list-style-type: none"> • Basic gym access through SilverSneakers Fitness • NurseHelp 24/7SM (telephone and online support) • Personal Emergency Response System (PERS) (24/7 medical alert) | \$0 copay \$0 copay \$0 copay | |
| Acupuncture (non-Medicare covered) | \$0 copay per visit | Limited to 24 visits per year. |
| Over-the-counter items | You have a \$90 allowance 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. |
| Chiropractic services (non-Medicare covered) | \$0 copay per visit | Limited to 24 visits per year. |

Prescription drug coverage

Blue Shield 65 Plus (HMO)
San Diego County

Effective January 1, 2021 - December 31, 2021

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 supply^{NDS} | 30-day supply | 90-day supply^{NDS} | 100-day supply^{NDS} |
| 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 | \$5 copay | \$7.50 copay | Not Covered | \$12 copay | \$36 copay | Not Covered |
| Tier 3: Preferred Brand Drugs | \$40 copay | \$100 copay | Not Covered | \$47 copay | \$141 copay | Not Covered |
| Tier 4: Non- Preferred Drugs | \$95 copay | \$237.50 copay | Not Covered | \$100 copay | \$300 copay | Not Covered |
| Tier 5: Specialty Tier Drugs | 33% coinsurance | Not Covered | Not Covered | 33% coinsurance | Not Covered | Not Covered |

[^]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 \$4,130, until your yearly out-of-pocket drug costs reach \$6,550 | Tier 1: Preferred Generic Drugs and Tier 2: Generic 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 year-to-date out-of-pocket drug costs total \$6,550, 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 | <p>After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through mail service) reach \$6,550, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$3.70 copay for a generic drug (including brand-name drugs treated as generic) and a \$9.20 copay for all other drugs <p>(This stage protects you from any additional costs once you have paid your yearly out-of-pocket drug costs.)</p> | |





Mail Service Pharmacy

CVS Caremark is our network mail service pharmacy where you may obtain a 90- or 100-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].

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.

[‡]Accepts e-prescribing

Optional supplemental dental HMO and PPO plans

Blue Shield 65 Plus (HMO)
San Diego County

Effective January 1, 2021 - December 31, 2021

You pay the following:

| Network access | Blue Shield 65 Plus | Optional supplemental dental HMO | Optional supplemental dental PPO | |
|--|-----------------------------|---|---|----------------------------|
| | Participating dentists only | Participating dentists only | Participating dentists | Non-participating dentists |
| Monthly optional supplemental dental plan premium | None | \$11.60 | \$40.50 | |
| Calendar year deductible per member (not applicable to diagnostic and preventive services) | \$0 | \$0 | You pay \$50 before major services begin | |
| Calendar year benefit 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 Period | No 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)

Blue Shield 65 Plus (HMO)
San Diego County

Effective January 1, 2021 - December 31, 2021

| Network access | Blue Shield 65 Plus | 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% (1 cleaning every 6 months) |
| 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.