blue of california

Blue Shield 65 Plus (HMO)
summary of benefits

Los Angeles County (partial) & Orange County

January 1, 2015 to December 31, 2015

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

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You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Shield 65 Plus (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Blue Shield 65 Plus (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- 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.

Sections in this booklet

- Things to Know About **Blue Shield 65 Plus (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Optional Benefits (you must pay an extra premium for these benefits)

This document is available in other formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call us at (800) 776-4466 (TTY: 711).
Este documento puede estar disponible en otro idioma que no sea el inglés. Para obtener más información, llámenos al (800) 776-4466 (TTY: 711).

Things to Know About Blue Shield 65 Plus (HMO)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 7:00 a.m. to 8:00 p.m. Pacific time.
- From February 15 to September 30, you can call us Monday through Friday from 7:00 a.m. to 8:00 p.m. Pacific time.

Blue Shield 65 Plus (HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free (800) 776-4466 [TTY: 711].
- If you are not a member of this plan, call toll-free (800) 488-8000 [TTY: 711].
- Our website: http://www.blueshieldca.com/findamedicareplan

Who can join?

To join **Blue Shield 65 Plus (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in California: Los Angeles* and Orange.
* denotes partial county

The service area for Los Angeles County includes all ZIP codes **except for the ZIP codes listed below**. You must live in an area other than the following ZIP codes to join the plan:

93510	93532	93534	93535	93536	93539
93543	93544	93550	93551	93552	93553
93563	93584	93586	93590	93591	93599

Which doctors, hospitals, and pharmacies can I use?

Blue Shield 65 Plus (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider directory at our website (http://www.blueshieldca.com/findaprovider).

You can see our plan's pharmacy directory at our website (http://www.blueshieldca.com/med_pharmacy).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.

- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.blueshieldca.com/med_formulary.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

SUMMARY OF BENEFITS
January 1, 2015 – December 31, 2015

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

How much is the monthly premium?	$0 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $2,800 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

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

COVERED MEDICAL AND HOSPITAL BENEFITS

NOTE:

- **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.**
- **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**

OUTPATIENT CARE AND SERVICES

Acupuncture and Other Alternative Therapies	Not covered
Ambulance[1]	$200 copay
Chiropractic Care[1,2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing

OUTPATIENT CARE AND SERVICES

Dental Services[1,2]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing This plan covers comprehensive dental services for an extra plan premium. See "Optional benefits – Package 1: Dental" on page [A-12] for more information.
Diabetes Supplies and Services[1,2]	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing For blood glucose monitors, please see "Durable Medical Equipment" below.
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1,2]	Diagnostic radiology services (such as MRIs, CT scans): $40 copay Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost While you pay 20% of the cost for therapeutic radiology services, you will never pay more than your $2,800 total out-of-pocket maximum for the year.
Doctor's Office Visits[1,2]	Primary care physician visit: You pay nothing Specialist visit: You pay nothing
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	20% of the cost
Emergency Care	$65 copay You pay the copay regardless of whether or not you are admitted to a hospital for the same condition. World-wide coverage. You have a $10,000 combined annual limit for covered emergency care or urgently needed care outside the United States and its territories.
Foot Care *(podiatry services)*[1,2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing
Hearing Services[1,2]	Exam to diagnose and treat hearing and balance issues: You pay nothing Routine hearing exam: You pay nothing

OUTPATIENT CARE AND SERVICES

Home Health Care[1,2]	You pay nothing
Mental Health Care[1,2]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • $900 copay per stay Outpatient group therapy visit: $30 copay Outpatient individual therapy visit: $30 copay
Outpatient Rehabilitation[1,2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $20 copay Occupational therapy visit: $15 copay Physical therapy and speech and language therapy visit: $15 copay
Outpatient Substance Abuse[1,2]	Group therapy visit: $30 copay Individual therapy visit: $30 copay
Outpatient Surgery[1,2]	Ambulatory surgical center: You pay nothing Outpatient hospital: $100 copay
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: You pay nothing Related medical supplies: You pay nothing
Renal Dialysis[1,2]	10% of the cost
Transportation	Not covered
Urgent Care	$5 copay You pay the copay regardless of whether or not you are admitted to a hospital for the same condition. World-wide coverage. You pay a $65 copay and have a $10,000 combined annual limit for covered emergency care or urgently needed care outside the United States and its territories.

OUTPATIENT CARE AND SERVICES

Vision Services[1,2]	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing Routine eye exam (for up to 1 every year): $10 copay Eyeglasses frames (for up to 1 every two years): $20 copay Our plan pays up to $75 every two years for eyeglass frames. Eyeglasses lenses (for up to 1 every year): $20 copay Eyeglasses or contact lenses after cataract surgery: You pay nothing For routine eye exams, no authorization or referral is required. See the plan *Evidence of Coverage* for a full description of covered services and for cost-sharing for non-network providers.
Preventive Care[1]	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.

OUTPATIENT CARE AND SERVICES

Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

INPATIENT CARE

Inpatient Hospital Care[1,2]	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay nothing
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1,2]	Our plan covers up to 100 days in a SNF. • $0 copay per day for days 1 through 20 • $75 copay per day for days 21 through 100 No prior hospital stay is required.

PRESCRIPTION DRUG BENEFITS

How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost When Part B drugs are given in an office/clinic you pay 20% of the Medicare-allowed amount. When obtained at a network pharmacy, you pay 20% of Blue Shield's contracted rate.
Initial Coverage	You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

PRESCRIPTION DRUG BENEFITS

Preferred Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Non-Preferred Generic)	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$40 copay	$80 copay	$80 copay
Tier 4 (Non-Preferred Brand)	$85 copay	$170 copay	$170 copay
Tier 5 (Injectable Drugs)	25% of the cost	25% of the cost	25% of the cost
Tier 6 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost

Standard Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$5 copay	$10 copay	$15 copay
Tier 2 (Non-Preferred Generic)	$9 copay	$18 copay	$27 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	$135 copay
Tier 4 (Non-Preferred Brand)	$90 copay	$180 copay	$270 copay
Tier 5 (Injectable Drugs)	25% of the cost	25% of the cost	25% of the cost
Tier 6 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost

Standard Mail Order Cost-Sharing

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0
Tier 2 (Non-Preferred Generic)	$10 copay
Tier 3 (Preferred Brand)	$80 copay
Tier 4 (Non-Preferred Brand)	$170 copay
Tier 5 (Injectable Drugs)	25% of the cost
Tier 6 (Specialty Tier)	33% of the cost

PRESCRIPTION DRUG BENEFITS

If you reside in a long-term care facility, you pay the same as at a standard retail cost-sharing pharmacy.

You may get drugs from an out-of-network pharmacy at the same cost as an in-network standard retail cost-sharing pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Preferred Retail Cost-Sharing

Tier	Drugs Covered	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	All	$0	$0	$0
Tier 2 (Non-Preferred Generic)	All	$5 copay	$10 copay	$10 copay

Standard Retail Cost-Sharing

Tier	Drugs Covered	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	All	$5 copay	$10 copay	$15 copay
Tier 2 (Non-Preferred Generic)	All	$9 copay	$18 copay	$27 copay

Standard Mail Order Cost-Sharing

Tier	Drugs Covered	Three-month supply
Tier 1 (Preferred Generic)	All	$0
Tier 2 (Non-Preferred Generic)	All	$10 copay

PRESCRIPTION DRUG BENEFITS

Catastrophic Coverage After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of:

- 5% of the cost, or
- $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.

Optional Benefits *(you must pay an extra premium each month for these benefits)*

Package 1: Dental Benefits include:

- Preventive Dental
- Comprehensive Dental

How much is the monthly premium? Additional $12.20 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.

How much is the deductible? This package does not have a deductible.

Is there a limit on how much the plan will pay?? No. There is no limit to how much our plan will pay for benefits in this package.

Exceptions include a $1,000 calendar year maximum for specialty services, and a $100 calendar year limit on the amount reimbursed for out-of area emergency dental care. See the plan *Evidence of Coverage* for a complete list of copays for covered services, as well as limitations, and exclusions.

ADDITIONAL INFORMATION ABOUT BLUE SHIELD 65 PLUS (HMO)

Blue Shield of California is a not-for-profit company that's been serving Californians for more than 70 years. Our mission is to ensure all Californians have access to high-quality health care at an affordable price.

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