blue california

2024 Summary of Benefits

Blue Shield 65 Plus (HMO)

Group Medicare Advantage Prescription Drug Plan for Upland Unified School District

Effective October 1, 2024 – September 30, 2025

blueshieldca.com/medicare
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2024 Summary of Benefits

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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 contact your former employer group/union or call Blue Shield 65 Plus Customer Service at (800) 776-4466** [TTY: **711**], 8 a.m. to 8 p.m., seven days a week.

Blue Shield 65 Plus is a Medicare Advantage (Part C) plan that covers everything that Original Medicare (Part A and Part B) and includes Part D prescription drug coverage, offering you the convenience of having both your medical services 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, meet your former employer group/union's eligibility requirements, and live in our service area. Your Medicare-eligible dependents may also join Blue Shield 65 Plus (HMO) if they meet these requirements.

Our service area includes the following counties in California:
Alameda County, Contra Costa County*, Kern County, Los Angeles County, Merced County, Nevada County*, Orange County, Riverside County, Santa Barbara County, San Bernardino County, San Diego County, San Francisco County, San Joaquin County, San Luis Obispo County, San Mateo County, Santa Clara County, Santa Cruz County and Stanislaus County.

*Denotes partial county. Refer to the ZIP code listing on page 11 for details on the partial county service area coverage.

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

October 1, 2024 – September 30, 2025

You pay the following:

Premiums and Benefits	You Pay	What you should know
Monthly plan premium	Your former employer group/union is responsible for paying premiums beyond your monthly Medicare Part B premium. If you are responsible for any contribution to the premiums, your benefits administrator will tell you the amount you and your former employer group/union contribute to the premium	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Deductible	$0	
Annual maximum out-of-pocket	$1,500	Does not include Part D prescription drugs. This is the most you would pay for the year for in-network covered Medicare Parts A and Part B services.
Inpatient hospital care	$250 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	$0 copay for each visit to an outpatient hospital facility $0 copay for Medicare-covered observation services $50 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)	**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.

Premiums and Benefits	You Pay	What you should know
Outpatient surgery	$0 copay for each visit to an ambulatory surgical center $0 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	$35 copay per visit $35 copay per visit	**A referral from your doctor may be required for Specialist visits.**
Preventive services	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care Worldwide coverage	$50 copay per visit $10,000 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.
Urgently needed services Worldwide coverage	$25 copay for each visit to a network urgent care center within your plan service area $50 copay for each visit to an urgent care center outside of your plan service area but within the United States and its territories $50 copay for each visit to an emergency room outside of your plan service area but within the United States and its territories $50 copay for each visit to an emergency room or $25 for each visit to an urgent care center that is outside of the United States and its territories You have a $10,000 combined annual limit for covered emergency care and urgently needed services outside the United States and its territories	These copay are waived if you are admitted to a hospital within one day for the same condition.

Premiums and Benefits	You Pay	What you should know
Diagnostic services, labs, and imaging • 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)	$0 copay for each diagnostic radiology service $0 copay $0 copay $0 copay $0 copay	**A referral from your doctor may be required for diagnostic services, labs and imaging services**. Covered according to Medicare guidelines; prior authorization is required.
Hearing services • Hearing exam (Medicare-covered) • Hearing aids	$35 copay per visit $2,000 allowance per ear every 24 months	**A referral from your doctor may be required for hearing services.** **You may obtain hearing aides at the provider of your choice.**
Dental services • Non-routine dental care	$35 copay per visit if performed by your PCP $35 copay per visit if performed by a specialist	This does not include services in connection with care, treatment, filling, removal, or replacement of teeth.
Vision services • Exam to diagnose and treat diseases and conditions of the eye • Yearly glaucoma screening • Eyeglasses or contact lenses after cataract surgery	$35 copay for each Medicare-covered visit $0 copay $0 copay	**A referral from your doctor may be required for an exam and treat diseases and conditions of the eye**. A referral from your doctor may be required for yearly glaucoma screenings.

Premiums and Benefits	You Pay	What you should know
Mental health services • Inpatient services in a psychiatric hospital	For each Medicare-covered stay you pay: • $0 copay per stay for days 1 through 150 • 100% of the cost of the hospital for days 151 and over unless new benefit period begins.	**A referral and/or prior authorization from your doctor may be required for mental health services.** You are covered for 150 days per benefit period, up to the 190-day lifetime limit. If you go over the 150-day limit, you will be responsible for all costs.
• Outpatient group therapy visit	$35 copay per visit	
• Outpatient individual therapy visit	$35 copay per visit	
Skilled nursing facility (SNF) care	$0 copay per admission	**A referral 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 authorization required with network provider.
Rehabilitation services • Cardiac (heart) rehabilitation services	$35 copay per visit	**A referral from your doctor may be required for rehabilitation services.**
• Occupational therapy services	$35 copay per visit	
• Physical therapy and speech and language therapy services	$35 copay per visit	
Ambulance	$0 copay per trip (one way)	

Premiums and Benefits	You Pay	What you should know
Medicare Part B prescription drugs	$35 copay when administered by your PCP or by a specialist.	If the drug listed on the Part B rebatable drug list and obtained at a retail pharmacy or your doctor's office, you will pay either the applicable tier copay or coinsurance, whichever amount is lesser. Insulin obtained under Part B (when taken with an insulin pump) should not exceed a $35 copay for a one-month supply.

Summary of Benefits

October 1, 2024 – September 30, 2025

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	$0 copay	**A referral and prior authorization from your doctor may be required for Opioid Treatment Program Services.**
Additional Telehealth Services (Teladoc)	$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication.
Foot care (podiatry services) • Foot exams and treatment	$35 copay for each Medicare-covered visit	**A referral from your doctor may be required for Medicare-covered foot care services.**
Diabetic Supplies & Services • Blood glucose monitors • Diabetes self-management training, diabetic services and supplies	$0 copay for ACCU-CHEK monitors and 20% coinsurance for blood glucose monitors from all other manufacturers $0 copay for all training, services and supplies (except blood glucose monitors)	Prior authorization from the plan may be required for diabetic supplies and services (including blood glucose monitors). See the plan EOC for more information. Your copay for a month's supply of insulin will be capped at $35.
Durable Medical Equipment (DME) and Related Supplies • Durable medical equipment (e.g., wheelchairs, oxygen)	$0 copay	Prior authorization from the plan may be required for DME. See the plan EOC for more information.
Prosthetics/Medical Supplies • Prosthetics (e.g.,	$0 copay	**Prior authorization from your doctor may be required for**

Premiums and Benefits	You Pay	What you should know
braces, artificial limbs) • Medical supplies (e.g., splints, casts)	$0 copay	**prosthetics/medical supplies.**
Health and Wellness programs • NurseHelp 24/7℠ (Telephone and online support) • LifeReferrals 24/7 – Access to counselors, consultations, information and referrals for a wide range of family and personal issue •	$0 copay $0 copay $0 copay	
Routine chiropractic services (non-Medicare covered)	$10 copay per visit	Limited to 30 visits per year.

Part D Prescription Drug Coverage

Effective October 1, 2024 – September 30, 2025
You pay the following:

Annual Deductible Stage	This stage does not apply because there is no deductible.
Initial Coverage Stage	You pay the following until your total out-of-pocket Part D drug costs reach $8,000.

What you pay:	**Preferred retail cost-sharing (in-network)**		**Standard retail cost-sharing (in-network)^**	
	30-day supply	**90-day supply*NDS**	**30-day supply**	**90-day supply*NDS**
Tier 1: Generic Drugs	$10 copay	$20 copay	$10 copay	$20 copay
Tier 2: Preferred Brand Drugs	$25 copay	$50 copay	$25 copay	$50 copay
Tier 3: Non-Preferred Drugs	$40 copay	$80 copay	$40 copay	$80 copay
Tier 3: Covered Insulins**	$35 copay	$80 copay	$35 copay	$80 copay
Tier 4: Injectable Drugs	20% coinsurance (up to a $200 copay maximum)	20% coinsurance (up to a $600 copay maximum)	20% coinsurance (up to a $200 copay maximum)	20% coinsurance (up to a $600 copay maximum)
Tier 4: Covered Insulins**	$35 copay	$105 copay	$35 copay	$105 copay
Tier 5: Specialty Tier Drugs	20% coinsurance (up to a $200 copay maximum)	Not covered	20% coinsurance (up to a $200 copay maximum)	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.
***** 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. The drugs that are not available for a long-term supply are marked with the symbol NDS in our Drug List.
For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC.

Part D Prescription Drug Coverage (cont'd)

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Coverage Gap Stage
Because there is no coverage gap for the plan, this payment stage does not apply to you.

Catastrophic Coverage Stage
After your yearly out-of-pocket drug costs (including drugs purchased 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 the Tier 1: Generic Drugs copayments 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-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. After enrolling in your Blue Shield Medicare plan, you can log in to your Blue Shield of California member account at blueshieldca.com/login.

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 (You do not have to be a member to use the pharmacy.)	(800) 955-2292 [TTY: 711]

Ralphs, Walmart, and other pharmacies are also available in our network

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‡Accepts e-prescribing

Partial county service area zip code listing

Contra Costa County, the following ZIP codes only:
94506, 94507, 94526, 94528, 94583

Nevada County, the following ZIP codes only:
95602, 95712, 95924, 95945, 95946, 95949, 95959, 95960, 95975, 95977, 95986

Blue Shield of California is an HMO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal. Blue Shield of California offers individual and employer group retiree plans to Medicare beneficiaries who have Part A and Part B. Individual plans are open to all Medicare beneficiaries who reside within a plan's specific service area. Employer group retiree plans are open only to Medicare beneficiaries who are eligible group retirees and who reside within a plan's specific service area. Individual and employer group retiree plans have different service areas, benefits and provider networks.

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