



Blue Shield 65 Plus (HMO) summary of benefits

Group Medicare Advantage-Prescription Drug Plan for High Desert & Inland Trust retirees

July 1, 2016 to June 30, 2017

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

High Desert and Inland Trust

H0504_15_141B 04282016

SUMMARY OF BENEFITS

July 1, 2016 – June 30, 2017

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."

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)**, a Group Medicare Advantage-Prescription Drug plan offered to you by High Desert and Inland Trust).

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

This document is available in other formats such as Braille and large print. For additional information, call us at (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) 776-4466 [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, meet your former employer group/union's eligibility requirements, and live in the plan 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:

* denotes partial county

Contra Costa County	Fresno County	Imperial County*	Kern County*
Los Angeles County	Madera County*	Nevada County*	Orange County
Riverside County*	Sacramento 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	Ventura County

*These counties only provide coverage in certain areas. Please refer to the ZIP code listing at the end of this booklet for details on partial county service area coverage.

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 five "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.

If you have any questions about this plan's benefits or costs, please contact Blue Shield of California for details.

SUMMARY OF BENEFITS
July 1, 2016 – June 30, 2017

Blue Shield 65 Plus (HMO)

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

How much is the monthly 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. 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:

- \$6,700 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.

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	Not covered
Ambulance ¹	You pay nothing
Chiropractic Care ^{1,2}	For Medicare-covered manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$5 copay For non-Medicare covered chiropractic services, up to 30 visits per year, when obtained from a network provider: \$5 copay
Dental Services ^{1,2}	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$5 copay
Diabetes Supplies and Services ^{1,2}	Tests strips, lancets, glucose solution: You pay a \$5 copay if provided in PCP office. If provided by the pharmacy, you pay the applicable drug tier cost-sharing amount. Blood glucose monitor: You pay nothing Diabetes self-management training: You pay nothing. A \$5 office visit copay may apply. Therapeutic shoes or inserts: You pay nothing
Diagnostic Tests, Lab and Radiology Services, and X-Rays (Costs for these services may be different if received in an outpatient surgery setting) ^{1,2}	Diagnostic radiology services (such as MRIs, CT scans): \$0 copay Diagnostic tests and procedures: \$0 copay Lab services: \$0 copay Outpatient x-rays: \$0 copay Therapeutic radiology services (such as radiation treatment for cancer): \$0 copay
Doctor's Office Visits ^{1,2}	Primary care physician visit: \$5 copay Specialist visit: \$5 copay
Durable Medical Equipment (wheelchairs, oxygen, etc.) ¹	You pay nothing

Emergency Care	<p>\$50 copay</p> <p>If you are admitted to the hospital within 24 hours for the same condition, you pay nothing.</p> <p>World-wide coverage. You pay a \$50 copay and have a \$10,000 combined annual limit for covered emergency care or urgently needed services outside the United States.</p>
Foot Care (<i>podiatry services</i>) ^{1,2}	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$5 copay
Hearing Services ^{1,2}	<p>Exam to diagnose and treat hearing and balance issues: \$5 copay</p> <p>Routine hearing exam: \$5 copay</p> <p>Hearing aid: Plan will reimburse up to \$2,000 every 24 months.</p>
Home Health Care ^{1,2}	\$5 copay
Mental Health Care ^{1,2}	<p>Inpatient visit:</p> <p>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.</p> <p>Our plan covers 150 days for an inpatient hospital stay.</p> <p>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.</p> <p>You pay nothing per admission for days 1-150</p> <p>Outpatient group therapy visit: \$5 copay</p> <p>Outpatient individual therapy visit: \$5 copay</p>
Outpatient Rehabilitation ^{1,2}	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): \$5 copay</p> <p>Occupational therapy visit: \$5 copay</p> <p>Physical therapy and speech and language therapy visit: \$5 copay</p>

Outpatient Substance Abuse ^{1,2}	Group therapy visit: \$5 copay Individual therapy visit: \$5 copay
Outpatient Surgery ^{1,2}	Ambulatory surgical center: You pay nothing Outpatient hospital: You pay nothing
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}	You pay nothing
Transportation	Not covered
Urgently Needed Services	\$5 copay If you are admitted to the hospital within 24 hours for the same condition, you pay nothing. World-wide coverage. You pay a \$5 copay (waived if admitted to the hospital within 24 hours for the same condition) and have a \$10,000 combined annual limit for covered emergency care or urgently needed services outside the United States.
Vision Services ^{1,2}	Exam to diagnose and treat diseases and conditions of the eye: \$5 copay Yearly glaucoma screening: You pay nothing Eyeglasses or contact lenses after cataract surgery: You pay nothing Yearly routine (non-Medicare covered) eye exam: \$10 copay
Preventive Care¹	You pay nothing Our plan covers many preventive services, including: <ul style="list-style-type: none"> • 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 • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening

- Diabetes screenings
- 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.

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. Hospice is covered outside of our plan. Please contact us for more details.

INPATIENT CARE

Inpatient Hospital Care^{1,2}

Our plan covers an unlimited number of days for an inpatient hospital stay.
\$0 copay per admission

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.
• You pay nothing per day for days 1 to 100

PRESCRIPTION DRUG BENEFITS

How much do I pay? For Part B drugs such as chemotherapy drugs¹ and other Part B drugs¹:

When administered in a physician's office/clinic: \$5 copay
When obtained at a network pharmacy: You pay the applicable drug tier cost-sharing amount

Initial Coverage

You pay the following until your total yearly out-of-pocket drug costs reach \$4,850.

You may get your drugs at network retail pharmacies and our mail service pharmacy.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Generic)	\$7 copay	\$21 copay
Tier 2 (Preferred Brand)	\$14 copay	\$42 copay
Tier 3 (Non-Preferred Brand)	\$14 copay	\$42 copay
Tier 4 (Injectable Drugs)	\$14 copay	\$42 copay
Tier 5 (Specialty Tier)	\$14 copay	\$42 copay

Preferred Retail Cost-Sharing

Tier	Three-month supply
Tier 1 (Generic)	\$14 copay
Tier 2 (Preferred Brand)	\$28 copay
Tier 3 (Non-Preferred Brand)	\$28 copay
Tier 4 (Injectable Drugs)	\$42 copay
Tier 5 (Specialty Tier)	\$42 copay

Standard Mail Order Cost-Sharing

Tier	Three-month supply
Tier 1 (Generic)	\$14 copay
Tier 2 (Preferred Brand)	\$28 copay
Tier 3 (Non-Preferred Brand)	\$28 copay
Tier 4 (Injectable Drugs)	\$28 copay
Tier 5 (Specialty Tier)	\$28 copay

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

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

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the lower of:

- 5% of the cost, or

- Your applicable drug tier cost-sharing amount.

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 75 years. Our mission is to ensure all Californians have access to high-quality health care at an affordable price.

PARTIAL COUNTY SERVICE AREA ZIP CODE LISTING

Imperial County, the following ZIP codes only:

92227	92231	92232	92233	92243	92244
92249	92250	92251	92259	92273	92274
92281					

Nevada County, the following ZIP codes only:

95602	95712	95924	95945	95946	95949
95959	95960	95975	95977	95986	

Kern County, the following ZIP codes only:

93203	93206	93215	93216	93220	93226
93241	93243	93250	93263	93268	93276
93280	93285	93287	93301	93302	93303
93304	93305	93306	93307	93308	93309
93311	93312	93313	93314	93380	93383
93384	93385	93386	93387	93388	93389
93390	93518	93531			

Madera County, the following ZIP codes only:

93610	93614	93620	93622	93626	93636
93637	93638	93639	93645	93653	93720

Riverside County, the following ZIP codes only:

91752	92028	92201	92202	92203	92210
92211	92220	92223	92230	92234	92235
92236	92239	92240	92241	92247	92248
92253	92254	92255	92258	92260	92261
92262	92263	92264	92270	92274	92276
92282	92292	92320	92324	92373	92399
92501	92502	92503	92504	92505	92506
92507	92508	92509	92513	92514	92515
92516	92517	92518	92519	92521	92522
92530	92531	92532	92536	92539	92543
92544	92545	92546	92548	92549	92551
92552	92553	92554	92555	92556	92557
92561	92562	92563	92564	92567	92570
92571	92572	92581	92582	92583	92584
92585	92586	92587	92589	92590	92591
92592	92593	92595	92596	92599	92860
92877	92878	92879	92880	92881	92882
92883					

Santa Barbara County, the following ZIP codes only:

93434	93454	93455	93458		
-------	-------	-------	-------	--	--

San Bernardino County, the following ZIP codes only:

91701	91708	91709	91710	91729	91730
91737	91739	91743	91758	91759	91761

91762	91763	91764	91766	91784	91785
91786	91792	91798	92252	92256	92277
92278	92284	92285	92286	92301	92305
92307	92308	92311	92312	92313	92314
92315	92316	92317	92318	92321	92322
92324	92325	92326	92327	92329	92331
92333	92334	92335	92336	92337	92339
92340	92341	92342	92344	92345	92346
92347	92350	92352	92354	92356	92357
92358	92359	92365	92368	92369	92371
92372	92373	92374	92375	92376	92377
92378	92382	92385	92386	92391	92392
92393	92394	92395	92397	92398	92399
92401	92402	92403	92404	92405	92406
92407	92408	92410	92411	92412	92413
92414	92415	92418	92420	92423	92424
92427	92880				

MG00007-Hi-Des (5/16)