

Effective January 1, 2021 – December 31, 2021

2021

Summary of Benefits

Blue Shield Medicare (PPO)

Group Medicare Advantage Prescription Drug Plan
for County of San Mateo



blueshieldca.com/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 contact your former employer group/union or call Blue Shield of California Customer Care 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.

Blue Shield Medicare includes Medicare health care (Part C) and prescription drug (Part D) coverage offering you the convenience of having both your medical services and prescription drugs covered through one plan.

To join **Blue Shield Medicare (PPO)** 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 Medicare if they meet these requirements.

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 <https://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 service area includes all Zip Codes in the following counties in California:

Alameda County	Alpine County	Amador County	Calaveras County
Colusa County	Contra Costa County	El Dorado County	Fresno County
Glenn County	Lake County	Los Angeles County	Marin County
Orange County	Placer County	Plumas County	Riverside County
Sacramento County	San Benito County	San Bernardino County	San Diego County
San Francisco County	San Joaquin County	San Luis Obispo County	San Mateo County
Santa Barbara County	Santa Clara County	Santa Cruz County	Sierra County
Stanislaus County	Sutter County	Ventura County	Yolo County

Look up providers, pharmacies and covered drugs on our website:

- Provider Directory – blueshieldca.com/find-a-doctor
- Pharmacy Directory – blueshieldca.com/medpharmacy2021
- Formulary (List of covered drugs) – blueshieldca.com/medformulary2021

Out-of-network/non-contracted providers are under no obligation to treat Blue Shield Medicare members, except in emergency situations. Please call our Customer Care number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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You pay the following:

Out-of-pocket costs	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.
Annual Maximum out-of-pocket	\$1,500 for services you receive from in-network providers. \$1,500 in-network and \$1,500 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.

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Deductible	\$0	\$0 per year	The deductible amount must be met before the plan will pay its share of cost for covered services.
Inpatient hospital care	\$0 each stay	0 each stay	Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay.
Outpatient hospital care <ul style="list-style-type: none"> Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery 	\$20 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) \$10 copay for each visit to an outpatient hospital facility \$10 copay for observation services	\$20 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) \$10 copay for each visit to an outpatient hospital facility \$10 copay for 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. Prior authorization may be required and is the responsibility of your provider.
Outpatient surgery	\$10 copay for each visit to an ambulatory surgical center \$10 copay for each visit to an outpatient hospital facility	\$10 copay for each visit to an ambulatory surgical center \$10 copay for each visit to an outpatient hospital facility	Prior authorization may be required and is the responsibility of your provider.

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Doctor visits <ul style="list-style-type: none"> • Physician of choice (POC) • Specialists 	\$10 copay per visit \$20 copay per visit	\$10 copay per visit \$20 copay per visit	Prior authorization may be required and is the responsibility of your provider.
Preventive services	\$0 copay	\$0 copay	The 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.
Emergency care	\$20 copay per visit No combined annual limit for covered emergency care and 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.	This copay is waived if you are admitted to a hospital within one day for the same condition. Worldwide coverage.	

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p>Urgently needed services</p>	<p>\$10 copay for each visit to a network urgent care center within your plan service area.</p> <p>\$10 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>\$20 copay for each visit to an emergency room outside of your plan service area but within the United States and its territories.</p> <p>\$20 copay for each visit to an emergency room, \$10 copay for urgent care center that is outside of the United States and its territories.</p>		<p>The copay is waived for each visit to an emergency room that is outside of the plan service area or outside the United States and its territories, if you are admitted to the hospital within one day for the same condition.</p> <p>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.</p> <p>Worldwide coverage.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<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>\$0 copay for each diagnostic radiology service</p> <p>\$0 copay for each laboratory service</p> <p>\$0 copay for each diagnostic test</p> <p>\$0 copay</p> <p>\$0 copay of the Medicare-allowed amount</p>	<p>\$0 copay for each diagnostic radiology service</p> <p>\$0 copay for each laboratory service</p> <p>\$0 copay for each diagnostic test</p> <p>\$0 copay</p> <p>\$0 copay of the Medicare-allowed amount</p>	<p>Prior authorization may be required for diagnostic services and is the responsibility of your provider.</p> <p>Covered according to Medicare guidelines; prior authorization is required.</p> <p>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.</p>
<p>Hearing services</p> <ul style="list-style-type: none"> • Exam to diagnose and treat hearing and balance issues 	<p>\$20 copay per visit</p>	<p>\$20 copay for each visit</p>	<p>Prior authorization may be required and is the responsibility of your provider.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p>Vision services</p> <ul style="list-style-type: none"> • Medicare-covered vision exam to diagnose and treat diseases and conditions of the eye • Yearly glaucoma screening • Eyeglasses or contact lenses after cataract surgery 	<p>\$20 copay for each Medicare-covered visit</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>\$20 copay for each Medicare-covered visit</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>Prior authorization may be required for an exam, treatment of diseases, conditions of the eye, and yearly glaucoma screenings and is the responsibility of your provider.</p>
<p>Vision Care (non-Medicare covered)</p> <ul style="list-style-type: none"> • Routine eye exam, including refraction • Eyeglass lenses (standard)* • Frames and contact lenses 	<p>\$10 copay every 12 months</p> <p>\$150 allowance every 2 years</p> <p>\$150 combined frame allowance every 2 years</p> <p>\$150 contact lens allowance in lieu of eyewear</p>	<p>\$10 copay every 12 months</p> <p>\$150 allowance every 2 years</p> <p>\$150 combined frame allowance every 2 years</p> <p>\$150 contact lens allowance in lieu of eyewear</p>	<p>*Includes single, bifocal, trifocal and lenticular lenses.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p>Mental health services</p> <ul style="list-style-type: none"> <li data-bbox="203 373 456 478">• Inpatient mental health care <li data-bbox="203 590 456 688">• Outpatient group therapy visit <li data-bbox="203 764 423 869">• Outpatient individual therapy visit 	<p>\$0 copay for days 1 to 150 100% of the cost for days 151</p> <p>\$20 copay per visit</p> <p>\$20 copay per visit</p>	<p>\$0 copay for days 1 to 150 100% of the cost for days 151</p> <p>\$20 copay per visit</p> <p>\$20 copay per visit</p>	<p>Prior authorization may be required and is the responsibility of your provider.</p> <p>You are covered for 150 days each benefit period, up to the 190-day lifetime limit.</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. If you go into the hospital after one benefit period has ended, a new benefit period begins.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Skilled nursing facility (SNF) care	\$0 copay for days 1 through 100	\$0 copay for days 1 through 100	<p>Prior authorization may be required and is the responsibility of your provider.</p> <p>100 days per benefit period; no prior hospitalization required with network provider.</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. If you go into the hospital after one benefit period has ended, a new benefit period begins.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Rehabilitation services <ul style="list-style-type: none"> Occupational therapy services Physical therapy and speech and language therapy services 	\$10 copay per visit \$10 copay per visit	\$10 copay per visit \$10 copay per visit	Prior authorization may be required and is the responsibility of your provider.
Ambulance	\$50 copay per trip (each way)	\$50 copay per trip (each way)	The 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.
Medicare Part B drugs	\$0 copay	\$0 copay	Step therapy may be required.
Opioid treatment program services	\$0 copay	\$0 copay	

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Telehealth Services (Teladoc)	\$0 copay	Not covered	Teladoc Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication. See the plan EOC for more information.
Foot care (podiatry services) <ul style="list-style-type: none"> • Foot exams and treatment 	\$20 copay for each Medicare-covered visit	\$20 copay for each Medicare-covered visit	Medicare-covered services include: <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p>Medical equipment/supplies</p> <ul style="list-style-type: none"> • Durable medical equipment (e.g., wheelchairs, oxygen) • Blood glucose monitors • Prosthetics (e.g., braces, artificial limbs) • Diabetes self-management training; diabetic services and supplies 	<p>\$0 copay</p> <p>\$0 copay for ACCU-CHEK® blood glucose monitors and 20% of the Medicare-allowed amount for blood glucose monitors from all other manufacturers</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>\$0 copay</p> <p>\$0 copay for ACCU-CHEK® blood glucose monitors and 20% of the Medicare-allowed amount for blood glucose monitors from all other manufacturers</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>Prior authorization from the plan may be required for durable medical equipment and is the responsibility of your provider. See the plan EOC for more information.</p> <p>Prior authorization from the plan may be required for prosthetics and diabetes self-management training. See the plan EOC for more information.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p>Health and Wellness programs</p> <ul style="list-style-type: none"> • NurseHelp 24/7SM (Telephone and online support) • LifeReferrals 24/7 – Access to counselors, consultations, information and referrals for a wide range of family and personal issue • Basic gym access through SilverSneakers Fitness 	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>NurseHelp 24/7 offers Registered Nurses that you can Connect with anytime day or night for advice and answers to your health-related questions.</p>

Prescription Drug Coverage

You pay the following:

Annual Prescription Deductible	This plan does not have a deductible
Initial Coverage Limit	You pay the following until your total yearly out-of-pocket drug costs reach \$6,550.

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	\$30 copay
Tier 2: Preferred Brand Drugs	\$20 copay	\$40 copay	\$20 copay	\$60 copay
Tier 3: Non-Preferred Drugs	\$35 copay	\$60 copay	\$35 copay	\$105 copay
Tier 4: Specialty Tier Drugs	30% coinsurance (up to a \$150 copay maximum) per prescription	Not covered	30% coinsurance (up to a \$150 copay maximum) per prescription	Not covered

* Three-month supply preferred cost-sharing also applies to Blue Shield's mail service pharmacy, with the exception of Tier 4.

^{NDS} A long-term (up to a 90-day) supply is not available for select drugs. We limit the amount of 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.

For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC.

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 service) reach \$6,550, you pay the lower of:

- 5% of the cost, or
- Your applicable drug tier cost-sharing amount.





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. After enrolling in Blue Shield Medicare, 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 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 of pharmacies with preferred cost-sharing.

†Accepts e-prescribing

Blue Shield of California is a PPO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal. Blue Shield Medicare 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. Blue Shield Medicare individual and employer group retiree plans have different service areas, benefits and provider networks.

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