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2027 Summary of Benefits

Blue Shield 65 Plus (HMO)

Medicare Advantage Prescription Drug Plan
for San Bernardino County

Effective January 1, 2027 - December 31, 2027

blueshieldca.com/medicare

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2027 Summary of Benefits
Blue Shield 65 Plus (HMO)
San Bernardino County

Effective January 1, 2027 - December 31, 2027

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 refer to the ***Evidence of Coverage*** **(EOC)** at **blueshieldca.com/MAPDdocuments2027** or by calling Customer Service at **(800) 776-4466 (TTY: 711)**, 8 a.m. to 8 p.m. PT, seven days a week. **Note: The EOC will be available on our website by October 15, 2026.**

Blue Shield 65 Plus includes Part D coverage, which provides prescription drug coverage, offering you the convenience of having both your medical and prescription drugs covered through one plan.

To join **Blue Shield 65 Plus**, you must have both Medicare Part A and Part B, permanently live in the plan service area, and be a United States citizen or national, or an eligible noncitizen. **Our service area includes San Bernardino County.**

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/medicare-and-you** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven 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/medformulary2027**.

To get the most complete and current information about which drugs are covered, you can visit our website at **blueshieldca.com/medformulary2027**.

Summary of Benefits

Effective January 1, 2027 - December 31, 2027

Blue Shield 65 Plus (HMO)
San Bernardino County

Premiums and benefits	You pay
Monthly plan premium You must continue to pay your Medicare Part B premium in addition to the plan premium.	$0
Health plan deductible	$0
Annual maximum out-of-pocket amount 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.	$2,550
Inpatient hospital care* For each Medicare-covered stay in a network hospital.	$50 per day for days 1 to 5 $0 per day for days 6 and over
Outpatient hospital services* Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery.	
• Outpatient hospital facility	$225
• Observation services	$0
• Emergency room visit Waived if you are admitted to the hospital within one day for the same condition.	$150
Outpatient surgery*	
• Ambulatory surgical center	$75
• Outpatient hospital facility	$225

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/MAPDdocuments2027**.

Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

Blue Shield 65 Plus (HMO)
San Bernardino County

Premiums and benefits	You pay
Doctor visits	
• Primary care physician	$0
• Specialists*	$0
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered.	$0
Emergency care	
• Worldwide coverage This copay is waived if you are admitted to the hospital within one day for the same condition. $50,000 combined annual limit for 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.	$150
Urgently needed services	
• Worldwide coverage These copays are waived if you are admitted to the hospital within one day for the same condition. $50,000 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.	
- Network urgent care center within the plan service area	$0
- Urgent care center outside of the plan service area but within the United States and its territories	$0
- Emergency room outside of the plan service area but within the United States and its territories	$150
- Emergency room or urgent care center that is outside of the United States and its territories	$150

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/MAPDdocuments2027**.

Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

Blue Shield 65 Plus (HMO)
San Bernardino County

Premiums and benefits	You pay
Diagnostic services, labs, and imaging*	
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.) Covered according to Medicare guidelines.	$20
• Lab services	$0
• Diagnostic tests and procedures	$0
• Outpatient X-rays	$0
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance
Hearing services	
• Hearing exam (Medicare-covered)*	$0
• Routine (non-Medicare covered) hearing exam	Not covered
Hearing aids	Not covered

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/MAPDdocuments2027**.

Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

Blue Shield 65 Plus (HMO)
San Bernardino County

Premiums and benefits	You pay
Dental services (Medicare-covered)*	
• Performed by your PCP	$0
• Performed by a specialist	$0
Dental services (non-Medicare covered)	
• Teeth cleaning (prophylaxis) Two cleanings every 12 months.	$0
• Dental X-rays One series of bitewing X-rays every 6 months. One series of full set X-rays every 24 months.	$0 - $10
• Fluoride treatment One visit every 6 months.	$5
• Oral exam The frequency limit depends on the service being provided.	$0 - $16
Vision services	
• Exam to diagnose and treat diseases and conditions of the eye*	$0
• Routine (non-Medicare covered) eye exam and refraction One exam every year.	$0
• Eyeglass frames **$175** allowance every **2** years.	$20
• Eyeglass lenses or contact lenses **$175** allowance for contact lenses every **2** years.	$20
Mental health services*	
• Inpatient services in a psychiatric hospital (For each Medicare-covered stay for days 1 - 150) If you go over the 150-day limit, you will be responsible for all costs.	$900
• Outpatient individual therapy visit	$30
• Outpatient group therapy visit	$30

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/MAPDdocuments2027**.

Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

Blue Shield 65 Plus (HMO)
San Bernardino County

Premiums and benefits	You pay
Skilled nursing facility (SNF) care* For each stay in a Medicare-certified skilled nursing facility. If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.	$0 per day for days 1 - 20 $100 per day for days 21 - 100
Rehabilitation services*	
• Occupational therapy	$0
• Physical therapy	$0
• Speech and language therapy	$0
Ambulance services* Per trip (each way).	
• Medicare-covered ground ambulance services	$275
• Medicare-covered air ambulance services	20% coinsurance
Transportation services (non-Medicare covered)	Not covered
Medicare Part B prescription drugs* Members may pay 0% to 20% coinsurance for select Medicare Part B drugs which can change each quarter as established by CMS. Insulin obtained under Part B (when taken with an insulin pump) will not exceed a $35 copay for a one-month supply.	0% to 20% coinsurance

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/MAPDdocuments2027**.

Additional benefits included in your plan

Benefits	You pay
Opioid treatment program services*	$15
Podiatry services (foot care)*	
• Medicare-covered foot exams and treatment*	$0
• Routine (non-Medicare covered) foot care	Not covered
Diabetic supplies and services*	
• ACCU-CHEK blood glucose monitors	$0
• Dexcom and Freestyle Libre continuous glucose monitors	$0
• Blood glucose monitors and continuous glucose monitors from all other manufacturers	20% coinsurance
• Diabetes self-management training, diabetic services, and supplies (excluding blood glucose monitors) and continuous glucose monitors	$0
Durable medical equipment (DME) and related supplies (e.g., wheelchairs, oxygen)*	20% coinsurance
Prosthetic and orthotic devices and related supplies*	
• Prosthetic and orthotic devices (e.g., braces, artificial limbs)	20% coinsurance
• Medical supplies (e.g., splints, casts)	$0
Health and wellness programs	
• Basic gym access through SilverSneakers	$0
• NurseHelp 24/7℠ (telephone and online support)	$0

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/MAPDdocuments2027**.

Prescription drug coverage

Effective January 1, 2027 - December 31, 2027

Blue Shield 65 Plus (HMO)
San Bernardino County

You pay the following

Part D prescription drug benefit				
Stage 1: Annual deductible	$390 (The deductible doesn't apply to Tier 1 and Tier 2, covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.)			
Stage 2: Initial coverage	**Preferred retail cost-sharing (in-network)**		**Standard retail cost-sharing (in-network)^**	
	30-day supply	**100-day supply[NDS]**	**30-day supply**	**100-day supply[NDS]**
Tier 1: Preferred generic drugs	$0	$0	$5	$5
Tier 2: Generic drugs	$10	$15	$18	$54
Tier 3: Preferred brand drugs	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Tier 3: Covered insulins**	The lesser of $35 or 20% coinsurance	The lesser of $105 or 20% coinsurance	The lesser of $35 or 20% coinsurance	The lesser of $105 or 20% coinsurance
Tier 4: Non-preferred drugs	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4: Covered insulins**	The lesser of $35 or 25% coinsurance	The lesser of $105 or 25% coinsurance	The lesser of $35 or 25% coinsurance	The lesser of $105 or 25% coinsurance
Tier 5: Specialty tier drugs	29% coinsurance	Not covered	29% coinsurance	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.

NDS A long-term (up to a 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.

Prescription drug coverage (cont'd)

Effective January 1, 2027 - December 31, 2027

Blue Shield 65 Plus (HMO)
San Bernardino County

Part D prescription drug benefit

Stage 3: Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through home delivery service) reach $2,400, the plan pays the full cost for your covered Part D drugs. (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.

Home delivery service

Amazon Pharmacy is our prescription home delivery service provider where you can get a 100-day supply of maintenance drugs on Tier 1 through Tier 4 at a lower cost share. Your order will be delivered with $0 shipping. See the plan EOC for more information.

Tier 5 drugs are limited to a 30-day supply by home delivery 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) 276-9637 (TTY: 711)**
- Costco‡ **(800) 955-2292 (TTY: 711)**
- Ralphs‡, Walmart‡, and many more.

‡ Accepts e-prescribing.

You do not have to be a Costco member to use Costco Pharmacies. Other pharmacies are available in our network.

For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC at **blueshieldca.com/MAPDdocuments2027**.

Optional supplemental dental HMO plan

Effective January 1, 2027 - December 31, 2027

Blue Shield 65 Plus (HMO)
San Bernardino County

You pay the following

Optional supplemental dental HMO plan	Participating dentists only
Monthly plan premium	$16.20
Calendar year deductible	$0
Calendar year benefit maximum*	None
Waiting period	None
Summary list of services covered (ADA code)†	
Diagnostic and preventive services	
• Oral exam (D0150)	$5
• Dental X-rays (D0210) One series every 24 months.	$0
• Teeth cleaning (D1110) One cleaning every 6 months.	$5
Restorative services	
• Crown (D2750) One per plan year, every 5 years (exact tooth).	$275‡
Periodontics	
• Deep cleaning of four or more teeth per quadrant (D4341) One every 12 months (exact tooth).	$45
Endodontics	
• Root canal therapy (D3310) One per lifetime (exact tooth).	$195/$268§

* If you are enrolled in the optional supplemental dental HMO plan, 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. For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/MAPDdocuments2027**.

† 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.

§ The higher copayment applies when a specialist performs the service.

Optional supplemental dental In-Network Only (INO) plan

Effective January 1, 2027 - December 31, 2027

Blue Shield 65 Plus (HMO)
San Bernardino County

You pay the following

Optional supplemental dental INO plan	Participating dentists
Monthly plan premium	$49
Calendar year deductible Not applicable to diagnostic and preventive services.	$50
Calendar year benefit maximum* Covered preventive and comprehensive dental services combined, no matter if the services are performed by a participating general dentist or a dental specialist. You pay any amount above the $1,500 calendar year benefit maximum.	$1,500
Waiting period	None
Summary list of services covered (ADA code)†	
Diagnostic and preventive services	
• Oral exam (D0150) One every 6 months.	0% coinsurance
• Dental X-rays (D0210) One series every 24 months.	0% coinsurance
• Teeth cleaning (D1110) One cleaning every 6 months.	0% coinsurance
Restorative services	
• Crown (D2750) One every 5 years (exact tooth).	50% coinsurance
Periodontics	
• Deep cleaning of four or more teeth per quadrant (D4341) One every 24 months (exact tooth).	50% coinsurance

* If you are enrolled in the optional supplemental dental INO plan and you need to see a specialist, you may go directly to the specialist. For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/MAPDdocuments2027**.

† ADA codes are procedure codes established by the American Dental Association for efficient processing and reporting of dental claims.

Optional supplemental dental In-Network Only (INO) plan (cont'd)

Effective January 1, 2027 - December 31, 2027

Blue Shield 65 Plus (HMO)
San Bernardino County

You pay the following

Optional supplemental dental INO plan	Participating dentists
Endodontics	
• Root canal therapy (D3310)	50% coinsurance
Implant services	
• Implant services (D6010) One per lifetime.	50% coinsurance

* If you are enrolled in the optional supplemental dental INO plan and you need to see a specialist, you may go directly to the specialist. For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/MAPDdocuments2027**.

† ADA codes are procedure codes established by the American Dental Association for efficient processing and reporting of dental claims.

We're here to help

Contact Blue Shield at **(888) 534-4263 (TTY: 711)**

8 a.m. to 8 p.m., seven days a week.

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's pharmacy network includes limited lower-cost, pharmacies with preferred cost sharing in certain counties within California. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost pharmacies with preferred cost sharing in your area, please call Customer Service at **(800) 776-4466 (TTY: 711)**, 8 a.m. to 8 p.m. PT, seven days a week, or consult the online pharmacy directory at **blueshieldca.com/medpharmacy2027**.

Amazon Pharmacy is independent of Blue Shield of California and is contracted with Blue Shield to provide home delivery service of prescription medications to Blue Shield members. Members are responsible for their share of costs, as stated in their benefit plan details.

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