



2025 Summary of Benefits

Blue Shield TotalDual Plan (HMO D-SNP)

Dual Special Needs Plan
for Orange and San Bernardino Counties

Effective January 1, 2025 – December 31, 2025

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 refer to the ***Evidence of Coverage (EOC)*** at blueshieldca.com/DSNPdocuments2025 or by calling Customer Service at **(800) 452-4413 (TTY: 711)**, 8 a.m. to 8 p.m., seven days a week. **Note: The EOC will be available on our website by October 15, 2024.**

Blue Shield TotalDual Plan 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 TotalDual Plan**, you must have both Medicare Part A and Medicare Part B, live in our service area, be a United States citizen or be lawfully present in the United States, and be eligible for both Medicare and Medi-Cal (Medicaid). **Our service area includes Orange and San Bernardino Counties.**

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/medpharmacy2025.

To get the most complete and current information about which drugs are covered, you can visit our website at blueshieldca.com/medformulary2025.

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Premiums and benefits	You pay	What you should know
Monthly plan premium	\$0	
Health plan deductible	\$0	
Annual out-of-pocket maximum amount	\$9,350	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. Dual eligible members are not responsible for paying any out-of-pocket costs applied to the out-of-pocket maximum (OOPM) for covered Part A and B services as they get assistance from Medi-Cal, resulting in most members never reaching the OOPM.
Inpatient hospital care	\$0	Prior authorization and a referral from your provider may be required. 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 or an emergency room \$0 copay for observation services	Prior authorization and/or a referral from your provider may be required. Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
Outpatient surgery	\$0 copay for each visit to an ambulatory surgical center and outpatient hospital facility	Prior authorization and a referral from your provider may be required.
Doctor visits • Primary care physician • Specialists	\$0 copay per visit \$0 copay per visit	A referral from your provider may be required for specialist visits.

Summary of Benefits (cont'd)

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Premiums and benefits	You pay	What you should know
Preventive care	\$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care • Worldwide coverage	\$0 copay for each Medicare-covered emergency room visit 20% coinsurance for worldwide emergency coverage (waived if admitted to the hospital within one day for the same condition) No combined annual limit for emergency care and urgently needed services outside the United States and its territories	
Urgently needed services • Worldwide coverage	\$0 copay for urgently needed services 20% coinsurance for worldwide urgent coverage (waived if admitted to the hospital within one day for the same condition) No combined annual limit for emergency care and urgently needed services outside the United States and its territories	
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 for each therapeutic radiology service	Prior authorization and/or a referral from your provider may be required. Covered according to Medicare guidelines.

Summary of Benefits (cont'd)

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Premiums and benefits	You pay	What you should know
Hearing services <ul style="list-style-type: none"> • Hearing exam (Medicare-covered) • Routine (non-Medicare covered) hearing exam • Hearing aids 	<p>\$0 copay per visit</p> <p>\$0 copay per visit</p> <p>You will be reimbursed up to \$2,000 every year for two hearing aids and two hearing aid fitting and evaluations</p>	<p>A referral from your provider may be required.</p> <p>Applies to both ears combined. You may obtain these services at the hearing aid provider of your choice.</p>
Dental services (Medicare-covered)	<p>\$0 copay per visit if performed by your PCP or a specialist</p>	<p>A referral from your provider may be required.</p>
Dental services (non-Medicare covered) <ul style="list-style-type: none"> • Crowns • Dentures (removable) • Dentures (fixed) 	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>Two per calendar year.</p> <p>One per calendar year (not covered within 6 months of initial placement).</p> <p>One per tooth per 5 calendar years.</p>

Summary of Benefits (cont'd)

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Premiums and benefits	You pay	What you should know
<p>Vision services</p> <ul style="list-style-type: none"> • Exam to diagnose and treat diseases and conditions of the eye • Routine (non-Medicare covered) eye exam and refraction • Eyeglass frames • Eyeglass lenses or contact lenses 	<p>\$0 copay for each Medicare-covered visit</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>Prior authorization and a referral from your provider may be required.</p> <p>Some coverage at non-network providers included; see the plan EOC for details.</p> <p>One visit every 12 months with a network provider.</p> <p>Our plan pays for one pair of eyeglass frames (priced up to a regular retail value of \$295) every 24 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p> <p>Our plan pays for either one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses (priced up to \$295 for contact lens service and materials) every 12 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p>

Summary of Benefits (cont'd)

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Premiums and benefits	You pay	What you should know
Mental health services <ul style="list-style-type: none"> • Inpatient services in a psychiatric hospital • Outpatient individual therapy visit • Outpatient group therapy visit 	\$0 copay \$0 copay \$0 copay	Prior authorization and a referral from your provider may be required.
Skilled nursing facility (SNF) care	\$0 copay	Prior authorization and a referral from your provider may be required. When a network provider coordinates your admission, Blue Shield TotalDual Plan waives the 3-day prior hospital stay required by Medicare to qualify for coverage.
Rehabilitation services <ul style="list-style-type: none"> • Occupational therapy • Physical therapy • Speech and language therapy 	\$0 copay per visit \$0 copay per visit \$0 copay per visit	Prior authorization and a referral from your provider may be required.
Ambulance services	\$0 copay per trip (each way)	Prior authorization from your provider may be required.
Transportation services (non-Medicare covered)	\$0 copay	Limited to 48 one-way trips to plan-approved health-related locations per year.
Medicare Part B prescription drugs	\$0 copay	Prior authorization from your provider may be required.

Summary of Benefits (cont'd)

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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 services	\$0 copay	Prior authorization and a referral from your provider may be required.
Foot care (podiatry services) <ul style="list-style-type: none"> • Foot exams and treatment • Routine (non-Medicare covered) foot care 	\$0 copay for each Medicare-covered visit \$0 copay for each routine (non-Medicare covered) visit	A referral from your provider may be required.
Diabetic supplies and services <ul style="list-style-type: none"> • Blood glucose monitors • Diabetes self-management training, diabetic services, and supplies 	\$0 copay for FreeStyle® blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers \$0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	Prior authorization and/or a referral from your provider may be required. See the plan EOC for more information.

Summary of Benefits (cont'd)

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Premiums and benefits	You pay	What you should know
Durable medical equipment (DME) and related supplies <ul style="list-style-type: none"> Durable medical equipment (e.g., wheelchairs, oxygen) 	\$0 copay	Prior authorization from your provider may be required. See the plan EOC for more information.
Prosthetic and orthotic devices and related supplies <ul style="list-style-type: none"> Prosthetic and orthotic devices (e.g., braces, artificial limbs) Medical supplies (e.g., splints, casts) 	\$0 copay \$0 copay	Prior authorization from your provider may be required.
Health and wellness programs <ul style="list-style-type: none"> Basic gym access through SilverSneakers® fitness NurseHelp 24/7SM (telephone and online support) Personal Emergency Response System (PERS) (24/7 medical alert) 	\$0 copay \$0 copay \$0 copay	
Over-the-counter (OTC) Items	You have a \$170 allowance per quarter to spend on covered items	You can place two orders per quarter and cannot roll over your unused allowance into the next quarter. Some limitations may apply. Refer to the OTC Items catalog for more information.
Routine chiropractic services (non-Medicare covered)	\$0 copay per visit	Limited to 12 visits per year.

Prescription drug coverage

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You pay the following:

Part D prescription drug benefit		
Stage 1: Annual deductible stage	\$590 (The deductible doesn't apply to drugs listed on Tier 1, covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.)	
Stage 2: Initial coverage stage	Standard retail cost-sharing (in-network) [^]	
	30-day supply	100-day supply ^{*NDS}
Tier 1: Preferred generic drugs	\$0 copay	\$0 copay
Tier 2: Generic drugs	\$0, \$1.60, or \$4.90 copay	\$0, \$1.60, or \$4.90 copay
Tier 3: Preferred brand drugs	\$0, \$4.80, or \$12.15 copay	\$0, \$4.80, or \$12.15 copay
Tier 3: Covered insulins^{**}	\$0, \$4.80, or \$12.15 copay	\$0, \$4.80, or \$12.15 copay
Tier 4: Non-preferred drugs	\$0, \$4.80, or \$12.15 copay	\$0, \$4.80, or \$12.15 copay
Tier 4: Covered insulins^{**}	\$0, \$4.80, or \$12.15 copay	\$0, \$4.80, or \$12.15 copay
Tier 5: Specialty tier drugs	\$0, \$4.80, or \$12.15 copay	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.

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

^{*}100-day supply cost-sharing also applies to Amazon Pharmacy home delivery service.

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) Blue Shield TotalDual Plan (HMO D-SNP) Orange and San Bernardino Counties

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Part D prescription drug benefit

Stage 3: Catastrophic coverage stage	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through home delivery service) reach \$2,000, 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.)
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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 network home delivery service where you can get a 100-day supply of maintenance drugs. Your order will be delivered with \$0 shipping. See plan EOC for more information.

Tier 5 drugs are limited to a 30-day supply by home delivery service.

Medi-Cal Covered Benefits

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Medi-Cal covered benefits chart

This plan is a Dual Eligible Special Needs Plan (D-SNP) for people who have both Medicare and Medi-Cal. How much Medi-Cal covers depends on your income, resources, and other factors.

You can only access the full list of Medi-Cal benefits if you are in one of these Medi-Cal categories:

- **Qualified Medicare Beneficiary Plus (QMB+):** You are eligible for full Medi-Cal benefits and Medi-Cal pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts. You pay nothing, except for Part D prescription drug copays.
- **Specified Low-Income Medicare Beneficiary (SLMB+):** You are eligible for full Medi-Cal benefits and Medi-Cal pays your Part B premium. Generally, your cost share is \$0 when the service is covered by both Medicare and Medi-Cal. There may be cases where a service or benefit is not covered by Medi-Cal, in which case you will have to pay a cost share.
- **Full Benefits Dual Eligible (FBDE):** You are eligible for full Medi-Cal benefits and Medi-Cal may provide limited cost-sharing assistance for Medicare. Generally, your cost share is \$0 when the service is covered by both Medicare and Medi-Cal. There may be cases where a service or benefit is not covered by Medi-Cal, in which case you will have to pay a cost share.
- If your category of Medi-Cal eligibility changes, your cost share and access to the below services may also change. You must recertify your Medi-Cal enrollment each year to continue your enrollment in our plan.

The following services are covered by your Medi-Cal Managed Care Plan or Medi-Cal Fee-For-Service. When services are covered by both Medi-Cal and Blue Shield TotalDual Plan, Blue Shield will pay first and Medi-Cal will pay second. Blue Shield will work with your Medi-Cal carrier to coordinate access to your full scope of benefits as a dual-eligible, but Blue Shield is not responsible for the authorization, referral, or reimbursement of the Medi-Cal covered services listed below.

The benefits listed below may have exclusions and/or limitations. For more details on Medi-Cal covered services, contact your Medi-Cal Managed Care Plan or the Department of Health Care Services' Office of the Ombudsman at **(888) 452-8609**, Monday through Friday, 8 a.m. to 5 p.m. PST, excluding holidays.

Medi-Cal Covered Benefits (cont'd)

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Benefit/Service	Medi-Cal	Blue Shield TotalDual
Acupuncture	Covered	Covered
Ambulance services	Covered	Covered
Anesthesiology services	Covered	Covered
Blood and blood derivatives	Covered	Covered
Chiropractic services	Covered	Covered
Chronic hemodialysis and dialysis	Covered	Covered
Community-based adult services	Covered	Not covered
Dental services	Covered	Covered
Diabetes Prevention Program	Covered	Covered
Durable medical equipment	Covered	Covered
Emergency and urgent services	Covered	Covered
Enhanced case management	Covered	Covered
Eyeglasses and contact lenses	Covered	Covered
Federally qualified health center (FQHC) services	Covered	Covered
Hearing aids	Covered	Covered
Home and community-based waiver services	Covered	Not covered
Home health agency services	Covered	Covered
Home health aide services	Covered	Covered
Hospice care	Covered	Covered
Hospital outpatient services	Covered	Covered
Human immunodeficiency virus and AIDS drugs	Covered	Covered
Indian health services	Covered	Not covered
In-Home Supportive Services (IHSS)	Covered	Not covered
Inpatient hospital services	Covered	Covered
Intermediate care facility services for the developmentally disabled	Covered	Not covered
Intermediate care services	Covered	Not covered
Laboratory, radiological, and radioisotope services	Covered	Covered
Licensed midwife services	Covered	Covered
Long-term care	Covered	Not covered
Multipurpose Senior Services Program (MSSP)	Covered	Not covered
Nursing facility services	Covered	Covered
Optometry services	Covered	Covered
Organ transplant services	Covered	Covered

Medi-Cal Covered Benefits (cont'd)

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Benefit/Service	Medi-Cal	Blue Shield TotalDual
Outpatient clinic services	Covered	Covered
Outpatient detox services	Covered	Covered
Outpatient mental health	Covered	Covered
Over-the-counter (OTC) items	Not covered	Covered
Pharmaceutical and prescription drug services	Covered	Covered
Physician and specialist services	Covered	Covered
Podiatry services	Covered	Covered
Prosthetics and orthotics	Covered	Covered
Physical, occupational, speech, and audiological therapy services	Covered	Covered
Rehabilitation center services	Covered	Covered
Rural health clinic services	Covered	Covered
Skilled nursing facility services	Covered	Covered
Specialty mental health services	Covered	Not covered
Substance use disorder services	Covered	Covered
Transportation services	Covered	Covered
Virtual care	Covered	Covered

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 D-SNP plan with a Medicare contract and a contract with the California State Medicaid Program. Enrollment in Blue Shield of California depends on contract renewal.

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.

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