PLAN G EXTRA

MEDICARE (PART A)
HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* – Semiprivate room and board, general nursing, and miscellaneous services and supplies.			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* – You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G EXTRA

MEDICARE (PART B)
MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES			
	100%	$0	$0

PLAN G EXTRA

PARTS A & B

* Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC GYM ACCESS THROUGH SILVERSNEAKERS® FITNESS PROGRAM			
	$0	100%	$0
PHYSICIAN CONSULTATION BY PHONE OR VIDEO THROUGH TELADOC			
	$0	100%	$0 per consult
OVER-THE-COUNTER ITEMS THROUGH CVS – Eligible over-the-counter (OTC) items are available through the OTC Items Catalog, at **blueshieldca.com/medicareOTC**. Limitations may apply. Refer to the OTC Items Catalog for more information.			
Up to two orders per quarter	$0	Up to $100 allowance per quarter	All costs above the $100 allowance per quarter

PLAN G EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES – Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor*.			
Comprehensive eye exam once every 12 months	$0	**In-Network:** 100% after the $20 copayment **Out-Of-Network:** Up to $50 allowance	**In-Network:** $20 copay **Out-Of-Network:** All costs above the $50 allowance
Eyeglass frame once every 24 months	$0	**In-Network:** Up to $100 allowance **Out-Of-Network:** Up to $40 allowance	**In-Network:** All costs above the $100 allowance **Out-Of-Network:** All costs above $40 allowance

PLAN G EXTRA

Other benefits - not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES – Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor.*			
Eyeglass lenses once every 12 months • Single vision • Bifocal • Trifocal • Aphakic, lenticular monofocal, or multifocal	$0	**In-Network:** 100% after the $25 copayment **Out-Of-Network:** Single vision: Up to $43 allowance Bifocal: Up to $60 allowance Trifocal: Up to $75 allowance Aphakic or lenticular monofocal or multifocal: Up to $104 allowance	**In-Network:** $25 copay **Out-Of-Network:** All costs above the allowance

PLAN G EXTRA

Other benefits - not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES – Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor.*			
Contact lenses (instead of eyeglass lenses) once every 12 months • Non-elective (medically necessary) – Hard or Soft – one pair • Elective (cosmetic/convenience) – Hard – one pair • Elective (cosmetic/convenience) – Soft – Up to a three- to six-month supply for each eye based on lenses selected	$0	**Non-elective In-Network:** Up to $500 allowance after the $25 copayment **Non-elective Out-Of-Network:** Non-elective (Hard or Soft): Up to $200 allowance **Elective In-Network:** Up to $120 allowance after the $25 copayment **Elective Out-Of-Network:** Up to $100 allowance	**Non-elective and Elective In-Network:** $25 copay **Non-elective and Elective Out-Of-Net-work:** All costs above the allowance

PLAN G EXTRA

Other benefits - not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HEARING AID SERVICES – Your hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. EPIC Participating Providers are listed at **blueshieldca.com/HearingAids**. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.			
Hearing aid benefits every year include:			
• One routine hearing exam	$0	100%	$0
• Hearing aid instrument	$0	$0	**Silver Technology Level** $449 per hearing aid
o Choice of the private-labeled Silver (mid-level) or Gold (premium-level) technology hearing aid models			**Gold Technology Level** $699 per hearing aid
o Up to two hearing aids in the following styles:			
– In the ear			
– In the canal			
– Completely-in canal			
– Behind-the-ear; or			
– Receiver-in-the-ear			
o All technology levels include:			
– One consultation			
– Two-year supply of batteries per hearing aid; and			
– Three-year extended warranty			

PLAN G EXTRA

Other benefits - not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HEARING AID SERVICES – Your hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. EPIC Participating Providers are listed at **blueshieldca.com/HearingAids**. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.			
o Silver technology level hearing aids include: – One behind-the-ear hearing aid (non-ear mold model) delivered directly to your home; and – Up to three virtual follow-up visits by a participating provider for hearing aid fitting, consultation, device check, and adjustment for no additional cost	$0	$0	**Silver Technology Level** $449 per hearing aid
o Gold technology level hearing aids include: – One hearing aid delivered in-person by a participating provider – Up to three in-person follow-up visits for hearing aid fitting, consultation, device check, and adjustment for no additional cost; and – Standard ear molds and impressions			**Gold Technology Level** $699 per hearing aid