Effective January 1, 2022 – December 31, 2022

2022 Summary of Benefits

Blue Shield AdvantageOptimum Plan (HMO)

Medicare Advantage Prescription Drug Plan

Santa Clara and Merced County

blue california

blueshieldca.com/medicare

H5928_21_374G_050_M Accepted 09012021

2022 Summary of Benefits
Blue Shield AdvantageOptimum Plan
Santa Clara and Merced County

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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/MAPDdocuments2022 or by calling** Customer Care at **(800) 776-4466** [TTY:**711**], 8 a.m. to 8 p.m., seven days a week, year round. **Note: The EOC will be available on our website by October 15.**

Blue Shield AdvantageOptimum 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 AdvantageOptimum Plan**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. **Our service area includes Santa Clara and Merced 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 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.

Our plan Provider Directory is located on our website at **blueshieldca.com/find-a-doctor**.

Our plan Pharmacy Directory is located on our website at **blueshieldca.com/medpharmacy2022**.

To get the most complete and current information about which drugs are covered, you can visit our website at **blueshieldca.com/medformulary2022**.

Summary of benefits

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Santa Clara and Merced County

Premiums and benefits	You pay	What you should know
Monthly plan premium	$0	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Deductible	$0	
Annual out-of-pocket maximum amount	$3,400	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.
Inpatient hospital care	$300 copay per day for days 1 - 5 $0 copay per day for days 6 and over	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	$350 copay for each visit to an outpatient hospital facility $0 copay for observation services $85 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)	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	$150 copay for each visit to an ambulatory surgical center $350 copay for each visit to an outpatient hospital facility	
Doctor visits • Primary care physician • Specialists	 $10 copay per visit $25 copay per visit	 **A referral from your doctor may be required for Specialist visits.**
Preventive care	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.

Premiums and benefits	You pay	What you should know
Emergency care	$85 copay per visit $25,000 combined annual limit for emergency care and urgently needed services outside the United States and its territories every year. 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.
Urgently needed services	$15 copay per visit $85 copay for each visit to an emergency room, urgent care center, or physician office that is outside of the United States and its territories. $25,000 combined annual limit for emergency 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.	These copays are waived if you are admitted to a hospital within one day for the same condition. Worldwide coverage.
Diagnostic services, labs, and imaging		**A referral from your doctor may be required for diagnostic services, labs and imaging services.**
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$45 copay for each diagnostic radiology service	Covered according to Medicare guidelines.
• Lab services	$0 copay	
• Diagnostic tests and procedures	$0 copay	
• Outpatient X-rays	$0 copay	
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance for each therapeutic radiology service	While you pay 20% coinsurance for therapeutic radiology services, you will never pay more than your $3,400 total out-of-pocket maximum for the year.

Premiums and benefits	You pay	What you should know
Hearing services		**A referral from your doctor may be required for hearing services.**
• Hearing exam (Medicare covered)	$10 copay per visit	
• Routine (non-Medicare covered) hearing exam	$0 copay	Routine hearing exams are limited to one exam every year.
• Hearing aids		Our plan pays up to $350 for 2 hearing aids, hearing aid fitting and evaluation every year (both ears combined) when obtained from a network provider.
Dental services (non-Medicare covered)		
• Prophylaxis (cleaning)	$0 copay	One visit every 6 months.
• Dental X-rays	$0 - $5 copay, depending on the service/type	One series of bitewing X-rays every 6 months.
		One series of full mouth X-rays every 24 months.
• Fluoride treatment	$5 copay	Two visits every 12 months for fluoride treatment.
• Oral exam	$0 copay	
Vision services		
• Exam to diagnose and treat diseases and conditions of the eye	$0 copay for each Medicare-covered visit	**A referral from your doctor may be required for an exam to diagnose and treat diseases and conditions of the eye.**
• Routine eye exam and refraction	$0 copay per visit	One visit every 12 months with network provider.
• Eyeglasses (frames and lenses) or contact lenses	$0 copay	Our plan pays up to $125 for either eyeglasses (frames and lenses) or for contact lenses every 24 months.

Premiums and benefits	You pay	What you should know
Mental health services		
• Inpatient mental health care	$100 copay per day for days 1 - 8 $0 copay per day for days 9 - 90	**A referral from your doctor may be required for mental health services.**
• Outpatient group therapy visit	$25 copay per visit	90 days per benefit period; no prior hospitalization required with network provider.
• Outpatient individual therapy visit	$25 copay per visit	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.
Skilled nursing facility (SNF) care	$0 copay per day for days 1 - 20 $100 copay per day for days 21-100	**A referral from your doctor may be required for skilled nursing facility care.** 100 days per benefit period; no prior hospitalization required with network provider. 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.
Rehabilitation Services		
• Occupational therapy	$30 copay per visit	
• Physical therapy and speech and language therapy	$30 copay per visit	**A referral from your doctor may be required for rehabilitation services.**
Ambulance	$250 copay per trip (each way) $0 copay if admitted	
Transportation	$0 copay	Limited to 12 one-way trips to plan-approved health-related locations every 12 months.
Medicare Part B Drugs	20% coinsurance for chemotherapy/radiation drugs and other Part B drugs	Some Part B drugs may require a prior authorization from your provider.

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	
Additional telehealth services	$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions, and can also prescribe certain medication.
Foot care (podiatry services)		**A referral from your doctor may be required for foot care services.**
• Foot exams and treatment	$25 copay for each Medicare-covered visit	
• Routine (non-Medicare covered) foot care	$25 copay per visit	
Diabetic Supplies & Services		**A referral from your doctor may be required for diabetic supplies & services.**
• Blood glucose monitors	$0 copay for FreeStyle® blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers	Prior authorization from the plan may be required for durable medical equipment, blood glucose monitors and test strips.
• Diabetes self- management training, diabetic services and supplies	$0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	See the plan EOC for more information.
Durable Medical Equipment (DME) and Related Supplies		**A referral from your doctor may be required for DME and related supplies.**
• Durable medical equipment (e.g., wheelchairs, oxygen	20% coinsurance	Prior authorization from the plan may be required for DME.
		See the plan EOC for more information.
Prosthetics/Medical Supplies		**A referral from your doctor may be required for prosthetics/ medical supplies.**
• Prosthetics (e.g., braces, artificial limbs)	20% coinsurance	
• Medical supplies (e.g., splints, casts)	$0 copay	
Health and Wellness programs		
• Basic gym access through SilverSneakers Fitness	$0 copay	
• NurseHelp 24/7SM (telephone and online support)	$0 copay	

Premiums and benefits	You pay	What you should know
Over-the-Counter (OTC) Items	You have a $50 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 catalog for more information.

Prescription drug coverage

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You pay the following:

Part D prescription drug benefit						
Stage 1: Annual Deductible Stage	You pay $200 (Tier 1 and Tier 2 excluded)					
Stage 2: Initial Coverage Stage	**Preferred retail cost-sharing (in-network)**			**Standard retail cost-sharing (in-network)^**		
	30-day supply	**90-day supply*NDS**	**100-day supplyNDS**	**30-day supply**	**90-day supplyNDS**	**100-day supplyNDS**
Tier 1: Preferred Generic Drugs	$0 copay	See 100-day supply	$0 copay	$3 copay	See 100-day supply	$3 copay
Tier 2: Generic Drugs	$5 copay	$12.50 copay	Not Covered	$12 copay	$30 copay	Not Covered
Tier 3: Preferred Brand Drugs	$40 copay	$100 copay	Not Covered	$47 copay	$117.50 copay	Not Covered
Tier 4: Non-Preferred Drugs	$95 copay	$237.50 copay	Not Covered	$100 copay	$250 copay	Not Covered
Tier 5: Specialty Tier Drugs	29% coinsurance	Not Covered	Not Covered	29% coinsurance	Not Covered	Not Covered

^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.

*90- and 100-day supply cost-sharing also applies to Blue Shield's mail service pharmacy.

NDS A long-term (up to a 90- or 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.

Part D prescription drug benefit		
Stage 3: Coverage Gap Stage	Coverage for outpatient prescription drugs after the total yearly drug costs paid by both you and Blue Shield reach $4,430, until your yearly out-of-pocket drug costs reach $7,050	Tier 1: Preferred Generic Drugs and Tier 2: Generic Drugs are covered at the copays described above. For all other tiers, you pay 25% of the price for brand-name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs until your year-to-date out- of-pocket drug costs total $7,050, which is the end of the coverage gap stage. Whether a drug is considered generic or brand can be determined using the plan formulary.
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through mail service) reach $7,050, you pay the greater of: • 5% of the cost, or • $3.95 copay for a generic drug (including brand-name drugs treated as generic) and a $9.85 copay for all other drugs (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- or 100-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. Sign up at caremark.com or call (866) 346-7200 [TTY: 711].

Tier 5 drugs are limited to a 30-day supply by mail 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) 932-7948 [TTY: 711]
- Costco‡ (800) 955-2292 [TTY: 711]
- Ralphs‡, Walmart‡ and many more.

You do not have to be a Costco member to use Costco Pharmacies.
‡Accepts e-prescribing

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, year round.

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 very limited lower-cost, preferred pharmacies in Santa Clara and Merced County, 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 preferred pharmacies in your area, please call (800) 776-4466 [TTY: 711], 8 a.m. to 8 p.m., seven days a week, year round or consult the online pharmacy directory at blueshieldca.com/medpharmacy2022.

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California cumple con las leyes estatales y las leyes federales de derechos civiles vigentes, y no discrimina por motivos de raza, color, país de origen, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad.

Blue Shield of California 遵循適用的州法律和聯邦公民權利法律，並且不以種族、膚色、原國籍、血統、宗教、性別、婚姻 狀況、性別認同、性取向、年齡或殘障爲由而進行歧視。

Blue Shield of California is an independent member of the Blue Shield Association MA050-SOB-SCME-1021