Effective January 1, 2022 – December 31, 2022

2022 Summary of Benefits

Blue Shield TotalDual Plan (HMO D-SNP)

Medicare Advantage Prescription Drug Plan

Los Angeles, Orange, San Bernardino and San Diego Counties

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blueshieldca.com/medicare

H5928_21_374D_005_M Accepted 09012021

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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 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, be eligible for Medi-Cal (Medicaid), and live in our service area. **Our service area includes Los Angeles, Orange, San Bernardino, and San Diego 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 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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Los Angeles, Orange, San Bernardino and San Diego Counties

Premiums and benefits	You pay	What you should know
Monthly plan premium	$33.20	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	$6,700	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	$1,556 deductible for each benefit period Days 1-60: $0 coinsurance Days 61-90: $389 coinsurance per day Days 91-150: $778 coinsurance per each lifetime reserve day after day 90 (up to 60 days over your lifetime)	
Outpatient hospital services • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	20% coinsurance for each visit to an outpatient hospital facility or an emergency room $0 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.
Outpatient surgery	20% coinsurance for each visit to an ambulatory surgical center and outpatient hospital facility	
Doctor visits • Primary care physician • Specialists	 $0 copay per visit $0 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	20% coinsurance No 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 for emergency care and worldwide emergency coverage if you are admitted to a hospital within one day of the same condition. Worldwide coverage.
Urgently needed services	20% coinsurance No 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 for emergency care and worldwide emergency coverage if you are admitted to a hospital within one day of 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.)	20% coinsurance for each diagnostic radiology service	Covered according to Medicare guidelines.
• Lab services	$0 copay	
• Diagnostic tests and procedures	20% coinsurance	
• Outpatient X-rays	20% coinsurance	
• 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 $6,700 total out- of-pocket maximum for the year.
Hearing services		**A referral from your doctor may be required for hearing services.**
• Hearing exam (Medicare covered)	20% coinsurance 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 $2,000 for 2 hearing aids, hearing aid fitting and evaluation every year (both ears combined) when obtained from a network provider.

Premiums and benefits	You pay	What you should know
Dental services (non-Medicare covered)		
• Prophylaxis (cleaning)	$0 copay	One visit every 6 months.
• Dental X-rays	$0 copay	One series of bitewing X-rays every 6 months. One series of full mouth X-rays every 24 months.
• Fluoride treatment	$0 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	20% coinsurance 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 a network provider.
• Eyeglasses (lenses and frames) or contact lenses	$0 copay	Our plan pays up to $300 for either eyeglasses (frames and lenses) or for contact lenses every 12 months when obtained from a network provider.
Mental health services		**A referral from your doctor may be required for mental health services.**
• Inpatient mental health care	$1,556 deductible for each benefit period Days 1-60: $0 coinsurance Days 61-90: $389 coinsurance per day Days 91-150: $778 coinsurance per each lifetime reserve day after day 90 (up to 60 days over your lifetime)	150 days per benefit period, up to the 190-day limit. 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.
• Outpatient group therapy visit	20% coinsurance per visit	
• Outpatient individual therapy visit	20% coinsurance per visit	

Premiums and benefits	You pay	What you should know
Skilled nursing facility (SNF) care	$0 copay per day for days 1 - 20 $194.50 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 • Physical therapy and speech and language therapy	 20% coinsurance per visit 20% coinsurance per visit	**A referral from your doctor may be required for rehabilitation services.**
Ambulance	20% coinsurance per trip (each way)	
Transportation	$0 copay	Unlimited 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	20% coinsurance for each Medicare-covered visit	
• Routine (non-Medicare covered) foot care	$0 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)	20% coinsurance	

Premiums and benefits	You pay	What you should know
Health and Wellness programs		
• Basic gym access through SilverSneakers Fitness	$0 copay	
• NurseHelp 24/7℠ (telephone and online support)	$0 copay	
• Personal Emergency Response System (PERS) (24/7 medical alert)	$0 copay	
Over-the-Counter (OTC) Items	You have a $200 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.
Acupuncture (non Medicare-covered)	$0 copay per visit	Limited to 24 visits per year.
Routine (non-Medicare covered) chiropractic services	$0 copay per visit	Limited to 24 visits per year.

You pay the following:

Part D prescription drug benefit			
Stage 1: Annual Deductible Stage	You pay $480 (Tier 1 excluded)		
Stage 2: Initial Coverage Stage	**Standard retail cost-sharing (in-network)^**		
	30-day supply	**90-day supply[NDS]**	**100-day supply[NDS]**
Tier 1: Preferred Generic Drugs	$0 copay	See 100-day supply	$0 copay
Tier 2: Generic Drugs	25% coinsurance	25% coinsurance	Not Covered
Tier 3: Preferred Brand Drugs	25% coinsurance	25% coinsurance	Not Covered
Tier 4: Non-Preferred Drugs	25% coinsurance	25% coinsurance	Not Covered
Tier 5: Specialty Tier Drugs	25% 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.

Prescription drug coverage

(cont'd)

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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 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.

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, 8am to 5 pm PST, excluding holidays.

Benefit/Service	Medi-Cal	Blue Shield TotalDual or Inspire Plan (HMO D-SNP)
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

Benefit/Service	Medi-Cal	Blue Shield TotalDual or Inspire Plan (HMO D-SNP)
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
Outpatient clinic services	Covered	Covered
Outpatient detox services	Covered	Covered
Outpatient mental health	Covered	Covered
Over-the-counter (OTC) items	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, year round.

Blue Shield of California is an HMO and 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.

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。

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