

2023 Summary of Benefits

Blue Shield AdvantageOptimum Plan 1 (HMO)

Medicare Advantage Prescription Drug Plan

San Diego County

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Blue Shield AdvantageOptimum Plan 1

San Diego County

Effective January 1, 2023 – December 31, 2023

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/MAPDdocuments2023 or by calling Customer Care at **(800) 776-4466** [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, 2022.**

Blue Shield AdvantageOptimum Plan 1 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 1**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. **Our service area includes San Diego 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 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/medpharmacy2023.

To get the most complete and current information about which drugs are covered, you can visit our website at blueshieldca.com/medformulary2023.

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San Diego County

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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	No deductible	
Annual out-of-pocket maximum amount	\$3,500	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	\$125 copay per day for days 1 - 7 \$0 copay per day for days 8 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	\$200 copay for each visit to an outpatient hospital facility \$0 copay for observation services \$125 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	\$50 copay for each visit to an ambulatory surgical center \$200 copay for each visit to an 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.

Summary of benefits (cont'd)

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Emergency care	<p>\$125 copay per visit</p> <p>\$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.</p>	<p>This copay is waived if you are admitted to the hospital within one day for the same condition.</p> <p>Worldwide coverage.</p>
Urgently needed services	<p>\$0 copay for each visit to an urgent care center within plan service area.</p> <p>\$25 copay for each visit to an urgent care center outside of the plan service area but within the United States and its territories.</p> <p>\$125 copay worldwide emergency/urgent coverage.</p> <p>\$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.</p>	<p>This copay is waived if you are admitted to the hospital within one day for the same condition.</p> <p>Worldwide coverage.</p>

Summary of benefits (cont'd)

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Diagnostic services, labs, and imaging <ul style="list-style-type: none"> • 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) 	\$20 copay \$0 copay \$0 copay \$0 copay 20% coinsurance for each therapeutic radiology service	<p>A referral from your doctor may be required for diagnostic services, labs and imaging services.</p> <p>Covered according to Medicare guidelines.</p> <p>While you pay 20% coinsurance for therapeutic radiology services, you will never pay more than your \$3,500 total out-of-pocket maximum for the year.</p>
Hearing services <ul style="list-style-type: none"> • Hearing exam (Medicare-covered) • Routine (non-Medicare covered) hearing exam • Hearing aids 	\$10 copay per visit \$10 copay \$0 copay	<p>A referral from your doctor may be required for hearing services.</p> <p>Routine hearing exams are limited to one exam every year.</p> <p>Our plan pays up to \$600 for 2 hearing aids, hearing aid fitting and evaluation every year (both ears combined).</p>
Dental services (non-Medicare covered) <ul style="list-style-type: none"> • Prophylaxis (cleaning) • Dental X-rays • Fluoride • Oral exam 	\$0 copay \$0 - \$5 copay, depending on the service provided \$5 copay \$0 copay	<p>One visit every 6 months.</p> <p>One series of bitewing X-rays every 6 months.</p> <p>One series of full mouth X-rays every 24 months.</p> <p>Two visits per calendar year for fluoride.</p> <p>Two exams in 12 months.</p>

Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
Vision services <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 Eyeglasses (frames and lenses) or contact lenses 	<p>\$0 copay for each Medicare-covered visit</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>A referral from your doctor may be required for an exam to diagnose and treat diseases and conditions of the eye.</p> <p>One visit every 12 months with network provider.</p> <p>Our plan pays up to \$290 for either eyeglasses (lenses and frames) or for contact lenses every 12 months.</p>
Mental health services <ul style="list-style-type: none"> Inpatient mental health care Outpatient group therapy visit Outpatient individual therapy visit 	<p>\$200 copay per day for days 1 - 8</p> <p>\$0 copay per day for days 9 - 90</p> <p>\$20 copay per visit</p> <p>\$20 copay per visit</p>	<p>A referral from your doctor may be required for mental health services.</p> <p>90 days per admission; no prior hospitalization required with network provider.</p>
Skilled nursing facility (SNF) care	<p>\$0 copay per day for days 1 - 20</p> <p>\$140 copay per day for days 21-100</p>	<p>A referral from your doctor may be required for skilled nursing facility care.</p> <p>100 days per admission; no prior hospitalization required with network provider.</p> <p>If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.</p>
Rehabilitation Services <ul style="list-style-type: none"> Occupational therapy Physical therapy and speech and language therapy 	<p>\$0 copay per visit</p> <p>\$0 copay per visit</p>	<p>A referral from your doctor may be required for rehabilitation services.</p>

Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
Ambulance	Medicare-covered ground ambulance services: \$200 copay per trip (each way) Medicare-covered air ambulance services: 20% per trip (each way)	This copay is waived if you are admitted to the hospital
Transportation	\$0 copay	Limited to 30 one-way trips to plan-approved health-related locations per year.
Medicare Part B Drugs	20% coinsurance	Some Part B drugs may require a prior authorization from your provider.

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	
Additional telehealth services	\$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication.
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	A referral from your doctor may be required for foot care services.
Diabetic Supplies & 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)	A referral from your doctor may be required for diabetic supplies & services. Prior authorization from the plan may be required for durable medical equipment, blood glucose monitors and test strips. See the plan EOC for more information.
Durable Medical Equipment (DME) and Related Supplies <ul style="list-style-type: none"> • Durable medical equipment (e.g., wheelchairs, oxygen) 	20% coinsurance	A referral from your doctor may be required for DME and related supplies. Prior authorization from the plan may be required for DME. See the plan EOC for more information.
Prosthetics/Medical Supplies <ul style="list-style-type: none"> • Prosthetics (e.g., braces, artificial limbs) • Medical supplies (e.g., splints, casts) 	20% coinsurance \$0 copay	A referral from your doctor may be required for prosthetics/medical supplies.

Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
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) 	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>	
Over-the-Counter (OTC) Items	<p>You have a \$105 allowance per quarter to spend on covered items</p>	<p>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.</p>

Important Message About What You Pay for Vaccines: Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information.

Important Message About What You Pay for Insulin: You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

You may pay up to 20% coinsurance for select Medicare Part B drugs, which can change each quarter as established by CMS. Beginning April 1, 2023, coinsurance for select Part B rebatable drugs will be reduced, if the drug's price has increased at a rate faster than the rate of inflation. The list of Part B rebatable drugs as well as the coinsurance amount for those drugs could change each quarter, as established by CMS.

Prescription drug coverage

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You pay the following:

Part D prescription drug benefit						
Stage 1: Annual Deductible Stage	This stage does not apply because there is no deductible.					
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 supply^{NDS}	30-day supply	90-day supply^{NDS}	100-day supply^{NDS}
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	\$10 copay	\$25 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	33% coinsurance	Not Covered	Not Covered	33% 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 \$4,660, until your yearly out-of-pocket drug costs reach \$7,400.	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 \$7,400, 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 \$7,400, you pay the greater of: <ul style="list-style-type: none"> • 5% of the cost, or • \$4.15 copay for a generic drug (including brand-name drugs treated as generic) and a \$10.35 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 can get a 90- or 100-day supply of maintenance drugs at a lower cost share. Your order will be delivered to your home or office with no charge for standard shipping. After enrolling in your Blue Shield Medicare plan, you can log in to your Blue Shield of California member account at blueshieldca.com/login. 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. Other pharmacies are available in our network.

[‡]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.

Blue Shield of California is an HMO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.

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