Effective January 1, 2023 – December 31, 2023

2023 Summary of Benefits

Blue Shield AdvantageOptimum Plan (HMO)

Medicare Advantage Prescription Drug Plan

Los Angeles and Orange Counties

blue california

blueshieldca.com/medicare

H5928_22_532B_004_M Accepted 09052022

2023 Summary of Benefits
Blue Shield AdvantageOptimum Plan
Los Angeles and Orange Counties

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 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 Los Angeles County and Orange 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.**

Summary of benefits

Effective January 1, 2023 - December 31, 2023

Blue Shield AdvantageOptimum Plan (HMO)
Los Angeles and Orange Counties

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	$1,200	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	$0 copay per admission	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	$100 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	$0 copay for each visit to an ambulatory surgical center $100 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.

Premiums and benefits	You pay	What you should know
Emergency care	$125 copay per visit 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 if you are admitted to the hospital within one day for the same condition. Worldwide coverage.
Urgently needed services	$0 copay for each visit to an urgent care center within plan service area. $45 copay for each visit to an urgent care center outside of the plan service area but within the United States and its territories $125 copay for worldwide emergency/urgent coverage No combined annual limit for emergency care and urgently needed services outside the United States and its territories	This copay is waived if you are admitted to the 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.)	$0 copay	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 $1,200 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	$10 copay	Routine hearing exams are limited to one exam every year.
• Hearing aids	$0 copay	Our plan pays up to $1,500 for 2 hearing aids, hearing aid fitting and evaluation every year (both ears combined)
Dental services (non-Medicare covered)		
• Prophylaxis (cleaning)	$0 copay	One cleaning every 6 months.
• Dental X-rays	$0 - $5 copay, depending on the service provided	One series of bitewing X-rays every 6 months. One series of full mouth X-rays every 24 months.
• Fluoride	$5 copay	Two visits every 6 months for fluoride.
• Oral exam	$0 copay	Two exams in a calendar year
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 (non-Medicare covered) eye exam and refraction	$0 copay	One visit every 12 months with network provider.
• Eyeglasses (frames and lenses) or contact lenses	$0 copay	Our plan pays up to $275 for either eyeglasses (lenses and frames) or for contact lenses every 12 months.
Mental health services		**A referral from your doctor may be required for mental health services.**
• Inpatient mental health care	$100 copay per day for days 1 - 8 $0 copay per day for days 9 – 90	90 days per admission; no prior hospitalization required with network provider.
• Outpatient group therapy visit	$25 copay per visit	
• Outpatient individual therapy visit	$25 copay per visit	

Premiums and benefits	You pay	What you should know
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 admission; no prior hospitalization required with network provider. If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.
Rehabilitation Services • Occupational therapy • Physical therapy and speech and language therapy	 $10 copay per visit $10 copay per visit	**A referral from your doctor may be required for rehabilitation services.**
Ambulance	Medicare-covered ground ambulance services: $200 copay per trip (each way) Medicare-covered air ambulance services: 20% per trip (each way)	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 every year.
Medicare Part B Drugs	20% coinsurance	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	$0 copay for each Medicare-covered visit	
• Routine (non-Medicare covered) foot care	$0 copay	
Diabetic Supplies & Services		**A referral from your doctor may be required for diabetic supplies & services.** Prior authorization from the plan may be required for blood glucose monitors and test strips. See the plan EOC for more information.
• Blood glucose monitors	$0 copay for FreeStyle® blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers	
• 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)	
Durable Medical Equipment (DME) and Related Supplies		**A referral from your doctor may be required for durable supplies & services.** Prior authorization from the plan may be required for DME. See the plan EOC for more information.
• Durable medical equipment (e.g., wheelchairs, oxygen)	20% coinsurance	
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	

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	
Acupuncture (non Medicare-covered)	$0 copay per visit	Limited to 12 visits per year.
Over-the-Counter (OTC) Items	You have a $105 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.

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.

Prescription drug coverage

Effective January 1, 2023 - December 31, 2023

Blue Shield AdvantageOptimum Plan (HMO)
Los Angeles and Orange Counties

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 supplyNDS**	**30-day supply**	**90-day supplyNDS**	**100-day supplyNDS**
Tier 1: Preferred Generic Drugs	$0 copay	See 100-day supply	$0 copay	$5 copay	See 100-day supply	$5 copay
Tier 2: Generic Drugs	$3 copay	$7.50 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.

Prescription drug coverage

(cont'd)

Effective January 1, 2023 - December 31, 2023

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: • 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 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. Other pharmacies are available in our network.

‡Accepts e-prescribing