Effective January 1, 2021 – December 31, 2021

2021 Summary of Benefits

Blue Shield AdvantageOptimum Plan 2 (HMO)

Medicare Advantage Prescription Drug Plan

San Diego County

blue california

blueshieldca.com/medicare

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Blue Shield AdvantageOptimum
Plan 2 (HMO)
San Diego 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.
Part B premium buy-down		This plan will reduce your monthly Part B premium by $50 per month. This reduction is set up by Medicare and administered through the Social Security Administration (SSA). Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Reductions may take several months to be issued; however, you will receive a full credit.
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	$120 copay per day for days 1 - 5 $0 copay 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	$150 copay for each visit to an outpatient hospital facility $0 copay for observation services $120 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 $150 copay for each visit to an outpatient hospital facility	

Premiums and benefits	You pay	What you should know
Doctor visits • Primary care physician • Specialists	 $0 copay per visit $10 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.
Emergency care	$120 copay per visit $10,000 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	$10 copay for each visit $120 copay for each visit to an emergency room, urgent care center, or physician office that is outside of the United States and its territories. $10,000 combined annual limit for emergency/urgent 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.

Premiums and benefits	You pay	What you should know
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.)	$5 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.
Hearing services		**A referral from your doctor may be required for hearing services.**
• Hearing exam (Medicare-covered)	$0 copay per visit if performed at your PCP's office	
• Routine (non-Medicare covered) hearing exam	$10 copay per visit if performed at a specialist's office	
Dental services		
• 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	$10 copay per visit	**A referral from your doctor may be required for an exam and treat diseases and conditions of the eye.**
• Routine eye exam and refraction	$10 copay	One visit every 12 months with network provider.
• Eyeglasses (frames and lenses) or contact lenses	$0 copay	Our plan pays up to $75 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	For each Medicare-covered stay you pay $250 **plus**: $120 copay per day for days 1 - 10 $0 copay per day for days 11 - 90	**A referral from your doctor may be required for mental health services.** 90 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.
• Outpatient group therapy visit	$20 copay per visit	
• Outpatient individual therapy visit	$20 copay per visit	
Skilled nursing facility (SNF) care	$20 copay per day for days 1 - 20 $75 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 do into the hospital after one benefit period has ended, a new benefit period begins.
Rehabilitation Services		
• Occupational therapy	$0 copay per visit	**A referral from your doctor may be required for rehabilitation services.**
• Physical therapy and speech and language therapy	$0 copay per visit	
Ambulance	$100 copay per trip (each way)	
Transportation	Not covered	
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	
Foot care (podiatry services) • Foot exams and treatment	$10 copay for each Medicare-covered visit	**A referral from your doctor may be required for foot care services.**
Diabetic Supplies & Services •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 • 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 • 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.**
Health and Wellness programs • NurseHelp 24/7℠ (telephone and online support)	$0 copay	

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	$3 copay	See 100-day supply	$3 copay
Tier 2: Generic Drugs	$10 copay	$25 copay	Not Covered	$17 copay	$42.50 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 $4,130, until your yearly out-of-pocket drug costs reach $6,550	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 $6,550, 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 $6,550, you pay the greater of: • 5% of the cost, or • $3.70 copay for a generic drug (including brand-name drugs treated as generic) and a $9.20 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