

2021 Summary of Benefits

Blue Shield AdvantageOptimum Plan (HMO)

Medicare Advantage Prescription Drug Plan

Santa Clara County

Summary of benefits

January 1, 2021 - December 31, 2021

Blue Shield AdvantageOptimum
Plan (HMO)
Santa Clara County

Premiums and benefits	You pay	What you should know
Monthly plan premium	\$48	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	\$175 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 <ul style="list-style-type: none"> • 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 \$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	\$50 copay for each visit to an ambulatory surgical center \$150 copay for each visit to an outpatient hospital facility	
Doctor visits <ul style="list-style-type: none"> • Primary care physician • Specialists 	\$0 copay per visit \$5 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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Premiums and benefits	You pay	What you should know
<p>Emergency care</p>	<p>\$85 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 a hospital within one day for the same condition.</p> <p>Worldwide coverage.</p>
<p>Urgently needed services</p>	<p>\$15 copay for each in-network urgent care visit</p> <p>\$25 copay for each out-of-network urgent care visit</p> <p>\$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.</p> <p>\$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.</p>	<p>These copays are waived if you are admitted to a hospital within one day for the same condition.</p> <p>Worldwide coverage.</p>
<p>Diagnostic services, labs, and imaging</p> <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) 	<p>\$25 copay for each diagnostic radiology service</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>20% coinsurance for each therapeutic radiology service</p>	<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 \$3,400 total out-of-pocket maximum for the year.</p>

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Hearing services <ul style="list-style-type: none"> Hearing exam (Medicare-covered) Routine (non-Medicare covered) hearing exam Hearing aids 	<p>\$10 copay per visit</p> <p>\$10 copay</p> <p>\$0 copay</p>	<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 \$350 for up to 2 hearing aids every year (both ears combined) when obtained from a network provider.</p>
Dental services <ul style="list-style-type: none"> Prophylaxis (cleaning) Dental X-rays Fluoride treatment Oral exam 	<p>\$0 copay</p> <p>\$0 - \$5 copay, depending on the service/type</p> <p>\$5 copay</p> <p>\$0 copay</p>	<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 every 12 months for fluoride treatment.</p>
Vision services <ul style="list-style-type: none"> Exam to diagnose and treat diseases and conditions of the eye Routine eye exam and refraction Eyeglasses (frames and lenses) or contact lenses 	<p>\$0 copay for each Medicare-covered visit</p> <p>\$0 copay per visit</p> <p>\$0 copay</p>	<p>A referral from your doctor may be required for an exam 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 \$250 for either eyeglasses (frames and lenses) or for contact lenses every 12 months.</p>

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Premiums and benefits	You pay	What you should know
Mental health services <ul style="list-style-type: none"> Inpatient mental health care Outpatient group therapy visit Outpatient individual therapy visit 	\$100 copay per day for days 1 - 8 \$0 copay per day for days 9 - 90 \$25 copay per visit \$25 copay per visit	<p>A referral from your doctor may be required for mental health services.</p> <p>90 days per benefit period; no prior hospitalization required with network provider.</p> <p>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.</p> <p>If you go into the hospital after one benefit period has ended, a new benefit period begins.</p>
Skilled nursing facility (SNF) care	\$0 copay per day for days 1 - 20 \$50 copay per day for days 21-100	<p>A referral from your doctor may be required for skilled nursing facility care.</p> <p>100 days per benefit period; no prior hospitalization required with network provider.</p> <p>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.</p> <p>If you do into the hospital after one benefit period has ended, a new benefit period begins.</p>
Rehabilitation Services <ul style="list-style-type: none"> Occupational therapy Physical therapy and speech and language therapy 	\$10 copay per visit \$10 copay per visit	<p>A referral from your doctor may be required for rehabilitation services.</p>
Ambulance	\$150 copay per trip (each way)	
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.

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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 	\$5 copay for each Medicare-covered visit \$5 copay per visit	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	AA 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.
Health and Wellness programs <ul style="list-style-type: none"> • Basic gym access through SilverSneakers Fitness • NurseHelp 24/7SM (telephone and online support) 	\$0 copay \$0 copay	

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Over-the-Counter Items	You have a \$35 allowance per quarter to spend on covered items	You can place one order per quarter and cannot roll over your unused allowance into the next quarter.
Acupuncture (non Medicare-covered)	\$5 copay per visit	Limited to 15 visits per year
Routine chiropractic services (non Medicare-covered)	\$10 copay per visit	Limited to 15 visits per year.

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	\$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	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: <ul style="list-style-type: none"> • 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