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# 2024 Summary of Benefits

Blue Shield Advantage Optimum

Plan 1 (HMO)

Medicare Advantage Prescription Drug Plan  
for San Diego County

Effective January 1, 2024 – December 31, 2024

[blueshieldca.com/medicare](https://blueshieldca.com/medicare)

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# 2024 Summary of Benefits

## Blue Shield AdvantageOptimum Plan 1

### San Diego County

Effective January 1, 2024 – December 31, 2024

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/MAPDdocuments2024](https://blueshieldca.com/MAPDdocuments2024) or by calling Customer Service 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, 2023.**

**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](https://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/medicare/providerdirectory](https://blueshieldca.com/medicare/providerdirectory).

Our plan ***Pharmacy Directory*** is located on our website at [blueshieldca.com/medpharmacy2024](https://blueshieldca.com/medpharmacy2024).

To get the most complete and current information about which drugs are covered, you can visit our website at [blueshieldca.com/medformulary2024](https://blueshieldca.com/medformulary2024).

# Summary of benefits

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San Diego County

Effective January 1, 2024 - December 31, 2024

Premiums and benefits	You pay	What you should know
<b>Monthly plan premium</b>	\$0	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
<b>Health plan deductible</b>	\$0	
<b>Annual out-of-pocket maximum amount</b>	\$4,200	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.
<b>Inpatient hospital care</b>	\$295 copay per day for days 1 - 7 \$0 copay per day for days 8 and over	<b>Prior authorization and a referral from your doctor may be required for inpatient hospital care.</b> Our plan covers an unlimited number of days for a Medicare-covered inpatient hospital stay in a network hospital.
<b>Outpatient hospital services</b> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	\$350 copay for each visit to an outpatient hospital facility \$0 copay for observation services \$120 copay for each visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition)	<b>A referral and/or prior authorization may be required for outpatient hospital facility and observation services.</b> Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
<b>Outpatient surgery</b>	\$200 copay for each visit to an ambulatory surgical center \$350 copay for each visit to an outpatient hospital facility	<b>A referral and prior authorization from your doctor may be required.</b>
<b>Doctor visits</b> • Primary care physician • Specialists	\$0 copay per visit \$20 copay per visit	<b>A referral from your doctor may be required for Specialist visits.</b>

# Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
<b>Preventive care</b>	\$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
<b>Emergency care</b> <ul style="list-style-type: none"> <li>Worldwide coverage</li> </ul>	\$120 copay per visit \$25,000 combined annual limit for emergency care 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	This copay is waived if you are admitted to the hospital within one day for the same condition.
<b>Urgently needed services</b> <ul style="list-style-type: none"> <li>Worldwide coverage</li> </ul>	\$30 copay for each visit to an urgent care center within plan service area \$30 copay for each visit to an urgent care center outside of the plan service area but within the United States and its territories \$120 copay for each visit to an emergency room or urgent care center that is outside of the United States and its territories \$120 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories \$25,000 combined annual limit for emergency care and urgently needed services outside the United States and its territories	These copays are waived if you are admitted to the hospital within one day for the same condition.

# Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
<b>Diagnostic services, labs, and imaging</b> <ul style="list-style-type: none"> <li>• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)</li> <li>• Lab services</li> <li>• Diagnostic tests and procedures</li> <li>• Outpatient X-rays</li> <li>• Therapeutic radiology services (such as radiation treatment for cancer)</li> </ul>	\$60 copay for each diagnostic radiology service  \$0 copay \$0 copay  \$0 copay 20% coinsurance for each therapeutic radiology service	<b>A referral from your doctor may be required for diagnostic services, labs and imaging services.</b>  Covered according to Medicare guidelines.    While you pay 20% coinsurance for therapeutic radiology services, you will never pay more than your \$4,200 total out-of-pocket maximum for the year.
<b>Hearing services</b> <ul style="list-style-type: none"> <li>• Hearing exam (Medicare-covered)</li> <li>• Routine (non-Medicare covered) hearing exam</li> </ul>	\$0 copay per visit  \$0 copay per visit	<b>A referral from your doctor may be required for Medicare-covered hearing services.</b>
<b>Dental services (Medicare-covered)</b>	\$0 copay per visit if performed by your PCP  \$20 copay per visit if performed by a specialist	<b>A referral from your doctor may be required.</b>
<b>Dental services (non-Medicare covered)</b> <ul style="list-style-type: none"> <li>• Prophylaxis (cleaning)</li> <li>• Dental X-rays</li> <li>• Fluoride</li> <li>• Oral exam</li> </ul>	\$0 copay \$0 - \$5 copay, depending on the service provided   \$5 copay \$0 copay	One visit cleaning 6 months. One series of bitewing X-rays every 6 months. One series of full mouth X-rays every 24 months. One visit every 6 months. Unlimited.

# Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
<b>Vision services</b> <ul style="list-style-type: none"> <li>• Exam to diagnose and treat diseases and conditions of the eye</li> <li>• Routine (non-Medicare covered) eye exam and refraction</li> <li>• Eyeglass frames</li> <li>• Eyeglass lenses or contact lenses</li> </ul>	<p>\$20 copay for each Medicare-covered visit</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p><b>A referral from your doctor may be required for an exam to diagnose and treat diseases and conditions of the eye.</b></p> <p>One visit every 12 months with network provider.</p> <p>Our plan pays for one pair of eyeglass frames (priced up to a regular retail value of \$190) every 24 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p> <p>Our plan pays for either one pair of prescription eyeglass lenses (regardless of size of power) OR for contact lenses (priced up to \$190 for contact lens service and materials) every 12 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p>
<b>Mental health services</b> <ul style="list-style-type: none"> <li>• Inpatient services in a psychiatric hospital</li> <li>• Outpatient individual therapy visit</li> <li>• Outpatient group therapy visit</li> </ul>	<p>\$250 copay per day for days 1 - 8 \$0 copay per day for days 9 - 150</p> <p>\$30 copay per visit</p> <p>\$30 copay per visit</p>	<p><b>A referral and/or prior authorization from your doctor may be required for mental health services.</b></p> <p>If you go over the 150-day limit, you will be responsible for all costs. See the plan EOC for more information.</p>

# Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
<b>Skilled nursing facility (SNF) care</b>	\$0 copay per day for days 1 - 20 \$200 copay per day for days 21 - 100	<b>A referral and prior authorization from your doctor may be required for skilled nursing facility care.</b>  If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.
<b>Rehabilitation Services</b> • Occupational therapy • Physical therapy • Speech and language therapy	\$40 copay per visit \$40 copay per visit \$40 copay per visit	<b>A referral and prior authorization from your doctor may be required for rehabilitation services.</b>
<b>Ambulance services</b>	Medicare-covered ground ambulance services: \$275 copay per trip (each way)  Medicare-covered air ambulance services: 20% coinsurance per trip (each way)	
<b>Transportation services (non-Medicare covered)</b>	\$0 copay	Limited to 14 one-way trips to plan-approved health-related locations per year.
<b>Medicare Part B Prescription Drugs</b>	0% to 20% coinsurance	Some Part B drugs may require a prior authorization from your doctor.  Members may pay 0% to 20% coinsurance for select Medicare Part B drugs which can change each quarter as established by CMS.  Insulin obtained under Part B when taken with an insulin pump should not exceed a \$35 copay for a one-month supply.

# Summary of benefits (cont'd)

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## Additional benefits included in your plan

Premiums and benefits	You pay	What you should know
<b>Annual Physical Exam</b>	\$0 copay	One every 12 months.
<b>Opioid Treatment Program Services</b>	\$0 copay	<b>A referral and prior authorization from your doctor may be required for Opioid Treatment Program Services.</b>
<b>Additional telehealth services</b>	\$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication.
<b>Foot care (podiatry services)</b> <ul style="list-style-type: none"> <li>• Foot exams and treatment</li> <li>• Routine (non-Medicare covered) foot care</li> </ul>	\$20 copay for each Medicare-covered visit \$20 copay for each routine (non-Medicare covered) visit	<b>A referral from your doctor may be required for Medicare-covered foot care services.</b>
<b>Diabetic Supplies &amp; Services</b> <ul style="list-style-type: none"> <li>• Blood glucose monitors</li> <li>• Diabetes self-management training, diabetic services and supplies</li> </ul>	\$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)	Prior authorization from the plan may be required for diabetic supplies and services (including blood glucose monitors). See the plan EOC for more information.
<b>Durable Medical Equipment (DME) and Related Supplies</b> <ul style="list-style-type: none"> <li>• Durable medical equipment (e.g., wheelchairs, oxygen)</li> </ul>	20% coinsurance	Prior authorization from the plan may be required for DME. See the plan EOC for more information.



# Summary of benefits (cont'd)

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Premiums and benefits	You pay	What you should know
<b>Prosthetics/Medical Supplies</b> <ul style="list-style-type: none"> <li>• Prosthetics (e.g., braces, artificial limbs)</li> <li>• Medical supplies (e.g., splints, casts)</li> </ul>	20% coinsurance  \$0 copay	<b>Prior authorization from your doctor may be required for prosthetics/medical supplies.</b>
<b>Health and Wellness programs</b> <ul style="list-style-type: none"> <li>• Basic gym access through SilverSneakers Fitness</li> <li>• NurseHelp 24/7<sup>SM</sup> (telephone and online support)</li> </ul>	\$0 copay  \$0 copay	
<b>Over-the-Counter (OTC) Items</b>	You have a \$65 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.

# Prescription drug coverage

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## You pay the following:

Part D prescription drug benefit						
<b>Stage 1: Annual Deductible Stage</b>	This stage does not apply because there is no deductible.					
<b>Stage 2: Initial Coverage Stage</b>	<b>Preferred retail cost-sharing (in-network)</b>			<b>Standard retail cost-sharing (in-network)<sup>^</sup></b>		
	<b>30-day supply</b>	<b>90-day supply<sup>*NDS</sup></b>	<b>100-day supply<sup>NDS</sup></b>	<b>30-day supply</b>	<b>90-day supply<sup>NDS</sup></b>	<b>100-day supply<sup>NDS</sup></b>
<b>Tier 1: Preferred Generic Drugs</b>	\$0 copay	See 100-day supply	\$0 copay	\$3 copay	See 100-day supply	\$3 copay
<b>Tier 2: Generic Drugs</b>	\$5 copay	\$12.50 copay	Not Covered	\$10 copay	\$25 copay	Not Covered
<b>Tier 3: Preferred Brand Drugs</b>	\$40 copay	\$100 copay	Not Covered	\$47 copay	\$117.50 copay	Not Covered
<b>Tier 3: Covered Insulins<sup>**</sup></b>	\$35 copay	\$100 copay	Not Covered	\$35 copay	\$105 copay	Not Covered
<b>Tier 4: Non-Preferred Drugs</b>	\$95 copay	\$237.50 copay	Not Covered	\$100 copay	\$250 copay	Not Covered
<b>Tier 4: Covered Insulins<sup>**</sup></b>	\$35 copay	\$105 copay	Not Covered	\$35 copay	\$105 copay	Not Covered
<b>Tier 5: Specialty Tier Drugs</b>	33% coinsurance	Not Covered	Not Covered	33% coinsurance	Not Covered	Not Covered

<sup>\*\*</sup> Covered Insulins are marked with the symbol INS on the drug list. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs (“Extra Help”).

<sup>^</sup>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.

<sup>\*</sup>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		
<b>Stage 3: Coverage Gap Stage</b>	Coverage for outpatient prescription drugs after the total yearly drug costs paid by both you and Blue Shield reach \$5,030, until your yearly out-of-pocket drug costs reach \$8,000.	Tier 1: Preferred Generic Drugs, Tier 2: Generic Drugs, Tier 3: Covered Insulins and Tier 4: Covered Insulins 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 \$8,000, which is the end of the coverage gap stage. Whether a drug is considered generic or brand can be determined using the plan formulary.
<b>Stage 4: Catastrophic Coverage Stage</b>	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through mail service) reach \$8,000, the plan pays the full cost for your covered Part D drugs.  (This stage <b>protects</b> you from any additional costs once you have paid your yearly out-of-pocket drug costs.)	

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

## 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. See plan EOC for more information.

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.**

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