



---

# 2024 Summary of Benefits

## Blue Shield Medicare (PPO)

Group Medicare Advantage Prescription Drug Plan for Santa Clara Valley Water District

Effective April 1, 2024 – March 31, 2025

## 2024 Summary of Benefits

### **Blue Shield Medicare (PPO)**

April 1, 2024 – March 31, 2025

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 contact your former employer group/union or call Blue Shield Medicare Customer Service at (800) 776-4466 [TTY: 711], 8 a.m. to 8 p.m., seven days a week.**

**Blue Shield Medicare** includes Medicare health care (Part C) and prescription drug (Part D) coverage offering you the convenience of having both your medical services and prescription drugs covered through one plan.

To join **Blue Shield Medicare** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, meet your former employer group/union's eligibility requirements, and live in our service area. Your Medicare-eligible dependents may also join Blue Shield Medicare they meet these requirements.

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 <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 service area includes all 50 states and the District of Columbia.**

**Look up providers, pharmacies and covered drugs on our website:**

- Provider Directory – [blueshieldca.com/medicare/providerdirectory](https://blueshieldca.com/medicare/providerdirectory)
- Pharmacy Directory – [blueshieldca.com/medpharmacy2024](https://blueshieldca.com/medpharmacy2024)
- Formulary (List of covered drugs) – [blueshieldca.com/medformulary2024](https://blueshieldca.com/medformulary2024)

## Summary of Benefits

Effective April 1, 2024 – March 31, 2025

You pay the following:

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<b>Monthly plan premium</b>	Your former employer group/union is responsible for paying premiums beyond your monthly Medicare Part B premium. If you are responsible for any contribution to the premiums, your benefits administrator will tell you the amount you and your former employer group/union contribute to the premium.		You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
<b>Annual out-of-pocket maximum amount</b>	\$2,000 for services you receive from both in- and out-of-network providers combined.		Does not include Part D prescription drugs. This is the most you would pay for the year for covered Medicare Parts A and B services.
<b>Health Plan Deductible</b>	\$0	\$0	
<b>Inpatient hospital care</b>	\$0 copay per admission	\$0 copay per admission	Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay.
<b>Outpatient hospital services</b> <ul style="list-style-type: none"> <li>Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery</li> </ul>	\$100 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)  \$0 copay for each visit to an outpatient hospital facility  \$0 copay for observation services	\$100 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)  \$0 copay for each visit to an outpatient hospital facility  \$0 copay for observation services	Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  Prior authorization may be required and is the responsibility of your provider.

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<b>Outpatient surgery</b>	\$0 copay for each visit to an ambulatory surgical center  \$0 copay for each visit to an outpatient hospital facility	\$0 copay for each visit to an ambulatory surgical center  \$0 copay for each visit to an outpatient hospital facility	Prior authorization may be required and is the responsibility of your provider.
<b>Doctor visits</b>	For all covered services:	For all covered services:	
<ul style="list-style-type: none"> <li>Physician of choice (POC)</li> </ul>	\$10 copay per visit	\$10 copay per visit	
<ul style="list-style-type: none"> <li>Specialists</li> </ul>	\$30 copay per visit	\$30 copay per visit	
<b>Preventive care</b>	\$0 copay	\$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
<b>Emergency care</b>	\$100 copay per visit		This copay is waived if you are admitted to a hospital within one day for the same condition.
<ul style="list-style-type: none"> <li><b>Worldwide coverage</b></li> </ul>	\$10,000 combined annual limit for covered emergency care and urgently needed services outside the United States and its territories		
<b>Urgently needed services</b>	\$10 copay for each visit to a network urgent care center within your plan service area		These copays are waived if you are admitted to the hospital within one day for the same condition.
<ul style="list-style-type: none"> <li><b>Worldwide coverage</b></li> </ul>	\$10 copay for each visit to an urgent care center outside your plan service area but within the United States and its territories		
	\$100 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories		
	\$100 copay for each visit to an emergency room, \$10 copay for urgent care center that is outside the United States and its territories		
	\$10,000 combined annual limit for covered emergency care and urgently needed services outside the United States and its territories		

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p><b>Diagnostic services, labs, and imaging</b></p> <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>	<p>\$0 copay for each diagnostic radiology service</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay for each therapeutic radiology service</p>	<p>\$0 copay for each diagnostic radiology service</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay for each therapeutic radiology service</p>	<p>Prior authorization may be required for diagnostic services and is the responsibility of your provider.</p>
<p><b>Hearing services</b></p> <ul style="list-style-type: none"> <li>• Hearing exam (Medicare covered)</li> <li>• Routine (non-Medicare covered) hearing exam</li> <li>• Hearing aids</li> </ul>	<p>\$30 copay per visit</p> <p>\$0 copay (limited to 1 exam per year)</p> <p>You will be reimbursed up to \$2,000 every 2 years for hearing aids</p>	<p>\$30 copay per visit</p> <p>\$0 copay (limited to 1 exam per year)</p> <p>You will be reimbursed up to \$2,000 every 2 years for hearing aids</p>	<p>Applies to both ears combined; cost of hearing aids does not apply to plan's maximum out-of-pocket limit.</p>

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p><b>Vision services</b></p> <ul style="list-style-type: none"> <li>Exam to diagnose and treat diseases and conditions of the eye</li> <li>One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens</li> </ul>	<p>\$10 copay for each Medicare-covered visit</p> <p>\$0 copay</p>	<p>\$10 copay for each Medicare-covered visit</p> <p>\$0 copay</p>	<p>Prior authorization may be required for an exam, treatment of diseases and conditions of the eye, and yearly glaucoma screenings and is the responsibility of your provider.</p>
<p><b>Mental health services</b></p> <ul style="list-style-type: none"> <li>Inpatient mental health care</li> <li>Outpatient group therapy visit</li> <li>Outpatient individual therapy visit</li> </ul>	<p>\$0 copay per stay for days 1 to 150</p> <p>100% of the cost for days 151 and over, unless a new benefit period begins.</p> <p>\$10 copay per visit</p> <p>\$10 copay per visit</p>	<p>\$0 copay per day for days 1 to 150</p> <p>100% of the cost for days 151 and over, unless a new benefit period begins.</p> <p>\$10 copay per visit</p> <p>\$10 copay per visit</p>	<p>Prior authorization may be required and is the responsibility of your provider.</p> <p>There is a 190-day lifetime limit in a Medicare-certified psychiatric hospital.</p>
<p><b>Skilled nursing facility (SNF) care</b></p>	<p>\$0 copay per day for days 1-100</p>	<p>\$0 copay per day for days 1-100</p>	<p>Prior authorization may be required and is the responsibility of your provider.</p> <p>If you go over the 100-day limit, you will be responsible for all cost; no prior hospitalization required with network provider.</p>

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<b>Rehabilitation services</b> <ul style="list-style-type: none"> <li>Occupational therapy services</li> <li>Physical therapy and speech</li> <li>Language therapy services</li> </ul>	\$10 copay per visit  10 copay per visit  \$10 copay per visit	\$10 copay per visit  \$10 copay per visit  \$10 copay per visit	
<b>Ambulance services</b>	\$100 copay for each Medicare-covered one way trip	\$100 copay for each Medicare-covered one way trip	
<b>Medicare Part B drugs</b>	\$0 copay	\$0 copay	Some Part B drugs may require a prior authorization from your provider. Insulin obtained under Part B (when taken with an insulin pump) should not exceed \$35 copay for a one-month supply.

## Summary of Benefits

Effective April 1, 2024 – March 31, 2025

## Additional benefits included in your plan

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<b>Annual physical exam</b>	\$0 copay	<b>\$0 copay</b>	One every 12 months.
<b>Opioid treatment program services</b>	\$0 copay	\$0 copay	Prior authorization may be required and is the responsibility of your provider.
<b>Foot care (podiatry services) (Medicare-covered)</b> <ul style="list-style-type: none"> <li>Foot exams and treatment</li> </ul>	\$10 copay for each Medicare-covered visit	\$10 copay for each Medicare-covered visit	
<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 ACCU-CHEK® blood glucose monitors and 20% coinsurance of Medicare-allowed amount for all other manufacturers  \$0 copay for all training services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	\$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance of Medicare-allowed amount for 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 diabetes supplies, services and self-management training and is the responsibility of your provider. 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	20% coinsurance	Prior authorization from the plan may be required. See the plan EOC for more information.

Premiums and benefits	In Network You Pay	Out-of-Network 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> </ul>	\$0 copay	\$0 copay	Prior authorization from your doctor may be required.
<b>Health and Wellness programs</b> <ul style="list-style-type: none"> <li>NurseHelp 24/7<sup>SM</sup> (telephone and online support)</li> <li>Basic gym access through SilverSneakers Fitness</li> <li>LifeReferrals 24/7 – Access to counselors, consultations, information and referrals for a wide range of family and personal issue</li> </ul>	\$0 copay	\$0 copay	

## Part D Prescription Drug Coverage

You pay the following:

<b>Annual Deductible Stage</b>	This stage does not apply because there is no deductible.
<b>Initial Coverage Stage</b>	You pay the following until you have paid \$8,000 out-of-pocket for Part D drugs.

<b>What you pay:</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>30-day supply<sup>*</sup></b>	<b>90-day supply<sup>NDS</sup></b>
<b>Tier 1: Generic Drugs</b>	\$10 copay	\$20 copay	\$10 copay	\$30 copay
<b>Tier 2: Preferred Brand Drugs</b>	\$15 copay	\$30 copay	\$15 copay	\$45 copay
<b>Tier 3: Non-Preferred Drugs</b>	\$30 copay	\$60 copay	\$30 copay	\$90 copay
<b>Tier 4: Specialty Tier Drugs</b>	20% coinsurance (up to a \$200 per prescription)	Not covered	20% coinsurance (up to a \$200 per prescription)	Not covered

\* Three-month supply preferred retail cost-sharing also applies to Blue Shield's mail service pharmacy, with the exception of Tier 4.

\*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>NDS</sup> A long-term (up to a 90-day) supply is not available for select drugs. The drugs that are not available for a long-term supply are marked with the symbol <sup>NDS</sup> in our Drug List.

For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC.

<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.

**Coverage Gap Stage**

Because there is no coverage gap for the plan, this payment stage does not apply to you.

**Catastrophic Coverage Stage**

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail service) reach \$8,000, the plan pays the full cost for your covered Part D drugs. For excluded drugs covered under our enhanced benefit, you pay the Tier 1: Generic Drugs copayments listed in the table shown above.

(This stage **protects** 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-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 4 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:

<b>CVS/pharmacy<sup>‡</sup></b> (including CVS pharmacy at Target)	(888) 607-4287 [TTY: 711]
<b>Safeway and Vons pharmacies</b>	(877) 723-3929 [TTY: 711]
<b>Albertsons/Sav-on/Osco pharmacies</b>	(877) 932-7948 [TTY: 711]
<b>Costco</b> (You do not have to be a member to use the pharmacy.)	(800) 955-2292 [TTY: 711]

**Ralphs, Walmart, and other pharmacies are also available in our network of pharmacies with preferred cost-sharing. You do not have to be a Costco member to use Costco pharmacies. Other pharmacies are available in our network.**

<sup>‡</sup>Accepts e-prescribing

Out-of-network/non-contracted providers are under no obligation to treat Blue Shield Medicare members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. Out-of-network/non-contracted providers who provide covered services to Blue Shield Medicare members will be paid according to the Medicare Fee Schedules.

Blue Shield of California is a PPO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal. Blue Shield of California offers individual and employer group retiree plans to Medicare beneficiaries who have Part A and Part B. Individual plans are open to all Medicare beneficiaries who reside within a plan's specific service area. Employer group retiree plans are open only to Medicare beneficiaries who are eligible group retirees and who reside within a plan's specific service area. Individual and employer group retiree plans have different service areas, benefits and provider networks.

Blue Shield Medicare and NurseHelp 24/7 are service marks of Blue Shield of California. Blue Shield and the Shield symbol are registered trademarks of the BlueCross BlueShield Association, an association of independent Blue Cross and Blue Shield plans.

SilverSneakers is a registered trademarks of Tivity Health, Inc. © 2023 Tivity Health, Inc. All rights reserved.

The company complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability, or physical disability. La compañía cumple con las leyes de derechos civiles federales y estatales aplicables, y no discrimina, ni excluye ni trata de manera diferente a las personas por su raza, color, país de origen, identificación con determinado grupo étnico, condición médica, información genética, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad, ni discapacidad física ni mental. 本公司遵守適用的州法律和聯邦民權法律，並且不會以種族、膚色、原國籍、族群認同、醫療狀況、遺傳資訊、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡、精神殘疾或身體殘疾而進行歧視、排斥或區別對待他人。

Blue Shield of California is an independent member of the Blue Shield Association  
MG00007-Santa Clara Valley Water District\_0424