2025 Summary of Benefits

Blue Shield 65 Plus (HMO)

Group Medicare Advantage Prescription Drug Plan for Self-Insured Schools of California

Effective October 1, 2025 – September 30, 2026

blueshieldca.com/medicare

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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 65 Plus Customer Service at (800) 776-4466** [TTY: **711**], 8 a.m. to 8 p.m. PT, seven days a week.

Blue Shield 65 Plus 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 65 Plus** 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 65 Plus if they meet these requirements.

Our service area includes the following counties in California:
Alameda County, Contra Costa County*, Kern County, Los Angeles County, Merced County, Nevada County*, Orange County, Riverside County, Santa Barbara County, San Bernardino County, San Diego County, San Francisco County, San Joaquin County, San Luis Obispo County, San Mateo County, Santa Clara County, Santa Cruz County and Stanislaus County.

*Denotes partial county. Refer to the ZIP code listing below for details on the partial county service area coverage.

Partial county service area zip code listing
Contra Costa County, the following ZIP codes only:
94506, 94507, 94526, 94528, 94583

Nevada County, the following ZIP codes only:
95602, 95712, 95924, 95945, 95946, 95949, 95959, 95960, 95975, 95977, 95986

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**.

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

- Provider Directory – **blueshieldca.com/fad/home**
- Pharmacy Directory – **blueshieldca.com/medpharmacy2025**

- Formulary (List of covered drugs) – **blueshieldca.com/medformulary2025**

Blue Shield of California's pharmacy network includes limited lower-cost pharmacies with preferred cost sharing in certain counties within California. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost pharmacies with preferred cost sharing in your area, please call Customer Service at (800) 776-4466 (TTY: 711), 8 a.m. to 8 p.m. PT, seven days a week, or consult the online pharmacy directory at **blueshieldca.com/medpharmacy2025**.

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You pay the following:

Premiums and Benefits	You Pay	What you should know
Monthly plan premium	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.
Deductible	$0	
Annual maximum out-of-pocket	$1,500	Does not include Part D prescription drugs. This is the most you would pay for the year for in-network covered Medicare Parts A and Part B services.
Inpatient hospital care	$0 copay per admission	Prior authorization and a referral from your provider may be required. 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	$0 copay for each visit to an outpatient hospital facility $0 copay for Medicare-covered observation services $50 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)	Prior authorization and/or a referral from your provider may be required. 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 $0 copay for each visit to an outpatient hospital facility	Prior authorization and a referral from your provider may be required.

Premiums and Benefits	You Pay	What you should know
Doctor visits • Primary care physician • Specialists	 $20 copay per visit $20 copay per visit	 A referral from your doctor may be required for Specialist visits.
Preventive services	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care Worldwide coverage.*	$50 copay per visit	This copay is waived if you are admitted to a hospital within one day for the same condition. $10,000 combined annual limit for covered emergency care and urgently needed services outside the United States and its territories. *Services do not apply to the plan's maximum out-of-pocket limit.
Urgently needed services Worldwide coverage.*	$20 copay for each visit to a network urgent care center within your plan service area $50 copay for each visit to an urgent care center outside of your plan service area but within the United States and its territories $50 copay for each visit to an emergency room outside of your plan service area but within the United States and its territories $50 copay for each visit to an emergency room or $50 for each visit to an urgent care center that is outside of the United States and its territories	These copays are waived if you are admitted to a hospital within one day for the same condition. $10,000 combined annual limit for covered emergency care and urgently needed services outside the United States and its territories. *Services do not apply to the plan's maximum out-of-pocket limit.

Premiums and Benefits	You Pay	What you should know
Diagnostic services, labs, and imaging • 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)	 $0 copay $0 copay $0 copay $0 copay $0 copay	Prior authorization and/or a referral from your provider may be required.
Hearing services • Hearing exam (Medicare-covered) • Routine (non-Medicare covered) hearing exam	 $20 copay per visit $20 copay per visit	**A referral from your doctor may be required for hearing services.**
Dental services • Non-routine dental care	 $20 copay per visit if performed by your PCP $20 copay per visit if performed by a specialist	This does not include services in connection with care, treatment, filling, removal, or replacement of teeth. A referral from your provider may be required.
Vision services • Exam to diagnose and treat diseases and conditions of the eye • Eyeglasses or contact lenses after cataract surgery	 $20 copay for each Medicare-covered visit $0 copay	Prior authorization and/or a referral from your provider may be required.

Premiums and Benefits	You Pay	What you should know
Mental health services • Inpatient services in a psychiatric hospital	For each Medicare-covered stay you pay: • $0 copay per stay for days 1 through 150 • 100% of the cost of the hospital for days 151 and over	Prior authorization and/or a referral from your provider may be required. You are covered for 150 days per benefit period, up to the 190-day lifetime limit. If you go over the 150-day limit, you will be responsible for all costs.
• Outpatient group therapy visit	$20 copay per visit	
• Outpatient individual therapy visit	$20 copay per visit	
Skilled nursing facility (SNF) care	$0 copay per day for days 1 - 100	Prior authorization and/or a referral from your provider may be required. If you go over the 100-day limit, you will be responsible for all costs.
Rehabilitation services • Cardiac (heart) rehabilitation services	$20 copay per visit	Prior authorization and/or a referral from your provider may be required.
• Occupational therapy services	$20 copay per visit	
• Physical therapy and speech and language therapy services	$20 copay per visit	
Ambulance services	$0 copay per trip (one way)	Prior authorization may be required and is the responsibility of your provider.
Medicare Part B prescription drugs	$20 copay when administered by your PCP or by a specialist.	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 a $35 copay for a one-month supply.

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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. *Services do not apply to the plan's maximum out-of-pocket limit.
Opioid treatment program services	$0 copay	Prior authorization and a referral from your provider may be required.
Foot care (podiatry services) • Foot exams and treatment	$20 copay for each Medicare-covered visit	A referral from your provider may be required.
Diabetic Supplies & Services • Blood glucose monitors • Diabetes self-management training, diabetic services and supplies	$0 copay for ACCU-CHEK monitors and 20% coinsurance for blood glucose monitors from all other manufacturers $0 copay for all training, services and supplies (except blood glucose monitors)	Prior authorization may be required and is the responsibility of your provider. See the plan EOC for more information.
Durable Medical Equipment (DME) and Related Supplies • Durable medical equipment (e.g., wheelchairs, oxygen)	$0 copay	Prior authorization may be required and is the responsibility of your provider. See the plan EOC for more information.
Prosthetic and orthotic devlces and related supplies • Prosthetic and orthotic devices (e.g., braces, artificial limbs) • Medical supplies (e.g., splints, casts)	$0 copay $0 copay	Prior authorization may be required and is the responsibility of your provider.

Premiums and Benefits	You Pay	What you should know
Health and Wellness programs*		*Services do not apply to the plan's maximum out-of-pocket limit.
• NurseHelp 24/7℠ (Telephone and online support)	$0 copay	
• LifeReferrals 24/7 – Access to counselors, consultations, information and referrals for a wide range of family and personal issue	$0 copay	

Part D Prescription Drug Coverage

Effective October 1, 2025 – September 30, 2026
You pay the following:

Annual Deductible Stage	This stage does not apply because there is no deductible.
Initial Coverage Stage	You pay the following until your total out-of-pocket Part D drug costs reach $2,000.

What you pay:	**Preferred retail cost-sharing (in-network)**		**Standard retail cost-sharing (in-network)^**	
	30-day supply	**100-day supply*NDS**	**30-day supply**	**100-day supply*NDS**
Tier 1: Generic Drugs	$10 copay	$20 copay	$10 copay	$30 copay
Tier 2: Preferred Brand Drugs	$30 copay	$60 copay	$30 copay	$90 copay
Tier 2: Covered Insulins**	$30 copay	$60 copay	$30 copay	$90 copay
Tier 3: Non-Preferred Drugs	$50 copay	$100 copay	$50 copay	$150 copay
Tier 4: Injectable Drugs	20% coinsurance (up to a $100 copay maximum)	20% coinsurance (up to a $300 copay maximum)	20% coinsurance (up to a $100 copay maximum)	20% coinsurance (up to a $300 copay maximum)
Tier 4: Covered Insulins**	$35 copay	$105 copay	$35 copay	$105 copay
Tier 5: Specialty Tier Drugs	20% coinsurance (up to a $100 copay maximum)	Not covered	20% coinsurance (up to a $100 copay maximum)	Not covered

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").
^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.
*****The 100-day supply preferred retail cost-sharing also applies to Amazon Pharmacy's home delivery services, with the exception of Tier 5: Specialty Tier Drugs.
NDS A long-term (up to a 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. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC.

Part D Prescription Drug Coverage (cont'd)

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Catastrophic Coverage Stage

After your yearly out-of-pocket costs for covered Part D drugs (including drugs purchased through your retail pharmacy and through home delivery) reach $2,000, the plan pays the full cost for your covered Part D drugs at no cost to you. For excluded drugs covered under our enhanced benefit, you pay the Tier 1: Generic Drugs copayments listed in the table on the previous page.

(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.

Home delivery service

Amazon Pharmacy is our network home delivery service pharmacy where you can get a 100-day supply of maintenance drugs at a lower cost share. Your order will be delivered with $0 shipping. If you have questions about this, please contact **Amazon Pharmacy at (856) 208-4665, 24 hours a day, 7 days a week. TTY users call 711.** See plan EOC for more information.

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) 276-9637 [TTY: 711]
Costco‡ (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	

‡Accepts e-prescribing

Blue Shield of California is an HMO 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.

Amazon Pharmacy is independent of Blue Shield of California and is contracted with Blue Shield to provide home delivery service of prescription medications to Blue Shield members.

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。

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