blue california

2025 Summary of Benefits

Blue Shield Medicare (PPO)

Group Medicare Advantage Prescription Drug Plan for CalPERS

Effective January 1, 2025 – December 31, 2025

H4937_24_540C1_M 10082024

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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 Medicare Customer Service** at **(888) 802-4599** [TTY: **711**], 7 a.m. to 8 p.m. PT, 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 if 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 **www.medicare.gov/medicare-and-you** 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/fad/home**
- Pharmacy Directory **–blueshieldca.com/calpers-retirees**
- Formulary (List of covered drugs) **–blueshieldca.com/calpers-retirees**

Blue Shield of California's pharmacy network includes limited lower-cost, pharmacies with preferred cost sharing. 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 (888) 802-4599 [TTY: 711], 7 a.m. to 8 p.m. PT, seven days a week, or consult the online pharmacy directory at **blueshieldca.com/calpers-retirees.**

You pay the following:

Premiums and benefits	In Network You Pay	Out-of-Network 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.
Annual out-of-pocket maximum amount	$1,500 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.
Health Plan Deductible	$0		
Inpatient hospital care	$0 copay per stay	$0 copay per stay	Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay. Prior authorization may be required and is the responsibility of your provider.
Outpatient hospital services • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	$50 copay for each visit to an emergency room (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	$50 copay for each visit to an emergency room (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
Outpatient surgery	$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
Doctor visits • Physician of choice (POC) • Specialists	For all covered services: $0 copay per visit $0 copay per visit	For all covered services: $0 copay per visit $0 copay per visit	A Physician of Choice (POC) is a doctor you would see regularly for your primary care.
Preventive care	$0 copay	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care Worldwide coverage.*	$50 copay per visit	$50 copay per visit	This copay is waived if you are admitted to a hospital within one day for the same condition. No 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	In Network You Pay	Out-of-Network You Pay	What you should know
Urgently needed services Worldwide coverage.*	$0 copay for each visit to a network urgent care center within your plan service area $0 copay for each visit to an urgent care center outside your plan service area $50 copay for each visit to an emergency room within your plan service area $50 copay for each visit to an emergency room outside your plan service area	$0 copay for each visit to an urgent care center within your plan service area $0 copay for each visit to an urgent care center outside your plan service area $50 copay for each visit to an emergency room within your plan service area $50 copay for each visit to an emergency room outside your plan service area	These copays are waived if you are admitted to the hospital within one day for the same condition. No 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.
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 for each diagnostic radiology service $0 copay $0 copay $0 copay $0 copay for each therapeutic radiology service	$0 copay for each diagnostic radiology service $0 copay $0 copay $0 copay $0 copay for each therapeutic radiology service	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
Hearing services • Hearing exam (Medicare covered)	$10 copay per visit	$10 copay per visit	*Services do not apply to the plan's maximum out-of-pocket limit.
• Routine (non-Medicare covered) hearing exam*	$0 copay (limited to 1 exam per year)	$0 copay (limited to 1 exam per year)	
• Hearing aids*	You will be reimbursed up to $1,000 every 3 years for 2 hearing aids and 2 hearing aid fittings and evaluations	You will be reimbursed up to $1,000 every 3 years for 2 hearing aids and 2 hearing aid fittings and evaluation	Applies to both ears combined. You may obtain these services at the hearing aid provider of your choice.
Dental services (Medicare covered)	$0 copay per visit when performed at a POC's office $0 copay per visit when performed at a specialist's office	$0 copay per visit when performed at a POC's office $0 copay per visit when performed at a specialist's office	

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Vision services			
• Exam to diagnose and treat diseases and conditions of the eye	$10 copay for each Medicare-covered visit	$10 copay for each Medicare-covered visit	Prior authorization may be required and is the responsibility of your provider
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens	$0 copay	$0 copay	
• Routine (non-Medicare covered) eye exam, including refraction*	$10 copay (limited to one exam every 12 months)	$10 copay (limited to one exam every 12 months)	See the "Optional Supplemental Dental and Vision PPO Plan" section for more information about dental and vision services for an additional plan premium. *Services do not apply to the plan's maximum out- of-pocket limit.
Mental health services			Prior authorization may be required and is the responsibility of your provider
• Inpatient services in a psychiatric hospital	$0 copay per stay for days 1 to 150 100% of the cost for days 151 and over	$0 copay per stay for days 1 to 150 100% of the cost for days 151 and over.	
• Outpatient group therapy visit	$0 copay per visit	$0 copay per visit	
• Outpatient individual therapy visit	$0 copay per visit	$0 copay per visit	

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Skilled nursing facility (SNF) care	$0 copay per day for days 1 - 100	$0 copay per day for days 1 - 100	Prior authorization may be required and is the responsibility of your provider If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.
Rehabilitation services • Occupational therapy • Physical therapy • Speech and language therapy	 $0 copay per visit $0 copay per visit $0 copay per visit	 $0 copay per visit $0 copay per visit $0 copay per visit	
Ambulance services	$0 copay per trip (one way)	$0 copay per trip (one way)	Prior authorization may be required and is the responsibility of your provider
Transportation services (non-Medicare covered)*	$0 copay for each one-way trip to plan-approved health-related locations (limited to 24 one-way trips (combined in- and out-of-network) per year)	$0 copay for each one-way trip to plan-approved health-related locations (limited to 24 one-way trips (combined in- and out-of-network) per year)	*Services do not apply to the plan's maximum out-of-pocket limit.
Medicare Part B drugs	$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.

Additional benefits included in your plan

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Annual physical exam*	$0 copay	$0 copay	One every 12 months from either an in-network or an out-of-network provider, but not both. *Services do not apply to the plan's maximum out-of-pocket limit.
Opioid treatment program services	$0 copay	$0 copay	Prior authorization may be required and is the responsibility of your provider
Foot care (podiatry services)			
• Foot exams and treatment	$10 copay for each Medicare-covered visit	$10 copay for each Medicare-covered visit	
• Routine foot care (non-Medicare covered)*	You will be reimbursed up to $100 per year for routine (non-Medicare covered) foot care	You will be reimbursed up to $100 per year for routine (non-Medicare covered) foot care	Limited to 6 visits (combined in- and out-of-network) per year. *Services do not apply to the plan's maximum out-of-pocket limit.
Diabetic Supplies & Services			Prior authorization may be required and is the responsibility of your provider
• Blood glucose monitors	$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers	$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers	
• Diabetes self-management training, diabetic services and supplies	$0 copay for all training services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	$0 copay for all training services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Durable Medical Equipment (DME) and related supplies (e.g., wheelchairs, oxygen)	$0 copay	$0 copay	Prior authorization may be required and is the responsibility of your provider
Prosthetic and orthotic devices and related supplies • Prosthetic and orthotic devices (e.g., braces, artificial limbs) • Medical supplies (e.g., splints, casts)	 $0 copay $0 copay	 $0 copay $0 copay	Prior authorization may be required and is the responsibility of your provider
Health and Wellness programs* • NurseHelp 24/7℠ (telephone and online support) • Basic gym access through SilverSneakers Fitness • LifeReferrals 24/7 – Access to counselors, consultations, information and referrals for a wide range of family and personal issue • Personal Emergency Response System (PERS)	 $0 copay $0 copay $0 copay $0 copay	 $0 copay $0 copay $0 copay $0 copay	*Services do not apply to the plan's maximum out-of-pocket limit.
Routine acupuncture (non-Medicare covered)*	$15 copay per visit (limited to 20 visits combined for routine chiropractic services and routine acupuncture services per year)	$15 copay per visit (limited to 20 visits combined for routine chiropractic services and routine acupuncture services per year)	*Services do not apply to the plan's maximum out-of-pocket limit.

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Over-the-Counter (OTC) Items*	You have an $80 allowance per quarter to spend on covered items	You have an $80 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. Some limitations may apply. Refer to the OTC Items Catalog for more information. *Services do not apply to the plan's maximum out-of-pocket limit.
Routine chiropractic services (non-Medicare covered)*	$15 copay per visit (limited to 20 visits combined for routine chiropractic services and routine acupuncture services per year)	$15 copay per visit (limited to 20 visits combined for routine chiropractic services and routine acupuncture services per year)	*Services do not apply to the plan's maximum out-of-pocket limit.

Part D Prescription drug coverage

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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 you have paid $2,000 out-of-pocket for Part D drugs.
Annual Mail Service Out-of-Pocket Maximum>	Once you've paid $1,000 a year for Tier 1, Tier 2 and Tier 4 formulary drugs through the plan's mail service pharmacy, you pay $0 for Tier 1, Tier 2 and Tier 4 formulary home delivery drugs.

What you pay:	**Preferred retail cost-sharing (in-network)**		**Standard retail cost-sharing (in-network)^**	
	30-day supply	**90-day supply*NDS**	**30-day supply***	**90-day supply*NDS**
Tier 1: Generic Drugs	$5 copay	$10 copay	$5 copay	$15 copay
Tier 2: Preferred Brand Drugs	$20 copay	$40 copay	$20 copay	$60 copay
Tier 2: Covered Insulins**	$20 copay	$40 copay	$20 copay	$60 copay
Tier 3: Non-Preferred Drugs	$50 copay	$100 copay	$50 copay	$150 copay
Tier 3: Covered Insulins**	$35 copay	$100 copay	$35 copay	$105 copay
Tier 4: Specialty Tier Drugs	$20 copay	Not covered	$20 copay	Not covered

***The 90-day supply preferred retail cost-sharing also applies to Amazon Pharmacy's home delivery services, 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").

NDSA 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 **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.

^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.

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) reaches $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 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 adult Part D vaccines at no cost to you. Call Customer Service for more information.

Home delivery service
Amazon Pharmacy is our network home delivery pharmacy where you can get a 90-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	(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.	

‡Accepts e-prescribing

Optional supplemental dental and vision PPO Plan

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You pay the following:

	Optional supplemental dental and vision PPO plan	
	Participating dentists	**Non-participating dentists**
Monthly optional supplemental dental plan premium	$39.14	
Calendar year deductible (not applicable to diagnostic and preventive services)	You pay $100	
Calendar year benefit maximum*	$1,500 for covered preventive and comprehensive dental services, no matter if the services are performed by a participating general dentist or a dental specialist. You pay any amount above the $1,500 calendar year benefit maximum.	
Waiting period	No waiting period	

	Optional supplemental vision PPO plan	
Vision	**Participating providers**	**Non-participating providers**
Routine eye exam	You pay $0 for one exam every 12 months when you use either a participating or non-participating provider.	
• **Eyeglass frames** • **Eyeglass lenses (including single, lined bifocal, lined trifocal and lenticular lenses)** • **Contact lenses (in lieu of eyeglass frames and eyeglass lenses)**	• $0 copay • You pay $0 for one pair of eyeglass frames and eyeglass lenses (up to a maximum plan benefit coverage amount of $70 every 24 months). **OR** • If you select contact lenses instead of eyeglass frames and eyeglass lenses, you pay $0 for contact lenses (up to a maximum plan benefit coverage amount of $105 for contact lens services and materials) every 24 months.	

*All services must be performed, prescribed, or authorized by your network dentist. If you need to see a specialist, you must get a referral from your primary dentist to receive covered specialist services. If you are enrolled in the optional supplemental dental PPO plan and you need to see a specialist, you may go directly to the specialist. See the plan EOC for more information.

Optional supplemental dental PPO plan		
	Participating dentists	**Non-participating dentists**
Summary list of services covered (ADA code)†		
	You pay	**You pay**
Diagnostic and preventive services		
Oral exam (D0150)	0% coinsurance (Two procedures per calendar year)	0% coinsurance (Two procedures per calendar year)
X-rays (D0210)	0% coinsurance (One procedure every 3 years)	0% coinsurance (One procedure every 3 years)
Teeth cleaning (D1110)	0% coinsurance (Two cleanings per calendar year)	0% coinsurance (Two cleanings per calendar year)
Restorative services		
Crown (D2750)	80% coinsurance (One every 5 years)	80% coinsurance (One every 5 years)
Periodontics		
Deep cleaning of four or more teeth per quadrant (D4341)	80% coinsurance (One every 24 months)	80% coinsurance (One every 24 months)
Endodontics		
Root canal therapy (D3310)	80% coinsurance (One procedure every year)	80% coinsurance (One procedure every year)

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.
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.
Amazon Pharmacy is independent of Blue Shield of California and is contracted with Blue Shield to provide home delivery 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。

Blue Shield of California is an independent member of the Blue Shield Association
MG00007-CalPERS-DV_1024