



2026 Summary of Benefits

Blue Shield 65 Plus (HMO)

Group Medicare Advantage Prescription Drug Plan
for Santa Ana Unified School District – Classified &
Certificated MGMT

Effective July 1, 2026 - June 30, 2027

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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 Plan Sponsor 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 (HMO) 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 (HMO)**, you must be entitled to Medicare Part A and Part B, meet your plan sponsor's eligibility requirements, permanently live in the plan service area, and be a United States Citizen or lawfully present in the United States. Your Medicare-eligible dependents may also join **Blue Shield 65 Plus (HMO)** 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 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

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

- *Provider Directory* – **blueshieldca.com/medicare/providerdirectory**
- *Pharmacy Directory* – **blueshieldca.com/medpharmacy2026**
- *Formulary* (List of covered drugs) – **blueshieldca.com/medformulary2026**

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/medpharmacy2026**.

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Premiums and benefits		You pay
 Monthly plan premium You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.		Your Plan Sponsor is responsible for paying premiums beyond your monthly Medicare Part B premium, Medicare Part A premium (if applicable), and extra amounts (i.e. IRMAA, Part D Late Enrollment Penalties (LEP), etc.). If you are responsible for any contribution to the premiums, your Plan Sponsor will tell you the amount you must contribute to the premium.
Annual maximum out-of-pocket amount 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.		\$6,700
Health plan deductible		\$0

* Prior authorization and/or a referral from your provider may be required.

† Services do not apply to the plan's maximum out-of-pocket limit.

For a complete list of services, limitations, or exclusions, please refer to the EOC by logging into your member portal at blueshieldca.com/sausd.

Summary of Benefits (cont'd)

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Benefits	You pay
 Ambulance services* Per trip (one way)	\$0
 Dental services (Medicare-covered) • Performed by your primary care physician (PCP)	\$20
 • Performed at a specialist's office	\$20
 Diabetic supplies and services* • ACCU-CHEK® blood glucose monitors • Dexcom and Freestyle Libre continuous glucose monitors • Blood glucose monitors and continuous glucose monitors from all other manufacturers	\$0
• Diabetes self-management training, diabetic services, and supplies (excluding blood glucose monitors and continuous glucose monitors)	20% coinsurance
 Diagnostic services, labs, and imaging*	
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	\$20
• Lab services	\$20
• Diagnostic tests and procedures	\$20
• Outpatient X-rays	\$20
• Therapeutic radiology services (such as radiation treatment for cancer)	\$20
 Doctor visits • Primary care physician (PCP)	\$20
• Specialists*	\$20
 Durable medical equipment (DME) and related supplies (e.g., wheelchairs, oxygen)*	\$0
 Emergency care • Worldwide coverage[†] This copay is waived if you are admitted to the 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.	\$50

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Benefits		You pay
	Hearing services Hearing exam (Medicare-covered)	\$20
	Inpatient hospital care* Copay per admission. Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay.	\$250
	Medicare Part B prescription drugs* Insulin obtained under Part B (when taken with an insulin pump) will not exceed \$35 copay for a one-month supply.	\$20
	Mental health services* - Inpatient services in a psychiatric hospital for days 1 – 150 - For days 151 and over	\$0 100% of the cost
	• Outpatient group therapy visit	\$5
	• Outpatient individual therapy visit	\$5
	Opioid treatment program services*	\$0
	Outpatient hospital services* Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery. Emergency room visit Waived if you are admitted to the hospital within one day for the same condition	\$50
	• Outpatient hospital facility	\$0
	• Observation services	\$0
	Outpatient surgery* - Ambulatory surgical center - Outpatient hospital facility	\$0
	Podiatry services (foot care) Foot exams and treatment (Medicare-covered)	\$20

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Benefits		You pay
	Preventive care Any additional preventive services approved by Medicare during the contract year will be covered.	\$0
	Prosthetic and orthotic devices and related supplies* • Prosthetic and orthotic devices (e.g., braces, artificial limbs)	\$0
	• Medical supplies (e.g., splints, casts)	\$0
	Rehabilitation services* • Occupational therapy	\$20
	• Physical therapy	\$20
	• Speech language therapy	\$20
	Skilled nursing facility (SNF) care* Per day for days 1 -100 If you go over the 100-day limit, you will be responsible for all costs.	\$0
	Urgently needed services • Worldwide coverage† These copays are waived if you are admitted to the 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 outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit.	
	- Network urgent care center within the plan service area	\$25
	- Urgent care center outside your plan service area but within the United States and its territories	\$50
	- Emergency room outside your plan service area but within the United States and its territories	\$50
	- Emergency room or urgent care center that is outside of the United States and its territories	\$50

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Benefits		You pay
	Vision services*	
	• Exam to diagnose and treat diseases and conditions of the eye Copey for each Medicare-covered visit.	\$20
	• Yearly glaucoma screening	\$0
	• Eyeglasses or contact lenses after cataract surgery	\$0

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† Services do not apply to the plan’s maximum out-of-pocket limit.
For a complete list of services, limitations, or exclusions, please refer to the EOC by logging into your member portal at blueshieldca.com/sausd.

Part D prescription drug coverage

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Additional benefits included in your plan

Benefits	You pay
 Annual physical exam[†] One exam every 12 months.	\$0
 Health and wellness programs[†] • Basic gym access through SilverSneakers® fitness • NurseHelp 24/7SM (telephone and online support)[†] • LifeReferrals 24/7 – Access to counselors, consultations[†], information, and referrals for a wide range of family and personal issues • Routine chiropractic services (non-Medicare covered)[†] Limited to 20 visits per year.	\$0 \$0 \$0 \$15
 Hearing services[†] • Hearings aids[†] You will be reimbursed up to \$500 every 12 months for: ○ Up to two hearing aids and two hearing aid fittings and evaluations (applies to both ears combined) ○ Hearing aid supplies and accessories (including batteries) ○ Hearing aid repairs and modifications You may obtain these services at the hearing aid provider of your choice. This allowance cannot be rolled over from year to year.	\$0
 Podiatry services (foot care)^{*†} • Routine (non-Medicare covered) foot care You will be reimbursed up to \$100 per visit for routine foot care. Limited to 12 visits per plan year.	\$0

Part D prescription drug coverage

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You pay the following

Part D prescription drug benefit				
Stage 1: Annual deductible		This stage does not apply because there is no deductible.		
Stage 2: Initial coverage		You pay the following until you have paid \$2,100 out-of-pocket for Part D drugs.		
	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	\$20	\$10	\$30
Tier 2: Preferred brand drugs	\$20	\$40	\$20	\$60
Tier 2: Covered insulins**	\$20	\$40	\$20	\$60
Tier 3: Non-preferred drugs	\$40	\$80	\$40	\$120
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**	The lesser of \$35 copay or 20% coinsurance	The lesser of \$105 copay or 20% coinsurance	The lesser of \$35 copay or 20% coinsurance	The lesser of \$105 copay or 20% coinsurance
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”).

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.

^ 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.

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) reaches \$2,100, 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 cost sharing amounts 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 prescription home delivery service provider where you can get up to a 100-day supply of maintenance drugs on Tier 1 through Tier 4 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, seven days a week. TTY users call **711**. See plan EOC for more information.

Tier 5 drugs are limited to a 30-day supply by home delivery 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) 276-9637 (TTY: 711) |
| • Costco‡ | (800) 955-2292 (TTY: 711) |
| • Ralphs‡, Walmart‡, and many more. | |

‡ Accepts e-prescribing.

You do not have to be a Costco member to use Costco Pharmacies. Other pharmacies are available in our network.

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

Blue Shield of California is an HMO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.

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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.

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