blue california

2025 Summary of Benefits

Blue Shield 65 Plus Choice Plan (HMO)

Medicare Advantage Prescription Drug Plan
for San Bernardino and Riverside Counties

Effective January 1, 2025 – December 31, 2025

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2025 Summary of Benefits
Blue Shield 65 Plus Choice Plan (HMO)
San Bernardino and Riverside Counties

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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 refer to the ***Evidence of Coverage (EOC)*** at **blueshieldca.com/MAPDdocuments2025** 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, 2024.**

Blue Shield 65 Plus Choice Plan 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 Choice Plan**, 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 Bernardino and Riverside Counties.**

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, seven 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**.

Our plan ***Pharmacy Directory*** is located on our website at **blueshieldca.com/medpharmacy2025**.

To get the most complete and current information about which drugs are covered, you can visit our website at **blueshieldca.com/medformulary2025**.

Summary of Benefits

Effective January 1, 2025 - December 31, 2025

Blue Shield 65 Plus Choice Plan (HMO)
San Bernardino and Riverside Counties

Premiums and benefits	You pay	What you should know
Monthly plan premium	$0	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Health plan deductible	$0	
Annual out-of-pocket maximum amount	$800	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.
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	$150 copay for each visit to an outpatient hospital facility $0 copay for observation services $140 copay for each visit to an emergency room (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 $150 copay for each visit to an outpatient hospital facility	Prior authorization and a referral from your provider may be required.
Doctor visits • Primary care physician • Specialists	 $0 copay per visit $0 copay per visit	 A referral from your provider may be required for specialist visits.
Preventive care	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.

Premiums and benefits	You pay	What you should know
Emergency care • Worldwide coverage	$140 copay per visit No combined annual limit for emergency care and urgently needed services outside the United States and its territories	This copay is waived if you are admitted to the hospital within one day for the same condition.
Urgently needed services • Worldwide coverage	$0 copay for each visit to a network urgent care center within the plan service area $0 copay for each visit to an urgent care center outside of the plan service area but within the United States and its territories $140 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories $140 copay for each visit to an emergency room or urgent care center that is outside of the United States and its territories No 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.

Premiums and benefits	You pay	What you should know
Diagnostic services, labs, and imaging		Prior authorization and/or a referral from your provider may be required.
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$0 copay	Covered according to Medicare guidelines.
• Lab services	$0 copay	
• Diagnostic tests and procedures	$0 copay	
• Outpatient x-rays	$0 copay	
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance for each therapeutic radiology service	While you pay 20% coinsurance for therapeutic radiology services, you will never pay more than your $800 total out-of-pocket maximum for the year.
Hearing services		A referral from your provider may be required.
• Hearing exam (Medicare-covered)	$0 copay per visit	
• Routine (non-Medicare covered) hearing exam	$0 copay per visit	Routine hearing exams are unlimited if provided by your doctor but are limited to one exam every 12 months with network hearing aid provider.
• Hearing aids	$449 copay for each Silver Technology level hearing aid or $699 copay for each Gold Technology level hearing aid	Coverage is limited to two hearing aids per year.

Premiums and benefits	You pay	What you should know
Dental services (Medicare-covered)	$0 copay per visit if performed by your PCP or a specialist	A referral from your provider may be required.
Dental services (non-Medicare covered)		
• Teeth cleaning	$0 copay	Two visits every 12 months.
• Dental X-rays	$0 - $10 copay, depending on the service/type	One series of bitewing X-rays every 6 months. One series of full set X-rays every 24 months.
• Fluoride	$5 copay	One every 6 months
• Oral exam	$0 - $16 copay, depending on the service	See the "Optional Supplemental Dental HMO and PPO plans" section for more information about dental services for an additional plan premium.
Vision services		Prior authorization and a referral from your provider may be required.
• Exam to diagnose and treat diseases and conditions of the eye	$0 copay for each Medicare-covered visit	
• Routine (non-Medicare covered) eye exam and refraction	$0 copay per visit	One visit every 12 months with network provider. Some coverage at non-network providers included; see the plan EOC for details.
• Eyeglass frames	$0 copay	Our plan pays for one pair of eyeglass frames (priced up to a regular retail value of $220) every 24 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.
• Eyeglass lenses or contact lenses	$0 copay	Our plan pays for either one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses (priced up to $220 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.

Premiums and benefits	You pay	What you should know
Mental health services		Prior authorization and a referral from your provider may be required.
• Inpatient services in a psychiatric hospital	$900 copay per Medicare-covered stay for days 1-150	If you go over the 150-day limit, you will be responsible for all costs. See EOC for more information.
• Outpatient individual therapy visit	$30 copay per visit	
• Outpatient group therapy visit	$30 copay per visit	
Skilled nursing facility (SNF) care	$0 copay per day for days 1 - 20 $75 copay per day for days 21 – 100	Prior authorization and a referral from your provider may be required. 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	$0 copay per visit	Prior authorization and a referral from your provider may be required.
• Physical therapy	$0 copay per visit	
• Speech and language therapy	$0 copay per visit	
Ambulance services	Medicare-covered ground ambulance services: $250 copay per trip (each way) Medicare-covered air ambulance services: 20% coinsurance per trip (each way)	Prior authorization from your provider may be required.
Transportation services (non-Medicare covered)	$0 copay	Limited to 14 one-way trips to plan-approved health-related locations every year.
Medicare Part B prescription drugs	0% to 20% coinsurance	Prior authorization from your provider may be required. 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.

Additional benefits included in your plan

Premiums and benefits	You pay	What you should know
Annual physical exam	$0 copay	One every 12 months.
Opioid treatment program services	$0 copay	Prior authorization and a referral from your provider may be required.
Foot care (podiatry services)		A referral from your provider may be required.
• Foot exams and treatment	$0 copay for each Medicare-covered visit	
• Routine (non-Medicare covered) foot care	$0 copay for each routine (non-Medicare covered) visit	
Diabetic supplies and services		Prior authorization from your provider may be required. See the plan EOC for more information.
• Blood glucose monitors	$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 glucose monitors (see "Blood glucose monitors" above)	
Durable medical equipment (DME) and related supplies		
• Durable medical equipment (e.g., wheelchairs, oxygen)	20% coinsurance	Prior authorization from your provider may be required. See the plan EOC for more information.
Prosthetic and orthotic devices and related supplies		Prior authorization from your provider may be required.
• Prosthetic and orthotic devices (e.g., braces, artificial limbs)	20% coinsurance	
• Medical supplies (e.g., splints, casts)	$0 copay	

Premiums and benefits	You pay	What you should know
Health and wellness programs		
• Basic gym access through SilverSneakers® fitness	$0 copay	
• NurseHelp 24/7℠ (telephone and online support)	$0 copay	
• Personal Emergency Response System (PERS) (24/7 medical alert)	$0 copay	
Over-the-counter (OTC) Items	You have a $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.
Routine chiropractic services (non-Medicare covered)	$0 copay per visit	Limited to 12 visits per year.

Prescription drug coverage

Effective January 1, 2025 - December 31, 2025

You pay the following:

Part D prescription drug benefit				
Stage 1: Annual deductible stage	This stage does not apply because there is no deductible.			
Stage 2: Initial coverage stage	**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: Preferred generic drugs	$0 copay	$0 copay	$5 copay	$5 copay
Tier 2: Generic drugs	$3 copay	$4.50 copay	$10 copay	$30 copay
Tier 3: Preferred brand drugs	$35 copay	$87.50 copay	$47 copay	$141 copay
Tier 3: Covered insulins**	$35 copay	$87.50 copay	$35 copay	$105 copay
Tier 4: Non-preferred drugs	$95 copay	$237.50 copay	$100 copay	$300 copay
Tier 4: Covered insulins**	$35 copay	$105 copay	$35 copay	$105 copay
Tier 5: Specialty tier drugs	33% coinsurance	Not covered	33% coinsurance	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.

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

*100-day supply cost-sharing also applies to Amazon Pharmacy home delivery service.

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.

Part D prescription drug benefit	
Stage 3: Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through home delivery service) reach $2,000, the plan pays the full cost for your covered Part D drugs. For excluded drugs covered under our enhanced benefit, you pay Tier 2: Generic drugs copayment 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 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 service where you can get a 100-day supply of maintenance drugs. Your order will be delivered with $0 shipping. 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.

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 HMO and PPO plans

Effective January 1, 2025 - December 31, 2025

You pay the following:

	Optional supplemental dental HMO plan	Optional supplemental dental PPO plan	
	Participating dentists only	Participating dentists	Non-participating dentists
Monthly optional supplemental dental plan premium	$16.00	$47.00	
Calendar year deductible (not applicable to diagnostic and preventive services)	$0	You pay $50 before coverage for major services begins.	
Calendar year benefit maximum*	None	$1,500 for covered preventive and comprehensive dental services combined, 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. Up to $1,000 of this maximum amount may be used for covered preventive and comprehensive dental services performed by non-participating dentists in a calendar year. You pay any amount above the $1,000 calendar year benefit maximum.	
Waiting period	No waiting period	No waiting period	

*Members enrolled in the optional supplemental dental HMO plan, 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 HMO and PPO plans (cont'd)

Effective January 1, 2025 - December 31, 2025

	Optional supplemental dental HMO plan	Optional supplemental dental PPO plan	
	Participating dentists only	Participating dentists	Non-participating dentists
Summary list of services covered (ADA code)†			
	You pay	**You pay**	**You pay**
Diagnostic and preventive services			
Oral exam (D0150)	$5 copay	0% coinsurance (One every 6 months)	20% coinsurance (One every 6 months)
X-rays (D0210)	$0 copay (One series every 24 months)	0% coinsurance (One series every 24 months)	20% coinsurance (One series every 24 months)
Teeth cleaning (D1110)	$5 copay (One cleaning every 6 months)	0% coinsurance (One cleaning every 6 months)	20% coinsurance (One cleaning every 6 months)
Restorative services			
Crown (D2750)	$275 copay‡ (One per plan year exact tooth every 5 years)	50% coinsurance (One every 5 years exact tooth)	50% coinsurance (One every 5 years exact tooth)
Periodontics			
Deep cleaning of four or more teeth per quadrant (D4341)	$45 copay (One every 12 months exact tooth)	50% coinsurance (One every 24 months exact tooth)	50% coinsurance (One every 24 months exact tooth)
Endodontics			
Root canal therapy (D3310)	$195 copay /$268 copay* (One per lifetime exact tooth)	50% coinsurance	50% coinsurance
Implant services			
Implant services (D6010)	Not covered	50% coinsurance (One per lifetime)	50% coinsurance (One per lifetime)

† ADA codes are procedure codes established by the American Dental Association for efficient processing and reporting of dental claims.

‡ You pay the copayment plus the cost of precious or semi-precious metals. Porcelain on molar crowns is not a covered benefit.

* The higher copayment applies when a specialist performs the service.

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.

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'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., seven days a week, or consult the online pharmacy directory at **blueshieldca.com/medpharmacy2025**.

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。