2025 Summary of Benefits

Blue Shield AdvantageOptimum Plan (HMO)

Medicare Advantage Prescription Drug Plan
for Los Angeles and Orange Counties

Effective January 1, 2025 – December 31, 2025

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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 AdvantageOptimum 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 AdvantageOptimum 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 Los Angeles and Orange 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**.

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	$2,900	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	$50 per day for days 1 - 5 $0 per day for days 6 and over	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	$200 copay for each visit to an outpatient hospital facility $0 copay for observation services $140 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	$50 copay for each visit to an ambulatory surgical center $200 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 $5 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 $50,000 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	$10 copay for each visit to a network urgent care center within the plan service area $10 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 or urgent care center that is outside of 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 $50,000 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.
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.)	$15 copay for each diagnostic radiology service	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 $2,900 total out-of-pocket maximum for the year.

Premiums and benefits	You pay	What you should know
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	
Dental services (Medicare-covered)	$0 copay per visit if performed by your PCP $5 copay per visit if performed by a specialist	A referral from your provider may be required.
Dental services (non-Medicare covered)		
• Teeth cleaning	$0 copay	One cleaning every 6 months.
• Dental X-rays	$0 - $5 copay, depending on the service provided	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 copay	Unlimited.
Vision services		
• Exam to diagnose and treat diseases and conditions of the eye	$5 copay for each Medicare-covered visit	Prior authorization and a referral from your provider may be required.
• Routine (non-Medicare covered) eye exam and refraction	$0 copay	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 $230) 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 $230 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 for each 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 $175 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		Prior authorization and a referral from your provider may be required.
• Occupational therapy	$15 copay per visit	
• Physical therapy	$15 copay per visit	
• Speech and language therapy	$15 copay per visit	
Ambulance services	Medicare-covered ground ambulance services: $300 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) • Foot exams and treatment • Routine (non-Medicare covered) foot care	 $5 copay for each Medicare-covered visit $5 copay for each routine (non-Medicare covered) visit	A referral from your provider may be required.
Diabetic supplies and services • Blood glucose monitors • Diabetes self-management training, diabetic services, and supplies	 $0 copay for FreeStyle® blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers $0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	Prior authorization and/or a referral from your provider may be required. See the plan EOC for more information.
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 • Prosthetic and orthotic devices (e.g., braces, artificial limbs) • Medical supplies (e.g., splints, casts)	 20% coinsurance $0 copay	Prior authorization from your provider may be required.

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	
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.

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	$7.50 copay	$10 copay	$25 copay
Tier 3: Preferred brand drugs	$40 copay	$100 copay	$47 copay	$117.50 copay
Tier 3: Covered insulins**	$35 copay	$100 copay	$35 copay	$105 copay
Tier 4: Non-preferred drugs	$95 copay	$237.50 copay	$100 copay	$250 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.

Prescription drug coverage (cont'd)

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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. (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

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. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved.

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