blue california

2025 Summary of Benefits

Blue Shield Select (PPO)

Medicare Advantage Prescription Drug Plan
for Alameda County

Effective January 1, 2025 – December 31, 2025

blueshieldca.com/medicare

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2025 Summary of Benefits
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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 Select 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 Select**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. **Our service area includes Alameda County.**

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

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Blue Shield Select (PPO)
Alameda County

Premiums and benefits	In-network you pay	Out-of-network you pay	What you should know
Monthly plan premium	$49		You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Health plan deductible	$0	$750	This is the amount you must pay out-of-pocket before we will pay our share for your covered medical services. Until you have paid the deductible amount, you must pay the full cost for most of your covered services. See the plan EOC for details.
Annual out-of-pocket maximum amount	$6,400	$10,000 (combined in-network and out-of-network)	Does not include Part D prescription drugs. This is the most you would pay for the year for covered Medicare Part A and Part B services.
Inpatient hospital care	$300 per day for days 1-7 $0 per day for days 8 and over	30% coinsurance after you pay your plan deductible	Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay. Prior authorization from your provider may be required.

Premiums and benefits	In-network you pay	Out-of-network you pay	What you should know
Outpatient hospital services • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	$250 copay for each visit to an outpatient hospital facility $10 copay for observation services $125 copay for each visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition)	40% coinsurance after you pay your plan deductible for each visit to an outpatient hospital facility or for observation services $125 copay for each visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition)	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 from your provider may be required.
Outpatient surgery	$100 copay for each visit to an ambulatory surgical center $250 copay for each visit to an outpatient hospital facility	40% coinsurance after you pay your plan deductible	Prior authorization from your provider may be required.
Doctor visits • Physician of choice (POC) • Specialists	$0 copay per visit $20 copay per visit	40% coinsurance after you pay your plan deductible 40% coinsurance after you pay your plan deductible	
Preventive care	$0 copay	40% coinsurance	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care • Worldwide coverage	$125 copay per visit No combined annual limit for emergency care and urgently needed services outside the United States and its territories	$125 copay per visit No combined annual limit for covered 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.

Premiums and benefits	In-network you pay	Out-of-network you pay	What you should know
Urgently needed services	$5 copay for each visit to a network urgent care center within the plan service area $5 copay for each visit to an urgent care center outside the plan service area, but within the United States and its territories $125 copay for each visit to an emergency room outside of the plan service area, but within the United States and its territories $125 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	$5 copay for each visit to a network urgent care center within the plan service area $5 copay for each visit to an urgent care center outside the plan service area, but within the United States and its territories $125 copay for each visit to an emergency room outside of the plan service area, but within the United States and its territories $125 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 covered emergency care and urgently needed services outside the United States and its territories	These copays are waived if you are admitted to a hospital within one day for the same condition.

Premiums and benefits	In-network you pay	Out-of-network you pay	What you should know
Diagnostic services, labs, and imaging			Prior authorization from your provider may be required.
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$75 copay for each diagnostic radiology service	40% coinsurance after you have paid your plan deductible	
• Lab services	$0 copay	40% coinsurance after you have paid your plan deductible	
• Diagnostic tests and procedures	$0 copay	40% coinsurance after you have paid your plan deductible	
• Outpatient x-rays	$0 copay	40% coinsurance after you have paid your plan deductible	
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance for each therapeutic radiology service	40% coinsurance after you have paid your plan deductible	
Hearing services			
• Hearing exam (Medicare covered)	$0 copay per visit	40% coinsurance after you have paid your plan deductible	
• Routine (non-Medicare covered) hearing exam	$0 copay per visit	40% coinsurance after you have paid your plan deductible	
• Hearing aids and fitting/evaluation for hearing aids	You will be reimbursed up to $1,000 every two years for 2 hearing aids and 2 hearing aid fitting and evaluations	You will be reimbursed up to $1,000 every two years for 2 hearing aids and 2 hearing aid fitting and evaluations	Applies to both ears combined. You may obtain these services at the hearing aid provider of your choice.

Premiums and benefits	In-network you pay	Out-of-network you pay	What you should know
Dental services (Medicare-covered)	$0 copay per visit if performed by your POC $20 copay per visit if performed by a specialist	40% coinsurance after you pay your plan deductible	
Dental services (non-Medicare covered)			
• Teeth cleaning	$0 copay	20% coinsurance	One cleaning every 6 months.
• Dental X-rays	$0 copay	20% coinsurance	One series of bitewing X-rays every 6 months. One series of full set X-rays every 24 months.
• Fluoride treatment	$0 copay	20% coinsurance	Two every 6 months.
• Oral exam	$0 copay	20% coinsurance	One exam every 6 months. See the "Optional Supplemental Dental PPO plan" section for more information about dental services for an additional plan premium.

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	$20 copay for each Medicare-covered visit	40% coinsurance after you have paid your plan deductible	
• Routine (non-Medicare covered) eye exam and refraction	$0 copay	You pay a 50% coinsurance for one exam every 12 months	One visit every 12 months with either an in-network or out-of-network provider (but not both).
• Eyeglass frames	$0 copay	$0 copay	Our plan pays up to $260 for one pair of eyeglass frames every 24 months when you use either an in-network or an out-of-network provider (but not both).
• Eyeglass lenses or contact lenses	You pay $0 for either one pair of prescription eyeglass lenses (regardless of size or power, including progressive lenses) or for contact lenses (priced up to a maximum plan benefit coverage amount of $260 for contact lens services and materials) every 12 months when you use an in-network provider	You pay a 50% coinsurance for either one pair of prescription eyeglass lenses (regardless of size or power, including progressive lenses) or for contact lenses (priced up to a maximum plan benefit coverage amount of $260 for contact lens services and materials) every 12 months when you use an out-of-network provider	You may obtain either eyeglass lenses or contact lenses (but not both) from either an in-network or an out-of-network provider (but not both) every 12 months.
Mental health services			Prior authorization from your provider may be required.
• Inpatient services in a psychiatric hospital	$1,660 copay per Medicare-covered stay	40% coinsurance after you have paid your plan deductible	See plan EOC for more information.
• Outpatient group therapy visit	$35 copay per visit	40% coinsurance after you have paid your plan deductible	
• Outpatient individual therapy visit	$35 copay per visit	40% coinsurance after you have paid your plan deductible	

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 - 20 $178 copay per day for days 21 - 100	40% coinsurance after you have paid your plan deductible	Prior authorization 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 • Physical therapy • Speech and language therapy	$25 copay per visit $25 copay per visit $25 copay per visit	40% coinsurance after you have paid your plan deductible	Prior authorization from your provider may be required.
Ambulance services	Medicare-covered ground ambulance services: $290 copay per trip (each way) Medicare-covered air ambulance services: 20% coinsurance per trip (each way)	Medicare-covered ground ambulance services: $290 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)	Not covered	Not covered	
Medicare Part B prescription drugs	0% to 20% coinsurance	0% to 20% coinsurance after you have paid your plan deductible	Prior authorization from your provider may be required. Members may pay up to 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	In-network you pay	Out-of-network you pay	What you should know
Annual physical exam	$0 copay	40% coinsurance after you have paid your plan deductible	One every 12 months.
Opioid treatment program services	$0 copay	40% coinsurance after you have paid your plan deductible	Prior authorization from your provider may be required.
Foot care (podiatry services) (Medicare-covered)			
• Foot exams and treatment	$20 copay per visit	40% coinsurance after you have paid your plan deductible	
Diabetic supplies and services			
• Blood glucose monitors	$0 copay for ACCU-CHEK blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers	30% coinsurance after you have paid your plan deductible	Prior authorization from your provider may be required.
• 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)	40% coinsurance for diabetic self-management training and 20% coinsurance for diabetic supplies and services except blood glucose monitors (see "Blood glucose monitors" above)	See the plan EOC for more information.

Premiums and benefits	In-network you pay	Out-of-network you pay	What you should know
Durable medical equipment (DME) and related supplies			
• Durable medical equipment (e.g., wheelchairs, oxygen)	20% coinsurance	30% coinsurance after you have paid your plan deductible	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	30% coinsurance after you have paid your plan deductible	
• Medical supplies (e.g., splints, casts)	$0 copay	30% coinsurance after you have paid your plan deductible	
Health and wellness programs			
• Basic gym access through SilverSneakers® fitness	$0 copay	$0 copay	
• NurseHelp 24/7℠ (telephone and online support)	$0 copay	$0 copay	
Over-the-counter (OTC) items	You have a $40 allowance per quarter to spend on covered items	You have a $40 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.

Prescription drug coverage

Effective January 1, 2025 - December 31, 2025

Blue Shield Select (PPO)
Alameda County

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	$5 copay	$7.50 copay	$20 copay	$60 copay
Tier 3: Preferred brand drugs	$40 copay	$100 copay	$47 copay	$141 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	$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 the Tier 2: Generic Drugs copayments listed in the tables 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 PPO Plan

Effective January 1, 2025 - December 31, 2025

You pay the following:

	Optional supplemental dental PPO plan	
	Participating dentists	**Non-participating dentists**
Monthly optional supplemental dental plan premium	$47.00	
Calendar year deductible (not applicable to diagnostic and preventive services)	You pay $50	
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. 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	

*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 (cont'd)

Effective January 1, 2025 - December 31, 2025

	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 (One every 6 months)	20% coinsurance (One every 6 months)
X-rays (D0210)	0% coinsurance (One series every 24 months)	20% coinsurance (One series every 24 months)
Teeth cleaning (D1110)	0% coinsurance (One cleaning every 6 months)	20% coinsurance (One cleaning every 6 months)
Restorative services		
Crown (D2750)	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)	50% coinsurance (One every 24 months exact tooth)	50% coinsurance (One every 24 months exact tooth)
Endodontics		
Root canal therapy (D3310)	50% coinsurance	50% coinsurance
Implant services		
Implant services (D6010)	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.

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 a PPO 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.

Out-of-network/non-contracted providers are under no obligation to treat Plan 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.

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。