2024 Summary of Benefits

Blue Shield Medicare (PPO)

Group Medicare Advantage Prescription Drug Plan for CalPERS

Effective January 1, 2024 – December 31, 2024

blueshieldca.com/medicare

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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. [TTY: **711**], 7 a.m. to 8 p.m., 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 https://www.medicare.gov 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/medicare/providerdirectory**
- Pharmacy Directory **– blueshieldca.com/medpharmacy2024**
- Formulary (List of covered drugs) **– blueshieldca.com/medformulary2024**

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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	$0	
Inpatient hospital care	$0 copay per admission	$0 copay per admission	Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay.
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 (this copay is 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 (this copay is 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	
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 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 a 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 your plan service area $0 copay for each visit to an urgent care center outside your plan service area but within the United States and its territories $50 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories $50 copay for each visit to an emergency room, $0 copay for urgent care center that is outside 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 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
Diagnostic services, labs, and imaging			Prior authorization may be required for diagnostic services and is the responsibility of your provider.
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$0 copay for each diagnostic radiology service	$0 copay for each diagnostic radiology service	
• Lab services	$0 copay	$0 copay	
• Diagnostic tests and procedures	$0 copay	$0 copay	
• Outpatient X-rays	$0 copay	$0 copay	
• Therapeutic radiology services (such as radiation treatment for cancer)	$0 copay for each therapeutic radiology service	$0 copay for each therapeutic radiology service	
Hearing services			
• Hearing exam (Medicare covered)	$10 copay per visit	$10 copay per visit	
• 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 hearing aids	You will be reimbursed up to $1,000 every 3 years for hearing aids	Applies to both ears combined; cost of hearing aids does not apply to plan's maximum out-of-pocket limit.
Dental services Non-routine dental care	$0 copay per visit performed at a POC's office $0 copay per visit performed at a specialist's office	$0 copay per visit performed at a POC's office $0 copay per visit performed at a specialist's office	This does not include services in connection with care, treatment, filling, removal, or replacement of teeth.

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 for an exam, treatment of diseases and conditions of the eye, and yearly glaucoma screenings 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	$10 copay	One exam every 12 months.
Mental health services • Inpatient mental health care	$0 copay per stay for days 1 to 150 100% of the cost for days 151 and over, unless a new benefit period begins.	$0 copay per day for days 1 to 150 100% of the cost for days 151 and over, unless a new benefit period begins.	Prior authorization may be required and is the responsibility of your provider. There is a 190-day lifetime limit in a Medicare-certified psychiatric hospital.
• Outpatient group therapy visit	$0 copay per visit	$0 copay per visit	
• Outpatient individual therapy visit	$0 copay per visit	$0 copay per visit	
Skilled nursing facility (SNF) care	$0 copay per day for days 1 through 100	$0 copay per day for days 1 through 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 cost; no prior hospitalization required with network provider.

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Rehabilitation services			
• Occupational therapy services	$0 copay per visit	$0 copay per visit	
• Physical therapy and speech	$0 copay per visit	$0 copay per visit	
• Language therapy services	$0 copay per visit	$0 copay per visit	
Ambulance services	$0 copay per trip (one way)	$0 copay per trip (one way)	
Transportation Services (non-Medicare covered)	$0 copay for each one-way trip to plan-approved health-related locations (limited to 24 one-way trips per year)	$0 copay for each one-way trip to plan-approved health-related locations (limited to 24 one-way trips per year)	
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.

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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.
Opioid treatment program services	$0 copay	$0 copay	Prior authorization may be required and is the responsibility of your provider.
Foot care (podiatry services) (Medicare-covered)			
• 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 every year for routine (non-Medicare covered) foot care	You will be reimbursed up to $100 every year for routine (non-Medicare covered) foot care	Limited to 6 visits per year.
Diabetic Supplies & Services			Prior authorization from the plan may be required for diabetes supplies, services and self-management training and is the responsibility of your provider. See the plan EOC for more information.
• Blood glucose monitors	$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance of Medicare-allowed amount for all other manufacturers	$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance of Medicare-allowed amount for 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** Durable medical equipment (e.g., wheelchairs, oxygen)	$0 copay	$0 copay	Prior authorization from the plan may be required. See the plan EOC for more information.
Prosthetics/Medical Supplies • Prosthetics (e.g., braces, artificial limbs)	$0 copay	$0 copay	Prior authorization from your doctor may be required.
Health and Wellness programs • NurseHelp 24/7SM (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	
Acupuncture (non-Medicare covered)	$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year	$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year	
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.

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Routine chiropractic services (non-Medicare covered)	$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year	$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year	

Part D Prescription Drug Coverage

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 $8,000 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 mail service 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 supplyNDS**
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 3: Non-Preferred Brand 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

***** Three-month supply preferred retail cost-sharing also applies to Blue Shield's mail service pharmacy, 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").

NDS A 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.

Coverage Gap Stage

Because there is no coverage gap for the plan, this payment stage does not apply to you.

Catastrophic Coverage Stage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail service) reach $8,000, the plan pays the full cost for your covered Part D drugs. For excluded drugs covered under our enhanced benefit, you pay the Tier 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 Part D vaccines at no cost to you. Call Customer Service for more information.
Mail Service Pharmacy
CVS Caremark® is our network mail service pharmacy where you can get a 90-day supply of maintenance drugs at a lower cost share. Your order will be delivered to your home or office with no charge for standard shipping. After enrolling in your Blue Shield Medicare plan, you can log in to your Blue Shield of California member account at blueshieldca.com/login.

Tier 4 drugs are limited to a 30-day supply by mail 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) 932-7948 [TTY: 711]
Costco (You do not have to be a member to use the pharmacy.)	(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 Costo members to use Costco pharmacies. Other pharmacies are available in our network.	

‡Accepts e-prescribing

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.

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. Out-of-network/non-contracted providers who provide covered services to Blue Shield Medicare members will be paid according to the Medicare Fee Schedules.

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
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