

Effective January 1, 2022 – December 31, 2022

# 2022

## Summary of Benefits

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### Blue Shield Medicare (PPO)

**Group Medicare Advantage Prescription Drug Plan**  
for CalPERS



[blueshieldca.com/medicare](https://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 (PPO) Customer Care at (888) 802 4599** [TTY: 711], 7 a.m. to 8 p.m., seven days a week, year round.

**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/find-a-doctor](https://blueshieldca.com/find-a-doctor)
- Pharmacy Directory – [blueshieldca.com/medpharmacy2022](https://blueshieldca.com/medpharmacy2022)
- Formulary (List of covered drugs) – [blueshieldca.com/medformulary2022](https://blueshieldca.com/medformulary2022)

Out-of-network/non-contracted providers are under no obligation to treat Blue Shield Medicare members, except in emergency situations. Please call our Customer Care 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.

## Summary of Benefits

Effective January 1, 2022 – December 31, 2022

You pay the following:

Out-of-pocket costs	You Pay	What you should know
<b>Monthly plan premium</b>	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.
<b>Annual out-of-pocket maximum amount</b>	\$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.

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<b>Deductible</b>	\$0	\$0	
<b>Inpatient hospital care</b>	\$0 copay per admission	\$0 copay per admission	Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay.

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p><b>Outpatient hospital services</b></p> <ul style="list-style-type: none"> <li>Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery</li> </ul>	<p>\$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)</p> <p>\$0 copay for each visit to an outpatient hospital facility</p> <p>\$0 copay for observation services</p>	<p>\$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)</p> <p>\$0 copay for each visit to an outpatient hospital facility</p> <p>\$0 copay for observation services</p>	<p>Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p><b>Prior authorization may be required and is the responsibility of your provider.</b></p>
<p><b>Outpatient surgery</b></p>	<p>\$0 copay for each visit to an ambulatory surgical center</p> <p>\$0 copay for each visit to an outpatient hospital facility</p>	<p>\$0 copay for each visit to an ambulatory surgical center</p> <p>\$0 copay for each visit to an outpatient hospital facility</p>	<p><b>Prior authorization may be required and is the responsibility of your provider.</b></p>
<p><b>Doctor visits</b></p> <ul style="list-style-type: none"> <li>Physician of choice (POC)</li> <li>Specialists</li> </ul>	<p>For all covered services:</p> <p>\$0 copay per visit if performed by your Physician of Choice or by a specialist's office.</p>	<p>For all covered services:</p> <p>\$0 copay per visit if performed by your Physician of Choice or by a specialist's office.</p>	
<p><b>Preventive care</b></p>	<p>\$0 copay</p>	<p>\$0 copay</p>	

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<b>Emergency care</b>	<p>\$50 copay per visit to an emergency room.</p> <p>You have no 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.</p>		<p>This copay is waived if you are admitted to a hospital within one day for the same condition.</p> <p>Worldwide coverage.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p><b>Urgently needed services</b></p>	<p>\$0 copay for each visit to a network urgent care center within your plan service area.</p> <p>\$0 copay for each visit to an urgent care center or physician office outside your plan service area but within the United States and its territories.</p> <p>\$0 copay for each visit to an urgent care center that is outside the United States and its territories.</p> <p>\$50 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories.</p> <p>\$50 copay for each visit to an emergency room that is outside the United States and its territories.</p>		<p>The copay is waived for each visit to an emergency room that is outside of the plan service area or outside the United States and its territories, if you are admitted to the hospital within one day for the same condition.</p> <p>There is no combined annual limit for covered emergency care or 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.</p> <p>Worldwide coverage.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p><b>Diagnostic services, labs, and imaging</b></p> <ul style="list-style-type: none"> <li>• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)</li> <li>• Lab services</li> <li>• Diagnostic tests and procedures</li> <li>• Outpatient X-rays</li> <li>• Therapeutic radiology services (such as radiation treatment for cancer)</li> </ul>	<p>\$0 copay for each diagnostic radiology service</p> <p>\$0 copay for each laboratory service</p> <p>\$0 copay for each diagnostic test</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>\$0 copay for each diagnostic radiology service</p> <p>\$0 copay for each laboratory service</p> <p>\$0 copay for each diagnostic test</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p><b>Prior authorization may be required for diagnostic services and is the responsibility of your provider.</b></p> <p>Covered according to Medicare guidelines.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p><b>Hearing services</b></p> <ul style="list-style-type: none"> <li>Exam to diagnose and treat hearing and balance issues</li> <li>Routine (non-Medicare covered) hearing exam</li> <li>Hearing aids</li> </ul>	<p>\$10 copay per visit</p> <p>\$0 copay (limited to 1 exam per year)</p> <p>You will be reimbursed up to \$1,000 every 3 years for hearing aids</p>	<p>\$10 copay per visit</p> <p>\$0 copay (limited to 1 exam per year)</p> <p>You will be reimbursed up to \$1,000 every 3 years for hearing aids</p>	<p><b>Prior authorization may be required and is the responsibility of your provider.</b></p> <p>Applies to both ears combined.</p>



Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p><b>Vision services</b></p> <ul style="list-style-type: none"> <li>Exam to diagnose and treat diseases and conditions of the eye</li> <li>One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens</li> <li>Routine (non-Medicare covered) eye exam, including refraction</li> </ul>	<p>\$10 copay for each Medicare-covered visit</p> <p>\$0 copay</p> <p>\$10 copay</p>	<p>\$10 copay for each Medicare-covered visit</p> <p>\$0 copay</p> <p>\$10 copay</p>	<p>One exam every 12 months.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p><b>Mental health services</b></p> <ul style="list-style-type: none"> <li>• Inpatient mental health care</li> <li>• Outpatient group therapy visit</li> <li>• Outpatient individual therapy visit</li> </ul>	<p>For each Medicare-covered stay you pay: \$0 copay per day for days 1 to 190</p> <p>\$0 copay per visit</p> <p>\$0 copay per visit</p>	<p>For each Medicare-covered stay you pay: \$0 copay per day for days 1 to 190</p> <p>\$0 copay per visit</p> <p>\$0 copay per visit</p>	<p><b>Prior authorization may be required and is the responsibility of your provider.</b></p> <p>There is a 190-day lifetime limit in a Medicare-certified psychiatric hospital.</p> <p>A benefit period starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<b>Skilled nursing facility (SNF) care</b>	For each stay in a Medicare-certified SNF you pay:  \$0 copay per day for days 1 through 100	For each stay in a Medicare-certified SNF you pay:  \$0 copay per day for days 1 through 100	<p><b>Prior authorization may be required and is the responsibility of your provider.</b></p> <p>100 days per benefit period; no prior hospitalization required with network provider.</p> <p>A benefit period starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without inpatient hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.</p>
<b>Rehabilitation services</b> <ul style="list-style-type: none"> <li>• Occupational therapy services</li> <li>• Physical therapy and speech and language therapy services</li> </ul>	\$0 copay per visit  \$0 copay per visit	\$0 copay per visit  \$0 copay per visit	<p><b>Prior authorization may be required and is the responsibility of your provider.</b></p>
<b>Ambulance</b>	\$0 copay per trip (one way)	\$0 copay per trip (one way)	

<b>Benefits</b>	<b>In Network You Pay</b>	<b>Out-of-Network You Pay</b>	<b>What you should know</b>
<b>Transportation services</b>	\$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)	
<b>Medicare Part B drugs</b>	\$0 copay	\$0 copay	Step therapy may be required.
<b>Opioid treatment program services</b>	\$0 copay	\$0 copay	
<b>Additional Telehealth Services (Teledoc)</b>	\$0 copay	\$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication. See the plan EOC for more information.
<b>Foot care (podiatry services)</b>			
<ul style="list-style-type: none"> <li>• Foot exams and treatment</li> <li>• Routine foot care (non-Medicare covered)</li> </ul>	<p>\$10 copay for each Medicare-covered visit</p> <p>You will be reimbursed up to \$100 every year for routine (non-Medicare covered) foot care (limited to 6 visits per year).</p>	<p>\$10 copay for each Medicare-covered visit</p> <p>You will be reimbursed up to \$100 every year for routine (non-Medicare covered) foot care (limited to 6 visits per year).</p>	

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p><b>Medical equipment/supplies</b></p> <ul style="list-style-type: none"> <li>• Durable medical equipment (e.g., wheelchairs, oxygen)</li> <li>• Blood glucose monitors</li> <li>• Prosthetics (e.g., braces, artificial limbs)</li> <li>• Diabetes self-management training; diabetic services and supplies</li> </ul>	<p>\$0 copay</p> <p>\$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>\$0 copay</p> <p>\$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p><b>Prior authorization from the plan may be required for durable medical equipment and is the responsibility of your provider.</b> See the plan EOC for more information.</p> <p><b>Prior authorization from the plan may be required for prosthetics and diabetes self-management training and is the responsibility of your provider.</b> See the plan EOC for more information.</p>

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p><b>Health and Wellness programs</b></p> <ul style="list-style-type: none"> <li>• NurseHelp 24/7<sup>SM</sup> (telephone and online support)</li> <li>• Basic gym access through SilverSneakers Fitness</li> <li>• LifeReferrals 24/7 – Access to counselors, consultations, information and referrals for a wide range of family and personal issue</li> <li>• Personal Emergency Response System (PERS)</li> </ul>	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>See the plan EOC for more information.</p>

## Prescription Drug Coverage

You pay the following:

<b>Annual Deductible Stage</b>	This stage does not apply because there is no deductible.
<b>Initial Coverage Stage</b>	You pay the following until your total out-of-pocket drug costs reach \$7,050.

What you pay:	Preferred retail cost-sharing (in network)		Standard retail cost-sharing (in network)	
	30-day supply	90-day supply <sup>*NDS</sup>	30-day supply*	90-day supply <sup>NDS</sup>
<b>Tier 1: Generic Drugs</b>	\$5 copay	\$10 copay	\$5 copay	\$15 copay
<b>Tier 2: Preferred Brand Drugs</b>	\$20 copay	\$40 copay	\$20 copay	\$60 copay
<b>Tier 3: Non-Preferred Drugs</b>	\$50 copay	\$100 copay	\$50 copay	\$150 copay
<b>Tier 4: Specialty Tier Drugs</b>	\$20 copay	n/a	\$20 copay	n/a

\* Three-month supply preferred retail cost-sharing also applies to Blue Shield's mail service pharmacy, with the exception of Tier 4.

<sup>NDS</sup> A long-term (up to a 90-day) supply is not available for select drugs. We limit the amount of select drugs that can be filled at one time **for your protection**. The drugs that are not available for a long-term supply are marked with the symbol <sup>NDS</sup> 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 a standard retail cost-sharing pharmacy. You may 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 \$7,050, your share of the cost for a covered drug will be 5% coinsurance or the applicable drug tier copay, whichever is lower.

This stage protects you from any additional costs once you have paid your yearly out-of-pocket drug costs.

### **Mail Service Pharmacy**





CVS Caremark is our network mail service pharmacy where you may obtain a 90-day supply of maintenance drugs at a lower cost. They will be delivered to your home or office with no charge for shipping or delivery. After enrolling in Blue Shield Medicare, sign up at [caremark.com](http://caremark.com) or call (866) 346-7200 [TTY: 711].

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:

<b>CVS/pharmacy</b> † (including CVS pharmacy at Target)	(888) 607-4287 [TTY: 711]	
<b>Safeway and Vons pharmacies</b>	(877) 723-3929 [TTY: 711]	
<b>Albertsons/Sav-on/Osco pharmacies</b>	(877) 932-7948 [TTY: 711]	
<b>Costco</b> (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.**

†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 Medicare 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. Blue Shield Medicare individual and employer group retiree plans have different service areas, benefits and provider networks.

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