blue CALIFORNIA

2027 Summary of Benefits

Blue Shield Group Medicare Advantage (PPO) with Optional Supplemental Dental and Vision Benefits

Group Medicare Advantage for CalPERS

Effective January 1, 2027 - December 31, 2027

blueshieldca.com/calpers

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2027 Summary of Benefits
Blue Shield Group Medicare Advantage (PPO)

Effective January 1, 2027 - December 31, 2027

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 Plan Sponsor or call Blue Shield Group Medicare Advantage Customer Service** at **(888) 802-4599 (TTY: 711)**, 7 a.m. to 8 p.m. PT, seven days a week.

Blue Shield Group Medicare Advantage includes Medicare healthcare (Part C) coverage through one plan.

To join **Blue Shield Group Medicare Advantage**, you must have both Medicare Part A and Part B, meet your Plan Sponsor's eligibility requirements, permanently live in the plan service area, and be a United States citizen or national, or an eligible noncitizen. Your Medicare-eligible dependents may also join Blue Shield Group Medicare Advantage 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 **www.medicare.gov/medicare-and-you** 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, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Look up providers on our website:

- *Provider Directory* – **blueshieldca.com/medicare/providerdirectory**

Summary of Benefits

Effective January 1, 2027 - December 31, 2027

Blue Shield Group
Medicare Advantage (PPO)
CalPERS

Premiums and benefits	In-network you pay	Out-of-network you pay
Monthly plan premium You must continue to pay your Medicare Part B premium in addition to the plan premium.	Your Plan Sponsor is responsible for paying premiums beyond your monthly Medicare Part B premium, Medicare Part A premium (if applicable), and extra amounts (i.e., IRMAA, etc.). If you are responsible for any contribution to the premiums, your Plan Sponsor will tell you the amount you must contribute to the premium.	
Health plan deductible	$0	
Annual maximum out-of-pocket amount This is the most you would pay for the year for covered Medicare Parts A and B services.	$1,500 for services you receive from both in- and out-of-network providers combined.	

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/calpers**.

Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

Blue Shield Group
Medicare Advantage (PPO)
CalPERS

Benefits	In-network you pay	Out-of-network you pay
Inpatient hospital care* Copay per stay. Your plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay.	$0	
Outpatient hospital services* Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery.		
• Outpatient hospital facility	$0	
• Observation services	$0	
• Emergency room visit Waived if you are admitted to the hospital within one day for the same condition.	$50	
Outpatient surgery*		
• Ambulatory surgical center	$0	
• Outpatient hospital facility	$0	
Doctor visits		
• Primary care physician (PCP)	$0	
• Specialists	$0	
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered.	$0	
Emergency care		
• Worldwide coverage† This copay is waived if you are admitted to the hospital within one day for the same condition. No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories.	$50	

* Prior authorization and/or a referral from your provider may be required.
† Services do not apply to the plan's maximum out-of-pocket limit.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/calpers**.

Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

Blue Shield Group
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Benefits	In-network you pay	Out-of-network you pay
Urgently needed services • Worldwide coverage† These copays are waived if you are admitted to the hospital within one day for the same condition. No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories.		
- Network urgent care center within the plan service area	$0	
- Urgent care center outside your plan service area	$0	
- Emergency room within your plan service area	$50	
- Emergency room outside your plan service area	$50	
Diagnostic services, labs, and imaging*		
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$0	
• Lab services	$0	
• Diagnostic tests and procedures	$0	
• Outpatient X-rays	$0	
• Therapeutic radiology services (such as radiation treatment for cancer)	$0	

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Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

Blue Shield Group
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CalPERS

Benefits	In-network you pay	Out-of-network you pay
Hearing services		
• Hearing exam (Medicare-covered)	$10	
• Routine (non-Medicare covered) hearing exam† Limited to **one** in- or out-of-network exam per year.	$0	
• Hearing aids† Up to two hearing aids and two hearing aid fittings and evaluations (applies to both ears combined). Hearing supplies and accessories (including batteries). Hearing aid repairs and modifications. You may obtain these services at the hearing aid provider of your choice. You will be reimbursed up to $1,000 every three years.	$0	
Dental services (Medicare-covered)		
• Performed by your primary care physician (PCP)	$0	
• Performed at a specialist's office	$0	
Vision services†		
• Exam to diagnose and treat diseases and conditions of the eye* Copay for each Medicare-covered visit.	$10	
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens	$0	
• Routine (non-Medicare covered) eye exam, including refraction† Limited to one in- or out-of-network exam every year.	$10	

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† Services do not apply to the plan's maximum out-of-pocket limit.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/calpers**.

Summary of Benefits (cont'd)

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Benefits	In-network you pay	Out-of-network you pay
Mental health services • Inpatient services in a psychiatric hospital (for each Medicare-covered stay for days 1 - 150)* If you go over the 150-day limit, you will be responsible for all costs.	$0	
• Outpatient group therapy visit	$0	
• Outpatient individual therapy visit	$0	
Skilled nursing facility (SNF) care* For each stay in a Medicare-certified skilled nursing facility. If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.	$0 per day for days 1 - 100	
Rehabilitation services*		
• Occupational therapy	$0	
• Physical therapy	$0	
• Speech and language therapy	$0	
Ambulance services* Per trip (one way).	$0	
Transportation services (non-Medicare covered)† 24 one-way trips to plan approved health-related locations every year and each trip may not exceed 70 miles.	$0	
Medicare Part B prescription drugs* Insulin obtained under Part B (when taken with an insulin pump) will not exceed $35 for a one-month supply.	$0	
Annual physical exam† Limited to one in- or out-of-network exam every 12 months.	$0	

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† Services do not apply to the plan's maximum out-of-pocket limit.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/calpers**.

Additional benefits included in your plan

Benefits	In-network you pay	Out-of-network you pay
Opioid treatment program services*	$0	
Podiatry services (foot care)		
• Foot exams and treatment (Medicare covered)	$10	
• Routine (non-Medicare covered) foot care† You will be reimbursed up to $100 per visit (limited to 6 visits per year, combined in- and out-of-network)	$0	
Diabetic supplies and services*		
• ACCU-CHEK® blood glucose monitors	$0	
• Dexcom and Freestyle Libre continuous glucose monitors	$0	
• Blood glucose monitors and continuous glucose monitors from all other manufacturers	20% coinsurance	
• Diabetes self-management training, diabetic services, and supplies (excluding blood glucose monitors and continuous glucose monitors)	$0	
Durable medical equipment (DME) and related supplies (e.g., wheelchairs, oxygen)*	$0	
Prosthetic and orthotic devices and related supplies*		
• Prosthetic and orthotic devices (e.g., braces, artificial limbs)	$0	
• Medical supplies (e.g., splints, casts)	$0	

* Prior authorization and/or a referral from your provider may be required.
† Services do not apply to the plan's maximum out-of-pocket limit.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/calpers**.

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Benefits	In-network you pay	Out-of-network you pay
Health and wellness programs†		
• Basic gym access through SilverSneakers®	$0	Not covered
• NurseHelp 24/7SM (telephone and online support)	$0	Not covered
• LifeReferrals 24/7SM – Access to counselors, consultations, information, and referrals for a wide range of family and personal issues	$0	Not covered
• Over-the-counter (OTC) items **$80** allowance per quarter for covered items. You can place **two orders** per quarter and cannot roll over your unused allowance into the next quarter.	$0	Not covered
• Acupuncture services (non-Medicare covered) Limited to 20 visits combined, per year, for chiropractic services and acupuncture services. The allowed amount for an out-of-network provider is the amount American Specialty Health (ASH) would have allowed for an in-network provider performing the same service.	$15	$15 plus all charges above the allowed amount
• Chiropractic services (non-Medicare covered) Limited to 20 visits combined, per year, for chiropractic services and acupuncture services. The allowed amount for an out-of-network provider is the amount American Specialty Health (ASH) would have allowed for an in-network provider performing the same service.	$15	$15 plus all charges above the allowed amount

* Prior authorization and/or a referral from your provider may be required.
† Services do not apply to the plan's maximum out-of-pocket limit.
For a complete list of services, limitations, or exclusions, please refer to the plan EOC at **blueshieldca.com/calpers**.

Optional supplemental dental/ vision PPO plan

Effective January 1, 2027 - December 31, 2027

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You pay the following

Optional supplemental dental/vision PPO plan	
Monthly plan premium	$40.31

Optional supplemental dental PPO plan	Participating dentists	Non-participating dentists
Calendar year deductible Not applicable to diagnostic and preventive services.	$100	
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.	
Waiting period	No waiting period	
Summary list of services covered (ADA code)†		
Diagnostic and preventive services		
• Oral exam (D0150) Two per plan year.	0% coinsurance	
• X-rays (D0210) One every 3 years	0% coinsurance	
• Teeth cleaning (D1110) Two per plan year.	0% coinsurance	
Restorative services		
• Crown (D2750) One every 5 years.	80% coinsurance	
Periodontics		
• Deep cleaning of four or more teeth per quadrant (D4341) One every 24 months.	80% coinsurance	

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 at **blueshieldca.com/calpers**.

Optional supplemental dental/ vision PPO plan

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Optional supplemental dental PPO plan	Participating dentists	Non-participating dentists
Endodontics • Root canal therapy (D3310) One procedure every year.	80% coinsurance	

Optional supplemental vision PPO plan	Participating providers	Non-participating providers
Routine eye exam	$0 for one exam every year.	
• Eyeglass frames • Eyeglass lenses Including single, lined bifocal, lined trifocal, and lenticular lenses. • Contact lenses In lieu of eyeglass frames and eyeglass lenses.	$0 for either one pair of eyeglass frames and eyeglass lenses (up to a maximum plan benefit coverage amount of $70) **OR** For contact lenses (up to a maximum plan benefit coverage amount of $105 for contact lens services and materials) every 2 years.	

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 at **blueshieldca.com/calpers**.

Out-of-network/non-contracted providers are under no obligation to treat Blue Shield Group Medicare Advantage 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.

Blue Shield of California is a PPO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.

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