2026 Summary of Benefits

Blue Shield Medicare (PPO)

Group Medicare Advantage Prescription Drug Plan for
San Francisco Health Service System

For San Francisco Health Service System Members Enrolled Under Medicare Contract Number: H4937-806

Effective January 1, 2026 - December 31, 2026

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2026 Summary of Benefits
Blue Shield Medicare (PPO)
H4937-806

Effective January 1, 2026 - December 31, 2026

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 Medicare Customer Service** at **(800) 370-8852 (TTY: 711)**, 8 a.m. to 8 p.m. PT, 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 have Medicare Part B, meet your Plan Sponsor's eligibility requirements, permanently live in the plan service area, and be a United States Citizen or lawfully present in the United States. 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 **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, pharmacies, and covered drugs on our website:

- *Provider Directory* – **blueshieldca.com/sfhss-retirees**
- *Pharmacy Directory* – **blueshieldca.com/sfhss-retirees**
- *Formulary* (List of covered drugs) – **blueshieldca.com/sfhss-retirees**

Blue Shield of California's pharmacy network includes limited lower-cost, pharmacies with preferred cost sharing. 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) 370-8852 (TTY: 711)**, 8 a.m. to 8 p.m., PT, or consult the online pharmacy directory at **blueshieldca.com/sfhss-retirees**.

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Blue Shield Medicare (PPO)
San Francisco Health
Service System

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, if applicable.	Your Plan Sponsor is responsible for paying premiums beyond your monthly Medicare Part B premium, and extra amounts (i.e. IRMAA, Part D Late Enrollment Penalties (LEP), 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.	
Annual maximum out-of-pocket amount Does not include Part D prescription drugs. This is the most you would pay for the year for most plan-covered services and all covered Medicare Part B services.	$3,750 for services you receive from both in- and out-of-network providers combined.	
Health plan deductible	$0	

For a complete list of services, limitations, or exclusions, please refer to the EOC at blueshieldca.com/sfhss-retirees.

Summary of Benefits (cont'd)

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Benefits	In-network you pay	Out-of-network you pay
Ambulance services* Per trip (one way)	$50	$50
Dental services (Medicare-covered) Medicare currently pays for dental services in a limited number of circumstances.		
• Performed by your primary care physician (PCP)	$15	$15
• Performed at a specialist's office	$15	$15
Diabetic supplies and services*		
• ACCU-CHEK® and One Touch blood glucose monitors	$0	$0
• Blood glucose monitors from all other manufacturers	$15	$15
• Continuous glucose monitors	$15	$15
• Continuous glucose monitor supplies	$15	$15
• Continuous glucose monitor sensors	$15	$15
• Diabetes self-management training, diabetic services, and supplies (excluding blood glucose monitors and continuous glucose monitors)	$0	$0
Diagnostic services, labs, and imaging*		
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$25	$25
• Lab services	$0	$0
• Diagnostic tests and procedures	$0	$0
• Outpatient X-rays	$0	$0
• Therapeutic radiology services (such as radiation treatment for cancer)	$25	$25

* 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.

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Summary of Benefits (cont'd)

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Benefits	In-network you pay	Out-of-network you pay
Doctor visits		
• Primary care physician (PCP)	$5	$5
• Specialists	$15	$15
Durable medical equipment (DME) and related supplies (e.g., wheelchairs, oxygen)*	$15	$15
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.	$65	$65
Hearing services		
• Hearing exam (Medicare-covered)	$15	$15
Inpatient hospital care* Copay per stay. Our plan covers an unlimited number of days for each covered inpatient hospital stay.	$150	$150
Medicare Part B prescription drugs* Insulin obtained under Part B (when taken with an insulin pump) will not exceed $35 copay for a one-month supply.	$15	$15
Mental health services*		
• Inpatient services in a psychiatric hospital Copay per admission. Our plan covers an unlimited number of days for each covered inpatient hospital stay.	$150	$150
• Outpatient group therapy visit	$5	$5
• Outpatient individual therapy visit	$15	$15

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Benefits	In-network you pay	Out-of-network you pay
Opioid treatment program services*	$0	$0
Outpatient hospital services* Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery.		
• Emergency room visit Waived if you are admitted to the hospital within one day for the same condition.	$65	$65
• Outpatient hospital facility	$100	$100
• Observation services	$100	$100
Outpatient surgery*		
• Ambulatory surgical center	$100	$100
• Outpatient hospital facility	$100	$100
Podiatry services (foot care)		
• Foot exams and treatment (Medicare covered)	$15	$15
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered.	$0	$0
Prosthetic and orthotic devices and related supplies*		
• Prosthetic and orthotic devices (e.g., braces, artificial limbs)	$15	$15
• Medical supplies (e.g., splints, casts)	$15	$15

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Benefits	In-network you pay	Out-of-network you pay
Rehabilitation services*		
• Occupational therapy	$20	$20
• Physical therapy	$20	$20
• Speech and language therapy	$20	$20
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	$0 per day for days 1 - 100
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	$20	$20
- Urgent care center outside your plan service area	$20	$20
- Emergency room within your plan service area	$65	$65
- Emergency room outside your plan service area	$65	$65

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† Services do not apply to the plan's maximum out-of-pocket limit.

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Benefits	In-network you pay	Out-of-network you pay
Vision services		
• Exam to diagnose and treat diseases and conditions of the eye* Copay for each Medicare-covered visit	$15	$15
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens	$0	$0

* Prior authorization and/or a referral from your provider may be required.

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Summary of Benefits (cont'd)

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Additional benefits included in your plan

Benefits	In-network you pay	Out-of-network you pay
Annual physical exam† Limited to one in- or out-of-network exam every 12 months.	$0	$0
Health and wellness programs† • Basic gym access through SilverSneakers® fitness	$0	Not covered
• NurseHelp 24/7℠ (telephone and online support)	$0	Not covered
• LifeReferrals 24/7 – Access to counselors, consultations, information, and referrals for a wide range of family and personal issues	$0	Not covered
• Routine (non-Medicare covered) acupuncture services Limited to 24 in- and out-of-network visits combined, per year.	$15	$15

* Prior authorization and/or a referral from your provider may be required.

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For a complete list of services, limitations, or exclusions, please refer to the EOC at plan blueshieldca.com/sfhss-retirees.

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Benefits	In-network you pay	Out-of-network you pay
• Routine (non-Medicare covered) chiropractic services Limited to 24 in- and out-of-network visits combined, per year.	$15	$15
Hearing services† • Routine (non-Medicare covered) hearing exam† Limited to 1 in- or out-of-network exam per year.	$0	$0
• Hearings aids† You will be reimbursed up to $2,500 every 3 years for: ○ 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.	$0	$0
Podiatry services (foot care) • 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	$0

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Benefits	In-network you pay	Out-of-network you pay
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	$0
Vision services† • Routine (non-Medicare covered) eye exam, including refraction† Limited to one in- or out-of-network exam per year.	$15	$15

* 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 EOC at plan blueshieldca.com/sfhss-retirees.

Part D prescription drug coverage

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You pay the following

Part D prescription drug benefit				
Stage 1: Annual deductible	This stage does not apply because there is no deductible.			
Stage 2: Initial coverage (After you pay our deductible, if applicable)	**Preferred retail cost-sharing (in-network)**		**Standard retail cost-sharing (in-network)^**	
	30-day supply	**Up to a 100-day supply[NDS]**	**30-day supply**	**Up to a 100-day supply[NDS]**
Tier 1: Generic drugs	$5	$10	$5	$15
Tier 2: Preferred brand drugs	$20	$40	$20	$60
Tier 2: Covered insulins**	$20	$40	$20	$60
Tier 3: Non-preferred drugs	$45	$90	$45	$135
Tier 3: Covered insulins**	$35	$90	$35	$105
Tier 4: Specialty tier drugs	$20	$40 (up to a 90-day supply)	$20	$60 (up to a 90-day supply)

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"). A long-term (up to a 90- or 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. 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.

Catastrophic coverage stage

After your yearly out-of-pocket costs for covered Part D drugs (including drugs purchased through your retail pharmacy and through home delivery) reaches $2,100, the plan pays the full cost for your covered Part D drugs at no cost to you. For excluded drugs covered under our enhanced benefit, you pay the cost sharing amounts 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 adult Part D vaccines at no cost to you. Call Customer Service for more information.

Home delivery service

Amazon Pharmacy is our prescription home delivery service provider where you can get up to a 100-day supply of maintenance drugs on Tier 1 through Tier 3 at a lower cost share. Your order will be delivered with $0 shipping. If you have questions about this, please contact **Amazon Pharmacy at (856) 208-4665**, 24 hours a day, seven days a week. TTY users call **711.** See plan EOC for more information.

Tier 4 drugs are limited to a 90-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.

‡ Accepts e-prescribing.

You do not have to be a Costco member to use Costco Pharmacies. Other pharmacies are available in our network.

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.

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

Amazon Pharmacy is independent of Blue Shield of California and is contracted with Blue Shield to provide home delivery of prescription medications to Blue Shield members.

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。

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