Effective January 1, 2023 – December 31, 2023

2023

Summary of Benefits

Blue Shield Medicare (PPO)

Group Medicare Advantage Prescription Drug Plan
for UCBT

blue california

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 Care** at **(800) 776-4466** [TTY: **711**], 8 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/find-a-doctor**
- Pharmacy Directory – **blueshieldca.com/medpharmacy2023**
- Formulary (List of covered drugs) – **blueshieldca.com/medformulary2023**

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.

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You pay the following:

Out-of-pocket costs	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	$3,000 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
Deductible	$400	$400	Combined in- and out-of-network
Inpatient hospital care	25% coinsurance per admission	25% coinsurance 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
Outpatient hospital services • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	$75 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) 25% coinsurance for each visit to an outpatient hospital facility 25% coinsurance for observation services	$75 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) 25% coinsurance for each visit to an outpatient hospital facility 25% coinsurance 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.**
Outpatient surgery	25% coinsurance for each visit to an ambulatory surgical center 25% coinsurance for each visit to an outpatient hospital facility	25% coinsurance for each visit to an ambulatory surgical center 25% coinsurance 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: $25 copay per visit $25 copay per visit	For all covered services: $25 copay per visit $25 copay per visit	

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Preventive care	$0 copay	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care	$75 copay per visit 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.		This copay is waived if you are admitted to a hospital within one day for the same condition. Worldwide coverage.

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Urgently needed services	$25 copay for each visit to a network urgent care center within your plan service area. $25 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. $75 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories. $75 copay for each visit to an emergency room, $25 copay for urgent care center that is outside the United States and its territories.		The copay listed in this section are waived if you are admitted to the hospital within one day for the same condition. 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. Worldwide coverage.

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.)	25% coinsurance for each diagnostic radiology service	25% coinsurance for each diagnostic radiology service	
• Lab services	25% coinsurance	25% coinsurance	
• Diagnostic tests and procedures	25% coinsurance	25% coinsurance	
• Outpatient X-rays	25% coinsurance	25% coinsurance	
• Therapeutic radiology services (such as radiation treatment for cancer)	25% coinsurance for each therapeutic radiology service	25% coinsurance for each therapeutic radiology service	

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Hearing services • Hearing exam (Medicare covered)	$25 copay per visit	$25 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 $2,000 every 3 years for hearing aids	You will be reimbursed up to $2,000 every 3 years for hearing aids	Applies to both ears combined; costs for hearing aids do not apply to the plan's maximum out-of-pocket limit.

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	$25 copay for each Medicare-covered visit	$25 copay for each Medicare-covered visit	
• 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.

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Mental health services • Inpatient psychiatric health care	25% coinsurance per stay for days 1 to 150 100% of the cost for days 151 and over, unless a new benefit period begins.	25% coinsurance per stay 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 for inpatient services in a psychiatric hospital.
• Outpatient group therapy visit	$25 copay per visit	$25 copay per visit	
• Outpatient individual therapy visit	$25 copay per visit	$25 copay per visit	
Skilled nursing facility (SNF) care	25% coinsurance per day for days 1 through 100	25% coinsurance 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.

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Rehabilitation services • Occupational therapy services • Physical therapy and speech and language therapy services	 25% coinsurance per visit 25% coinsurance per visit	 25% coinsurance per visit 25% coinsurance per visit	**A referral from you doctor may be required for rehabilitation services**
Ambulance services	25% coinsurance per trip (one way)	25% coinsurance per trip (one way)	
Medicare Part B drugs	$0 copay	$0 copay	Step therapy may be required. Some Part B drugs may require a prior authorization from your provider
Opioid treatment program services	$0 copay	$0 copay	**Referral and Prior Authorization may be required and is the responsibility of your provider.**
Additional Telehealth Services (Teladoc)	$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.

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Foot care (podiatry services) (Medicare-covered) • Foot exams and treatment	$25 copay for each Medicare-covered visit	$25 copay for each Medicare-covered visit	
Diabetic Supplies & Services • Blood glucose monitors	$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance for Medicare-allowed amount for all other manufacturers	$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance for Medicare-allowed amount for all other manufacturers	**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.
• Diabetes self-management training, diabetic services and supplies	$0 copay	$0 copay	
Durable Medical Equipment (DME) and Related Supplies • Durable medical equipment (e.g., wheelchairs, oxygen)	25% coinsurance	25% coinsurance	**Prior authorization from the plan may be required for durable medical equipment and is the responsibility of your provider.** See the plan EOC for more information.

Benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Prosthetics/Medical Supplies • Prosthetics (e.g., braces, artificial limbs)	25% coinsurance	25% coinsurance	**Prior authorization from the plan may be required for prosthetics/medical supplies and is the responsibility of your provider.** See the plan EOC for more information.
Health and Wellness programs • NurseHelp 24/7℠ (telephone and online support)	$0 copay	$0 copay	
• LifeReferrals 24/7 – Access to counselors, consultations, information and referrals for a wide range of family and personal issue	$0 copay	$0 copay	See the plan EOC for more information.

Important Message About What You Pay for Vaccines: Our plan covers most Part D vaccine at no cost to you. Call Customer Care for more information.

Important Message About What You Pay for Insulin: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Prescription Drug Coverage

You pay the following:

Annual Deductible Stage	This stage has a $100 deductible.
Initial Coverage Stage	You pay the following until you have paid $7,400 out-of-pocket for Part D 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	$10 copay	$20 copay	$20 copay	$60 copay
Tier 2: Preferred Brand Drugs	$20 copay	$40 copay	$47 copay	$141 copay
Tier 3: Non-Preferred Drugs	$35 copay	$70 copay	$100 copay	$300 copay
Tier 4: Specialty Tier Drugs	$35 copay	Not covered	$100 copay	Not covered
Covered Insulins ONLY	$20 copay	$40 copay	$35 copay	$105 copay

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

NDS 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 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 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 $7,400, 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 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.

Choose a network pharmacy that offers preferred cost-sharing

You may save money at a network pharmacy that offers preferred cost sharing. For a full list of pharmacies and to search for a retail pharmacy near you, visit blueshieldca.com/medpharmacy2023.

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.

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