



2024 Summary of Benefits

CCPOA Medical Plan Medicare (PPO)

Group Medicare Advantage Prescription Drug Plan for CCPOA

Effective January 1, 2024 – December 31, 2024

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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 CCPOA Medical Plan Medicare Customer Service at (800) 776-4466 [TTY: 711], 8 a.m. to 8 p.m., seven days a week.**

CCPOA Medical Plan 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 CCPOA Medical Plan 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 CCPOA Medical Plan 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	\$100 copay per admission	\$100 copay per admission	Our plan covers an unlimited number of days for each Medicare-covered inpatient hospital stay.
Outpatient hospital services <ul style="list-style-type: none"> Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery 	<p>\$0 copay for each visit to an emergency room</p> <p>\$0 copay for each visit to an outpatient hospital facility</p> <p>\$0 copay for observation services</p>	<p>\$0 copay for each visit to an emergency room</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>Prior authorization may be required and is the responsibility of your provider.</p>

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
Outpatient surgery	<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>Prior authorization may be required and is the responsibility of your provider.</p>
<p>Doctor visits</p> <ul style="list-style-type: none"> • Physician of choice (POC) • Specialists 	<p>For all covered services:</p> <p>\$10 copay per visit</p> <p>\$10 copay per visit</p>	<p>For all covered services:</p> <p>\$10 copay per visit</p> <p>\$10 copay per visit</p>	
Preventive care	\$0 copay	\$0 copay	<p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<p>Emergency care</p> <ul style="list-style-type: none"> • Worldwide coverage 	<p>\$0 copay per visit</p> <p>No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories</p>		
<p>Urgently needed services</p> <ul style="list-style-type: none"> • Worldwide coverage 	<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 outside your plan service area but within the United States and its territories</p> <p>\$0 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories</p> <p>\$0 copay for each visit to an emergency room, \$0 copay for urgent care center that is outside the United States and its territories</p> <p>No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories</p>		

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p>Diagnostic services, labs, and imaging</p> <ul style="list-style-type: none"> Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.) Lab services Diagnostic tests and procedures Outpatient X-rays Therapeutic radiology services (such as radiation treatment for cancer) 	<p>\$0 copay for each diagnostic radiology service</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay for each therapeutic radiology service</p>	<p>\$0 copay for each diagnostic radiology service</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay for each therapeutic radiology service</p>	<p>Prior authorization may be required for diagnostic services and is the responsibility of your provider.</p>
<p>Hearing services</p> <ul style="list-style-type: none"> Hearing exam (Medicare covered) Routine (non-Medicare covered) hearing exam Hearing aids 	<p>\$15 copay per visit</p> <p>\$0 copay (limited to 1 exam per year)</p> <p>You will be reimbursed up to \$500 every 12 months for hearing aids</p>	<p>\$15 copay per visit</p> <p>\$0 copay (limited to 1 exam per year)</p> <p>You will be reimbursed up to \$500 every 12 months for hearing aids</p>	<p>Applies to both ears combined; cost of hearing aids does not apply to plan's maximum out-of-pocket limit.</p>
<p>Dental services</p> <p>Non-routine dental care</p>	<p>\$10 copay per visit performed at a POC's office</p> <p>\$10 copay per visit performed at a specialist's office</p>	<p>\$10 copay per visit performed at a POC's office</p> <p>\$10 copay per visit performed at a specialist's office</p>	<p>This does not include services in connection with care, treatment, filling, removal, or replacement of teeth.</p>

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p>Vision services</p> <ul style="list-style-type: none"> Exam to diagnose and treat diseases and conditions of the eye One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens Routine (non-Medicare covered) eye exam, including refraction 	<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>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.</p> <p>One exam every 12 months.</p>
<p>Mental health services</p> <ul style="list-style-type: none"> Inpatient mental health care Outpatient group therapy visit Outpatient individual therapy visit 	<p>\$100 copay per stay for days 1 to 150</p> <p>100% of the cost for days 151 and over, unless a new benefit period begins.</p> <p>\$10 copay per visit</p> <p>\$10 copay per visit</p>	<p>\$100 copay per day for days 1 to 150</p> <p>100% of the cost for days 151 and over, unless a new benefit period begins.</p> <p>\$10 copay per visit</p> <p>\$10 copay per visit</p>	<p>Prior authorization may be required and is the responsibility of your provider.</p> <p>There is a 190-day lifetime limit in a Medicare-certified psychiatric hospital.</p>
<p>Skilled nursing facility (SNF) care</p>	<p>\$0 copay per day for days 1 through 100</p>	<p>\$0 copay per day for days 1 through 100</p>	<p>Prior authorization may be required and is the responsibility of your provider.</p> <p>If you go over the 100-day limit, you will be responsible for all cost; no prior hospitalization required with network provider.</p>

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p>Rehabilitation services</p> <ul style="list-style-type: none"> • Occupational therapy services • Physical therapy and speech • Language therapy services 	<p>\$0 copay per visit</p> <p>\$0 copay per visit</p> <p>\$0 copay per visit</p>	<p>\$0 copay per visit</p> <p>\$0 copay per visit</p> <p>\$0 copay per visit</p>	
<p>Ambulance services</p>	<p>\$0 copay per trip (one way)</p>	<p>\$0 copay per trip (one way)</p>	
<p>Transportation Services (non-Medicare covered)</p>	<p>Not covered</p>	<p>Not covered</p>	
<p>Medicare Part B drugs</p>	<p>\$10 copay</p>	<p>\$10 copay</p>	<p>Some Part B drugs may require a prior authorization from your provider.</p> <p>If the drug is listed on the Part B rebatable drug list and obtained at a retail pharmacy or your doctor’s office, you will pay either the applicable tier copay or coinsurance, whichever amount is lesser.</p> <p>Insulin obtained under Part B (when taken with an insulin pump) should not exceed \$35 copay for a one-month supply.</p>

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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) <ul style="list-style-type: none"> Foot exams and treatment 	\$10 copay for each Medicare-covered visit	\$10 copay for each Medicare-covered visit	
Diabetic Supplies & Services <ul style="list-style-type: none"> Blood glucose monitors Diabetes self-management training, diabetic services and supplies 	\$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance for all other manufacturers \$0 copay for all training services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	\$0 copay for ACCU-CHEK® blood glucose monitors and 20% coinsurance for all other manufacturers \$0 copay for all training services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	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.
Durable Medical Equipment (DME) and Related Supplies <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Prosthetics (e.g., braces, artificial limbs) 	\$0 copay	\$0 copay	Prior authorization from your doctor may be required.

Premiums and benefits	In Network You Pay	Out-of-Network You Pay	What you should know
<p>Health and Wellness programs</p> <ul style="list-style-type: none"> • 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 	<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>Acupuncture (non-Medicare covered)</p>	<p>\$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year</p>	<p>\$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year</p>	
<p>Routine chiropractic services (non-Medicare covered)</p>	<p>\$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year</p>	<p>\$15 copay limited to 20 visits combined routine chiropractic and routine acupuncture per year</p>	

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.

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 supply^{NDS}
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 Drugs	\$35 copay	\$70 copay	\$35 copay	\$105 copay
Tier 4: Specialty Tier Drugs	\$50 copay	Not covered	\$50 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 CCPOA Medical Plan 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 Costco members to use Costco pharmacies. Other pharmacies are available in our network.

[‡]Accepts e-prescribing

Out-of-network/non-contracted providers are under no obligation to treat CCPOA Medical Plan 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 CCPOA Medical Plan Medicare members will be paid according to the Medicare Fee Schedules.

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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