2027 Summary of Benefits

CCPOA Medical Plan Medicare (PPO)

Group Medicare Advantage for CCPOA

Effective January 1, 2027 - December 31, 2027

blueshieldca.com/ccpoa

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2027 Summary of Benefits
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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 Plan Sponsor or call CCPOA Medical Plan Medicare Customer Service** at **(800) 542-8364 (TTY: 711)**, 8 a.m. to 8 p.m. PT, seven days a week.

CCPOA Medical Plan Medicare includes Medicare healthcare (Part C) coverage through one plan.

To join **CCPOA Medical Plan Medicare**, 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 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 on our website:
- *Provider Directory* – **blueshieldca.com/medicare/providerdirectory**

Summary of Benefits

CCPOA Medical Plan
Medicare (PPO)

Effective January 1, 2027 - December 31, 2027

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.	

Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

CCPOA Medical Plan Medicare (PPO)

<table>
<tr><th>Benefits</th><th>In-network you pay</th><th>Out-of-network you pay</th></tr>
<tr><td>Inpatient hospital care*
Copay per stay.
Our plan covers an unlimited number of days for each Medicare-covered inpatient stay.</td><td colspan="2">$100</td></tr>
<tr><td>Outpatient hospital services*
Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery.</td><td colspan="2">$0</td></tr>
<tr><td>• Outpatient hospital facility</td><td colspan="2">$0</td></tr>
<tr><td>• Observation services</td><td colspan="2">$0</td></tr>
<tr><td>• Emergency room visit</td><td colspan="2">$0</td></tr>
<tr><td>Outpatient surgery*
• Ambulatory surgical center</td><td colspan="2">$0</td></tr>
<tr><td>• Outpatient hospital facility</td><td colspan="2">$0</td></tr>
<tr><td>Doctor visits
• Primary care physician (PCP)</td><td colspan="2">$10</td></tr>
<tr><td>• Specialists*</td><td colspan="2">$10</td></tr>
<tr><td>Preventive care
Any additional preventive services approved by Medicare during the contract year will be covered.</td><td colspan="2">$0</td></tr>
<tr><td>Emergency care
• Worldwide coverage†
No combined annual limit for covered emergency care and urgently needed services outside the United States and its territories.</td><td colspan="2">$0</td></tr>
</table>

* 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/ccpoa.**

Benefits	In-network you pay	Out-of-network you pay
Urgently needed services • Worldwide coverage† 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	$0	
- Emergency room outside your plan service area	$0	
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	

Benefits	In-network you pay	Out-of-network you pay
Hearing services†		
• Hearing exam (Medicare-covered)	$15	
• 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 $500 every 12 months.	$0	
Dental services (Medicare-covered)		
• Performed by your primary care physician (PCP)	$10	
• Performed at a specialist's office	$10	
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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Summary of Benefits (cont'd)

Effective January 1, 2027 - December 31, 2027

CCPOA Medical Plan Medicare (PPO)

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.	$100	
• Outpatient group therapy visit	$10	
• Outpatient individual therapy visit	$10	
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*		
• Physical therapy	$0	
• Occupational therapy	$0	
• Speech and language therapy	$0	
Ambulance services* Per trip (one way).	$0	
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.	$10	

* 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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CCPOA Medical
Plan Medicare (PPO)

Additional benefits included in your plan

<table>
<tr><th>Benefits</th><th>In-network you pay</th><th>Out-of-network you pay</th></tr>
<tr><td>Annual physical exam†
Limited to one in- or out-of-network exam every 12 months.</td><td colspan="2">$0</td></tr>
<tr><td>Opioid treatment program services*</td><td colspan="2">$0</td></tr>
<tr><td>Podiatry services (foot care)
• Foot exams and treatment (Medicare covered)</td><td colspan="2">$10</td></tr>
<tr><td>Diabetic supplies and services*
• ACCU-CHEK® blood glucose monitors</td><td colspan="2">$0</td></tr>
<tr><td>• Dexcom and Freestyle Libre continuous glucose monitors</td><td colspan="2">$0</td></tr>
<tr><td>• Blood glucose monitors and continuous glucose monitors from all other manufacturers</td><td colspan="2">20% coinsurance</td></tr>
<tr><td>• Diabetes self-management training, diabetic services, and supplies (excluding blood glucose monitors and continuous glucose monitors)</td><td colspan="2">$0</td></tr>
</table>

* 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/ccpoa.**

Benefits	In-network you pay	Out-of-network you pay
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	

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

Benefits	In-network you pay	Out-of-network you pay
Health and wellness programs†		
• Basic gym access through SilverSneakers®	$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
• 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

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.

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。