



Effective: July 01, 2026

Summary of Benefits

Northern California Pipe Trades H&W Trust Fund Retiree PPO Plan

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Summary of Benefits

Northern California Pipe Trades H&W
Trust Fund
Effective July 1, 2026
PPO Plan

Custom PPO Retiree

This Summary of Benefits shows the amount you will pay for Covered Benefits under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).¹ Please read both documents carefully for details.

Medical Provider Network:

Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Benefits when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)²

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Benefits under the Plan. Blue Shield pays for some Covered Benefits before the Calendar Year Deductible is met, as noted in the Benefits chart below.

When using a Participating³ or Non-Participating⁴ Provider

Calendar Year medical Deductible	Individual coverage	\$100
	Family coverage	\$100: individual
		\$200: Family

Calendar Year Out-of-Pocket Maximum⁵

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Benefits.

	When using a Participating Provider ³	When using any combination of Participating ³ or Non-Participating ⁴ Providers
Individual coverage	\$750	\$1,500
Family coverage	\$750: individual \$1,500: Family	\$1,500: individual \$3,000: Family

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	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Preventive Health Services⁷				
California Prenatal Screening Program	\$0		\$0	
Annual routine physical examination office visit	\$10/visit		30%	✓
Colorectal cancer screening	\$0		30%	✓
Osteoporosis screening	10%		30%	✓
Routine laboratory services	\$10/visit		30%	✓
Vision and hearing screening	\$10/visit		30%	✓
Medically necessary immunizations (according to age schedule)	\$10/visit		30%	✓
Well Baby office visits	\$10/visit		30%	✓
Well Baby routine laboratory services and immunizations	\$10/visit		30%	✓
Well Baby vision and hearing screening	\$10/visit		30%	✓
Physician services				
Primary care office visit	\$20/visit		30%	✓
Specialist care office visit	\$20/visit		30%	✓
Physician home visit	10%		30%	✓
Physician or surgeon services in an Outpatient Facility	\$0	✓	30%	✓
Physician or surgeon services in an inpatient facility	\$0	✓	30%	✓
Other professional services				
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, therapists, and podiatrists.</i>	\$20/visit		30%	✓
Acupuncture services <i>Up to 24 visits per Member, per Calendar Year.</i>	\$10/visit	✓	\$10/visit	✓
Chiropractic services <i>Up to 24 visits per Member, per Calendar Year.</i>	\$10/visit	✓	30%	✓
Teladoc Health consultation	\$5/consult		Not covered	
Family planning				
• Counseling, consulting, and education	\$10/visit		Not covered	
• Injectable contraceptive	\$25/injection		Not covered	
• Diaphragm fitting	10%	✓	Not covered	
• Intrauterine device (IUD)	50%	✓	Not covered	
• Insertion and/or removal of intrauterine device	10%	✓	Not covered	
• Implantable contraceptive	10%		Not covered	

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
• Tubal ligation	10%	✓	Not covered	
• Vasectomy	10%	✓	Not covered	
Medical nutrition therapy, not related to diabetes	\$0	✓	30%	✓
Infertility Services				
Physician or surgeon services in an Outpatient Facility	\$0	✓	30%	✓
Artificial Inseminations limited to 6 per lifetime	\$0	✓	30%	✓
Oocyte (egg) retrieval limited to 3 per lifetime				
• Ambulatory Surgery Center	\$35/surgery	✓	30% Subject to a Benefit maximum of \$350/day	✓
• Outpatient Department of a Hospital	\$35/surgery	✓	30% Subject to a Benefit maximum of \$350/day	✓
In vitro fertilization (IVF)	\$0	✓	30%	✓
Embryo transfer				
• Ambulatory Surgery Center	\$35/surgery	✓	30% Subject to a Benefit maximum of \$350/day	✓
• Outpatient Department of a Hospital	\$35/surgery	✓	30% Subject to a Benefit maximum of \$350/day	✓
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	\$0	✓	30%	✓
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	\$0	✓	30%	✓
Abortion and abortion-related services	\$0		\$0	
Emergency Services				
Emergency room services	\$20/visit		\$20/visit	
<i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i>				
Emergency room Physician services	\$100/visit	✓	\$100/visit	✓

Benefits⁶
Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Urgent care center services	\$20/visit		30%	✓
Ambulance services <i>This payment is for emergency or authorized transport.</i>	\$50/transport	✓	\$50/transport	✓
Outpatient Facility services				
Ambulatory Surgery Center	\$35/surgery	✓	30% Subject to a Benefit maximum of \$350/day	✓
Outpatient Department of a Hospital: surgery	\$35/surgery	✓	30% Subject to a Benefit maximum of \$350/day	✓
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	✓	30% Subject to a Benefit maximum of \$350/day	✓
Inpatient facility services				
Hospital services and stay	\$150/admission	✓	30% Subject to a Benefit maximum of \$600/day	✓
Transplant services <i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i>				
• Special transplant facility inpatient services	\$150/admission	✓	Not covered	
• Physician inpatient services	\$0	✓	Not covered	
Bariatric surgery services, designated California counties <i>This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.</i>				
Inpatient facility services	\$150/admission	✓	Not covered	
Outpatient Facility services	\$35/surgery	✓	Not covered	

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Physician services	\$0	✓	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services <i>This payment is for Covered Benefits that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Benefits that are considered Preventive Health Services, see Preventive Health Services.</i>				
Laboratory and pathology services				
<i>Includes diagnostic Papanicolaou (Pap) test.</i>				
• Laboratory center	\$20/visit	✓	30%	✓
• Outpatient Department of a Hospital	\$20/visit	✓	30% Subject to a Benefit maximum of \$350/day	✓
Basic imaging services				
<i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i>				
• Outpatient radiology center	\$20/visit	✓	30%	✓
• Outpatient Department of a Hospital	\$20/visit	✓	30% Subject to a Benefit maximum of \$350/day	✓
Other outpatient non-invasive diagnostic testing				
<i>Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i>				
• Office location	\$20/visit	✓	30%	✓
• Outpatient Department of a Hospital	\$20/visit	✓	30% Subject to a Benefit maximum of \$350/day	✓
Advanced imaging services				
<i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i>				
• Outpatient radiology center	\$0	✓	30%	✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
• Outpatient Department of a Hospital	\$0	✓	30% Subject to a Benefit maximum of \$350/day	✓
Rehabilitative and Habilitative Services				
<i>Includes physical therapy, occupational therapy, and respiratory therapy.</i>				
Office location	\$20/visit	✓	30%	✓
Outpatient Department of a Hospital	\$20/visit	✓	30% Subject to a Benefit maximum of \$350/day	✓
Speech Therapy services				
Office location	\$20/visit	✓	\$20/visit	✓
Outpatient Department of a Hospital	\$20/visit	✓	30% Subject to a Benefit maximum of \$350/day	✓
Durable medical equipment (DME)				
DME	10%	✓	30%	✓
Breast pump	Not covered		Not covered	
Orthotic equipment and devices	10%	✓	30%	✓
Prosthetic equipment and devices	10%	✓	30%	✓
Home health care services				
10%		✓	Not covered	
<i>Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.</i>				
Home infusion and home injectable therapy services				
Home infusion agency services	10%	✓	Not covered	
<i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i>				
Hemophilia home infusion services	10%	✓	Not covered	
<i>Includes blood factor products.</i>				

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Skilled Nursing Facility (SNF) services				
<i>Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.</i>				
Freestanding SNF	10%	✓	10%	✓
Hospital-based SNF	\$150/admission	✓	30% Subject to a Benefit maximum of \$600/day	✓
Hospice program services				
Pre-Hospice consultation	\$0		Not covered	
Routine home care	\$0		Not covered	
24-hour continuous home care	10%	✓	Not covered	
Short-term inpatient care for pain and symptom management	10%	✓	Not covered	
Inpatient respite care	\$0		Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	10%	✓	30%	✓
• Self-management training	\$20/visit		30%	✓
• Medical nutrition therapy	\$20/visit		30%	✓
			30%	
Dialysis services	10%	✓	Subject to a Benefit maximum of \$300/day	✓
PKU product formulas and special food products	10%	✓	10%	✓
Allergy serum billed separately from an office visit	10%	✓	30%	✓

Mental Health Benefits

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Outpatient services				
Office visit, including Physician office visit	\$10/visit		30%	✓
Teladoc Health mental health	\$5/consult		Not covered	

Mental Health Benefits

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Other outpatient services, including intensive outpatient care	\$0		30%	✓
Behavioral health treatment in an office setting	\$0	✓	30%	✓
Behavioral health treatment in home or other non-institutional facility	\$0	✓	30%	✓
Partial Hospitalization Program	\$0	✓	30% Subject to a Benefit maximum of \$350/day	✓
Psychological Testing	\$0	✓	30%	✓
Inpatient services				
Physician inpatient services	\$0	✓	30%	✓
Hospital services	\$150/admission	✓	30% Subject to a Benefit maximum of \$600/day	✓
Residential Care for mental health condition	\$150/admission	✓	30% Subject to a Benefit maximum of \$600/day	✓

Substance Use Disorder Benefits

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Outpatient services				
Office visit, including Physician office visit	\$10/visit		30%	✓
Teladoc mental health	\$5/consult		Not covered	
Other outpatient services, including intensive outpatient care and office-based opioid treatment	\$0		30%	✓
Behavioral health treatment in an office setting	\$0	✓	30%	✓
Behavioral health treatment in home or other non-institutional facility	\$0	✓	30%	✓
Partial Hospitalization Program	\$0	✓	30% of up to \$350/day plus 100% of additional charges	✓
Psychological Testing	\$0	✓	30%	✓

Substance Use Disorder Benefits

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Inpatient services				
Physician inpatient services	\$0	✓	30%	✓
Hospital services	\$0	✓	30% of up to \$600/day plus 100% of additional charges	✓
Residential care for substance use disorder condition	\$0	✓	30% of up to \$600/day plus 100% of additional charges	✓

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

Please review the Evidence of Coverage for more about Benefits that require prior authorization.

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Benefits under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Benefits subject to that Deductible are identified with a check mark (✓) in the Benefits chart above.

Covered Benefits not subject to the Calendar Year medical Deductible. Some Covered Benefits received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical Deductible. These Covered Benefits do not have a check mark (✓) next to them in the "CYD applies" column in the Benefits chart above.

This Plan has a combined Participating Provider and Non-Participating Provider Calendar Year Deductible.

Notes

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Benefits from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.
-

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Benefits from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
 - Charges above the Allowable Amount do not count towards the Deductible or Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
-

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Benefits in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Benefits for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the Calendar Year medical Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan has a Participating Provider OOPM as well as a combined Participating Provider and Non-Participating Provider OOPM. This means that any amounts you pay towards your Participating Provider OOPM also count towards your combined Participating and Non-Participating Provider OOPM.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Benefits are Received:

Each time you receive multiple Covered Benefits, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

Notes

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, a Copayment or Coinsurance may apply for the visit by a Participating Provider. If you receive both Preventive Health Services and other Covered Benefits during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Plans may be modified to ensure compliance with State and Federal requirements.

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Hearing Aid Services Rider

Group Rider
Effective July 1, 2026
PPO

Northern California Pipe Trades (Retiree) Additional Hearing Aid
Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Benefits under this Blue Shield of California hearing aid services Benefit.

Benefits	Your Payment
Up to a \$2,000 maximum per Member in any 24-month period. Services are not subject to the Calendar Year Deductible.	When using any provider
Hearing Aid Services Hearing aid examinations for the appropriate type of hearing aid and/or for fittings, counseling and adjustments Hearing aid device checks Electroacoustic evaluations for hearing aids Hearing aid instrument, monaural or binaural, including ear mold(s) and the initial battery and cords	All charges above \$2,000

Benefit Plans may be modified to ensure compliance with State and Federal Requirements.

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Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for hearing aid services, as described in this supplement. These hearing aid services Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply.

Because Blue Shield does not maintain a network of contracted providers for these services, the Benefits covered under this supplement can be received from any provider and you may submit a claim to Blue Shield for reimbursement.

Benefits

Benefits are available for hearing aid services as shown on the Summary of Benefits. Services are limited to a maximum payment per Member in any period, are not subject to the Calendar Year Deductible.

Blue Shield will reimburse you for Covered Benefits up to the maximum shown on the Summary of Benefits.

Submitting a Claim Form

Blue Shield will pay Members directly for services rendered. Claims for payment must be submitted to Blue Shield within one year after the month services were provided. Blue Shield will notify the Member of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of the itemized bill, along with a completed Blue Shield claim form to:

Blue Shield
P.O. Box 272540
Chico, CA 95927-2540

Claim forms are available online at www.blueshieldca.com or Members may call Blue Shield Customer Service to obtain a form. At a minimum, each claim submission must contain the Subscriber's name, home address, group contract number, Subscriber number, a copy of the provider's bill showing the services rendered, dates of treatment and the patient's name.

Blue Shield provides an Explanation of Benefits to describe how the claim was processed and to inform the Member of any financial responsibility.

Exclusions

Benefits do not include:

- surgically implanted hearing devices;
- spare hearing aids;
- assisted listening devices or amplification devices;
- purchase of batteries or other equipment, except those covered under the terms of the initial hearing aid purchase;
- charges for a hearing aid that exceed specifications prescribed for correction of a hearing loss; or

- replacement parts for hearing aids, repair of hearing aids after the covered warranty period, and replacement of hearing aids more than once in any 24-month period.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Please be sure to retain this document. It is not a contract but is a part of your EOC.



2026 Summary of Benefits

Blue Shield of California Medicare Rx Plan (PDP)

Group Medicare Prescription Drug Plan for Northern
California Pipe Trades Trust Fund

Effective July 1, 2026 - December 31, 2026

2026 Summary of Benefits

Blue Shield of California

Medicare Rx Plan (PDP)

Effective July 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 of California Medicare Rx Plan Customer Service at (888) 239-6469 [TTY: 711], 8 a.m. to 8 p.m. PT., seven days a week.**

To join **Blue Shield of California Medicare Rx Plan (PDP)**, you must be entitled to Medicare Part A and/or Part B, meet your Plan Sponsor's eligibility requirements, and 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 of California Medicare Rx Plan if they meet these requirements.

Our service area includes all 50 states and the District of Columbia.

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**.

Look up pharmacies and covered drugs on our website:

- *Pharmacy Directory* - **blueshieldca.com/medpharmacy2026**
- *Formulary* (List of covered drugs) **blueshieldca.com/medformulary2026**

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 **(888) 239-6469 (TTY: 711)**, 8 a.m. to 8 p.m. PT, seven days a week or consult the online pharmacy directory at **blueshieldca.com/medpharmacy2026**.

Prescription drug coverage Summary of Benefits

Effective July 1, 2026 - December 31, 2026

Blue Shield of California
Medicare Rx Plan (PDP)
Northern California Pipe
Trades Trust Fund

Monthly plan premium, deductible and limits on how much you pay for covered Part D prescription drugs.

You pay the following

Part D prescription drug benefit		
Monthly plan premium	Your Plan Sponsor is responsible for paying premiums beyond your monthly Medicare Part B premium. If you are responsible for any part of the premium, your benefits administrator will tell you the amount you and your Plan Sponsor contribute to the premium.	
Stage 1: Annual deductible stage	This stage does not apply because there is no deductible.	
Stage 2: Initial coverage stage	During this stage, the plan pays its share of your drug costs and you pay your share.	
What you pay:	Preferred retail cost-sharing (in-network)	
	30-day supply	100-day supply ^{NDS}
Tier 1: Generic drugs	\$10	\$20
Tier 2: Preferred brand drugs	\$20	\$40
Tier 2: Covered insulins**	\$20	\$40
Tier 3: Non-preferred drugs	\$35	\$70
Tier 4: Injectable drugs	30% coinsurance (up to a \$150 copay maximum)	30% coinsurance (up to a \$450 copay maximum)
Tier 4: Covered insulins**	The lesser of \$35 copay or 25% coinsurance	The lesser of \$105 copay or 25% coinsurance
Tier 5: Specialty tier drugs	30% coinsurance (up to a \$150 copay maximum)	Not covered

Prescription drug coverage

Summary of Benefits

Effective July 1, 2026 - December 31, 2026

What you pay:	Standard retail cost-sharing (in-network)^	
	30-day supply	100-day supply ^{NDS}
Tier 1: Generic drugs	\$10	\$30
Tier 2: Preferred brand drugs	\$20	\$60
Tier 2: Covered insulins**	\$20	\$60
Tier 3: Non-preferred drugs	\$35	\$105
Tier 4: Injectable drugs	30% coinsurance (up to a \$150 copay maximum)	30% coinsurance (up to a \$450 copay maximum)
Tier 4: Covered insulins**	The lesser of \$35 copay or 25% coinsurance	The lesser of \$105 copay or 25% coinsurance
Tier 5: Specialty tier drugs	30% coinsurance (up to a \$150 copay maximum)	Not covered

What you pay:	Home delivery cost-sharing	
	30-day supply	100-day supply ^{NDS}
Tier 1: Generic drugs	Home delivery is not available for drugs in Tier 1.	\$20 ^{NDS}
Tier 2: Preferred brand drugs	Home delivery is not available for drugs in Tier 2.	\$40 ^{NDS}
Tier 2: Covered insulins**	Home delivery is not available for drugs in Tier 2.	\$40 ^{NDS}
Tier 3: Non-preferred drugs	Home delivery is not available for drugs in Tier 3.	\$70 ^{NDS}
Tier 4: Injectable drugs	Home delivery is not available for drugs in Tier 4.	30% coinsurance (up to a \$450 copay maximum) ^{NDS}
Tier 4: Covered insulins**	Home delivery is not available for drugs in Tier 4.	The lesser of \$105 copay or 25% coinsurance ^{NDS}

Prescription drug coverage

Summary of Benefits

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Blue Shield of California
Medicare Rx Plan (PDP)
Northern California Pipe
Trades Trust Fund

What you pay:	Home delivery cost-sharing	
	30-day supply	100-day supply ^{NDS}
Tier 5: Specialty tier drugs	30% coinsurance (up to a \$150 copay maximum) ^{NDS}	Not covered

******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 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.

[^] If you reside in a long-term care facility, you pay the same as at an in-network standard retail cost-sharing pharmacy for up to a 31-day supply of a covered drug. 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.

Prescription drug coverage (cont'd)

Summary of Benefits

Effective July 1, 2026 - December 31, 2026

Blue Shield of California
Medicare Rx Plan (PDP)
Northern California Pipe
Trades Trust Fund

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. For excluded drugs covered under our enhanced benefit, you pay the cost sharing amounts listed in the tables 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.

Home delivery service

Amazon Pharmacy is our prescription home delivery service provider where you can get a 100-day supply of maintenance drugs on Tier 1 through Tier 4 at a lower cost share. Your order will be delivered with \$0 shipping. See the plan EOC for more information.

Tier 5 drugs are limited to a 30-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.

Blue Shield of California is a PDP 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。

Blue Shield of California is an independent member of the Blue Shield Association



NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: blueshieldca.com/notices. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Service at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en blueshieldca.com/notices. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Servicio al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 blueshieldca.com/notices。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。