blue california

2025 Summary of Benefits

Blue Shield 65 Plus (HMO)

Medicare Advantage Prescription Drug Plan
for San Luis Obispo and Santa Barbara Counties

Effective January 1, 2025 – December 31, 2025

blueshieldca.com/medicare

H0504_24_427I_039_M Accepted 09142024

2025 Summary of Benefits
Blue Shield 65 Plus (HMO)
San Luis Obispo and Santa Barbara Counties

Effective January 1, 2025 – December 31, 2025

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 refer to the ***Evidence of Coverage (EOC)*** at **blueshieldca.com/MAPDdocuments2025** or by calling Customer Service at **(800) 776-4466 (TTY: 711)**, 8 a.m. to 8 p.m., seven days a week. **Note: The *EOC* will be available on our website by October 15, 2024.**

Blue Shield 65 Plus includes Part D coverage, which provides prescription drug coverage, offering you the convenience of having both your medical and prescription drugs covered through one plan.

To join **Blue Shield 65 Plus**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. **Our service area includes San Luis Obispo and Santa Barbara Counties.**

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, seven days a week. TTY users should call **1-877-486-2048.**

Our plan ***Provider Directory*** is located on our website at **blueshieldca.com/medicare/providerdirectory**.

Our plan ***Pharmacy Directory*** is located on our website at **blueshieldca.com/medpharmacy2025**.

To get the most complete and current information about which drugs are covered, you can visit our website at **blueshieldca.com/medformulary2025**.

Summary of Benefits

Effective January 1, 2025 - December 31, 2025

Blue Shield 65 Plus (HMO)
San Luis Obispo and
Santa Barbara Counties

Premiums and benefits	You pay	What you should know
Monthly plan premium	$54	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Health plan deductible	$0	
Annual out-of-pocket maximum amount	$3,600	Does not include Part D prescription drugs. This is the most you would pay for the year for in-network covered Medicare Part A and Part B services.
Inpatient hospital care	$275 copay per day for days 1 - 5 $0 copay per day for days 6 and over	Prior authorization and a referral from your provider may be required. Our plan covers an unlimited number of days for a Medicare-covered inpatient hospital stay in a network hospital.
Outpatient hospital services • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	$150 copay for each visit to an outpatient hospital facility $0 copay for observation services $140 copay for each visit to an emergency room (waived if you are admitted to the hospital within one day for the same condition)	Prior authorization and/or a referral from your provider may be required. Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
Outpatient surgery	$0 copay for each visit to an ambulatory surgical center $150 copay for each visit to an outpatient hospital facility	Prior authorization and a referral from your provider may be required.
Doctor visits • Primary care physician • Specialists	 $0 copay per visit $0 copay per visit	 A referral from your provider may be required for specialist visits.

Premiums and benefits	You pay	What you should know
Preventive care	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care • Worldwide coverage	$140 copay per visit $50,000 combined annual limit for emergency care and urgently needed services outside the United States and its territories	This copay is waived if you are admitted to the hospital within one day for the same condition.
Urgently needed services • Worldwide coverage	$5 copay for each visit to a network urgent care center within the plan service area $5 copay for each visit to an urgent care center outside of the plan service area but within the United States and its territories $140 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories $140 copay for each visit to an emergency room or urgent care center that is outside of the United States and its territories $50,000 combined annual limit for emergency care and urgently needed services outside the United States and its territories	These copays are waived if you are admitted to the hospital within one day for the same condition.

Premiums and benefits	You pay	What you should know
Diagnostic services, labs, and imaging		Prior authorization and/or a referral from your provider may be required.
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$75 copay for each diagnostic radiology service	Covered according to Medicare guidelines.
• Lab services	$0 copay	
• Diagnostic tests and procedures	$0 copay	
• Outpatient x-rays	$0 copay	
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance for each therapeutic radiology service	While you pay 20% coinsurance for therapeutic radiology services, you will never pay more than your $3,600 total out-of-pocket maximum for the year.
Hearing services		A referral from your provider may be required.
• Hearing exam (Medicare-covered)	$0 copay per visit	
• Routine (non-Medicare covered) hearing exam	$0 copay per visit	Routine hearing exams are unlimited if provided by your doctor but are limited to one exam every 12 months with network hearing aid provider.
• Hearing aids	$449 copay for each Silver Technology level hearing aid or $699 copay for each Gold Technology level hearing aid	Coverage is limited to two hearing aids per year.

Premiums and benefits	You pay	What you should know
Dental services (Medicare-covered)	$0 copay per visit if performed by your PCP or a specialist	A referral from your provider may be required.
Dental services (non-Medicare covered)		
• Teeth cleaning	0% - 20% coinsurance, depending on the service	One cleaning every 6 months.
• Dental X-rays	0% - 20% coinsurance, depending on the service	One series of bitewing X-rays every 6 months. One series of full set X-rays every 24 months.
• Fluoride	0% - 20% coinsurance, depending on the service	One every 6 months for fluoride.
• Oral exam	0% - 20% coinsurance, depending on the service	One exam every 6 months. See the "Optional Supplemental Dental PPO plan" section for more information about dental services for an additional plan premium.

Premiums and benefits	You pay	What you should know
Vision services		
• Exam to diagnose and treat diseases and conditions of the eye	$0 copay for each Medicare-covered visit	Prior authorization and a referral from your provider may be required.
• Routine (non-Medicare covered) eye exam and refraction	$0 copay per visit	One visit every 12 months with network provider. Some coverage at non-network providers included; see the plan EOC for details.
• Eyeglass frames	$0 copay	Our plan pays for one pair of eyeglass frames (priced up to a regular retail value of $255) every 24 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.
• Eyeglass lenses or contact lenses	$0 copay	Our plan pays for either one pair of prescription eyeglass lenses (regardless of size or power), progressive lenses OR for contact lenses (priced up to $255 for contact lens service and materials) every 12 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.
Mental health services		Prior authorization and a referral from your provider may be required.
• Inpatient services in a psychiatric hospital	$900 copay per Medicare-covered stay for days 1 - 150	If you go over the 150-day limit, you will be responsible for all costs. See EOC for more information.
• Outpatient individual therapy visit	$30 copay per visit	
• Outpatient group therapy visit	$30 copay per visit	

Premiums and benefits	You pay	What you should know
Skilled nursing facility (SNF) care	$0 copay per day for days 1 - 20 $200 copay per day for days 21 - 100	Prior authorization and a referral from your provider may be required. If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.
Rehabilitation services		Prior authorization and a referral from your provider may be required.
• Occupational therapy	$20 copay per visit	
• Physical therapy	$20 copay per visit	
• Speech and language therapy	$20 copay per visit	
Ambulance services	Medicare-covered ground ambulance services: $280 copay per trip (each way) Medicare-covered air ambulance services: 20% coinsurance per trip (each way)	Prior authorization from your provider may be required.
Transportation services (non-Medicare covered)	Not covered	
Medicare Part B prescription drugs	0% to 20% coinsurance	Prior authorization from your provider may be required. Members may pay 0% to 20% coinsurance for select Medicare Part B drugs which can change each quarter as established by CMS. Insulin obtained under Part B (when taken with an insulin pump) should not exceed a $35 copay for a one-month supply.

Additional benefits included in your plan

Premiums and benefits	You pay	What you should know
Annual physical exam	$0 copay	One every 12 months.
Opioid treatment program services	$0 copay	Prior authorization and a referral from your provider may be required.
Foot care (podiatry services)		A referral from your provider may be required.
• Foot exams and treatment	$0 copay for each Medicare-covered visit	
Diabetic supplies and services		
• Blood glucose monitors	$0 copay for ACCU-CHEK blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers	Prior authorization and/or a referral from your provider may be required.
• Diabetes self-management training, diabetic services, and supplies	$0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	See the plan EOC for more information.
Durable medical equipment (DME) and related supplies		Prior authorization from your provider may be required.
• Durable medical equipment (e.g., wheelchairs, oxygen)	20% coinsurance	See the plan EOC for more information.
Prosthetics and orthotic devices and related supplies		Prior authorization from your provider may be required.
• Prosthetic and orthotic devices (e.g., braces, artificial limbs)	20% coinsurance	
• Medical supplies (e.g., splints, casts)	$0 copay	
Health and wellness programs		
• Basic gym access through SilverSneakers® fitness	$0 copay	
• NurseHelp 24/7℠ (telephone and online support)	$0 copay	
Over-the-counter (OTC) items	You have a $65 allowance per quarter to spend on covered items	You can place two orders per quarter and cannot roll over your unused allowance into the next quarter. Refer to the OTC Items catalog for more information.

Prescription drug coverage

Effective January 1, 2025 - December 31, 2025

Blue Shield 65 Plus (HMO)
San Luis Obispo and
Santa Barbara Counties

You pay the following:

Part D prescription drug benefit				
Stage 1: Annual deductible stage	This stage does not apply because there is no deductible.			
Stage 2: Initial coverage stage	**Preferred retail cost-sharing (in-network)**		**Standard retail cost-sharing (in-network)^**	
	30-day supply	**100-day supply*NDS**	**30-day supply**	**100-day supply*NDS**
Tier 1: Preferred generic drugs	$0 copay	$0 copay	$5 copay	$5 copay
Tier 2: Generic drugs	$10 copay	$15 copay	$15 copay	$45 copay
Tier 3: Preferred brand drugs	$40 copay	$100 copay	$47 copay	$141 copay
Tier 3: Covered insulins**	$35 copay	$100 copay	$35 copay	$105 copay
Tier 4: Non-preferred drugs	$95 copay	$237.50 copay	$100 copay	$300 copay
Tier 4: Covered insulins**	$35 copay	$105 copay	$35 copay	$105 copay
Tier 5: Specialty tier drugs	33% coinsurance	Not covered	33% coinsurance	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").

^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.

For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC.

*100-day supply cost-sharing also applies to Amazon Pharmacy home delivery service.

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.

Part D prescription drug benefit	
Stage 3: Catastrophic coverage stage	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through home delivery service) reach $2,000, the plan pays the full cost for your covered Part D drugs. For excluded drugs covered under our enhanced benefit, you pay the Tier 2: Generic drugs copayments listed in the table on the previous page. (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 network home delivery service where you can get a 100-day supply of maintenance drugs. Your order will be delivered with $0 shipping. See 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.

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

‡Accepts e-prescribing

Optional supplemental dental PPO plan

Effective January 1, 2025 - December 31, 2025

You pay the following:

	Optional supplemental dental PPO plan	
	Participating dentists	**Non-participating dentists**
Monthly optional supplemental dental plan premium	$47.00	
Calendar year deductible (not applicable to diagnostic and preventive services)	You pay $50 before coverage for major services begins.	
Calendar year benefit maximum*	$1,500 for covered preventive and comprehensive dental services combined, no matter if the services are performed by a participating general dentist or a dental specialist. You pay any amount above the $1,500 calendar year benefit maximum. Up to $1,000 of this maximum amount may be used for covered preventive and comprehensive dental services performed by non-participating dentists in a calendar year. You pay any amount above the $1,000 calendar year benefit maximum.	
Waiting period	No waiting period	

*All services must be performed, prescribed, or authorized by your network dentist. If you need to see a specialist, you must get a referral from your primary dentist to receive covered specialist services. If you are enrolled in the optional supplemental dental PPO plan and you need to see a specialist, you may go directly to the specialist. See the plan EOC for more information.

Optional supplemental dental PPO plan (cont'd)

Effective January 1, 2025 - December 31, 2025

	Optional supplemental dental PPO plan	
	Participating dentists	**Non-participating dentists**
Summary list of covered services (ADA code)†		
	You pay	**You pay**
Diagnostic and preventive services		
Oral exam (D0150)	0% coinsurance (One every 6 months)	20% coinsurance (One every 6 months)
X-rays (D0210)	0% coinsurance (One series every 24 months)	20% coinsurance (One series every 24 months)
Teeth cleaning (D1110)	0% coinsurance (One cleaning every 6 months)	20% coinsurance (One cleaning every 6 months)
Restorative services		
Crown (D2750)	50% coinsurance (One every 5 years exact tooth)	50% coinsurance (One every 5 years exact tooth)
Periodontics		
Deep cleaning of four or more teeth per quadrant (D4341)	50% coinsurance (One every 24 months exact tooth)	50% coinsurance (One every 24 months exact tooth)
Endodontics		
Root canal therapy (D3310)	50% coinsurance	50% coinsurance
Implant services		
Implant services (D6010)	50% coinsurance (One per lifetime)	50% coinsurance (One per lifetime)

† ADA codes are procedure codes established by the American Dental Association for efficient processing and reporting of dental claims.

We're here to help

Contact Blue Shield at **(888) 534-4263 (TTY: 711)**

8 a.m. to 8 p.m., seven days a week.

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

Blue Shield of California's pharmacy network includes limited lower-cost, pharmacies with preferred cost sharing in certain counties within California. 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) 776-4466 (TTY: 711)**, 8 a.m. to 8 p.m., seven days a week, or consult the online pharmacy directory at **blueshieldca.com/medpharmacy2025.**

Amazon Pharmacy is independent of Blue Shield of California and is contracted with Blue Shield to provide home delivery service 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。

Enrollment information

blue california

Understanding Medicare enrollment periods

These are the different types of enrollment periods throughout the year when you may enroll or make changes to your Medicare plan.

Annual Election Period (AEP)

Available October 15 through December 7.

During this time, you may join, drop, or switch to the Medicare Advantage Plan that is best for you.

Your change in enrollment will become effective January 1, 2025.

Medicare Advantage Open Enrollment Period

Available January 1 through March 31.

During this period, you can switch to another Medicare Advantage Plan (you can choose a plan that covers prescription drugs or one that does not cover prescription drugs) or disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you have until March 31 to join a separate prescription drug plan to add drug coverage.

Special Election Period (SEP)

Available all year to qualifying individuals.

During this time, you may join, drop, or switch your Medicare Advantage Plan if you move out of the plan's service area, lose your employer or union coverage, enroll in a PACE program, or have a chronic condition that allows you to enroll in a special needs plan designed to specifically treat individuals with your condition.

See the last page of the enrollment form for a list of common qualifying events.

Initial Coverage Election Period (ICEP)

Available all year to qualifying individuals.

This election period begins three months before the month of your 65th birthday or the 25th month of disability. It is associated with your entitlement to Medicare Part A, B, and D. This period begins three months before your first entitlement to Medicare Part A, B, and D and ends on the later of:

1. The last day of the month preceding entitlement to Part A, B, and D; or
2. The last day of your Part B initial enrollment period.

Open Enrollment Period for Institutionalized Individuals (OEPI)

Available all year to qualifying individuals.

If you are institutionalized, you may enroll in or disenroll from a Medicare Advantage Special Needs Plan for institutionalized individuals.

Call Blue Shield of California for questions about eligibility:

(888) 534-4263 (TTY: 711)

8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and
8 a.m. to 8 p.m., Monday through Friday, from April 1 to September 30

blueshieldca.com/medicare

blue shield of california

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or his or her authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

In the boxes below, please put your initials beside the plan type that you want the agent to discuss with you. If you do not want the agent to discuss a plan type with you, please leave the box empty. (Please note that an agent may also discuss Medicare Supplement plans with you.)

☐ **Standalone Medicare Prescription Drug Plans (Part D) (PDP)** – Standalone drug plans that add prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

☐ **Medicare Advantage Plans (Part C) (HMO)** – A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you receive care only from doctors or hospitals in the plan's network (except in emergencies). May include optional supplemental dental HMO and PPO plan information.

☐ **Medicare Advantage Plans (Part C) (HMO D-SNP)** – A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

☐ **Medicare Advantage Plans (PPO)** – A Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. PPO plans must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. May include optional supplemental dental PPO plan information.

☐ **Dental HMO, Dental PPO, or Dental + Vision plans** – Standalone plans that provide dental and vision coverage. Medicare has neither reviewed, nor endorses, these plans.

By signing this form, you agree to a sales meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the plan options is either employed by Blue Shield of California or contracted by a Medicare plan. They do not work directly for the federal government. The individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plan(s) to be discussed.

Beneficiary or authorized representative signature and signature date:

Signature:	**Signature date (MM/DD/YYYY):**

Y0118_24_327A_M Accepted 07072024
H2819_24_327A_M Accepted 07072024

If you are the authorized representative, please sign above and print below:

Representative's name:

Address (optional):

Phone number (optional): *Your relationship to the beneficiary:*

To be completed by the agent prior to meeting with beneficiary.

Agent name (required): Kian Kip Meredith **Agent phone** (required): 805-548-8672

Plan assigned agent ID: 00023003 **Agent NPN:** 2594225

Beneficiary name (required):

Beneficiary contact info (phone or address) (optional):

Initial method of contact (check one):

☐ Sales event ☐ Walk-in ☐ Inbound call ☐ Permission to call card ☐ Other

Plan(s) the agent represented during this event/meeting:

Agent signature (required):	**Date of appointment (required) (MM/DD/YYYY):**
K. Meredith	

By signing this form, Agent agrees and attests that this SOA was documented and agreed to by the beneficiary or their authorized representative prior to discussing plan information. Agent also agrees to provide a copy of this SOA when submitting the beneficiary's enrollment request. All SOA forms must be retained by the agent for no less than 10 years and be available to Blue Shield of California upon request regardless of whether or not the appointment resulted in an enrollment.

IMPORTANT: Beneficiary Medicare number to be completed by agent only after receipt of enrollment application.

Beneficiary Medicare number: _____

* Scope of Appointment documentation is subject to CMS record retention requirements.

Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:

Blue Shield Inspire (HMO)

- ☐ Alameda/San Mateo Counties ($39 per month)
- ☐ Los Angeles/Orange Counties ($0 per month)
- ☐ Merced/San Joaquin/Santa Clara/ Stanislaus Counties ($38 per month)

Blue Shield 65 Plus (HMO)

- ☐ Los Angeles/Orange Counties ($0 per month)
- ☐ Kern County ($0 per month)
- ☐ Riverside County ($0 per month)
- ☐ San Bernardino County ($0 per month)
- ☐ San Diego County ($0 per month)
- ☐ San Luis Obispo/Santa Barbara Counties ($54 per month)

Blue Shield 65 Plus Choice Plan (HMO)

- ☐ Riverside/San Bernardino Counties ($0 per month)

Blue Shield AdvantageOptimum Plan (HMO)

- ☐ Los Angeles/Orange Counties ($0 per month)

Blue Shield AdvantageOptimum Plan 1 (HMO)

- ☐ San Diego County ($0 per month)

Blue Shield 65 Plus Plan 2 (HMO)

- ☐ Los Angeles/Orange Counties ($0 per month)

Please indicate if you would like to enroll in the Optional Supplemental Dental HMO or PPO plan

☐ **Optional Supplemental Dental HMO plan**, ($16 per month)
(not available in all plans/service areas; refer to the plan Summary of Benefits for additional information.)

Name of dentist:

Provider ID#:

If you do not select a dentist, you will be assigned a dentist at the time of enrollment.

☐ **Optional Supplemental Dental PPO plan**, ($47 per month)
(not available in all plans/service areas; refer to the plan Summary of Benefits for additional information.)

No dentist selection necessary for the PPO plan.

Last name:	First name:	Middle initial: (optional)
Birth date (MM/DD/YYYY):	Sex: ☐ Male ☐ Female	
Phone number:	Phone type: ☐ Landline ☐ Mobile	

Permanent residence street address (Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.):

City: State: ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street Address:

City: State: ZIP code:

Your Medicare information:

Medicare Number:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to a Blue Shield Medicare Advantage Plan?

☐ Yes ☐ No

Prescription drug coverage:

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

Medical coverage:

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

Are you enrolled in your state Medicaid (Medi-Cal) program? ☐ Yes ☐ No
If yes, please provide your Medicaid (Medi-Cal) number

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in a Blue Shield Medicare Advantage Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Blue Shield Medicare Advantage Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Blue Shield Medicare Advantage Plan coverage begins, I must get all of my medical and prescription drug benefits from Blue Shield Medicare Advantage Plan. Benefits and services provided by Blue Shield Medicare Advantage Plan and contained in my Blue Shield Medicare Advantage Plan *Evidence of Coverage* (EOC) document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Blue Shield Medicare Advantage Plan will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date (MM/DD/YYYY):**

If you're the authorized representative, sign above and fill out these fields.

Name:

Street address:

City: State: ZIP code:

Phone number:

Relationship to enrollee:

Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

What is your gender?

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? (select one)

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

Select one if you want us to send you information in a language other than English.

- ☐ Spanish

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Customer Service at **(800) 776-4466 (TTY: 711)** if you need information in an accessible format other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your primary care physician (PCP), clinic, or health center:

Physician, clinic, or health center name:

Physician, clinic, or health center ID #:

Physician, clinic, or health center group name:

Current patient? ☐ Yes ☐ No

Email address:	**Mobile phone number:**

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (for example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. If your plan has a premium due, you will receive a monthly bill including the amount and the date of when your next payment is due, or **you can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

To learn more about your payment options, visit us at **blueshieldca.com/medicarewaystopay** or call Customer Service at **(800) 776-4466 (TTY: 711)**.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Blue Shield of California the Part D-IRMAA.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. SHIP counselors, family members, or other third parties) helping the enrollee fill out this form.

Name: _____ Relationship to enrollee:

Signature: _____ ☐ SHIP Counselors ☐ Authorized representative ☐ Other (third party) ☐ Self

Producer/Writing Agent information:

*Indicates required field.

Appointed agency name: _____

(please print appointed agency name)

Appointed agency's Tax ID*: 0002003

(please print appointed agency's tax ID)

Producer/Writing Agent's name*: Alan Kip Meredith

(please print producer/writing agent's name)

Producer/Writing Agent's individual NPN*: 2594225

(please print producer/writing agent's individual NPN)

Producer/Writing Agent's phone number: 805-548-8672

Producer/Writing Agent's email address: Kip@MeredithInsuranceCenter.com

Date application received by producer/writing agent: _____

Producer/Writing Agent's signature: A. Meredith

With my signature, I hereby certify that I have read and understand the CMS Medicare Communications and Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete enrollment kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

Blue Shield of California is an HMO and an HMO D-SNP plan with a Medicare contract and a contract with the California State Medicaid Program. Enrollment in Blue Shield of California depends on contract renewal.

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date MM/DD/YYYY)

_____.

☐ I recently was released from incarceration. I was released on (insert date MM/DD/YYYY)

_____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date MM/DD/YYYY)

_____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date MM/DD/YYYY)

_____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date MM/DD/YYYY)

_____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date MM/DD/YYYY)

_____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date MM/DD/YYYY)

_____.

☐ I recently left a PACE program on (insert date MM/DD/YYYY)

_____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date MM/DD/YYYY)

_____.

☐ I am leaving employer or union coverage on (insert date MM/DD/YYYY)

_____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date MM/DD/YYYY)

_____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in the plan. I was disenrolled from the SNP on (insert date MM/DD/YYYY)

_____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state, or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

- ☐ I missed Initial Election Period (IEP)
- ☐ I missed Annual Enrollment Period (AEP)

☐ I'm in a plan that was recently taken over by the state or territorial regulatory authority because of financial issues. I want to switch to another plan.

☐ I'm in a plan that had a star-rating less than 3 stars for the last 3 years. I want to join a plan with a star rating 3 stars or higher.

☐ I am new to Medicare AND Medicare entitlement was made retroactively so I was notified about getting Medicare after my Part A and/or B effective date.

If none of these statements applies to you or you're not sure, please contact Blue Shield of California at **(888) 534-4263 (TTY: 711)** or Authorized Agent, to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday, from April 1 to September 30.