# Summary of Benefits

Effective January 1, 2026 - December 31, 2026

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

| Premiums and benefits | You pay |
|---|---|
| **Monthly plan premium**<br>You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable. | $65 |
| **Health plan deductible** | $0 |
| **Annual maximum out-of-pocket amount**<br>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. | $4,100 |
| **Inpatient hospital care***<br>For each Medicare-covered stay in a network hospital. | $500 per day for days 1 to 4<br>$0 per day for days 5 and over |
| **Outpatient hospital services***<br>Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery. | |
| • Outpatient hospital facility | $200 |
| • Observation services | $50 |
| • Emergency room visit<br>Waived if you are admitted to the hospital within one day for the same condition. | $150 |
| **Outpatient surgery*** | |
| • Ambulatory surgical center | $50 |
| • Outpatient hospital facility | $200 |

DR. Groups are either:

1. CCPN
2. Physicians Choice Medical Grp

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the EOC at **blueshieldca.com/MAPDdocuments2026**.

# Summary of Benefits (cont'd)

Effective January 1, 2026 - December 31, 2026

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

| Premiums and benefits | You pay |
|---|---|
| **Doctor visits** | |
| • Primary care physician | $0 |
| • Specialists* | $0 |
| **Preventive care**<br>Any additional preventive services approved by Medicare during the contract year will be covered. | $0 |
| **Emergency care** | |
| • Worldwide coverage<br>This copay is waived if you are admitted to the hospital within one day for the same condition. $50,000 combined annual limit for emergency care or urgently needed services outside the United States and its territories. Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit. | $150 |
| **Urgently needed services** | |
| • Worldwide coverage<br>These copays are waived if you are admitted to the hospital within one day for the same condition. $50,000 combined annual limit for covered emergency care or urgently needed services outside the United States and its territories. Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit. | |
| - Network urgent care center within the plan service area | $0 |
| - Urgent care center outside of the plan service area but within the United States and its territories | $0 |
| - Emergency room outside of the plan service area but within the United States and its territories | $150 |
| - Emergency room or urgent care center that is outside of the United States and its territories | $150 |

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the EOC at **blueshieldca.com/MAPDdocuments2026**.

# Summary of Benefits (cont'd)

Effective January 1, 2026 - December 31, 2026

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

| Premiums and benefits | You pay |
|---|---|
| **Diagnostic services, labs, and imaging*** | |
| • Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.) Covered according to Medicare guidelines. | $100 |
| • Lab services | $0 |
| • Diagnostic tests and procedures | $0 |
| • Outpatient X-rays | $0 |
| • Therapeutic radiology services (such as radiation treatment for cancer) | 20% coinsurance |
| **Hearing services** | |
| • Hearing exam (Medicare-covered)* | $0 |
| • Routine (non-Medicare covered) hearing exam One in-person routine hearing exam provided through EPIC Hearing Healthcare. | $0 |
| **Hearing aids** | |
| • Each Silver Technology level hearing aid **or** | $449 |
| • Each Gold Technology level hearing aid **or** | $699 |
| • Each Platinum technology level hearing aid | $999 |

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the EOC at blueshieldca.com/MAPDdocuments2026.

# Summary of Benefits (cont'd)

Effective January 1, 2026 - December 31, 2026

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

| Premiums and benefits | You pay |
|---|---|
| **Dental services (Medicare-covered)*** | |
| • Performed by your PCP | $0 |
| • Performed by a specialist | $0 |
| **Dental services (non-Medicare covered)** | |
| • Teeth cleaning<br>One cleaning every 6 months. | 0% - 20% coinsurance depending on the service |
| • Dental X-rays<br>One series of bitewing X-rays every 6 months.<br>One series of full set X-rays every 24 months. | 0% - 20% coinsurance depending on the service |
| • Fluoride<br>One visit every 6 months for fluoride. | 0% - 20% coinsurance depending on the service |
| • Oral exam<br>The frequency limit depends on the service being provided. | 0% - 20% coinsurance depending on the service |
| **Vision services** | |
| • Exam to diagnose and treat diseases and conditions of the eye* | $0 |
| • Routine (non-Medicare covered) eye exam and refraction<br>One exam every year – network provider limitation. | $0 |
| • Eyeglass frames<br>$220 allowance every 2 years – network provider limitation. | $0 |
| • Eyeglass lenses or contact lenses<br>$220 allowance for contact lenses every year – network provider limitation. | $0 |
| Some coverage at non-network providers included; see the plan EOC for details. | |

* Prior authorization and/or a referral from your provider may be required.

For a complete list of services, limitations, or exclusions, please refer to the EOC at **blueshieldca.com/MAPDdocuments2026**.

# Summary of Benefits (cont'd)

Effective January 1, 2026 - December 31, 2026

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

| Premiums and benefits | 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. | $900 |
| • Outpatient individual therapy visit | $30 |
| • Outpatient group therapy visit | $30 |
| **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. | $10 per day for days 1 - 20<br>$200 per day for days 21 - 100 |
| **Rehabilitation services*** | |
| • Occupational therapy | $20 |
| • Physical therapy | $20 |
| • Speech and language therapy | $20 |
| **Ambulance services*** Per trip (each way). | |
| • Medicare-covered ground ambulance services | $285 |
| • Medicare-covered air ambulance services | 20% coinsurance |
| **Transportation services (non-Medicare covered)** | Not covered |
| **Medicare Part B prescription drugs*** 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) will not exceed a $35 copay for a one-month supply. | 0% to 20% coinsurance |

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the EOC at **blueshieldca.com/MAPDdocuments2026**.

## Additional benefits included in your plan

| Benefits | You pay |
|---|---|
| **Annual physical exam**<br>One every 12 months. | $0 |
| **Opioid treatment program services*** | $20 |
| **Podiatry services (foot care)*** | |
| • Medicare-covered foot exams and treatment* | $0 |
| **Diabetic supplies and services*** | |
| • ACCU-CHEK blood glucose monitors | $0 |
| • Dexcom and Freestyle Libre continuous glucose monitors | $0 |
| • Blood glucose monitors and continuous glucose monitors from all other manufacturers | 20% coinsurance |
| • Diabetes self-management training, diabetic services, and supplies (excluding blood glucose monitors and continuous glucose monitors) | $0 |
| **Durable medical equipment (DME) and related supplies** (e.g., wheelchairs, oxygen)* | 20% coinsurance |
| **Prosthetic and orthotic devices and related supplies*** | |
| • Prosthetic and orthotic devices (e.g., braces, artificial limbs) | 20% coinsurance |
| • Medical supplies (e.g., splints, casts) | $0 |
| **Health and wellness programs** | |
| • Basic gym access through SilverSneakers® fitness | $0 |
| • NurseHelp 24/7SM (telephone and online support) | $0 |

* Prior authorization and/or a referral from your provider may be required.
For a complete list of services, limitations, or exclusions, please refer to the EOC at blueshieldca.com/MAPDdocuments2026.

# Prescription drug coverage

Effective January 1, 2026 - December 31, 2026

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** | $425 (The deductible doesn't apply to Tier 1 and Tier 2, covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.) | | | |
| **Stage 2: Initial coverage** | **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 | $0 | $5 | $5 |
| **Tier 2: Generic drugs** | $5 | $7.50 | $12 | $36 |
| **Tier 3: Preferred brand drugs** | 25% coinsurance | 25% coinsurance | 25% coinsurance | 25% coinsurance |
| **Tier 3: Covered insulins**** | The lesser of $35 or 25% coinsurance | The lesser of $105 or 25% coinsurance | The lesser of $35 or 25% coinsurance | The lesser of $105 or 25% coinsurance |
| **Tier 4: Non-preferred drugs** | 30% coinsurance | 30% coinsurance | 30% coinsurance | 30% coinsurance |
| **Tier 4: Covered insulins**** | The lesser of $35 or 25% coinsurance | The lesser of $105 or 25% coinsurance | The lesser of $35 or 25% coinsurance | The lesser of $105 or 25% coinsurance |
| **Tier 5: Specialty tier drugs** | 28% coinsurance | Not covered | 28% 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.

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.

# Prescription drug coverage (cont'd)

Effective January 1, 2026 - December 31, 2026

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

## Part D prescription drug benefit

| | |
|---|---|
| **Stage 3: Catastrophic coverage** | After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through home delivery service) reach $2,100, the plan pays the full cost for your covered Part D drugs.<br><br>For excluded drugs covered under our enhanced benefit, you pay the Tier 2: Generic drugs copayments listed in the table on the previous page.<br><br>(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.

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

## 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 ($56 per month)
- ☐ Los Angeles/Orange counties ($0 per month)
- ☐ Merced/San Joaquin/Santa Clara/ Stanislaus counties ($58 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 ($65 per month)

**Blue Shield Advantage (HMO) *NEW***

- ☐ San Joaquin County ($20 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** ($49 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.

**Personal information:**

| 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 prescription coverage:

Member number for this coverage:

Group number for this coverage:

**Medical coverage:**

Name of other medical 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.**

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. PT, 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:**

**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. 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., agents, brokers, SHIP counselors, family members, or other third parties) helping the enrollee fill out this form.

Name: Alan Kip Meredith Relationship to enrollee: Agent

Signature: K. Meredith

**Producer/writing agent information:**

*Indicates required field.

Appointed agency name:

Appointed agency's Tax ID*: 0003003

Producer/writing agent's name*: Alan Kip Meredith

Producer/writing agent's **individual NPN***: 2594225

Producer/writing agent's email address: Kip@MeredithInsuranceCenter.com

Producer/writing agent's phone number: 805-548-8672

Producer/writing agent's signature: K. Meredith

Date application received by producer:

*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.*

## Attestation of Eligibility for an Enrollment Period

**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 have new options available to 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 Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP).

☐ 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'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.

☐ 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)

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

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

# 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.

☐ **Dental HMO or Dental PPO plans** – Optional Supplemental Dental plans that provide coverage.

**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):** |
|---|---|

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

Y0118_25_326A_M Accepted 07082025
H2819_25_326A_M Accepted 07082025

*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): Alan Kip Meredith

**Agent phone** (required): 805-548-8612

**Plan assigned agent ID:** 0003003

**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:**

MAPD

| **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.