

MEDICARE ADVANTAGE

Take the first steps on your journey
to a healthier, happier lifestyle.

Blue Shield Inspire (HMO)
Los Angeles County & Orange County
2023 Enrollment Kit

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

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WHAT'S INSIDE

This kit contains important information for you to review before enrolling, including:

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NEED HELP?

Questions? Call us at (888) 534-4263 (TTY: 711)

We're available 8 a.m. to 8 p.m., 7 days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30. Learn more online at blueshieldca.com/medicare

WHY BLUE – BLUE SHIELD OF CALIFORNIA

Blue Shield of California’s mission is to provide affordable access to health care that is worthy of our family and friends – and that includes you.

Here are two important considerations when choosing your Medicare plan:



HOW MUCH DOES MY PLAN COST?

Use the Summary of Benefits – located in this kit – to compare what you will pay with our plan versus other plans.



ARE MY PRESCRIPTIONS COVERED?

If you currently take medication, you can confirm if it is covered on our drug list.



MORE REASONS TO CHOOSE BLUE SHIELD

One of the largest networks in the state.

Our large network means that chances are good you can keep seeing your current doctor and specialists. If you want to switch doctors, you can search blueshieldca.com/find-a-doctor any time.



Here when you need us.

From our California-based Customer Care team to our money-saving network mail service pharmacy, we’re here for you.

BENEFITS AND SERVICES BEYOND ORIGINAL MEDICARE



Dental benefits

Blue Shield of California Medicare Advantage Plans offer coverage for many common dental procedures such as checkups, cleaning, gum care, and more. Simply choose a network dentist who will provide and coordinate all your dental care needs.

Your dental coverage features comprehensive benefits with diagnostic, restorative, and preventive services; low copays; and access to a network of general dentists. Additionally, you are covered for emergency dental needs.

For more comprehensive dental coverage, Blue Shield of California offers Optional Supplemental dental plans. These plans offer a wide range of dental benefits, including many diagnostic and preventive services at no charge to you.

Optional Supplemental Dental plans:

- **Dental HMO** – The Optional Supplemental Dental HMO plan has a low monthly premium and offers defined member out-of-pocket costs.
- **Dental PPO** – The Optional Supplemental Dental PPO plan lets you choose from a more extensive list of participating dentists, but you will pay a higher monthly premium.

Please see the Summary of Benefits included in this kit for more information on the Optional Supplemental Dental plans and the cost for the extra plan premiums. Use our Dental Directory online to locate a network provider anytime at blueshieldca.com/find-a-doctor.



Vision Benefits

Vision benefits for this plan include everything Medicare covers, and more. Please see the Summary of Benefits included in this kit for more information. Use our Vision Directory online to locate a Vision Service Plan (VSP) network provider near you at blueshieldca.com/find-a-doctor.



Hearing aid benefits

We offer a hearing aid benefit from EPIC Hearing Healthcare. This benefit includes an annual routine hearing test and coverage for Silver (mid-level) and Gold (premium level) hearing aids, at a low copay.

Please see the Summary of Benefits included in this kit for more information. You can locate network providers through the online directory at blueshieldca.com/hearingaids.





Over-the-counter (OTC) items benefit

Blue Shield of California offers an over-the-counter (OTC) items benefit which covers OTC health and wellness products, including first-aid supplies, pain relievers, cough and cold medicines, and more. This benefit includes an allowance to use every calendar quarter. You can place two orders per quarter. Unused allowance does not roll over into the next quarter. Some limitations may apply. Refer to the OTC catalog for more information.

Refer to the Summary of Benefits included in this kit for more information about the OTC items benefit allowance or visit blueshieldca.com/medicareOTC.



Personal Emergency Response System (PERS)

To keep you safe and independent, we offer a medical alert monitoring system from LifeStation that provides access to help 24/7 at the push of a button.

LifeStation's state-of-the-art services keep you connected to your caregiver network through easy-to-use technology and robust platforms – including in-home system or mobile device with GPS/WiFi. An experienced care specialist can then contact emergency services, caregivers, or loved ones – quickly getting you the help you need.

LifeStation's services allow you to remain self-sufficient in your own home while keeping you connected to all that life has to offer. For additional benefit details, visit blueshieldca.com/PERS.





SilverSneakers fitness program

SilverSneakers can help you live a healthier, more active life through fitness and social connection. With SilverSneakers, you are covered for a fitness benefit at thousands of participating locations¹ where you can take SilverSneakers instructor-led group classes² plus use exercise equipment and other amenities.

Additionally, SilverSneakers community classes offer options to get active outside of a traditional gym (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers LIVE™ classes, SilverSneakers On-Demand™ videos and our mobile app, SilverSneakers GO™. **Included** with SilverSneakers is a complimentary membership to Stitch³, an online social connection site for adults, where you can join in-person and online activities and events.



Go to blueshieldca.com/SilverSneakers to learn more about the benefit.

Always talk with your doctor before starting an exercise program.

1. Participating locations (“PL”) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.
2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.
3. Stitch is a third-party provider and is not owned or operated by Tivity Health or its affiliates. SilverSneakers members must have internet service to access Stitch service. Internet service charges are responsibility of SilverSneakers member.



Transportation services

Blue Shield of California provides transportation for plan members to plan-approved health related locations. Transportation is provided on an as-needed basis to facilitate non-emergent access to healthcare, e.g., physician office visits. Once a member you can call directly by using the number behind your ID card to arrange transportation. Arrangements for transportation must be made at least 24 hours in advance.

For additional benefit details or information on how to schedule transportation services, please refer to the *Evidence of Coverage* or visit blueshieldca.com/medtransport.





Acupuncture and chiropractic services

Visit any participating acupuncturist or chiropractor in the American Specialty Health Plans of California, Inc. (ASH Plans) network.

Benefits include:

- Initial and subsequent examinations
- Office visits for acupuncture and chiropractic adjustments
- *Adjunctive therapies

*When provided in conjunction with the acupuncture treatment or chiropractic adjustment

- X-rays and laboratory tests (chiropractic only)

Acupuncture and chiropractic are for non-Medicare covered services.

For additional benefit details or information, please refer to the *Evidence of Coverage* online at blueshieldca.com/alternativemedicine. You can locate participating providers through the online directory at blueshieldca.com/find-a-doctor.



Home meal delivery

If you're recovering from a stay in the hospital or a skilled nursing facility, we offer a home meal delivery service. Once a member you are eligible to receive home meal deliveries up to two discharges per year totaling 44 meals and 20 snacks per year. For additional benefit details or information, please refer to the *Evidence of Coverage* at blueshieldca.com/medMAPD2023.



Insulin Savings Program

To help keep your healthcare costs low, Select Insulins are no more than \$30 for a one-month (30-day) supply at our in-network pharmacy with preferred cost sharing and \$35 for a one-month (30-day) supply at our in-network pharmacy with standard cost sharing or our out-of-network pharmacy. This applies during the Initial Coverage and Coverage Gap phases of your benefits. For more information, see the *Evidence of Coverage* and the most recent drug list at blueshieldca.com/medformulary2023.



Note: This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs (such as Extra Help).

PRE ENROLLMENT CHECK LIST

- Pick your doctor**
Pick your primary care doctor also known as a primary care physician (PCP) or confirm that your doctor is in our network. **Search blueshieldca.com/find-a-doctor** or use our provider directory.
- Check our drug list (formulary)**
Make sure that all your medications are covered. Visit **blueshieldca.com/medformulary2023** to review our drug list or call the number listed below for verification of our drug listing.
- Locate your Medicare ID card**
When you apply, make sure to have your Medicare ID card available, or some form of proof that you are entitled to Medicare.

WAYS TO APPLY



In person

Meet with your local authorized Blue Shield of California sales agent.

Visit **blueshieldca.com/medicare** or call **(888) 534-4263 (TTY: 711)** to set up an appointment.



By phone

Call us at **(888) 534-4263 (TTY: 711)**. We're available 8 a.m. to 8 p.m., 7 days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30.



Online

Visit **blueshieldca.com/medicare** to conveniently enroll on your own time.



By mail

Fill out the enclosed application form completely and mail to:

Blue Shield of California
P.O. Box 948
Woodland Hills, CA 91365-9856



By fax

Fax the enclosed application form to: **(877) 251-3660**

WHAT TO EXPECT NEXT

1	Confirmation Within 10 days of enrollment, you will receive a confirmation enrollment letter in the mail. It is also confirmation that Medicare has approved your enrollment.
2	Member ID card You will also receive your member ID card. Keep this with you for all your doctor, hospital, and pharmacy visits.
3	Welcome package You will receive a package containing important plan documents. This includes instructions about how to access the <i>Evidence of Coverage</i> , drug list, and provider directory.
4	Premium assistance If you qualify for help, you will receive a Low-Income Subsidy (LIS) letter. Depending on your level of coverage, receiving LIS means lower prescription drug costs and financial assistance to cover your Part D premium.
NEED HELP?	Have questions? Call (888) 534-4263 (TTY: 711) 8 a.m. to 8 p.m., 7 days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30. Learn more online at blueshieldca.com/medicare .

HEALTHCARE RESOURCES

We want to help you stay healthy, so we offer tools and information that can assist you in making healthy lifestyle choices and healthcare decisions, including:



Senior Wellness Assessment

Regular wellness assessments are a great way to know where you stand and help identify issues that may be important to discuss with your healthcare team.

Once you take it, share your results with your physician so that you can work toward your health and longevity goals. To get started, visit blueshieldca.com/hra.



Medicare Diabetes Prevention Program

Medicare Diabetes Prevention Program services will be covered for eligible Medicare beneficiaries under all Medicare health plans.

The Medicare Diabetes Prevention Program can help you learn how to be more active, eat healthier and lose weight by making small changes to your daily routine. These changes can help you prevent type 2 diabetes.



Teladoc

Teladoc provides physician consultations 24/7 by phone or video. Teladoc physicians can diagnose and treat many non-emergency medical conditions outside of an emergency room, urgent care clinic, or doctor's office. Teladoc physicians can also prescribe certain medications.

To learn more about this benefit, visit blueshieldca.com/Teladoc.



NurseHelp 24/7

Connect with a registered nurse who will listen and offer you immediate, reliable information about treating minor illnesses and injuries, or help you choose the most appropriate treatment. Chat online at blueshieldca.com/nursehelp or call **(877) 304-0504** (TTY: 711), 24 hours a day, seven days a week.



KEY TERMS TO KNOW

Coinsurance

An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment (copay)

A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a prescription drug.

Cost sharing

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. This amount can include copayments, coinsurance, and deductibles.

Deductible

The amount you must pay for prescriptions before Original Medicare, your Blue Shield plan, or any other insurance begins to pay.

Exception

A determination that affects coverage of a prescription drug. A drug list exception is a drug plan's decision to cover a drug that is not on its drug list or to waive a coverage rule. A tiering exception is a drug plan's decision to lower the price for a covered non-preferred drug.

Extra Help

A Medicare program to help people with limited income and resources pay for prescription drug costs, such as premiums, deductibles, and coinsurance.

Formulary (drug list)

A list of Part D prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Out-of-pocket costs

Medical or prescription drug costs that you must pay on your own because they are not covered by Medicare or other insurance.

Premium

The monthly amount you pay for your insurance coverage.

Step therapy

A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

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EPIC Hearing Healthcare is an independent entity that administers services on behalf of Blue Shield of California.

LifeStation is an independent entity that administers services on behalf of Blue Shield of California.

AAA Northern California, Nevada & Utah is independent of Blue Shield of California.

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Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulations. Teladoc does not prescribe DEA-controlled substances, non-therapeutic drugs, and certain other drugs that may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services.

NurseHelp 24/7 is a service mark of Blue Shield of California.

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 A49530-65284043_1022

2023 Summary of Benefits

Blue Shield Inspire (HMO)

Medicare Advantage Prescription Drug Plan

Los Angeles and Orange Counties

2023 Summary of Benefits

Blue Shield Inspire (HMO)

Los Angeles and Orange Counties

Effective January 1, 2023 – December 31, 2023

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/MAPDdocuments2023 or by calling Customer Care 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, 2022.**

Blue Shield Inspire 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 Inspire**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. **Our service area includes Los Angeles and Orange 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 or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Our plan Provider Directory is located on our website at blueshieldca.com/find-a-doctor.

Our plan Pharmacy Directory is located on our website at blueshieldca.com/medpharmacy2023.

To get the most complete and current information about which drugs are covered, you can visit our website at blueshieldca.com/medformulary2023.

Summary of benefits

Blue Shield Inspire (HMO)
Los Angeles and Orange Counties

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
Monthly plan premium	\$0	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Deductible	\$0	
Annual out-of-pocket maximum amount	\$899	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	\$0 copay per admission	Our plan covers an unlimited number of days for a Medicare-covered inpatient hospital stay in a network hospital.
Outpatient hospital services <ul style="list-style-type: none"> 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 \$125 copay for each visit to an emergency room (this copay is waived if you are admitted to the hospital within one day for the same condition)	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	
Doctor visits <ul style="list-style-type: none"> Primary care physician Specialists 	\$0 copay per visit \$0 copay per visit	A referral from your doctor may be required for Specialist visits.
Preventive care	\$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care	\$125 copay per visit No 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. Worldwide coverage.

Summary of benefits (cont'd)

Blue Shield Inspire (HMO)
Los Angeles and Orange Counties

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
Urgently needed services	<p>\$0 copay for each visit to a network urgent care center within the plan service area</p> <p>\$0 copay for each visit to an urgent care center outside of the plan service area but within the United States and its territories</p> <p>\$125 copay for each visit to an emergency room outside of the plan service area but within the United States and its territories</p> <p>\$125 copay for each visit to an emergency room or urgent care center that is outside of the United States and its territories</p> <p>No combined annual limit for emergency care and urgently needed services outside the United States and its territories</p>	<p>This copay is waived if you are admitted to the hospital within one day for the same condition.</p> <p>Worldwide coverage.</p>
<p>Diagnostic services, labs, and imaging</p> <ul style="list-style-type: none"> • Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.) • Lab services • Diagnostic tests and procedures • Outpatient X-rays • Therapeutic radiology services (such as radiation treatment for cancer) 	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>20% coinsurance for each therapeutic radiology service</p>	<p>A referral from your doctor may be required for diagnostic services, labs and imaging services.</p> <p>Covered according to Medicare guidelines.</p> <p>While you pay 20% coinsurance for therapeutic radiology services, you will never pay more than your \$899 total out-of-pocket maximum for the year.</p>

Summary of benefits (cont'd)

Blue Shield Inspire (HMO)
Los Angeles and Orange Counties

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
Hearing services <ul style="list-style-type: none"> Hearing exam (Medicare covered) Routine (non-Medicare covered) hearing exam Hearing aids 	<ul style="list-style-type: none"> \$0 copay \$0 copay \$449 copay for each Silver Technology behind-the-ear hearing aid or \$699 copay for each Gold Technology hearing aid 	<p>A referral from your doctor may be required for hearing services.</p> <p>Routine hearing exams are unlimited if provided by your doctor but are limited to one exam every 12 months with network hearing aid provider. Coverage is limited to 2 hearing aids per year.</p>
Dental services (non-Medicare covered) <ul style="list-style-type: none"> Prophylaxis (cleaning) Dental X-rays Fluoride Oral exam 	<ul style="list-style-type: none"> \$0 copay \$0 - \$10 copay, depending on the service provided \$5 copay \$0 - \$16 copay, depending on the service 	<p>Two visits every 12 months.</p> <p>One series of bitewing X-rays every 6 months.</p> <p>One series of full mouth X-rays every 24 months.</p> <p>Two visits every 6 months for fluoride.</p> <p>Unlimited exams.</p> <p>See optional supplemental dental HMO and PPO plans for more information about dental services for an extra plan premium.</p>

Summary of benefits (cont'd)

Blue Shield Inspire (HMO)
Los Angeles and Orange Counties

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
Vision services <ul style="list-style-type: none"> Exam to diagnose and treat diseases and conditions of the eye Routine (non-Medicare covered) eye exam and refraction Eyeglass frames Eyeglass lenses or contact lenses 	<p>\$0 copay for each Medicare-covered visit</p> <p>\$0 copay per visit</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>A referral from your doctor may be required for an exam to diagnose and treat diseases and conditions of the eye.</p> <p>One visit every 12 months with network provider. Some coverage at non-network providers included; see the plan EOC for details.</p> <p>Our plan pays up to \$200 for eyeglass frames every 24 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p> <p>Our plan pays for either one pair of prescription eyeglass lenses or up to \$200 for contact lenses every 12 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.</p>
Mental health services <ul style="list-style-type: none"> Inpatient mental health care Outpatient group therapy visit Outpatient individual therapy visit 	<p>\$900 copay per Medicare-covered stay for days 1-150</p> <p>\$30 copay per visit</p> <p>\$30 copay per visit</p>	<p>A referral from your doctor may be required for mental health services.</p> <p>If you go over the 150-day limit, you will be responsible for all costs. See EOC for more information.</p>
Skilled nursing facility (SNF) care	<p>\$0 copay per day for days 1 - 20</p> <p>\$75 copay per day for days 21 - 100</p>	<p>A referral from your doctor may be required for skilled nursing facility care.</p> <p>If you go over the 100-day limit, you will be responsible for all costs; no prior hospitalization required with network provider.</p>

Summary of benefits (cont'd)

Blue Shield Inspire (HMO)
Los Angeles and Orange Counties

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
Rehabilitation Services <ul style="list-style-type: none"> Occupational therapy Physical therapy and speech and language therapy 	\$0 copay per visit \$0 copay per visit	A referral from your doctor may be required for rehabilitation services.
Ambulance	Medicare-covered ground ambulance services: \$200 copay per trip (each way) Medicare-covered air ambulance services: 20% coinsurance per trip (each way)	
Transportation	\$0 copay	Limited to 32 one-way trips to plan-approved health-related locations every year.
Medicare Part B Drugs	20% coinsurance	Some Part B drugs may require a prior authorization from your provider.

Summary of benefits (cont'd)

Blue Shield Inspire (HMO)
Los Angeles and Orange Counties

Effective January 1, 2023 - December 31, 2023

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	
Additional telehealth services	\$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions, and can also prescribe certain medication.
Foot care (podiatry services) <ul style="list-style-type: none"> • Foot exams and treatment • Routine (non-Medicare covered) foot care 	\$0 copay for each Medicare-covered visit You will be reimbursed up to \$1,000 every year for routine foot care	A referral from your doctor may be required for foot care services. You may obtain routine foot care at the provider of your choice.
Diabetic Supplies & Services <ul style="list-style-type: none"> • Blood glucose monitors • Diabetes self-management training, diabetic services and supplies 	\$0 copay for ACCU-CHEK blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers \$0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	A referral from your doctor may be required for diabetic supplies & services. Prior authorization from the plan may be required for durable medical equipment, blood glucose monitors and test strips. See the plan EOC for more information.
Durable Medical Equipment (DME) and Related Supplies <ul style="list-style-type: none"> • Durable medical equipment (e.g., wheelchairs, oxygen) 	20% coinsurance	A referral from your doctor may be required for DME and related supplies. Prior authorization from the plan may be required for DME. See the plan EOC for more information.
Prosthetics/Medical Supplies <ul style="list-style-type: none"> • Prosthetics (e.g., braces, artificial limbs) • Medical supplies (e.g., splints, casts) 	20% coinsurance \$0 copay	A referral from your doctor may be required for prosthetics/medical supplies.

Summary of benefits (cont'd)

Blue Shield Inspire (HMO)
Los Angeles and Orange Counties

Effective January 1, 2023 - December 31, 2023

Premiums and benefits	You pay	What you should know
Health and Wellness programs <ul style="list-style-type: none"> • Basic gym access through SilverSneakers Fitness • NurseHelp 24/7SM (telephone and online support) • Personal Emergency Response System (PERS) (24/7 medical alert) 	\$0 copay \$0 copay \$0 copay	
Acupuncture (non-Medicare covered)	\$0 copay per visit	Limited to 12 visits per year.
Over-the-Counter (OTC) Items	You have a \$100 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. Some limitations may apply. Refer to the OTC Items catalog for more
Routine chiropractic services (non-Medicare covered)	\$0 copay per visit	Limited to 12 visits per year.

Important Message About What You Pay for Vaccines: Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information.

Important Message About What You Pay for Insulin: You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Prescription drug coverage

Blue Shield Inspire (HMO)
Los Angeles and Orange Counties

Effective January 1, 2023 - December 31, 2023

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	90-day supply^{*NDS}	100-day supply^{NDS}	30-day supply	90-day supply^{NDS}	100-day supply^{NDS}
Tier 1: Preferred Generic Drugs	\$0 copay	See 100-day supply	\$0 copay	\$5 copay	See 100-day supply	\$5 copay
Tier 2: Generic Drugs	\$3 copay	\$4.50 copay	Not Covered	\$10 copay	\$30 copay	Not Covered
Tier 3: Preferred Brand Drugs	\$35 copay	\$87.50 copay	Not Covered	\$47 copay	\$141 copay	Not Covered
Tier 3: Select Insulins^{**}	\$25 copay	\$75 copay	Not Covered	\$35 copay	\$105 copay	Not Covered
Tier 4: Non-Preferred Drugs	\$95 copay	\$237.50 copay	Not Covered	\$100 copay	\$300 copay	Not Covered
Tier 5: Specialty Tier Drugs	33% coinsurance	Not Covered	Not Covered	33% coinsurance	Not Covered	Not Covered

^{**} Select Insulins are marked with the symbol SI 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.

^{*}90- and 100-day supply cost-sharing also applies to Blue Shield's mail service pharmacy.

NDS A long-term (up to a 90- or 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)

Blue Shield Inspire (HMO)
Los Angeles and Orange Counties

Effective January 1, 2023 - December 31, 2023

Part D prescription drug benefit		
Stage 3: Coverage Gap Stage	Coverage for outpatient prescription drugs after the total yearly drug costs paid by both you and Blue Shield reach \$4,660, until your yearly out-of-pocket drug costs reach \$7,400.	Tier 1: Preferred Generic Drugs, Tier 2: Generic Drugs, and Tier 3: Select Insulins only are covered at the copays described above. For all other tiers, you pay 25% of the price for brand-name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs until your year-to-date out-of-pocket drug costs total \$7,400, which is the end of the coverage gap stage. Whether a drug is considered generic or brand can be determined using the plan formulary. During this stage, your out-of-pocket costs for Tier 3: Select Insulins will be \$25 for a one-month (30-day) supply and \$75 for a long-term (90-day) supply.
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through mail service) reach \$7,400, you pay the greater of: <ul style="list-style-type: none"> • 5% of the cost, or • \$4.15 copay for a generic drug (including brand-name drugs treated as generic) and a \$10.35 copay for all other drugs (This stage protects you from any additional costs once you have paid your yearly out-of-pocket drug costs.)	

Mail Service Pharmacy

CVS Caremark is our network mail service pharmacy where you may obtain a 90- or 100-day supply of maintenance drugs at a lower cost. They will be delivered to your home or office with no charge for shipping or delivery. Sign up at caremark.com or call (866) 346-7200 [TTY: 711].

Tier 5 drugs are limited to a 30-day supply by mail service.

Network pharmacies that offer preferred cost-sharing

You may pay less when you visit one of our network pharmacies that offer preferred cost-sharing. Here's just a few:

- CVS/pharmacy[†] (including CVS pharmacy at Target) (888) 607-4287 [TTY: 711]
- Safeway and Vons pharmacies[†] (877) 723-3929 [TTY: 711]
- Albertsons/Sav-on/Osco pharmacies[†] (877) 932-7948 [TTY: 711]
- Costco[†] (800) 955-2292 [TTY: 711]
- Ralphs[†], Walmart[†] and many more.



You do not have to be a Costco member to use Costco Pharmacies.

[†]Accepts e-prescribing

Optional supplemental dental HMO and PPO plans

Blue Shield Inspire (HMO)
Los Angeles and Orange Counties

Effective January 1, 2023 - December 31, 2023

You pay the following:

	Optional supplemental dental HMO	Optional supplemental dental PPO	
	Participating dentists only	Participating dentists	Non-participating dentists
Monthly optional supplemental dental plan premium	\$12.50	\$42.30	
Calendar year deductible per member (not applicable to diagnostic and preventive services)	\$0	You pay \$50 before major services begin.	
Calendar year benefit maximum per member*	\$1,000 for covered endodontic, periodontic, and oral surgery services when performed by a network dental specialist.	\$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. 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 \$1,500 calendar year benefit maximum.	
Waiting Period	No 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. Plan pays a maximum of \$1,000 per calendar year for covered specialist services. You are responsible for amounts above \$1,000. 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.

Optional supplemental dental HMO and PPO plans (cont'd)

Blue Shield Inspire (HMO)
Los Angeles and Orange Counties

Effective January 1, 2023 - December 31, 2023

	Optional supplemental dental HMO	Optional supplemental dental PPO	
	Participating dentists only	Participating dentists	Non-participating dentists
Summary list of services covered (ADA code)[†]			
	You pay	You pay	You pay
Diagnostic services			
Comprehensive oral exam (D0150)	\$5 copay (2 visits in 12 months)	0% (2 visits in 12 months)	20% (2 visits in 12 months)
Complete X-rays (D0210)	\$0 copay (1 series every 24 months)	0% (1 series every 36 months)	20% (1 series every 36 months)
Preventive care			
Prophylaxis – adult (D1110)	\$5 copay (1 cleaning every 6 months)	0% (1 cleaning every 6 months)	20% (1 cleaning every 6 months)
Restorative services			
One surface composite resin restoration – anterior (D2330)	\$11 copay	20%	30%
Crown (porcelain fused to noble metal) (D2750)	\$275 copay [‡]	50%	50%
Periodontics	For the optional supplemental dental HMO plan, your copayment will be higher if these services are performed by a specialist.		
Periodontal scaling & root planing/four or more teeth per quadrant (D4341)	\$45 copay	50%	50%
Endodontics	For the optional supplemental dental HMO plan, your copayment will be higher if these services are performed by a specialist.		
Anterior root canal therapy (D3310)	\$195 copay	50%	50%
Molar tooth therapy (D3330)	\$335 copay	50%	50%

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

[‡] You pay the copayment plus the cost of precious or semi-precious metals. Porcelain on molar crowns is not a covered benefit.

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, year round.

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

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Blue Shield Inspire and NurseHelp 24/7 are service marks of Blue Shield of California. Blue Shield and the Shield symbol are registered trademarks of the BlueCross BlueShield Association, an association of independent Blue Cross and Blue Shield plans.

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。

IMPORTANT INFORMATION: 2022 Medicare Star Ratings



Blue Shield of California - H0504

For 2022, Blue Shield of California - H0504 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★★
Health Services Rating: ★★★★★
Drug Services Rating: ★★★★★



Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

- ★★★★★ EXCELLENT
- ★★★★☆ ABOVE AVERAGE
- ★★★☆☆ AVERAGE
- ★★☆☆☆ BELOW AVERAGE
- ★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

Questions about this plan?

Contact Blue Shield of California 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time at 800-776-4466 (toll-free) or 711 (TTY). Current members please call 800-776-4466 (toll-free) or 711 (TTY).

enrollment information

Blue Shield of California

Medicare Advantage–Prescription Drug Plans

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Care representative at **(800) 776-4466 [TTY: 711]**, 8 a.m. to 8 p.m., seven days a week.

Understanding the benefits

The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit blueshieldca.com/medmapd2023 or call Customer Care at **(800) 776-4466 [TTY: 711]**, 8 a.m. to 8 p.m., seven days a week, to view a copy of the EOC.

Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Review the formulary to make sure your drugs are covered.

Understanding important rules

If you're enrolling in a plan with a monthly premium: In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.

If you're enrolling in an HMO plan: Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

If you're enrolling in a PPO plan: Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

For HMO D-SNP plans – This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

Out-of-network/non-contracted providers are under no obligation to treat Blue Shield Medicare members, except in emergency situations. Please call our Customer Care number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **(800) 776-4466 [TTY: 711]**.

ATENCIÓN: Si no habla inglés, tiene a su disposición gratis el servicio de asistencia en idiomas. Llame al **(800) 776-4466 (TTY: [711])**.

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **(800) 776-4466 (TTY: 711)**。

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, 2022.

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., 7 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

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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.)

- Stand-alone Medicare Prescription Drug Plans (Part D) (PDP)** – Stand-alone 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** – Stand-alone 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: <input style="width: 100%;" type="text"/>
-------------------	--

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:

<input type="text"/>	<input type="text"/>
----------------------	----------------------

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

Agent name (required):

Agent phone (required):

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Plan assigned agent ID:

Agent NPN:

<input type="text"/>	<input type="text"/>
----------------------	----------------------

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):

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.



2023 Individual Enrollment Request Form

Blue Shield Medicare Advantage Plans: Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Plan 2 (HMO), Blue Shield 65 Plus Choice Plan (HMO), Blue Shield Inspire (HMO), Blue Shield Balance (HMO), Blue Shield Enhanced (HMO), Blue Shield AdvantageOptimum Plan (HMO), Blue Shield AdvantageOptimum Plan 1 (HMO), Blue Shield TotalDual Plan (HMO D-SNP), Blue Shield Inspire (HMO D-SNP)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have either, or both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.

- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Email, Mail, or Fax your completed and signed form to:

Email: WHMembership@blueshieldca.com

Mail: Blue Shield of California
PO Box 948
Woodland Hills, CA 91365-9856

Fax: (877) 251-3660

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call your Authorized Agent or your Blue Shield Representative at **(888) 534-4263**. TTY users can call **711**. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a su Agente Autorizado o a su Representante de Blue Shield al **(888) 534-4263**. Los usuarios del sistema TTY pueden llamar al **711** o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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

Select the plan you want to join:

- Blue Shield 65 Plus (HMO) Los Angeles/Orange Counties (\$0 per month)
 - Blue Shield 65 Plus (HMO) Kern County (\$0 per month)
 - Blue Shield 65 Plus (HMO) Riverside County (\$0 per month)
 - Blue Shield 65 Plus (HMO) San Bernardino County (\$0 per month)
 - Blue Shield 65 Plus (HMO) San Diego County (\$0 per month)
 - Blue Shield 65 Plus (HMO) San Luis Obispo/Santa Barbara Counties (\$39 per month)
 - Blue Shield 65 Plus (HMO) Ventura County (\$0 per month)
 - Blue Shield 65 Plus Plan 2 (HMO) Los Angeles/Orange Counties (\$0 per month)
 - Blue Shield 65 Plus Choice Plan (HMO) San Bernardino/Riverside Counties (\$0 per month)
 - Blue Shield Enhanced (HMO) Los Angeles/Orange Counties (\$39 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 Balance (HMO) Los Angeles County (\$0 per month)
 - Blue Shield Inspire (HMO) Alameda/San Mateo Counties (\$0 per month)
 - Blue Shield Inspire (HMO) Los Angeles/Orange Counties (\$0 per month)
 - Blue Shield Inspire (HMO) Sacramento County (\$53 per month)
 - Blue Shield Inspire (HMO) San Joaquin/Stanislaus/Merced/Fresno/Madera/Santa Clara Counties (\$0 per month)
 - Blue Shield Inspire (HMO D-SNP) Merced/San Joaquin/Stanislaus Counties (\$38.90 per month)
 - Blue Shield TotalDual Plan (HMO D-SNP) Los Angeles/San Diego Counties (\$0 per month)
-

Blue Shield Inspire (HMO) in the counties of Alameda, Fresno, Madera, Merced, Sacramento, San Joaquin, San Mateo, Santa Clara, and Stanislaus; Blue Shield Inspire (HMO D-SNP) in San Joaquin, Merced and Stanislaus; and Blue Shield Balance (HMO) in the county of Los Angeles includes one or more Special Supplemental Benefits for the Chronically Ill (SSBCI). SSBCI are part of special supplemental benefits available in select plans. Not all plan members will qualify. Refer to the Evidence of Coverage for details and eligibility requirements. To be eligible for each SSBCI benefit, you must have at least one of the required qualifying chronic conditions which can vary by plan. Please refer to the "Attestation for Special Supplemental Benefit for the Chronically Ill (SSBCI)" form included in the enrollment kit, online or contact Customer Care **(800) 776-4466 (TTY: 711)** for a copy. For members enrolled in D-SNP plans, please contact D-SNP Customer Care **(800) 452-4413 (TTY: 711)**.

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

- Optional Supplemental Dental HMO plan**, (\$12.50 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**, (\$42.30 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.

First Name:		(optional): Middle Initial:
Last Name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Birth Date (MM/DD/YYYY):	Phone Number:	(optional): <input type="checkbox"/> Landline <input type="checkbox"/> Cell
	Alternate Phone Number (optional):	(optional): <input type="checkbox"/> Landline <input type="checkbox"/> Cell

Optional: I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial or prerecorded voice; standard data rates apply. Yes No

Participation is voluntary and you can opt-out at any time, for more information visit blueshieldca.com/terms.

Go paperless! Please watch for an email with a link which will allow you to register your account, customize your communication preferences, and access your digital ID card and benefit information.

Email address (Optional, but required for electronic communications)

I would like to receive both required and non-required plan materials via email (i.e., enrollment notifications, Annual Notice of Change, benefit promotions, and plan newsletters) in place of mailed printed copies.

Not checking the box above means you will receive printed plan materials via mail. You may choose to go back to printed materials at any time by calling Customer Care at the number on your plan ID card.

Preferred communication channel: Email SMS (Text) Standard Mail Call

It's our goal to communicate with you in your preferred method. However, in some situations, we may need to adjust how we are providing you with information.

Permanent Residence street address:
Street 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:

ID # for this coverage:

Group #:

Medical coverage:

Name of other coverage:

ID # for this coverage:

Group #:

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 my 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 or Part D plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA or Part D 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 that Blue Shield Medicare Advantage Plan. Benefits and services provided by my Blue Shield Medicare Advantage Plan and contained in my Blue Shield Medicare Advantage Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor my 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
------------------	---------------------

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.

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

List your Primary Care Physician (PCP) or clinic:

Physician Name or Clinic Name:

Physician ID #:

Physician Group Name:

Current Patient? Yes No

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

Spanish Chinese

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

Braille Large Print Audio CD

Please contact Blue Shield Customer Care at **(800) 776-4466 (TTY: 711)** if you need information in an accessible format or language other than what is listed above. For members enrolled in D-SNP plans, please contact D-SNP Customer Care **(800) 452-4413 (TTY: 711)**. Our office hours are 8 a.m. to 8 p.m., seven days a week.

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, Cuban. Yes, another Hispanic, Latino, or Spanish origin.
- Yes, Mexican, Mexican American, Chicano/a I choose not to answer.

What's your race? Select all that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> White |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Other Asian | <input type="checkbox"/> I choose not to answer |

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty 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 may 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 Care at **(800) 776-4466 (TTY: 711)**. For members enrolled in D-SNP plans, please contact D-SNP Customer Care **(800) 452-4413 (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.

Producer information: Producer name and ID or NPN is required.

Agency name: Steve Shorr CA Department of Insurance 0596610

(please print appointed agency name)

Agency ID #: 8914

(please print agency tax ID)

Producer (writing agent) name (required): Steve Shorr

(please print writing agent name)

Producer ID #: 8914

(please print agent tax ID number)

Producer (writing agent) NPN or TIN (one required): 2710578

(please print NPN or TIN number)

Producer phone number: +1 310 519 1335

Producer email address: Steve@SteveShorr.com

Date application received by producer: _____

Producer signature: _____

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 and 1860D-1 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).

- I recently was released from incarceration. I was released on (insert date).

- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date).

- I recently obtained lawful presence status in the United States. I got this status on (insert date).

- 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).

- 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).

- 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).

- I recently left a PACE program on (insert date).

- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date).

- I am leaving employer or union coverage on (insert date).

- 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).

- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualifications required to be in the plan. I was disenrolled from the SNP on (insert date).

- 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'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.



2023 Individual Enrollment Request Form

Blue Shield Medicare Advantage Plans: Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Plan 2 (HMO), Blue Shield 65 Plus Choice Plan (HMO), Blue Shield Inspire (HMO), Blue Shield Balance (HMO), Blue Shield Enhanced (HMO), Blue Shield AdvantageOptimum Plan (HMO), Blue Shield AdvantageOptimum Plan 1 (HMO), Blue Shield TotalDual Plan (HMO D-SNP), Blue Shield Inspire (HMO D-SNP)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have either, or both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.

- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Email, Mail, or Fax your completed and signed form to:

Email: WHMembership@blueshieldca.com

Mail: Blue Shield of California
PO Box 948
Woodland Hills, CA 91365-9856

Fax: (877) 251-3660

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call your Authorized Agent or your Blue Shield Representative at **(888) 534-4263**. TTY users can call **711**. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a su Agente Autorizado o a su Representante de Blue Shield al **(888) 534-4263**. Los usuarios del sistema TTY pueden llamar al **711** o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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

Select the plan you want to join:

- Blue Shield 65 Plus (HMO) Los Angeles/Orange Counties (\$0 per month)
 - Blue Shield 65 Plus (HMO) Kern County (\$0 per month)
 - Blue Shield 65 Plus (HMO) Riverside County (\$0 per month)
 - Blue Shield 65 Plus (HMO) San Bernardino County (\$0 per month)
 - Blue Shield 65 Plus (HMO) San Diego County (\$0 per month)
 - Blue Shield 65 Plus (HMO) San Luis Obispo/Santa Barbara Counties (\$39 per month)
 - Blue Shield 65 Plus (HMO) Ventura County (\$0 per month)
 - Blue Shield 65 Plus Plan 2 (HMO) Los Angeles/Orange Counties (\$0 per month)
 - Blue Shield 65 Plus Choice Plan (HMO) San Bernardino/Riverside Counties (\$0 per month)
 - Blue Shield Enhanced (HMO) Los Angeles/Orange Counties (\$39 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 Balance (HMO) Los Angeles County (\$0 per month)
 - Blue Shield Inspire (HMO) Alameda/San Mateo Counties (\$0 per month)
 - Blue Shield Inspire (HMO) Los Angeles/Orange Counties (\$0 per month)
 - Blue Shield Inspire (HMO) Sacramento County (\$53 per month)
 - Blue Shield Inspire (HMO) San Joaquin/Stanislaus/Merced/Fresno/Madera/Santa Clara Counties (\$0 per month)
 - Blue Shield Inspire (HMO D-SNP) Merced/San Joaquin/Stanislaus Counties (\$38.90 per month)
 - Blue Shield TotalDual Plan (HMO D-SNP) Los Angeles/San Diego Counties (\$0 per month)
-

Blue Shield Inspire (HMO) in the counties of Alameda, Fresno, Madera, Merced, Sacramento, San Joaquin, San Mateo, Santa Clara, and Stanislaus; Blue Shield Inspire (HMO D-SNP) in San Joaquin, Merced and Stanislaus; and Blue Shield Balance (HMO) in the county of Los Angeles includes one or more Special Supplemental Benefits for the Chronically Ill (SSBCI). SSBCI are part of special supplemental benefits available in select plans. Not all plan members will qualify. Refer to the Evidence of Coverage for details and eligibility requirements. To be eligible for each SSBCI benefit, you must have at least one of the required qualifying chronic conditions which can vary by plan. Please refer to the "Attestation for Special Supplemental Benefit for the Chronically Ill (SSBCI)" form included in the enrollment kit, online or contact Customer Care **(800) 776-4466 (TTY: 711)** for a copy. For members enrolled in D-SNP plans, please contact D-SNP Customer Care **(800) 452-4413 (TTY: 711)**.

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

- Optional Supplemental Dental HMO plan**, (\$12.50 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**, (\$42.30 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.

First Name:		(optional): Middle Initial:
Last Name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Birth Date (MM/DD/YYYY):	Phone Number:	(optional): <input type="checkbox"/> Landline <input type="checkbox"/> Cell
	Alternate Phone Number (optional):	(optional): <input type="checkbox"/> Landline <input type="checkbox"/> Cell

Optional: I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial or prerecorded voice; standard data rates apply. Yes No

Participation is voluntary and you can opt-out at any time, for more information visit blueshieldca.com/terms.

Go paperless! Please watch for an email with a link which will allow you to register your account, customize your communication preferences, and access your digital ID card and benefit information.

Email address (Optional, but required for electronic communications)

I would like to receive both required and non-required plan materials via email (i.e., enrollment notifications, Annual Notice of Change, benefit promotions, and plan newsletters) in place of mailed printed copies.

Not checking the box above means you will receive printed plan materials via mail. You may choose to go back to printed materials at any time by calling Customer Care at the number on your plan ID card.

Preferred communication channel: Email SMS (Text) Standard Mail Call

It's our goal to communicate with you in your preferred method. However, in some situations, we may need to adjust how we are providing you with information.

Permanent Residence street address:

Street 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:

ID # for this coverage:

Group #:

Medical coverage:

Name of other coverage:

ID # for this coverage:

Group #:

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 my 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 or Part D plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA or Part D 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 that Blue Shield Medicare Advantage Plan. Benefits and services provided by my Blue Shield Medicare Advantage Plan and contained in my Blue Shield Medicare Advantage Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor my 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
------------------	---------------------

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.

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

List your Primary Care Physician (PCP) or clinic:

Physician Name or Clinic Name:

Physician ID #:

Physician Group Name:

Current Patient? Yes No

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

Spanish Chinese

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

Braille Large Print Audio CD

Please contact Blue Shield Customer Care at **(800) 776-4466 (TTY: 711)** if you need information in an accessible format or language other than what is listed above. For members enrolled in D-SNP plans, please contact D-SNP Customer Care **(800) 452-4413 (TTY: 711)**. Our office hours are 8 a.m. to 8 p.m., seven days a week.

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, Cuban. Yes, another Hispanic, Latino, or Spanish origin.

Yes, Mexican, Mexican American, Chicano/a I choose not to answer.

What's your race? Select all that apply.

American Indian or Alaska Native

Guamanian or Chamorro

Other Pacific Islander

Asian Indian

Japanese

Samoan

Black or African American

Korean

Vietnamese

Chinese

Native Hawaiian

White

Filipino

Other Asian

I choose not to answer

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(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.

Producer information: Producer name and ID or NPN is required.

Agency name: _____
(please print appointed agency name)

Agency ID #: _____
(please print agency tax ID)

Producer (writing agent) name (required): _____
(please print writing agent name)

Producer ID #: _____
(please print agent tax ID number)

Producer (writing agent) NPN or TIN (one required): _____
(please print NPN or TIN number)

Producer phone number: _____

Producer email address: _____

Date application received by producer: _____

Producer signature: _____

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.

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- 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).

- I recently was released from incarceration. I was released on (insert date).

- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date).

- I recently obtained lawful presence status in the United States. I got this status on (insert date).

- 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).

- 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).

- 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).

- I recently left a PACE program on (insert date).

- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date).

- I am leaving employer or union coverage on (insert date).

- 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).

- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualifications required to be in the plan. I was disenrolled from the SNP on (insert date).

- 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'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.

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Disclaimers



NONDISCRIMINATION NOTICE

Discrimination is against the law. Blue Shield of California complies with applicable state laws and federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Blue Shield of California provides:

- Aids and services at no cost to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

MULTI-LANGUAGE INSERT

English We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-776-4466. Someone who speaks English can help you. This is a free service.

Spanish Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-776-4466. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Mandarin 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-776-4466。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Cantonese 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-776-4466。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog Mayroon kaming libreng serbisyo sa pagsasalang-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggagamot. Upang makakuha ng tagasalang-wika, tawagan lamang kami sa 1-800-776-4466. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-776-4466. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-776-4466 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-776-4466. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-776-4466 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-776-4466. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول

ليس عليك سوى الاتصال بنا على 1-800-776-4466. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية على مترجم فوري،

Hindi हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब अब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-776-4466 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-776-4466. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-776-4466. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-776-4466. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-776-4466. Ta usługa jest bezpłatna.

Japanese 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-776-4466にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Hmong Peb muaj cov kev pab cuam txhais lus pab dawb los teb tej lus nug uas koj muaj hais txog ntawm peb li kev noj qab haus huv los sis lub phiaj xwm tshuaj kho mob. Kom tau txais tus kws pab cuam txhais lus, tsuas yog hu rau peb ntawm 1-800-776-4466. Muaj cov paub lus Hmoob tuaj yeem pab tau koj. Qhov no yog pab dawb.

Ukrainian Ми надаємо безкоштовні послуги перекладача, щоб відповісти на будь-які запитання щодо нашого плану лікування чи надання лікарських засобів. Щоб скористатися послугами перекладача, просто зателефонуйте нам за номером 1-800-776-4466. Вам може допомогти хтось, хто розмовляє Українською. Це безкоштовна послуга.

Navajo D77 ats'77s baa 1h1y3 47 doodago azee' bee aa 1h1y3 b7na'7d7|kidgo 47 n1 ata' hodoolnih77 h0l=. Ata' halne'4 biniiy4go, koj8' 1-800-776-4466 b44sh bee hod77lnih. Diné k'ehj7 y1[ti'i n7k1 adoolwo]. D77 t'11 j77k'eh bee an1'1wo.

Punjabi ਪੰਜਾਬੀ ਸਾਡੀ ਸਿਹਤ ਨਾਂ ਡਰੱਗ ਪਲਾਨ ਬਾਰੇ ਤੁਹਾਡੇ ਵਿਸ਼ੇ ਵੀ ਸਵਾਲ ਦਾ ਜਵਾਬ ਦੇਣ ਲਈ ਸਾਡੇ ਕੋਲ ਮੁਫਤ ਦੁਆਰੀਏ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਇੱਕ ਦੁਆਰੀਆ ਲੈਣ ਲਈ, ਸਾਨੂੰ 1-800-776-4466 'ਤੇ ਕਾਲ ਕਰੋ। ਪੰਜਾਬੀ ਬੋਲਣ ਵਾਲਾ ਕੋਈ ਵੀ ਵਿਅਕਤੀ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫਤ ਸੇਵਾ ਹੈ।

Khmer យើងមានសេវាអ្នកបកប្រែផ្តល់មាត់ដោយឥតគិតថ្លៃដើម្បីឆ្លើយសំណួរនានាដែលអ្នកអាចមានអំពីសុខភាព ឬគម្រោងឱសថរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្តល់មាត់ម្នាក់សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខ 1-800-776-4466។ អ្នកណាម្នាក់ដែលនិយាយភាសាខ្មែរអាចជួយអ្នកបាន។ សេវានេះមិនគិតថ្លៃនោះទេ។

Mien Yie mbuo mbenc duqv maaih tengx wang-henh nzie faan waac mienh liouh dau waac bun muangx dongh nzunc baav meih maaih waac naaic taux yie mbuo gorngv taux yie nyei heng-wangc jauv-louc a'fai ndie-daan. Liouh lorx zipv longc faan waac nor, douc waac lorx taux yie mbuo yiem njiec naaiv 1-800-776-4466. Maaih mienh gorngv benx Mienh waac haih tengx nzie duqv meih. Naaiv se benx wang-henh nzie weih jauv-louc oc.

Lao ພວກເຮົາມີນາຍພາສາໂດຍບໍ່ເສຍຄ່າເພື່ອຕອບຄໍາຖາມຕ່າງໆທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງພວກເຮົາ. ເພື່ອໃຫ້ໄດ້ຮັບນາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-800-776-4466. ມີຜູ້ຮູ້ພາສາລາວ ສາມາດຊ່ວຍທ່ານ. ນີ້ແມ່ນບໍລິການໂດຍບໍ່ເສຍຄ່າ.

Armenian Մեզ քնն համալսելի Են անվճար թարգմանչապան Ծառայողները՝ մեր առողջապահական կազմակերպության հետ կապված Ձեր ցանկացած հարցին պատասխանելու համար: Թարգմանիչ չունենալու համար պարզապես զանգահարեք մեզ 1-800-776-4466 հեռախոսահամարով: Ձեզ կօգնի հարերեն ինքնուրույն թարգմանիչը: Ծառայողները անվճար է:

Farsi ما خدمات مترجم شفاهی رایگان ارائه می‌دهیم تا به هر گونه سوالی که در مورد طرح سلامت یا داروی ما دارید پاسخ دهیم. برای داشتن مترجم شفاهی، کفایت با ما به شماره 1-800-776-4466 تماس بگیرید. کسی که فارسی صحبت می‌کند می‌تواند به شما کمک کند. این یک خدمت رایگان است.

Thai ภาษาไทย เรามีบริการล่ามฟรีเพื่อตอบคำถามของคุณเกี่ยวกับสุขภาพหรือแผนด้านยาของคุณ หากต้องการบริการล่าม โปรดโทรหาเราที่ 1-800-776-4466 มีคนที่สามารถพูดภาษาไทยได้เพื่อช่วยเหลือคุณ บริการนี้เป็นบริการฟรี